Patient Safety Incident Response Plan

Document control

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Related policies and documents:

04(d)(i)	SAFH - Learning Events Policy
04(d)(ii)	SAFH - Patient Safety Incident Response Policy
12(a)	Duty of Candour Policy
08(a)(i)	Complaints Policy
10 (k)(i)	NHS Freedom to Speak-up Policy
10(k)(ii)	Staff Whistleblowing and Speaking-up Procedure
05	Safeguarding Handbook
TeamNet resource:	PSIRF: Patient Safety Incident Review Framework – national guidance
TeamNet resource:	A Just Culture Guide/decision tree

Definition of Terms used in this plan:

Patient Safety Incident Response Framework (PSIRF)	PSIRF is a national framework introduced by NHS England to guide healthcare organisations in their response to patient safety incidents. It replaces the previous Serious Incident Framework, shifting the focus from blame and process-driven investigations to learning, improvement, and system-based approaches.
Patient Safety Incident Response Policy	The patient Safety incident Response Policy is a formal document developed to outline the organisation's approach to patient safety incident responses to meet the national requirements of PSIRF. The policy defines how we will investigate, learn from, and improve systems following patient safety incidents.
Patient Safety Incident Response Plan	This Patient Safety Incident Response Plan (PSIRP) supports the Patient Safety Incident Response Policy. It is a structured document that details how the organisation will implement the Patient Safety Incident Response Framework (PSIRF) over a defined period, typically 12 to 18 months. It sets priorities for investigating, learning from, and improving responses to patient safety incidents based on risk, impact, and learning potential.
Patient Safety Incident Investigation (PSII)	A PSII is an in-depth review of a single patient safety incident or cluster of events to understand what happened and how. It is used for incidents that have been identified of a potential harm level of moderate and above, are a near miss or low harm incident that has demonstrated significant further potential for learning that may have a wider patient safety impact.
Systems-based approach	A systems-based approach is a method of problem-solving and decision-making that focuses on understanding and improving the interconnected processes, structures, and factors that contribute to an outcome, rather than solely looking at individual actions or errors.
Swarm - safety incident huddle	Swarm is a safety incident huddle that takes place as close as possible in time and place to the incident. It is a form of post-incident huddle that encourages frankness by reassuring participants that they are in a blame-free environment. The meeting gives you a chance to review the facts, discuss what happened, as well as how and why it happened.

After Action Review (AAR)	A method of evaluation that is used when outcomes of an activity or event, have been particularly successful or unsuccessful. It aims to capture learning from these tasks to avoid failure and promote success for the future.
Just Culture	A Just Culture is a workplace environment that promotes accountability, fairness, and learning by balancing individual responsibility with system-based improvements in response to errors and patient safety incidents, where: • Staff feel safe to report errors or near misses without fear of unfair punishment or blame. • The focus is on understanding why errors happened rather than assigning blame. • There is a distinction between honest mistakes, systemic issues, and reckless behaviour—with appropriate responses for each. • Organisations use patient safety incidents as opportunities for learning and improvement, rather than punitive action. • Leaders encourage open communication, psychological safety, and a collaborative approach to solving safety concerns. A Just Culture ultimately helps create safer, higher-quality healthcare environments by fostering trust, transparency, and continuous improvement.

1. Introduction

This Patient Safety Incident Response Plan (PSIRP) sets out how Southport and Formby Health (SAFH) intends to respond to patient safety incidents over the next 18 months. It is an evolving plan that can be adapted as needed and will be flexible when considering the specific circumstances in which patient safety incidents occur and the needs of those affected.

The Patient Safety Incident Response Framework (PSIRF) is designed to foster learning and systemic improvement - moving away from the former national Serious Incident Framework, which was more process driven. Instead, PSIRF promotes a culture of continuous improvement in patient safety.

Our investigations will be conducted collaboratively by trained members of staff, providing active involvement of patients, their carers, families, and colleagues. The framework is a responsive system, tailoring investigations to the nature of each incident, while also providing a safe and supportive environment for those involved. There is a strong focus on system improvement.

