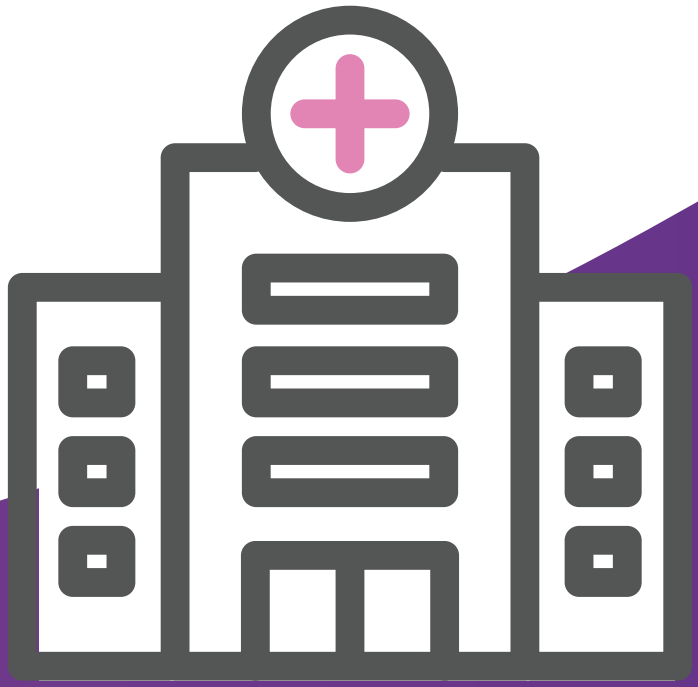
Practice Plus Group

Secondary Care

Patient Safety Incident Response Plan (PSIRP)



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Introduction

The NHS Patient Safety Strategy[1] was published in 2019 and described the Patient Safety Incident Response Framework (PSIRF), a replacement for the NHS Serious Incident Framework[2].

The Serious Incident Framework (or "SIF") defined criteria for establishing which incidents resulting in severe harm or death should be classified as "serious incidents", and their subsequent reporting and investigation requirements.

PSIRF,[3] by contrast, removes the "serious incident" classification and advocates a less prescriptive, proportionate approach to incident management. With the exception of a small number of nationally-determined requirements, the response to the majority of incidents is determined by individual organisations, informed by the patient safety priorities they have identified. The framework places greater emphasis on the learning to be derived from incidents that can change systems and cultures, rather than on producing a large number of detailed investigation reports. A range of different incident learning responses will be applied, meaning that fewer Patient Safety Incident Investigations (PSII – the equivalent of the old-style root cause analysis investigation) will be required, with a focus on quality of learning rather than a large quantity of investigations.

This document is Practice Plus Group's Secondary Care Patient Safety Incident Response Plan (PSIRP). It sets out how Practice Plus Group Secondary Care intends to respond to patient safety incidents over the next twelve months. The plan is not a permanent rule that cannot be changed; it is expected that our patient safety priorities will evolve over time. We will remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected.

Practice Plus Group's values are:

We treat patients and each other as we would like to be treated;

We embrace diversity;

We act with integrity;

We strive to do things better together.

These guiding principles flow through everything we do, from our decision-making to hiring, interactions with one another and how we engage with all of our colleagues. Patient safety incident responses are conducted for the sole purpose of learning and identifying system improvements to reduce risk (not accountability, liability, avoidability and cause of death). They must never undermine the focus on underlying systemic issues by requiring inappropriate automatic suspension of staff involved in patient safety incidents or their removal from business-as-usual activities.

Practice Plus Group uses the being fair tool[4], as appropriate, to ensure consistent, constructive and fair treatment of staff when concerns about an individual's conduct or fitness to practice are raised during a patient safety learning response.

Our services

Practice Plus Group was founded as Care UK in 1982 and rebranded in 2020. We are one of England's largest independent providers of NHS services. Our Secondary Care services range from hospitals, surgical centres and diagnostics to urgent treatment centres. We work in partnership with local NHS trusts and commissioners to provide flexible care to meet the needs of local communities, and welcome both NHS and private patients.

The sites and services that form the Secondary Care division have been mapped and are included in Appendix One.

Defining our patient safety incident profile

The framework for The measurement and monitoring of safety[5] was applied to the Practice Plus Group Secondary Care environment to identify the patient safety issues most pertinent to the organisation.

This framework highlights the following five dimensions which should be included in any safety and monitoring approach in order to give a comprehensive and rounded picture of an organisation's safety:

- **Past harm:** this encompasses both psychological and physical measures;
- **Reliability:** this is defined as 'failure free operation over time' and applies to measures of behaviour, processes and systems;
- **Sensitivity to operations:** the information and capacity to monitor safety on an hourly or daily basis;
- **Anticipation and preparedness:** the ability to anticipate, and be prepared for, problems;
- **Integration and learning:** the ability to respond to, and improve from, safety information.

Figure 1 – A framework for the measurement and monitoring of safety[5]

The decision to analyse data from the last five years, where available, was made (as opposed to the recommended two - three years) to account for the significant change in service provision during the COVID-19 pandemic.

