IG22 - Patient Safety Incident Response Policy and Plan

Version 1.0

Document Details	
Title	**Patient Safety Incident Response Policy and Plan**
Author	CIC Board
Quay Primary Healthcare CIC ref no:	IG22
Version	1.0

Approval process	
Approved by	CIC Board
Date approved	July 2026
Lead Director	Medical Director
Category	Information Governance
Sub Category	
Next Review Date	July 2027
Superseded document (If applicable)	

Distribution	
Who the policy will be distributed to	All Quay Primary Healthcare CIC Team
Method	Email and Team Net

Version Control		
No:	Date	Amendment
1.0	23 July 2026	Policy created

Patient Safety Incident Response Policy and Patient Safety Incident Response Plan (PSIRP)

Organisation: Quay Primary Healthcare CIC
Document Title: Patient Safety Incident Response Policy and Plan
Document Reference: IG22
Version: 1.0
Executive Lead: Chief Operating Officer

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1. Purpose

This Policy establishes the organisation's approach to responding to patient safety incidents in accordance with the NHS Patient Safety Incident Response Framework (PSIRF). PSIRF promotes a systems-based approach to learning and improvement rather than blame or assigning fault. The aim is to support compassionate engagement with patients, families and staff, learn from incidents, and implement sustainable improvements that reduce future harm. [england.nhs.uk], [england.nhs.uk]

This document incorporates both:

1. The **Patient Safety Incident Response Policy**
2. The **Patient Safety Incident Response Plan (PSIRP)**

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2. Scope

This policy applies to:

- All permanent, temporary and agency staff
- Contractors and volunteers
- Students and trainees
- All services commissioned or provided by the organisation
- All patient safety incidents involving patients receiving care from the organisation

The policy applies regardless of where the incident occurred if the organisation has responsibility for the patient's care.

3. Principles

The organisation will:

3.1 Prioritise Safety Learning

Patient safety incident response will focus on understanding:

- What happened
- Why it happened
- How systems contributed
- What improvements are required

3.2 Ensure Compassionate Engagement

Patients, families, carers and staff affected by incidents will:

- Be treated with respect
- Be kept informed
- Have opportunities to contribute
- Receive support throughout the process

3.3 Apply Proportionate Responses

The organisation will use the most appropriate response method based upon:

- Actual or potential harm
- Learning opportunity
- Complexity
- Risk of recurrence

3.4 Support a Just Culture

Incident reviews are undertaken to improve systems and care delivery, not to apportion blame.

4. Definitions

Patient Safety Incident

Any unintended or unexpected event, including omissions, that could have or did result in harm to one or more patients. [england.nhs.uk]

Patient Safety Incident Investigation (PSII)

A structured systems-based investigation undertaken for incidents where significant learning and improvement opportunities exist.

Learning Response

A range of methods used to explore incidents proportionately, including:

- After Action Reviews
- Multidisciplinary reviews
- Swarm huddles
- Thematic reviews
- PSIIs

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5. Governance Arrangements

5.1 Board Responsibilities

The Board will:

- Promote a culture of openness and learning
- Receive safety intelligence
- Review learning outcomes
- Monitor implementation of actions

5.2 Patient Safety Officer

The Patient Safety Officer (COO) will:

- Oversee implementation of PSIRF
- Monitor investigations
- Review trends and themes
- Escalate significant risks

5.3 Patient Safety Specialist

The Patient Safety Specialist will:

- Lead PSIRF implementation
- Provide expert advice
- Ensure quality of investigations
- Support learning and improvement

5.4 Service Leaders

Managers will:

- Promote incident reporting
- Ensure staff engagement
- Support investigations
- Deliver improvement actions

5.5 All Staff

All staff must:

- Report incidents promptly
- Participate openly in reviews
- Contribute to learning and improvement

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6. Incident Reporting

All patient safety incidents must be reported through the organisation's incident management system as soon as practicable.

Reported incidents will:

- Be reviewed daily
- Be risk assessed
- Receive an appropriate response
- Be escalated where required

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7. Duty of Candour

The organisation will comply with statutory and professional Duty of Candour requirements.