This improvement plan supports our PSIRF Policy. It is based on analysis of our current systems, incidents, and quality improvement initiatives over time. It prioritises areas with the greatest potential for positive impact over the next 18 months. Development of this plan has provided insights and has deepened our understanding of patient safety within the organisation, helping us to develop a strategic and effective approach going forward.

The plan should be read in on conjunction with Southport and Formby Health's Patient Safety Incident Response Framework (PSIRF) Policy.

2. Scope

There are various ways to respond to an incident. Our PSIRF plan will deliver investigations and responses aimed exclusively at systems-based learning and improvement. This includes both individual incidents and broader areas for enhancement, aligned with national requirements and our local priorities.

The purpose of PSIRF is not to assign blame, determine liability, assess preventability, or for example, to establish a cause of death. Other response processes exist to address these matters. For example, the complaints process, HR procedures, legal claims, and inquests which fall outside the scope of PSIRF.

3. Purpose

This plan aligns with our Patient Safety Incident Response Policy, detailing our approach to developing and maintaining effective systems for responding to patient safety incidents. It is designed to support learning, to drive improvements, and to enhance patient safety. The plan provides clear guidance on how we will prioritise, plan, prepare, and monitor patient safety incidents and improvements.

PSIRF promotes a coordinated, data-driven approach to patient safety incidents, embedding incident response within a broader system of continuous improvement. It represents a

significant cultural shift toward systematic patient safety management rather than reactive processes, based on the main aims of PSIRF, which are:

- Compassionate engagement and involvement of those affected by patient safety incidents.
- Application of a range of system-based approaches to learning from patient safety incidents.
- Considered and proportionate responses to patient safety incidents and safety issues.
- Supportive oversight focused on strengthening response systems, functioning and improvement.

4. Our services

Southport & Formby Health was established as an independent provider of NHS services in 2017. Our main purpose is to provide community and primary care services. We host staff on behalf of Southport and Formby Primary Care Network (PCN), and we deliver the following services on behalf of GP practices to patients registered with a GP in Southport and Formby:

- **Enhanced Access**
  The enhanced assess service provides a full range of general practice appointments available in the evening and on weekends. In 2024, the service offered 25,128 appointments; 68% of these were clinical consultations and assessment, and 32% related to clinical interventions and investigations.
- **Enhanced Health in Care Homes**
  The enhanced health in care homes team provides proactive care planning for patients in care homes.
- **Pharmacy Team**
  The pharmacy team works on behalf of practices to improve medicines optimisation and interventions to reduce polypharmacy.
- **Early Cancer Diagnosis & Screening**
  Review of cancer referrals and good practice in collaboration with partners for patients with a cancer diagnosis. We work with practices to improve early diagnosis, and to improve screening uptake for breast, bowel and cervical cancer.
- **Digital Transformation**
  The digital transformation team uses a data driven approach and population health management both to improve outcomes and data recording in population groups, identifying and managing CVD risk, hypertension and raised lipids in line with nationally agreed guidance and pathways.