The PSIRF Implementation Group was established, with representation from all disciplines across a number of sites, and met on a monthly basis.

The review of organisational patient safety data[6] documents the data analysis undertaken to define our patient safety incident profile, which forms the focus of this PSIRP.

The analysis included review of:

- Clinical negligence claims;
- Patient safety incident reports and investigations;
- Complaints;
- Risks identified in the organisational and local site risk registers.

The data was analysed according to frequency of associated events, the ratio of harm to no harm incurred by the events, and recent trends.
This analysis revealed the following significant themes:

- Breakdown in the diagnostic/treatment pathway;
- Emergency transfer to an NHS Trust;
- Unplanned return to theatre;
- Unplanned readmission;
- Venous thromboembolism;
- Surgical site infection.

The review of organisational patient safety data was refreshed in 2025. The revised data, combined with an analysis of the learning responses undertaken since the introduction of PSIRF, helped to establish the patient safety priorities.

Each Secondary Care site undertook a similar review to determine whether there are additional, site-specific priorities. These are included as a separate section in this Secondary Care PSIRP.

The review of organisational patient safety data also served to facilitate consultation with both internal and external stakeholders on the proposed patient safety priorities. Stakeholder analysis was undertaken, guided by the NHSEI Stakeholder analysis tool[7]. The PSIRF Implementation Stakeholder Map is included as Appendix Two. The majority of these stakeholders were kept appraised regarding progress with PSIRF implementation by means of monthly progress updates and were also consulted on draft documentation.

Defining our patient safety improvement profile

The patient safety improvement and service transformation work underway across Practice Plus Group Secondary Care services is aligned to the patient safety analysis explored above.

The patient safety improvement programme is supported by the head of clinical effectiveness and improvement, and monitored via the quarterly Clinical Audit and Effectiveness Group (CAG). The chair of the CAG is the head of clinical effectiveness and the head of patient safety is a member. The quality improvement strategy is aligned to the patient safety profile, and the various workstreams are designed to reduce the risks associated with our current patient safety priorities.

The current quality improvement priorities are defined in the annual Quality Account. Site-specific quality improvement projects are also undertaken and shared across sites at the CAG.

Practice Plus Group Secondary Care has implemented the Medical Practitioners Assurance Framework (MPAF) in response to the Paterson Inquiry, with an assessment of strengths and weaknesses against the four key recommendations. The clinical governance framework has been reinforced to support the provider and medical practitioners' responsibilities and provide assurance of behaviours, processes and systems. This is depicted in the Quality and Governance Review and Assurance Framework, Appendix Three.

Existing resources will be utilised more efficiently through the implementation of PSIRF, maximising the improvements derived through new learning from patient safety events, as opposed to focussing on repetitive investigations that were initiated in accordance with nationally-defined thresholds.

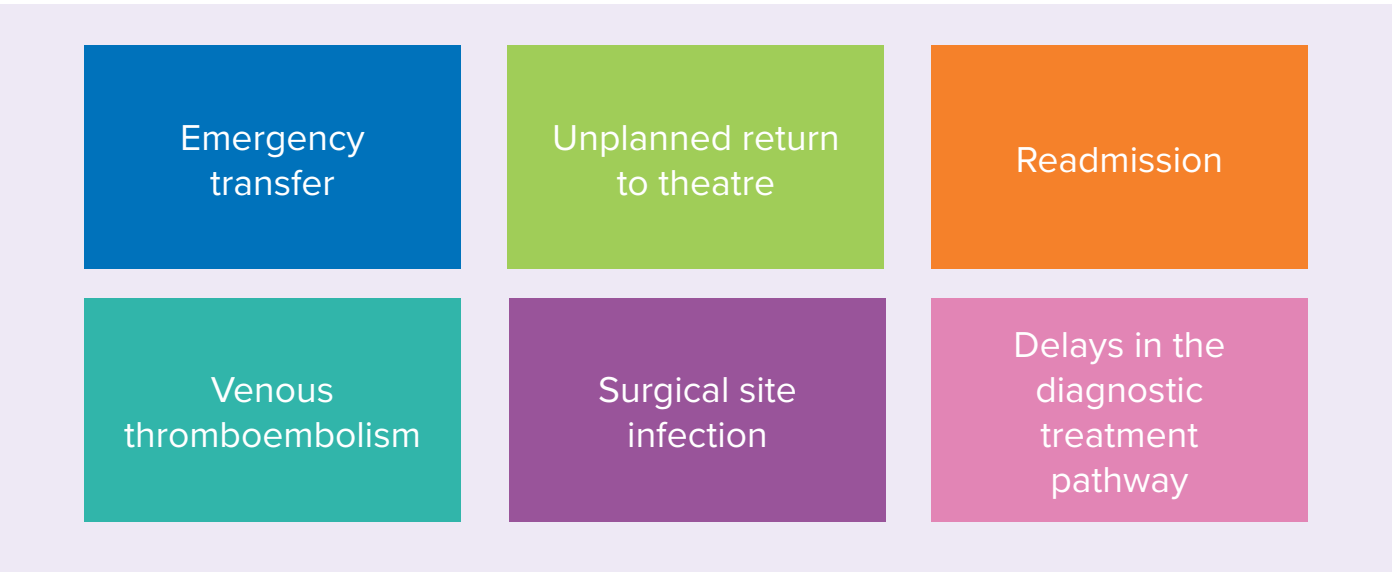
The review of organisational patient safety data considered the Secondary Care patient safety incident profile in conjunction with the patient safety improvement profile to identify six Secondary Care patient safety priorities, illustrated in figure 2, in addition to the nationally-mandated responses.

