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1. Introduction

Quay Primary Healthcare CIC is committed to providing safe, effective and high-quality care. The organisation recognises that responding to patient safety incidents in a structured, learning-focused way is essential to improving services and preventing harm.

This policy aligns with the NHS Patient Safety Incident Response Framework (PSIRF) and establishes a consistent approach to managing patient safety incidents, significant events and near misses. The framework supports a systems-based approach that prioritises learning and improvement rather than blame.

All staff are expected to actively contribute to a culture of safety, transparency and continuous improvement.

2. Purpose

The purpose of this policy is to:

- Provide a clear framework for responding to patient safety incidents
- Ensure incidents are reported, reviewed and learned from
- Promote a just and open safety culture
- Ensure compliance with national patient safety standards
- Support staff and patients affected by incidents
- Enable organisational learning and service improvement

3. Scope

This policy applies to:

- All employees of Quay Primary Healthcare CIC
- Clinical and non-clinical staff
- Contractors and agency staff
- Students and trainees
- Volunteers

This policy covers:

- Patient safety incidents
- Significant events
- Near misses
- Complaints involving safety concerns
- Safeguarding incidents
- Staff safety incidents
- Service delivery incidents

4. Policy Statement

The organisation is committed to:

- A **just and fair culture** that encourages openness and reporting
- Responding to incidents in proportion to the **potential for learning**
- Meaningful involvement of **patients, families, and carers**
- Supporting staff affected by patient safety incidents
- Using incident insights to drive **system improvement**
- Meeting statutory and regulatory requirements, including the **Duty of Candour**

5. Definitions

Patient Safety Incident

An unintended or unexpected event that could have or did result in harm to a patient, staff member or member of the public.

Significant Event/Harm

Any event thought by any member of staff to be significant in the care of patients or the delivery of services. Unintended physical or psychological injury, suffering or death arising from healthcare.

Near Miss

An incident that did not cause harm but had the potential to do so.

Learning Response

A structured review process designed to identify learning and improve systems.

6. Principles of Patient Safety Incident Response Framework (PSIRF)

The Patient Safety Incident Response Plan should ensure that any available patient safety response resources—even if this equates to a part-time contribution from one individual—are focused effectively. The emphasis should be on learning and improvement rather than on blame.

All responses to incidents will be:

- Learning focused
- Proportionate
- Timely
- Compassionate
- Transparent
- Systems-based
- Supportive of staff wellbeing

7. Safety Culture and Just Culture

Quay Primary Healthcare CIC promotes a Just Culture which:

- Encourages reporting
- Supports staff
- Focuses on systems improvement
- Avoids blame
- Promotes accountability

Disciplinary processes will only be considered where there is evidence of:

- Reckless behaviour/dishonest behaviour
- Deliberate harm
- Criminal activity

8. Reporting Patient Safety Incidents

All staff must report incidents immediately using the organisation's reporting system.

Immediate Actions

1. Ensure patient safety
2. Provide clinical care if required
3. Inform line manager
4. Complete incident report
5. Escalate if necessary
6. Contact a Senior Manager at Quay Primary Healthcare who will add the Incident to the Significant Event Log.

External Reporting

Incidents may be reported to:

- LFPSE (Learn from Patient Safety Events)
- Integrated Care Board (ICB)
- Care Quality Commission (CQC)
- Safeguarding authorities
- Health and Safety Executive (RIDDOR)
- Information Commissioner's Office (ICO)

9. Patient Safety Response Process - Seven-Stage Response Process

Stage 1 — Awareness and Prioritisation

Identify incident and ensure immediate safety.

Stage 2 — Information Gathering

Collect factual information and documentation.

Stage 3 — Team Discussion

Conduct structured team-based review meeting, if applicable.

Stage 4 — Analysis

Determine causes, contributing factors and learning.

Stage 5 — Implement Change

Agree and implement improvement actions.

Stage 6 — Documentation

Record findings and actions.

Stage 7 — Review and Learning

Monitor outcomes and review effectiveness.