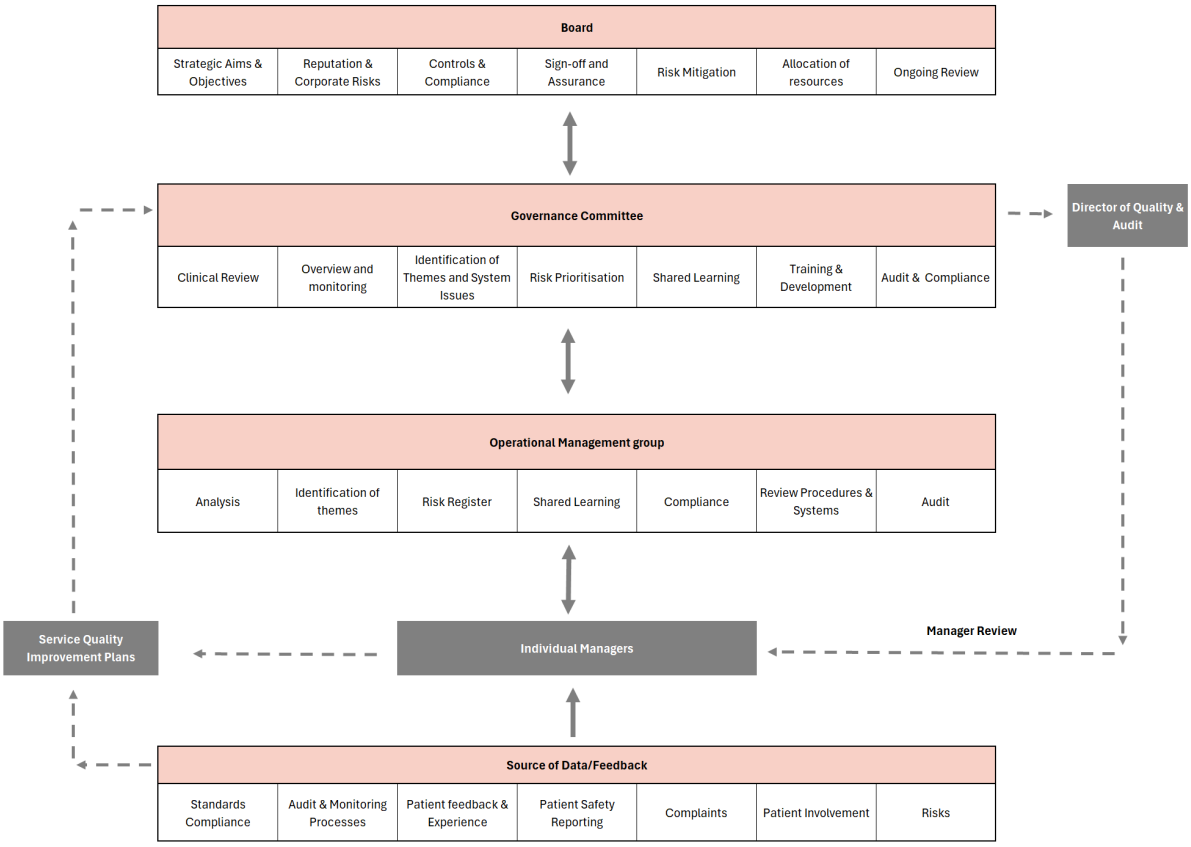
- **Digital Clinical Hub**
  The digital clinical hub supports practices by streamlining administration and reporting.

- **Community Cardiology Service**
  Cheshire and Merseyside ICB has commissioned us to provide a cardiology service for non-urgent cardiology consultations in a community setting, along with echocardiograms, and open-access diagnostics referred from local GP practices. The cardiology service provides information flows back to GP practice and onward to secondary and tertiary care where required.

We are known for delivering services that adapt to evolving needs and changing circumstances, working closely with our commissioners and local GP practices to ensure a strong local fit. We have effective governance structures to support new services and change processes and we are building on these to develop our improvement plans.

5. Duties and responsibilities

The following diagram summarises SAFH's organisational structure and accountability relating to patient safety:



Board

The Board of Directors has overall accountability for patient safety and the implementation of this Patient Safety Incident Response Plan (PSIRP). Their responsibilities include:

- Providing strategic oversight of patient safety ensuring that the company's quality, safety, and risk management strategies are aligned with the Patient Safety Incident Response Framework (PSIRF)
- Assessing corporate risks, ensuring that structures and processes are in place to monitor compliance, provide assurances and to mitigate risk.
- Promoting a Just Culture of transparency, learning, and system improvement across the organisation.
- Allocating resources to promote safe working practices.