These six priorities were selected based on the recent incident themes and reporting trends, the impact on patients and the wider health community and the potential for the learning responses to generate patient safety improvements.

The review of organisational patient safety data, including the proposed patient safety priorities, was circulated to the majority of stakeholders for consultation. The proposed patient safety priorities were agreed at a meeting of the PSIRF Implementation Group, at which all referring ICBs were invited to attend. Representation from our lead ICB was in attendance and the learning responses to each of the priorities were discussed and agreed.

Following further review in 2025, it was agreed that the six original patient safety priorities would remain our focus during 2025/2026. The learning response tools will be refined to maximise the learning from the reviews, balanced with ensuring efficient use of the resources available. Additionally, the question sets for the Post Infection Review and Endophthalmitis-specific Post Infection Review will be embedded in Datix in a similar way as the other learning response tools have been, to make them more user-friendly and to enhance the data analysis to inform quality improvements.

Figure 2 - The six Secondary Care patient safety priorities identified for 2025/2026



Our patient safety incident response plan

There are now just two nationally-mandated indications for which a Patient Safety Incident Investigation (PSII) must be undertaken:

1. Deaths thought more likely than not due to problems in care;
2. Incidents meeting the **Never Event** criteria.

Staff undertaking a Patient Safety Incident Response Investigation should use the Learning Response Review and Improvement Tool (Appendix Four) to inform the development of the written report. This tool will help the investigator to maintain focus on a systems approach and avoid the use of blame language. The tool should be applied again for peer review of the final draft to provide constructive feedback on the quality of reports and to learn from the approach of others.

Application of the learning response algorithm will inform decisions regarding the appropriate response to incidents relating to the six patient safety priorities identified for 2025/26.

Additionally, emergent patient safety risks might be identified through, for example, a cluster of similar incidents. The decision to undertake an extraordinary PSII to convene a Patient Safety Learning Team will be made locally in conjunction with the Central Governance Team via an escalation call request.

Urgent patient safety concerns may also be raised via the Freedom to Speak Up process. These will be recorded on the bespoke section of Datix and relevant subject matter expertise consulted to determine the most appropriate investigative approach and resolution.

Incidents that meet the statutory duty of candour thresholds

There is no legal duty to investigate a patient safety incident. Once an incident that meets the **Statutory Duty of Candour** threshold has been identified, as described in Regulation 20, a PSII is not automatically required unless indicated by the Learning Response Algorithm. Regulation 20 states we have a legal duty to:

- Tell the person/people involved (including family where appropriate) that the safety incident has taken place;
- Apologise. For example, “we are very sorry that this happened”;
- Provide a true account of what happened, explaining whatever you know at that point;
- Explain what else you are going to do to understand the events. For example, review the facts and develop a brief timeline of events;
- Follow up by providing this information, and the apology, in writing, and providing an update. For example, talking them through the timeline;
- Keep a secure written record (as part of the Datix incident investigation report) of all meetings and communications.

National patient safety priorities

The following table identifies the nationally-mandated indications for which a PSII must be undertaken, and the instances where referral to an external agency for investigation or review is required.

Event	Response	Improvement
Deaths thought more likely than not due to problems in care (identified through a patient death review, undertaken within 10 working days)	Patient Safety Incident Investigation (PSII)	Create local organisational recommendations and actions, feeding into the quality improvement programme
Incidents meeting the Never Event criteria		
Everyone with a learning disability aged four and above who dies and every adult (aged 18 and over) with a diagnosis of autism	Patient Safety Incident Investigation (PSII) and Refer for Learning Disability Review (LeDeR)	
Child deaths	Refer for Child Death Overview Panel review	Respond to recommendations made by external referred agency
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; • adults are in receipt of care and support needs from their local authority; • the incident relates to FGM, Prevent, modern slavery and human trafficking or domestic abuse/violence.	Refer to local authority safeguarding lead	
All stillbirths, early neonatal deaths and severe brain injuries that occur following labour at term	Refer to Health Services Safety Investigation Branch (HSSIB)	
Incidents meeting the maternal death criteria		
Death of patients in custody/ prison/probation	Report to Prison and Probation Ombudsman (PPO)	

Practice Plus Group Secondary Care patient safety priorities

The following table identifies the Secondary Care patient safety priorities and the associated learning responses that should be taken. These are in addition to the nationally-mandated responses described in the previous section, and any local site-specific priorities that have been identified in the next section.