10. Levels of Patient Safety Response

Responses may include:

- Immediate safety action
- Local review
- Significant Event Analysis (SEA)
- Patient Safety Incident Investigation (PSII)
- Independent Review

Independent review may be required when:

- Severe harm occurs
- Death occurs
- Incident attracts media attention
- Incident raises public concern

11. Duty of Candour

The organisation will comply with statutory Duty of Candour requirements.

This includes:

- Informing patients of incidents in a timely, open and sensitive manner
- Offer meaningful opportunities to contribute to the incident response
- Providing clear explanations, apologies where appropriate and ongoing communication

- Providing support
- Documenting communication

12. Staff Support

The organization recognizes staff involved in incidents may be affected emotionally and professionally. Staff involved in incidents will receive appropriate support including:

- Debriefing
- Clinical supervision
- Occupational health referral
- Counselling support
- Peer support
- Additional training needs/refresher training

13. Learning and Improvement

All incidents contribute to organisational learning.

Learning may result in:

- Policy updates
- Sharing with teams, organisational and system levels
- Inform safety improvement plans
- Training changes
- Service redesign
- Risk reduction measures

Safety improvements must be monitored and reviewed.

14. Governance and Oversight

The CIC Board holds overall responsibility for patient safety and reviews the significant events and patient safety incidents at each meeting, as a standing agenda item.

Governance responsibilities include:

- Monitoring incident data
- Reviewing trends

- Ensuring compliance
- Supporting improvement

Governance structures include:

- Board meetings
- Clinical governance meetings
- Safety review meetings
- Risk management processes

15. Equality, Diversity and Health Inequalities

The organisation will ensure that patient safety responses consider:

- Equality legislation
- Protected characteristics
- Health inequalities
- Accessibility of services

Incident data will be monitored for disparities in care.

16. Monitoring and Review

This policy will be monitored through:

- Incident audits
- Governance reporting
- Safety reviews
- Staff feedback
- Risk assessments

Policy review frequency:

Annually or when national guidance changes.

17. PSIRF Compliance Mapping

PSIRF Requirement	Policy Section	Compliance Status
Systems-based approach	Sections 5 and 8	Compliant
Learning-focused responses	Section 12	Compliant
Proportionate responses	Section 9	Compliant
Compassionate engagement	Sections 6 and 10	Compliant
Safety culture	Section 6	Compliant
Governance oversight	Section 13	Compliant
Incident reporting	Section 7	Compliant
Monitoring and improvement	Section 15	Compliant

18. CQC and ICB Readiness Statement

Quay Primary Healthcare CIC demonstrates readiness for regulatory inspection by ensuring:

- Patient safety incidents are reported and managed consistently
- Learning from incidents is documented
- Governance oversight is maintained
- Staff receive training in patient safety
- Duty of Candour requirements are met
- Risk management systems are in place
- Incident trends are monitored and reviewed

This policy supports compliance with:

- CQC Regulation 12 — Safe Care and Treatment
- CQC Regulation 17 — Good Governance
- CQC Regulation 20 — Duty of Candour
- NHS Patient Safety Incident Response Framework (PSIRF)

19. Roles and Responsibilities

Role	Responsibilities
Board	Overall accountability for patient safety
Medical Director	Clinical leadership and oversight

Role	Responsibilities
Clinical Leads	Incident review and learning implementation
Managers	Incident management and staff support
Staff	Reporting incidents and participating in learning
Governance Lead	Monitoring compliance and reporting