Governance Committee

The Board delegates oversight on governance and risk to the Governance Committee. The committee is Director-led, ensuring that PSIRP is effectively managed and continuously improved. Their key responsibilities include:

- Clinical review and analysis of patient safety incident data, trends, and learning outcomes.
- Facilitating system-based investigations and ensuring learning is embedded across the organisation.
- Engaging with patients, families, and staff to ensure compassionate and meaningful involvement in incident responses.
- Identifying themes and provision of data on patient safety trends and outcomes for review by Board.
- Ensuring appropriate action plans are developed and implemented based on patient safety learning.
- Monitoring risk management and governance processes to support continuous improvement.

Director of Quality and Audit

The Director of Quality and Audit the named patient safety lead, who provides leadership and direction for the effective implementation of PSIRP within the organisation. This includes:

- Oversight on quality, patient safety governance and audit systems, to identify trends and make recommendations for change.
- Liaison and follow up of matters arising from the Governance Committee with individual managers.
- Monitoring systems for investigating, learning from, and acting upon patient safety incidents.
- Embedding a systems-based approach to incident response and quality improvement.
- Agreement of service-specific improvement plans with service managers.

Service Managers – individually, and through Service Manager Meetings

Service managers play a key role in operationalising PSIRP within their respective areas. Their responsibilities include:

- Reviewing and sharing patient safety incidents and trends at monthly Service Manager Meetings.
- Ensuring that staff are engaged in reporting, learning, and improving patient safety.
- Facilitating local learning and improvement initiatives in response to incidents through service improvement plans.
- Supporting a just culture where staff feel safe to report and discuss incidents without fear of blame.

All Staff

All staff members contribute to a positive patient safety culture by:

- Reporting patient safety incidents in a timely and accurate manner.
- Participating in learning and improvement activities related to patient safety.
- Engaging in open and honest conversations with colleagues, patients, and families about safety concerns.
- Supporting a just and psychologically safe culture, ensuring that learning, and not blame, is the focus of patient safety responses.

6. Defining our patient safety incident profile

A crucial aspect in the development of our patient safety incident response plan was to identify the key factors that contribute to patient safety risks at SAFH. As an independent provider of NHS services, we have relatively few reportable patient safety incidents compared to larger organisations. We therefore analysed our reporting over the lifespan of the organisation to provide a profile of patient safety and to gain insight into the scale of patient safety activities within the company.

Data Collection and analysis

The following data sets were reviewed and evaluated:

- Learning events by type
- Data incidents
- Accidents and onward reporting
- Complaints
- Patient and relative feedback (patient experience questionnaires)
- Feedback and interactions with GP practices and secondary care providers
- Premises and equipment compliance
- Risk assessment and risk management processes
- Safeguarding processes
- Our CQC inspection report

In addition, we reviewed our programmes of audit, staff surveys, and our service improvement programmes, and we considered whether there were any legal claims or death-in-service incidents.

The following process was followed to understand and complete our incident profile and agree the plan:

Stakeholder engagement

Engaging with stakeholders is essential to ensure that we listen to and address people's needs within this process. This includes patients, families, carers, our staff and health partners.

A stakeholder mapping exercise was conducted to identify all relevant parties to be considered, as follows:

Internal stakeholders	External stakeholders
• Board of directors • Governance committee • Service managers • Contractors/frontline staff • Support staff	• Patients, families and carers • GP practices • Sub-contractors • Health providers • Social care providers • Cheshire and Merseyside ICB

The incident profile for the lifespan of the company, is summarised as follows:

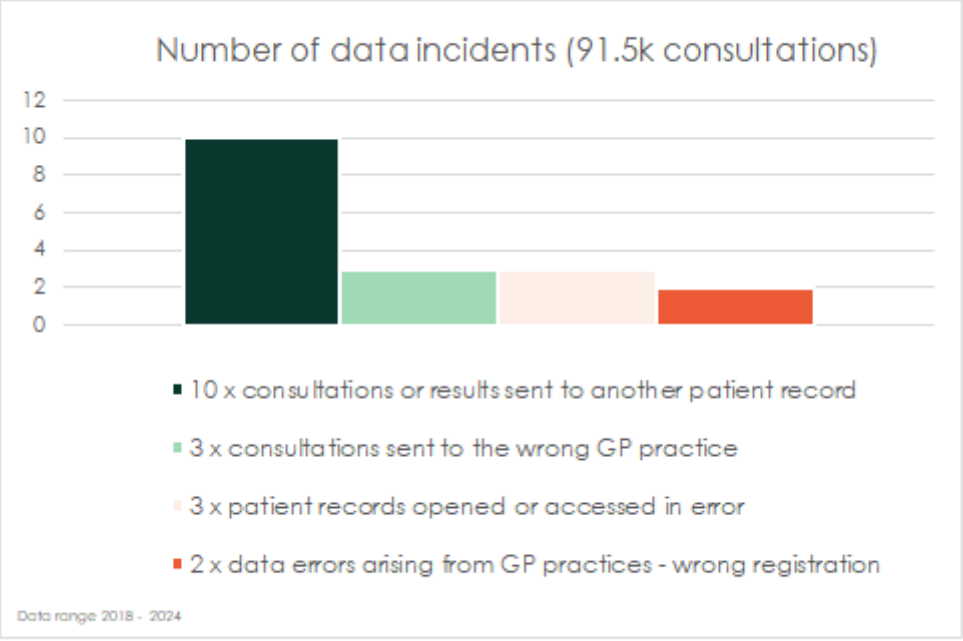
6,500 patient feedbacks (in 2024)	131 learning events (total)	18 data - learning events (13.7% - patient related)
19 complaints	Data Analysis	1 safeguarding concern
0 high-risk incidents	0 insurance claims	0 service-user deaths

Data range 2018 - 2024

Interpretation

The analysis of data showed that there have been no high-risk incidents for patients using our services, no service-user deaths and no insurance claims. We received feedback from 6,500 patients in 2024, representing 26% of consultations. Their feedback provides high levels of satisfaction with our services.

Out of 131 learning events, there were 18 patient-related data incidents. Of these, 13 consultations were allocated to the wrong patient record or sent to the wrong GP practice in error.



The number of data incidents represents 13.7% of total learning events reported, with an overall incidence of one in every 7.5k consultations. While these breaches were contained within the NHS family and each was rectified, they do represent a potential risk to patient safety. We have classed these incidents as safe transfer of information or care back to GP practices or onward to another provider.

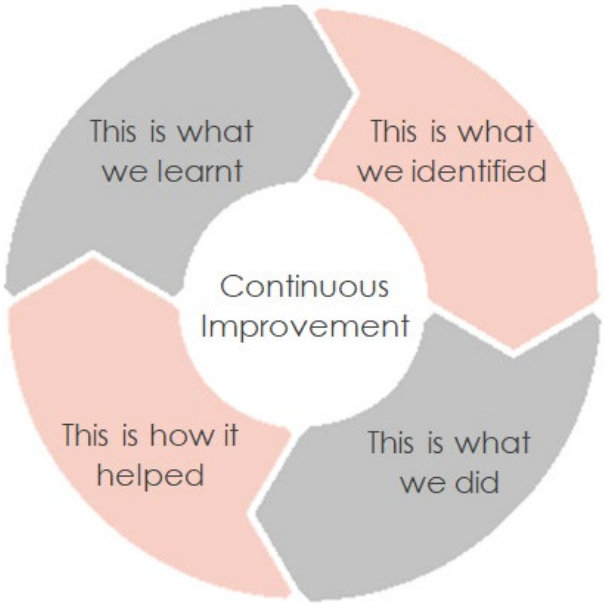
As part of ensuring the safe transfer of information and care, our audit data tracked the transfer of smear test results for follow-up by the registered GP practice. We also audit the transfer of test results and monitor the requirement for secondary care providers to return outpatient information to the home GP practice.

The transfer of care also includes the safe receipt of referrals by secondary and tertiary care providers. Our data recorded a case where a tertiary care referral was rejected without a return notification to our services, resulting in a delay for the patient.