	Event	Response	Improvement
Practice Plus Group Priorities	Surgical Site Infections Deep or organ/joint space	Post Infection Review (PIR)	Create local organisational recommendations and actions, feeding into the national quality improvement programme
	Surgical Site Infections Endophthalmitis	Endophthalmitis-specific PIR	
	Surgical Site Infections Superficial	Thematic review (frequency determined by site)	
	Venous thromboembolism	VTE-specific review	
	Emergency transfer to NHS Trust	Swarm huddle as soon as possible after the event	
	Unplanned return to theatre	Structured case note review. PSII if deficiencies in care identified	
	Unplanned readmission		
	Diagnostic / treatment pathway delay	If reasons for delay understood, clinical harm review; If not, PSII	

The reasons why each of the above responses were chosen and the timeframe in which they must be completed are described below.

Patient safety priority	Rationale for chosen response	Timeframe
Emergency transfer	SWARM huddles will be undertaken as soon as possible following all transfers to increase the likelihood that all those involved will be able to contribute, to improve retention of key information, identify immediate learning and early action, and as a means of debriefing.	Day of the transfer but, in exceptional circumstances, within forty-eight hours.
Unplanned return to theatre	The algorithm filters out incidents relating to SSI and then requires a structured review of each of the phases of care. Only if the review identifies	Initial review – 10 working days
Readmission	Any problems with the care of the patient that definitely or potentially led to harm, a PSII must be undertaken, thereby maximising the potential of investigative resources.	PSII – to be agreed in conjunction with patient/family & SMT, but no more than six months
Venous thromboembolism	The VTE review tool provides a standardised approach to the contributory and potentially causative factors that led to a VTE, with the advantage of providing direct comparison and contrast between a number of events to identify common themes and maximise learning.	Within 20 working days
Surgical site infection	The Post Infection Review tool focuses on comparison with nationally-recognised standards of best practice, thereby identifying system weaknesses for improvement. A similar tool, specific to endophthalmitis, has also been developed to capture the pertinent information. A thematic review of superficial SSIs will be undertaken as agreed by the site and IPC Team. This will identify common causation factors that might be lost if investigated as individual incidents.	Within 20 working days Within 40-60 days
Delays in diagnostic-treatment pathway	A clinical harm review for incidents where the causation factors are easily understood allows us to use a standardised approach to identify the level of potential harm that may have been caused. Where causation factors are more complex, or not understood at the time of the incident, a PSII provides the opportunity to fully explore actions taken and decision made as related to the incident.	Initial review – 5 working days PSII – to be agreed in conjunction with patient/family & SMT, but no more than six months

Roles and responsibilities

Heads of departments will be empowered to make the decision regarding the most appropriate response to patient safety incidents, guided by the learning response algorithm, and supported by the local site governance manager, who will liaise with external bodies / central governance team as necessary. The learning response will be documented on Datix, where the appropriate template to guide and record the response can be generated.

All learning responses will be conducted by learning response leads who have undergone the necessary training, as defined in the Patient Safety Incident Response Policy. Trained engagement leads will ensure that those affected by patient safety incidents are given the opportunity for involvement in the learning response, provided the support they require and consulted on the final draft report.

Collaboration with other organisations involved in incidents will be sought in all applicable cases to enrich and integrate learning responses across the health economy and foster the cross-boundary work ethic.

The PSIRF executive lead (medical director, Secondary Care), in conjunction with the chief nurse and the head of patient safety (patient safety specialist), will provide leadership, advice, and support in complex/high profile cases.

Monthly quality reviews, held between the central governance team and key senior members of each, individual site, offer the opportunity for oversight of the patient safety incidents that have occurred during the preceding month, the responses taken and the learning derived from incidents. Less reliance will be placed on the number of incident categories (other than to inform thematic reviews) and more on the learning and improvements made.