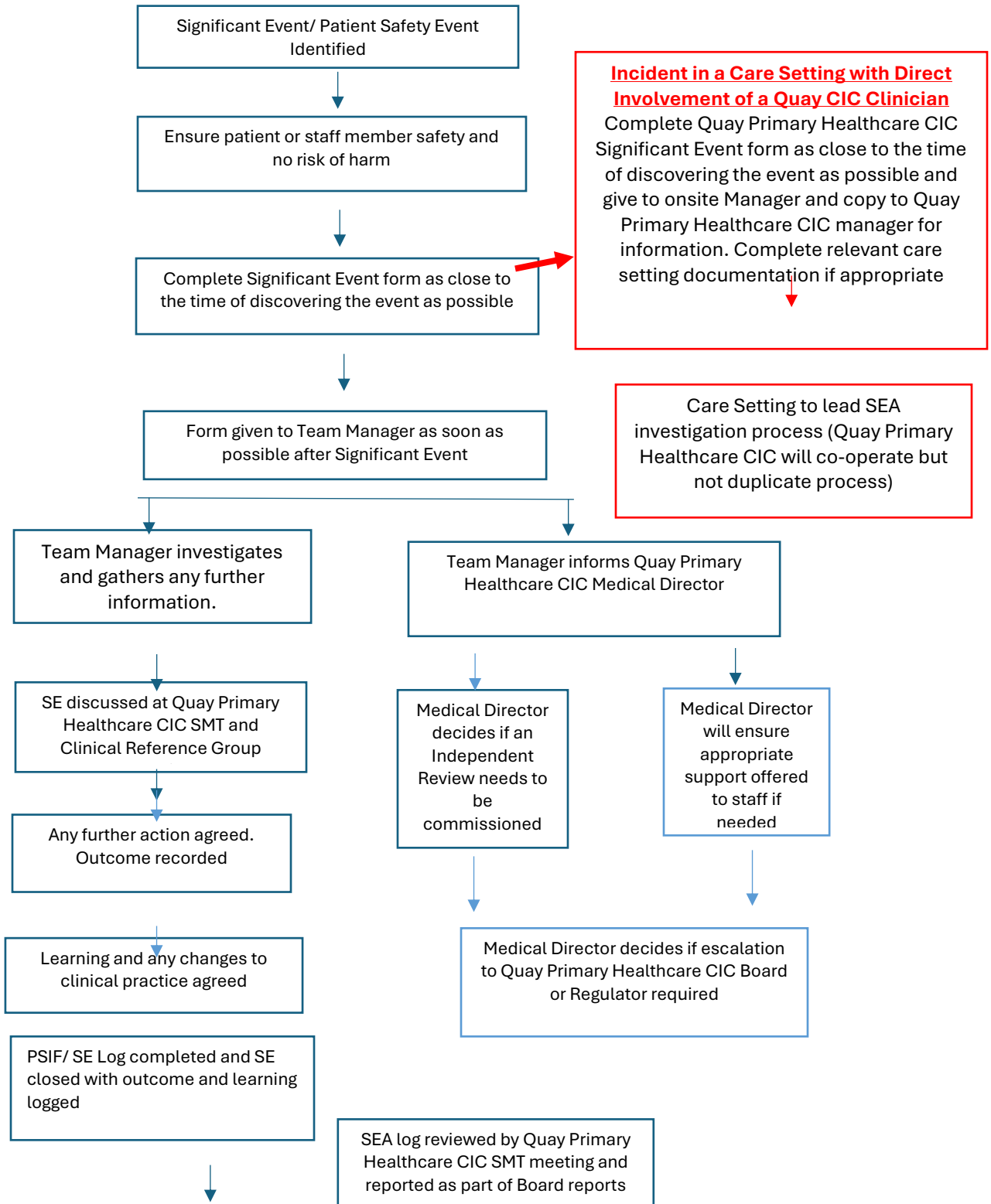
20. Flowcharts

Flowchart 1 — Incident Reporting Process

Incident Occurs
↓
Ensure Safety
↓
Report Incident
↓
Inform Manager
↓
Record Incident
↓
Review Incident
↓
Implement Learning

Flowchart 2 — Patient Safety Response Process

Incident Identified
↓
Assess Risk
↓
Select Response Level
↓
Conduct Review
↓
Identify Learning
↓
Implement Actions
↓
Monitor Outcomes