Service improvement and transformation work

Reporting to the Board of Southport and Formby Health, the Governance Committee is responsible for quality, patient safety, and oversight of events and trends to ensure follow-through on actions. They categorise learning events to effectively monitor patterns and types of incidents, with follow-up audits conducted to assess the effectiveness of implemented changes.

All learning events are reviewed and audited annually by the Director of Quality and Audit to ensure completeness. The results are reported to the Governance Committee, and feedback on areas for improvement is provided to individual service managers. Service improvement plans are developed, and these are followed up in quarterly review meetings, based on a continuous improvement approach:



The following table summarises service improvement initiatives implemented:

Quality Improvement Initiative	Workstream
Implementation of PSIRF	• Promotion and implementation of a Just Culture within the organisation ○ Incorporate information in meetings and communication bulletins to raise awareness of reporting • Provision of patient safety training to improve service manager expertise • Complete and agree the PSIRF Policy and Plan with the ICB
Reduction in the number of data-breach and data-transfer errors	• Clinicians to check during the consultation that the correct patient is registered • Use of EMIS consultation writeback technology - enabling consultations to be made direct to each patient record, eliminating the need for third-party return of information back to GP practice • Programmes of audit to check test results are returned to the GP practice
Annual audit of learning events	• Categorisation of learning events to monitor patterns and types of incidents effectively • Share feedback from the annual audit with the Governance Committee and follow up with individual service managers to drive quality improvements • Development of individual service improvement plans
Programmed quarterly review of service improvement plans	• Director of Quality and Audit scheduled meetings with individual service managers to discuss quality, audits and relevant issues relating to transfer of care • Development and monitoring of quality and service improvement plans.
Refined procedures	• Service improvement plan to follow up onward referrals and to request feedback to cardiology service if a tertiary referral is rejected.
Programmed audits	• Smear test audit to confirm results returned to GP practice for follow-up. • Prescribing audit to confirm appropriate prescribing • Quality of care audits • Review appropriate access to medical records

7. Defining our patient safety incident response plan: Local focus

Our patient safety incident response plan has been developed to meet both local and national requirements. Each incident will be looked at individually and our learning responses may differ, based on the incident type. The Governance Committee will receive an After-Action Review (AAR) and may consider progressing to an MDT or a Thematic Review. Examples of our local focus are defined, as follows:

No	Patient safety incident type:	Planned response/action required:	Anticipated improvement route:
1.	Patient data breach or problem with transfer of care	Learning Event recorded and investigated Thematic review	Create safety actions and inform ongoing improvement plans
2.	Delay in onward referral impacting on outcome in care or process occurring repeatedly	Learning Event recorded and investigated AAR and thematic review if required	Formulate a safety improvement plan via governance committee and service manager meetings
3.	Medicines Incident delayed, omitted or inappropriate prescription	Learning event response AAR and thematic review if required	Create organisational actions and share learning through governance committee
4.	Incidents with a significant or high-risk rating	Reviewed on a case-by-case basis. Reviewed by subject matter expert A PSII will be considered as the most appropriate learning response.	As required. Safety improvement plans reported to: Governance Committee Board Service manager meeting Other providers as required.

8. Defining our patient safety incident response plan: national requirements

Certain healthcare events necessitate a specific response outlined in national policies or regulations. Depending on the nature of the event, this response may involve a review or referral to another team or organisation.