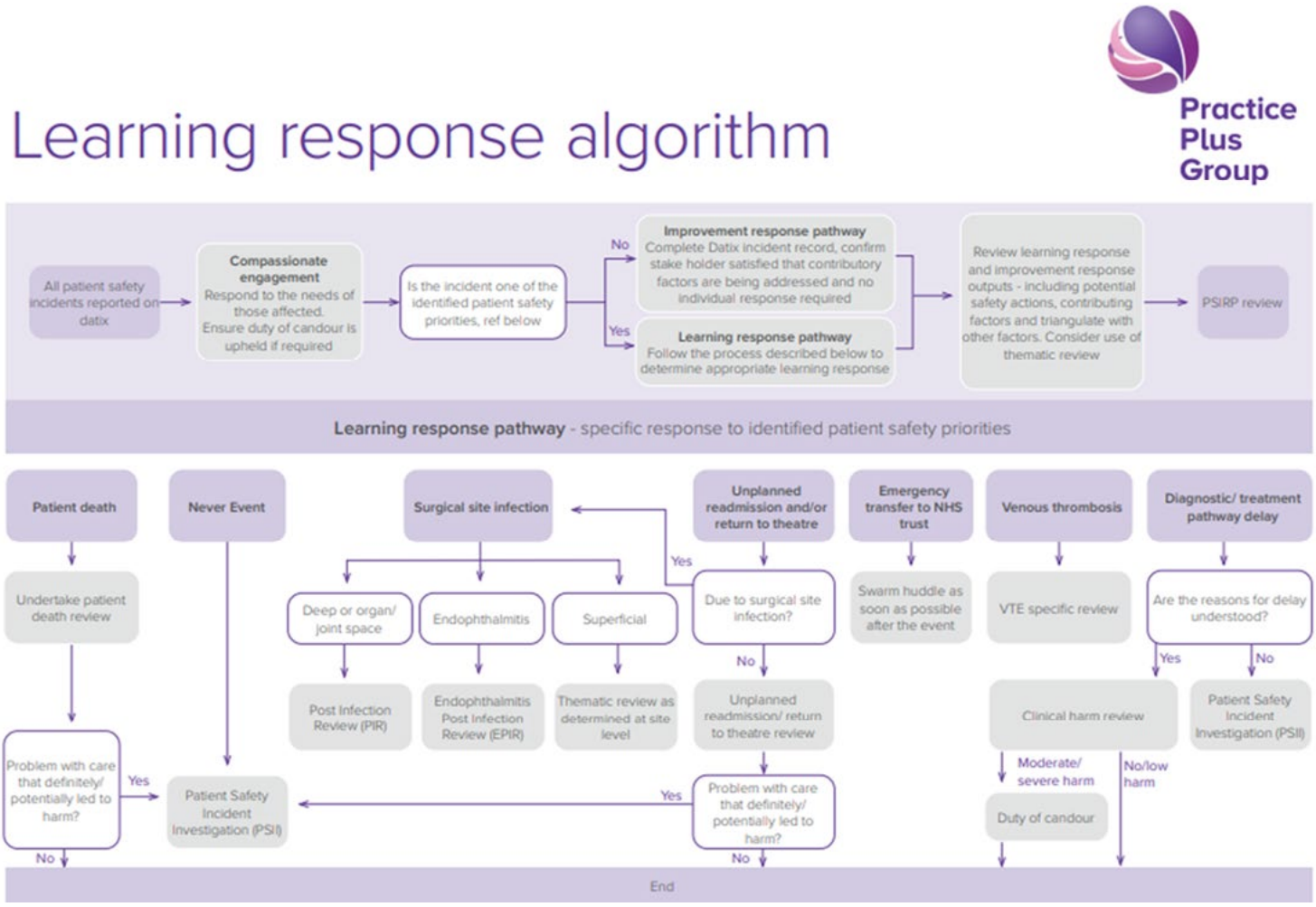
The quality governance and assurance committee will scrutinise an overview of patient safety incidents, their responses and the learning and make recommendations. The quarterly clinical quality and compliance committee and monthly data against key performance indicators provide assurance to the Practice Plus Group executive board that high quality services are being delivered.

Oversight under PSIRF focuses on engagement and empowerment. Oversight of patient safety incidents and approval of learning responses will be led by members of the central governance team according to their subject matter expertise in collaboration with the relevant forum membership:

- Medical Director;
- Chief Nurse;
- Head of Patient Safety;
- Head of Diagnostic Imaging and Endoscopy,
- Chief Pharmacist;
- Associate Chief Pharmacist and VTE Lead;
- Head of Infection Prevention and Control.

All of the above will have participated in the oversight training.

Approval of, and feedback on, PSII reports will be provided using the learning response review and improvement tool, appendix four, to focus on the key principles of PSIRF, particularly the learning to be derived from incidents that can change systems and cultures and the improvements to patient safety that can be made in response.



Site-specific priorities

Site	Event	Response
Practice Plus Group Hospital, Southampton	Inpatient fall	Swarm huddle, followed by review at the falls meeting
Practice Plus Group Hospital, Southampton Urgent Treatment Centre	Monthly unplanned re-attendance within seven days for same condition exceeds 5% of attendances	Thematic review
Practice Plus Group Hospital, Barlborough	Five adverse clinical outcomes (e.g., hip dislocations, leg length discrepancies) associated with the same surgeon in a six month period	Thematic review
Practice Plus Group Hospital, MSK & Spinal Service Lincolnshire.	Five patient pathway delays	Thematic review
	Five breaches of patient confidentiality e.g. wrong letter sent to patient	Thematic review
Practice Plus Group Hospital, Plymouth	More than two incidents relating to patient skin integrity during admission in one month	Patient Safety Learning Team approach
	Two adverse clinical outcomes in a month related to hip dislocations, leg length discrepancies or intraoperative fractures	After action review
	Readmissions related to wound ooze	Six monthly structured case notes and pathway review
	Patient-reported surgical site infections	Quarterly thematic case and pathway review
Practice Plus Group Hospital, Emerson's Green	Two incidents of wrong TTA medication given to patients on discharge from the same department	Thematic review Process mapping
Practice Plus Group Hospital, Ilford	Five or more avoidable cancellations in any one month	Thematic review
	Delayed MDT input	Swarm huddle
Practice Plus Group, NW Ophthalmology	Three or more patients with Posterior Capsule Ruptures in one month, or if recurring within a list	Thematic review
Practice Plus Group Hospital, Shepton Mallet	Five or more patient falls	Swarm huddle Thematic review
	Five or more medication administration errors	Thematic review
	Five or more MUA /CPN in three months	Multidisciplinary review
Practice Plus Group Hospital, Birmingham	Three or more broken suture needles for the same surgeon / SFA in a 12-month period	SWARM and thematic review. NB If not identified prior to wound closure, this constitutes a never event, and a PSII will be indicated
Practice Plus Group Surgical Centre, Gillingham	Five or more avoidable cancellations in a month	Patient Safety Learning Team
	Three or more laterality incidents in a month	Patient Safety Learning Team
	Two or more non infected wound complications in a month	Patient Safety Learning Team

