Day 1: Systems approaches to patient safety incident investigations

This course is for:
Staff conducting any PSIRF learning responses requiring systems analysis

Learning objectives:

1. **Apply** systems thinking principles to understand patient safety incidents as the product of complex work system interactions rather than individual failures
2. **Use** the SEIPS (Systems Engineering in Patient Safety) model to examine how work happens in healthcare environments
3. **Identify** system conditions and influences that shape human performance, moving beyond hindsight bias and individual attribution
4. **Distinguish** between "work-as-imagined" and "work-as-done," recognising how everyday adaptations and workarounds reveal system design issues
5. **Plan and scope** a Patient Safety Incident Investigation (PSII) including developing appropriate Terms of Reference and investigation questions
6. **Lead** different types of PSIRF learning responses, selecting appropriate methods and depth of analysis based on learning needs
7. **Develop** sustainable safety recommendations and improvement actions that address system design rather than relying on individual behaviour change or increased monitoring
8. **Evaluate** proposed actions against criteria for sustainability, using the IFACES guidance in the safety action development guide
9. **Communicate** systems-based findings in ways that promote learning and improvement rather than defensiveness

Most patient safety incidents don't happen because individuals make inexplicable errors - they happen because well-intentioned, skilled people are working in systems not designed to support safe care. PSIRF requires us to fundamentally shift from asking "who made a mistake?" to "what conditions made this outcome more likely?" This session develops the systems thinking skills to conduct investigations that reveal meaningful learning and generate actions that actually stick.

Our approach:

Led by faculty with extensive experience conducting systems-based investigations and implementing PSIRF, this workshop balances conceptual understanding with hands-on practice. We use real case studies to demonstrate how systems thinking reveals different insights - and crucially, leads to different, more effective actions.

We recognise that shifting to systems thinking can feel uncomfortable, especially when organisations or families seek individual accountability. We'll explore how to maintain this approach while acknowledging the human need to understand what happened, and how Being Fair principles support both systems learning and appropriate accountability.

This session is practical, realistic, and honest about the challenges of implementing sustainable improvement in complex, resource-constrained healthcare systems. You'll leave with frameworks, tools, realistic strategies, and the confidence to conduct investigations that generate actions that actually make a difference.

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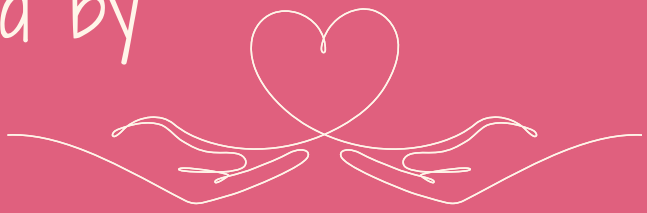
Day 2: Compassionate Engagement & Involvement of those affected by patient safety incidents



This course is for:
Clinical and non-clinical staff who engage with patients and families after incidents

Learning objectives:

1. **Apply** the PSIRF principles of compassionate engagement and involvement throughout the patient safety incident response process
2. **Conduct** meaningful responses that actively involve patients, families and staff in shaping the learning response, including co-designing investigation questions and Terms of Reference
3. **Apply** the Being Fair principles to support staff involved in incidents, recognising that compassionate cultures support both patients/families and the workforce
4. **Balance** the needs of multiple stakeholders - patients, families, and staff - while maintaining psychological safety and a just culture approach
5. **Implement** practical strategies for sustained engagement from immediate response through to sharing learning and closing the loop on improvement actions
6. **Navigate** the processes that sit alongside PSIRF in an incident response, including those involving the medical examiner, HM Coroner and professional conduct.

Led by faculty with extensive experience in patient and family engagement after serious incidents, this workshop balances evidence-based communication skills with the human reality of these interactions. We draw on the lived experience of families, the wisdom of seasoned practitioners, and contemporary research on trauma-informed care.
This is a psychologically safe space to be honest about what you find difficult, practice new approaches, and build the confidence to have conversations that truly matter. You'll leave with practical tools, renewed purpose, and the skills to turn the most painful moments in healthcare into opportunities for healing and learning.

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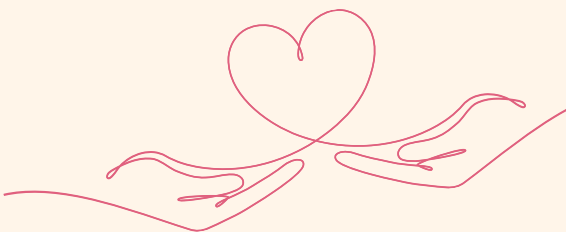

Day 3: Oversight of PSIRF

This course is for:
Executive and non-executive leaders of an organisation who are responsible for the oversight of PSIRF.

Learning outcomes:

1. **Describe** the key principles of the Patient Safety Incident Response Framework (PSIRF) and explain how it differs from the previous Serious Incident Framework
2. **Articulate** the board's specific oversight responsibilities under PSIRF, including approval of the Patient Safety Incident Response Plan and ongoing monitoring requirements
3. **Evaluate** whether their organisation's patient safety incident response approach aligns with the PSIRF standards and national expectations
4. **Apply** the principles of the Being Fair tool to ensure a just culture approach is embedded in the organisation's incident response processes
5. **Identify** key assurance metrics and reporting mechanisms the board should use to oversee effective implementation of PSIRF
6. **Recognise** their role in fostering a learning culture and psychological safety to support effective patient safety incident response

This session goes beyond the technical requirements of PSIRF to build practical confidence in your oversight role. Led by faculty who co-authored the Oversight Roles and Responsibilities Specification with NHS England, the session provides unique insight into the intent and application of these frameworks in practice.

Rather than a policy briefing, this is an interactive session designed to equip you with fluency with the oversight framework. We will enhance discussions using knowledge of the national context and intelligence, from our close working relationships with those in central roles. The leadership of the organisation has a pivotal role in fostering the just and learning culture that underpins effective patient safety incident response, and therefore this session is critical to a successful PSIRF implementation and maturity.

As Chartered professionals and national leaders with extensive experience building healthcare capability in patient safety, we translate complex policy requirements into actionable board-level practice. This session prepares you to provide assured, informed oversight while championing the cultural transformation PSIRF requires.

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