	Event Type	Action required	Lead body for response
1	Incidents meeting the **Never Events** criteria (2018 list or its replacement).	Locally led PSII to be considered	SAFH
2	Deaths thought more likely than not due to problems in care (incidents meeting the learning from deaths criteria for PSII)	Locally led PSII to be considered	SAFH
3	Deaths of patients detained under the Mental Health Act (1983) or where the Mental Capacity Act (2005) applies, where there is reason to think that the death may be linked to problems in care (incidents meeting the learning from deaths criteria)	Locally led PSII to be considered	SAFH
4	Deaths of persons with learning disabilities	Refer for Learning Disability Mortality Review: People with a learning disability and autistic people - **Learning from Lives and Deaths Review (LeDeR)** Locally-led PSII (or other response) may be required alongside the LeDeR – organisations should liaise with this.	Local authority via the LeDeR programme
5	Child deaths	Refer for **Child Death Overview Panel (CDOP)** review Locally-led PSII (or other response) may be required alongside the CDOP review – organisations should liaise with the panel	Child Death Overview Panel

	Event Type	Action required	Lead body for response
6	Mental health-related homicides	Referred to the NHS England **Regional Independent Investigation Team (RIIT)** for consideration for an independent PSII Locally led PSII may be required	As decided by the RIIT
7	Maternity and neonatal incidents meeting **Health Services Safety Investigation Body (HSSIB)** criteria or **Special Health Authority (SpHA)** criteria	Refer to HSIB of SpHA for independent PSII See also appendix B of Guide to responding proportionately to patient safety incidents.	HSSIB/SpHA
8	Safeguarding incidents in which: • babies, children, or young people are on a child protection plan; looked after plan or a victim of wilful neglect or domestic abuse/violence • adults (over 18 years old) are in receipt of care and support needs from their local authority • the incident relates to female genital mutilation, Prevent (radicalisation to terrorism), modern slavery and human trafficking or domestic abuse/violence	Refer to Sefton local authority safeguarding lead, and notify patient's GP practice Contribute to any inquiry or review, as required by the Local Safeguarding Partnership (for children) or Local Safeguarding Adults Board: Healthcare organisations must contribute towards domestic independent inquiries, joint targeted area inspections, child safeguarding practice reviews, domestic homicide reviews and any other safeguarding reviews (and inquiries) as required to do so by the local safeguarding partnership (for children) and local safeguarding adults board	Local authority, in conjunction with the patient's GP practice and our designated lead for child and adult safeguarding
9	Incidents in NHS screening programmes Guidance for managing incidents in NHS screening programmes	Refer to local **Screening Quality Assurance Service (SQAS)** for consideration of locally led learning response.	SAFH in conjunction with the SQAS Board.

	Event Type	Action required	Lead body for response
11	Domestic homicide	A domestic homicide is identified by the police usually in partnership with the **Community Safety Partnership (CSP)** with whom the overall responsibility lies for establishing a review of the case Where the CSP considers that the criteria for a **Domestic Homicide Review (DHR)** are met, it uses local contacts and requests the establishment of a DHR panel The Domestic Violence, Crime and Victims Act 2004 sets out the statutory obligations and requirements of organisations and commissioners of health services in relation to DHRs	CSP

9. Review

Southport and Formby Health will review the plan every 12 months, or sooner if needed if there is a cluster or an unexpected increase in incidents. Any changes will involve stakeholder consultation, including Cheshire and Merseyside Integrated Care Board to provide advice on further development of the plan.

Appendix A - Staff Training Matrix

The Patient Safety lead and staff will undergo the following training:

Course:	Content	Who
HSSIB - Health Services Safety Investigations Body	• 2-day HSSIB training course focussed on SEIPS	Patient Safety Lead
Patient safety syllabus level 2: Access to practice (NHS eLearning)	• Introduction to systems thinking and risk expertise. • Human factors • Safety culture	Patient Safety Lead Service Managers
Patient Safety syllabus level 1: Essentials for patient safety (NHS eLearning)	• Listening to patients and raising concerns • The systems approach to safety: improving the way we work, rather than the performance of individual members of staff • Avoiding inappropriate blame when things don't go well. • Creating a just culture that prioritise safety and is open to learn about the risk and safety.	All staff
Patient Safety Incident Response Framework Training (TeamNet)	• This module is designed for primary care staff to assist with their understanding of the patient safety incident response framework and how this information should be applied in their daily working lives in primary care.	All staff annually

Appendix B – Patient Safety Workflow