References

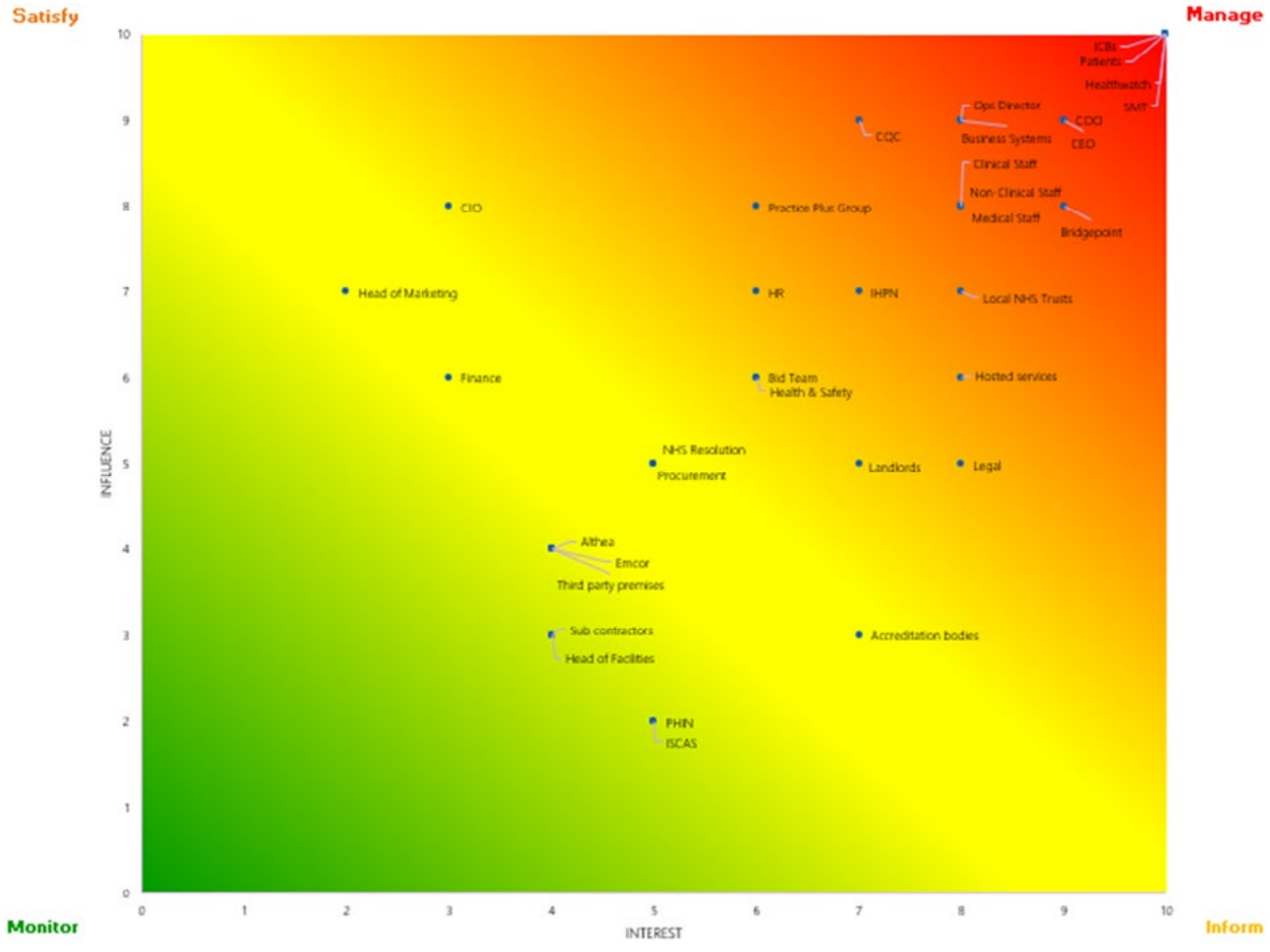
1. NHS England. NHS Patient Safety Strategy, 2019.
2. NHS England. Serious Incident Framework, March 2015.
3. NHS England. Patient Safety Incident Response Framework, version 1, August 2022.
4. NHS England and NHS Improvement. Being fair tool: Supporting staff following a patient safety incident. Available at: **england.nhs.uk/publication/being-fair-tool** NHS England » Being fair tool: Supporting staff following a patient safety incident.
5. Vincent C, Burnett S, Carthey J. The measurement and monitoring of safety. The Health Foundation, 2013. Available at: **health.org.uk/publications/the-measurement-and-monitoring-of-safety**.
6. Practice Plus Group, Secondary Care. Review of organisational patient safety data, July 2023. (Available on request).
7. NHS England and NHS Improvement Quality. Service Improvement and Redesign Tools: Stakeholder analysis, 2022.