Equality Impact Assessment

		YES/NO	COMMENTS
1	Does the policy/guidance affect one group less or more favourably than another on the basis of;		
	<ul style="list-style-type: none"> Race/ethnic or national origin/colour/nationality 	No	
	<ul style="list-style-type: none"> Disability 	No	
	<ul style="list-style-type: none"> Gender 	No	
	<ul style="list-style-type: none"> Religion / belief culture 	No	
	<ul style="list-style-type: none"> Sexual orientation 	No	
	<ul style="list-style-type: none"> Age 	No	
	<ul style="list-style-type: none"> Marital status 	No	
	<ul style="list-style-type: none"> Pregnancy or maternity 	No	
2	Is there any evidence that some groups are affected differently?	No	
3	If you have identified potential discrimination, are any exceptions valid, legal and/ or justifiable?	Yes	
4	Is the impact of the policy/ guidance likely to be negative?	No	
5	If so can the impact be avoided?	Yes	
6	What alternatives are there to achieving the policy/ guidance without the impact?	N/A	
7	Can we reduce the impact by taking different action?	N/A	

21. Appendices

Appendix 1 — Incident Reporting Form

Name of person completing form:
SEA Title:
Date and time of Incident:
Name, NHS number and DOB of patient if applicable: Name: NHS No.: DoB:
Description of Event and what happened (Include time and where the event, happened, who was involved)

In your opinion what has gone wrong

Additional Information (for example why do you think this is an SE)

Action taken as a result of SEA

Date and outcome of discussion with Quay Primary Healthcare CIC SMT / clinical team

Learning and change resulting from this event

Date SEA reviewed by CEO / Medical Director

Any further action

LOG NO:

Additional information

Date of 6-month review:

Any further incidents:

Any further actions:

Appendix 2 — Incident Log Template

Incident Number	Date	Location	Incident Type	Harm Level	Status	Review Date
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Appendix 3 — 6-Month Review Template

Incident Reference:

Date of Review:

Have further incidents occurred:

Yes / No

Further actions required:

Appendix 4 — Duty of Candour Record

Patient Name:

Incident Date:

Date patient informed:

Explanation provided:

Apology given:

Support offered:

Recorded by:

Appendix 5 — Training Record Template

Staff Name Role Training Completed Date Next Review

Appendix 6 — Lessons Learnt Template

Quay Healthcare Lessons Learned Template

Following a Significant Event, Patient Safety Incident, or Complaint

1. Core Event Information

- **Incident/Complaint Reference Number:**
- **Date of Event:**
- **Date of Review:**

2. Summary of the Event

- **Brief description of what occurred:**
- **Immediate clinical impact or potential harm:**
- **Initial actions taken to ensure safety:**

3. Severity & Classification

- **Incident category (e.g., medication error, delay in treatment, communication issue):**
- **Level of harm (e.g., no harm, low, moderate, severe, death):**
- **Was Duty of Candour triggered?**
- **Was safeguarding considered or required?**

4. Contributory Factors (Human, System, Environmental)

- **Human factors (e.g., workload, fatigue, communication):**
- **System/process factors (e.g., unclear protocols, IT issues):**
- **Environmental factors (e.g., equipment availability, layout):**
- **Organisational factors (e.g., staffing levels, culture):**

5. What Went Well

- **Positive clinical or operational responses:**
 -
 -
 -
- **Examples of good practice or compassionate care:**
 -
 -
 -
- **Actions that prevented further harm:**
 -
 -

6. What Didn't Go Well

- **Clinical or procedural gaps identified:**
- **Communication or documentation issues:**
- **Policy or guideline deviations:**
- **Barriers that prevented timely or safe care:**

7. Lessons Learned

- **Key learning points for service/organisation:**
 -
 -
 -
- **Learning relevant to patient safety or quality standards:**
 -
 -
 -
- **How this learning aligns with organisational values:**

Passionate - enthusiastic and motivated team, can do

Integrity - honest and accountable

Team work -act as a team in all we do

Quality - demonstrate outcomes we deliver

Communication - be clear and timely in communication and responses

Innovation - seek creative solutions to complex problems

Transparency - be open book about how we work and operate

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-
-

8. Improvement Actions

Improvement Action	Responsible Role/Team	Deadline	Status

9. Monitoring & Review

- **How improvements will be monitored (audits, spot checks, supervision):**
- **Review date to assess sustained change:**

10. Sign-Off

- **Reviewer Name & Role:**
- **Clinical Governance/Quality Lead Approval:**
- **Date:**

End of Policy