Patients and families will receive:

- A timely apology where appropriate
- A factual explanation
- Ongoing communication
- Information regarding the review process

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8. Patient Safety Incident Response Methods

The organisation will use one or more of the following approaches:

Response Type	Purpose
Immediate safety actions	Prevent further harm
Swarm review	Rapid learning from frontline teams
After Action Review	Structured team reflection
Multidisciplinary Review	Complex care pathway review
Thematic Review	Learning across multiple events
Observation Studies	Understanding work systems
PSII	Detailed systems investigation

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9. Workforce Support

The organisation recognises incidents can affect staff as "second victims".

Support available includes:

- Line manager support
- Freedom to Speak Up Guardian
- Occupational Health
- Staff wellbeing services
- Psychological support

10. Learning and Improvement

Learning must:

- Lead to measurable improvement
- Address system factors
- Be shared widely
- Be reviewed for effectiveness

Actions will be:

- SMART
- Assigned to accountable leads
- Monitored through governance processes
- Closed only after evidence of implementation

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11. Monitoring Compliance

The following indicators will be monitored:

Indicator	Target
Incident reporting rates	Increasing/appropriate
Completion of PSII reports	Within agreed timescales
Family engagement compliance	>95%
Action implementation	>90%
Learning dissemination	100%

PATIENT SAFETY INCIDENT RESPONSE PLAN (PSIRP)

12. Purpose of the Plan

This plan describes how the organisation intends to respond to patient safety incidents over the next 12–18 months.

The plan remains flexible and may be amended where emerging risks or learning indicate this is required. [cuh.nhs.uk]

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13. Organisational Context

Organisation: Quay Primary Healthcare CIC

Services provided:

- ADHD services
- Primary care support services

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15. Incidents Requiring Mandatory PSII

The following incidents will normally undergo Patient Safety Incident Investigation:

Always Investigate

1. Patient death where healthcare contributed to the outcome.
2. Suspected suicide of a patient receiving mental health care.
3. Maternal death.
4. Intrapartum stillbirth where care may have contributed.
5. Severe neonatal harm events.
6. Wrong site surgery.
7. Retained foreign object after procedure.
8. Never Events.
9. Incidents specifically directed by NHS England or regulatory bodies.
10. Significant system failures with high recurrence risk.

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16. Incidents Subject to Local PSII Priorities

The organisation will prioritise investigation of:

Priority 1

- Medication-related severe harm
- Diagnostic delays resulting in significant deterioration
- Deteriorating patient recognition failures

Priority 2

- Falls resulting in severe harm

Priority 3

- Digital and information system failures with patient impact
- Communication and handover incidents

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17. Thematic Reviews

The organisation will undertake thematic reviews in the following areas every 6–12 months:

Theme	Frequency
Medication Safety	Quarterly
Falls	Biannually
Deterioration	Biannually
Communication Failures	Biannually
Diagnostic Safety	Annually

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18. National Learning Response Requirements

The organisation will comply with:

- Learning from Patient Safety Events (LFPSE)
- National Patient Safety Alerts
- Maternity investigations (where applicable)
- Coroner Prevention of Future Death reports
- NHS England directed reviews

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19. Patient and Family Involvement

Patients and families will be invited to:

- Share their account of events
- Identify questions requiring answers
- Review draft findings where appropriate
- Participate in learning discussions

Support will be offered throughout the process.

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20. Learning Dissemination

Learning will be shared through:

- Board reports
- Team briefings
- Learning events
- Quality improvement programmes

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21. Review of the Plan

The PSIRP will be reviewed:

- At least annually
- Following significant safety concerns
- Following organisational change
- Following emerging national guidance

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22. Equality and Health Inequalities

The organisation will ensure incident responses consider:

- Protected characteristics
- Health inequalities
- Accessibility needs
- Cultural requirements

- Inclusion of seldom-heard groups

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23. References

- NHS England. *Patient Safety Incident Response Framework (PSIRF).* [england.nhs.uk], [england.nhs.uk]
- NHS England. *Patient Safety Incident Response Framework Supporting Guidance.* [england.nhs.uk]
- NHS Patient Safety Strategy. [bing.com], [england.nhs.uk]