Appendix one - Practice Plus Group Secondary Care services

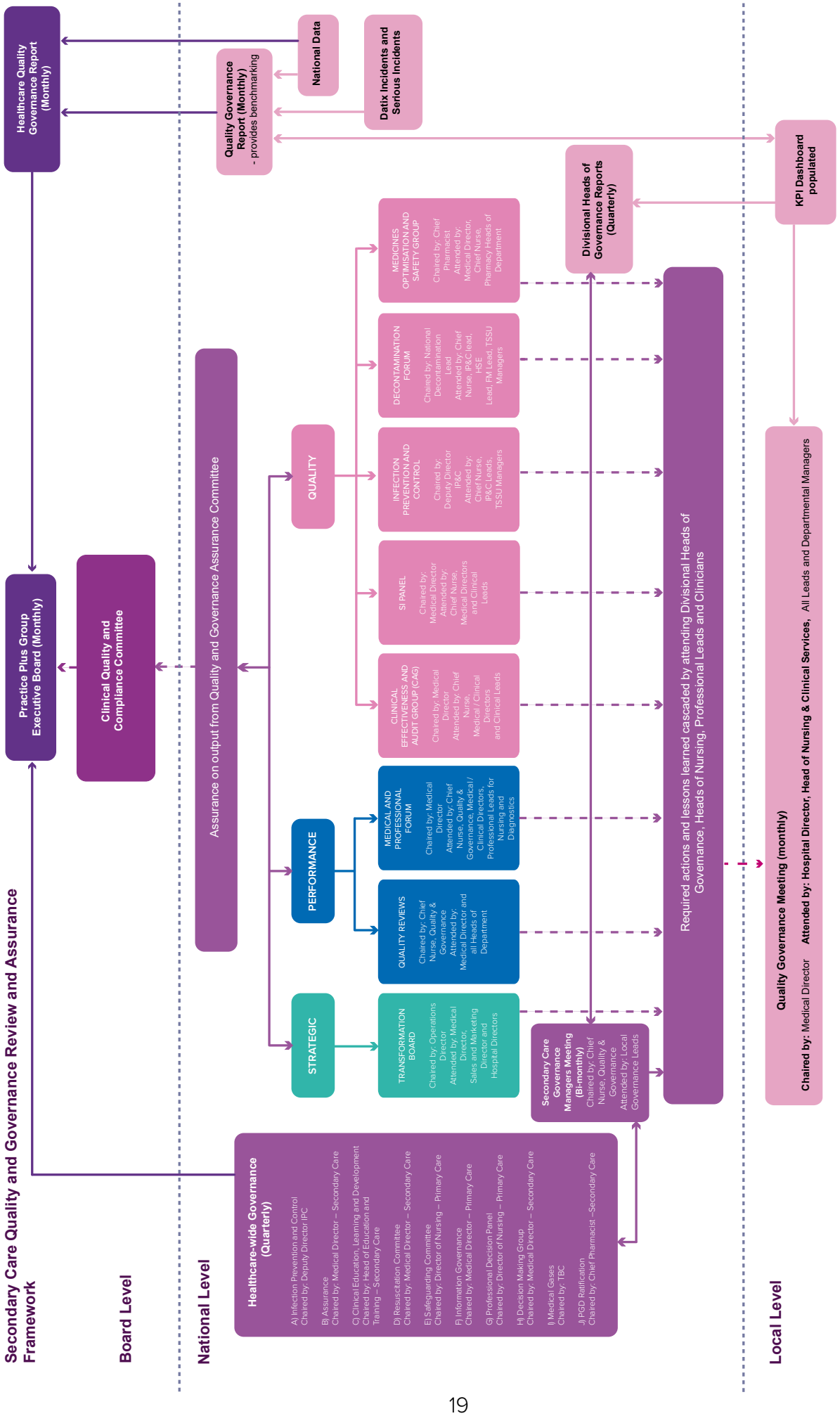
Hospitals and Surgical Centres	Bariatric surgery	Dental surgery	Diagnostic imaging	Ear, nose and throat	Endoscopy	Ophthalmology	Foot and ankle surgery	General practice	General surgery	Gynaecology	Hand and wrist surgery	Hip surgery	Knee surgery	Shoulder and elbow surgery	Spinal surgery	Urology	Vascular surgery
Practice Plus Group Hospital, Barlborough, Chesterfield, S43 4XE	✓		✓			✓	✓		✓		✓	✓	✓	✓	✓		
Practice Plus Group Hospital, Birmingham, B15 2QQ			✓		✓	✓	✓	✓	✓		✓	✓	✓				
Practice Plus Group Hospital, Emerson's Green, BS16 7FH		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓
Practice Plus Group Hospital, Ilford, IG3 8YY			✓		✓	✓	✓		✓		✓	✓	✓	✓			
Practice Plus Group Hospital, Plymouth, PL6 5XP			✓		✓	✓	✓		✓		✓	✓	✓	✓			
Practice Plus Group Hospital, Shepton Mallet, BA4 4LP			✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓
Practice Plus Group Hospital, Southampton SO14 0YG		✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓		✓	
Practice Plus Group Surgical Centre, Devizes, SN10 3UF		✓	✓	✓	✓	✓	✓		✓	✓	✓					✓	
Practice Plus Group Ophthalmology, Rochdale OL16 2UP						✓											
Practice Plus Group Surgical Centre, Gillingham, ME8 6AD			✓		✓	✓	✓		✓		✓						
Practice Plus Group Surgical Centre, St Mary's Portsmouth, PO3 6DW				✓	✓	✓	✓		✓		✓					✓	

UTCs, MSK and Diagnostics	Urgent Care	X-ray	MRI	Ultrasound	Echo-cardiogram	Landmark guided	Ultra-sound-guided	Hand & wrist	Men's health	Telemedicine	Spinal clinic	Sports injury	Women's health	Women's health
Practice Plus Group Urgent Treatment Centre, St Mary's Portsmouth, PO3	✓	✓												
Practice Plus Group Urgent Treatment Centre, Southampton, SO14 0YG	✓	✓												
Practice Plus Group MSK & Spinal Service, Lincolnshire		✓	✓	✓		✓	✓							
Practice Plus Group MSK, Buckinghamshire						✓	✓	✓	✓	✓	✓	✓	✓	✓
Practice Plus Group MSK, Berkshire West														✓
Practice Plus Group Diagnostics, Buckinghamshire		✓	✓	✓	✓									
Practice Plus Group Diagnostics, Havant		✓		✓	✓									

Appendix two – PSIRF implementation stakeholder map



Appendix three – Secondary Care quality and governance review and assurance framework



Version 4.0
Release Date: July 2022
Review Date: July 2023

Learning Response Review and Improvement Tool

Report details:	**ID**: «RECORDID»	**Title**:
How to use this tool:	There are 8 areas of review in the Learning Response Review and Improvement Tool (LRRT). The LRRT can be used by report writers and those reviewing written reports to: 1. Inform the development of the written report 2. Inform constructive feedback on the quality of reports.	
How did we develop this tool:	The tool was developed based on **research** undertaken by NHS Education for Scotland. It has been refined by HSSIB (previously HSIB) and NHS England. The content has been validated with users of the tool.	

	Area of review (Descriptor)	**Rating scale**			**Comments/examples of text quotes** Add comments to clarify your ratings, this may be things that can be improved or content that you thought worked well and should be used in other reports
1	People affected by incidents are compassionately engaged and meaningfully involved The report includes the perspectives of those affected such as staff, patients, families and carers.	Good evidence O	Some evidence O	Little evidence O	
2	A systems approach is used to investigate The report demonstrates consideration of system factors (such as workplace design, technology, culture, fatigue, commissioning) and how these interacted to contribute to the incident.	Good evidence O	Some evidence O	Little evidence O	
3	'Human Error' is considered as a symptom of a system problem The report includes the interactions of multiple factors which influenced the incident. It does not conclude 'human error' or similar terms (e.g., failure to follow policy, loss of situation awareness, missed opportunity) to be the 'cause' of the incident.	Good evidence O	Some evidence O	Little evidence O	

4	Blame language is avoided The language used in the report does not directly or indirectly infer blame of individuals, teams, departments, organisations or systems.	Good evidence ○	Some evidence ○	Little evidence ○	
5	Local rationality is considered The report clearly explores how the situation and context at the time (local) influenced the decisions (rationality) and the actions of those involved.	Good evidence ○	Some evidence ○	Little evidence ○	
6	Counterfactual reasoning is avoided The report does not focus on information that is counter to the facts of what happened i.e. the report does not focus on what 'could' or 'should' have happened during or before the incident (work-as-imagined). Instead, the report focuses on what actually happened (work-as-done).	Good evidence ○	Some evidence ○	Little evidence ○	
7	Safety actions/ improvements/ recommendations are systems-focussed, evidence based and were developed collaboratively Safety actions/ improvements/ recommendations proposed: • were developed collaboratively with relevant staff/stakeholders and with consideration of wider organisation priorities and improvement work	Good evidence ○	Some evidence ○	Little evidence ○	

	• focus on system elements (IT, equipment, care processes/pathways) not individuals • are specific, robust, actionable and do not add to 'safety clutter' (e.g., additional checks, policies, procedures that do not contribute to the safety of work) • include who/how progress will be monitored over time address the key contributory factors in the report.				
8	The written report is clear and easy to read The report is concise, written in easy to understand, and inclusive language i.e., it is written to 'inform rather than impress'.	Good evidence ○	Some evidence ○	Little evidence ○	
9	General comments Is there anything else that can be improved or content that you thought worked well and should be used in other reports?				

	Name	Title	Date
Author	Joanne Kinborough Mata	Head of Patient Safety	December 2023
Reviewer		Clinical Quality and Compliance Committee Practice Plus Group Board	26 February 2024 02 April 2024
Authoriser		NHS Hampshire and Isle of Wight ICB	05 March 2024