Patient Safety Incident Response Plan

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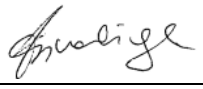
	NAME	TITLE	SIGNATURE	DATE
Author	Indra Sivalingam	Quality & Safety Manager		1 Nov 2025
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Contents

Introduction

Medical Clinics Limited is committed to providing patients with safe, effective quality care. This patient safety incident response plan sets out how Medical Clinics Limited intends to respond to patient safety incidents within the guidelines of the NHS Patient Safety Incident Response Framework. The organisation's Patient Safety Team comprising Dr Andrew Morris (Clinical Director), Anna Baldwin (NHS Operations Director), Carolyn Battes (Nurse Manager), Eve Beasley (Regional Practice Manager) and Indra Sivalingam (Quality & Safety Manager) will be responsible for the implementation of this policy across all services.

The implementation of the patient safety incident response plan will be aimed at learning from patient safety events and thereby ensuring improvement in patient safety measures. This will link with the NHS Patient Safety Strategy (2019) - patient safety is about maximising the things that go right and minimising the things that go wrong. The focus is on understanding how incidents happen – including the factors which contribute to them. This provides vital insight into how to improve care, ultimately making services safer for patients.

Our services

Medical Clinics Limited is a dermatology service providing specialised skin care to Private and NHS patients. The company provides private dermatology services from clinics based in Worthing, Brighton and Hove under the banner Laser & Skin Clinic.

Sussex Community Dermatology Services (SCDS), run community dermatology clinics under NHS contracts from various locations within Sussex, Surrey, North Kent and West Kent. SCDS has grown to be a very large independent healthcare organisation specialising in dermatological care, with 94 clinicians with many practicing at Consultant level and leading clinical care. They are supported by Clinicians with specialist interest in dermatology, surgically trained nurses and a team of nurse prescribers. SCDS run Consultant-led clinics in GP surgeries and community hospital sites and are the largest provider of NHS dermatology care in the Southeast, treating c.100,000 patients per year with inflammatory skin disease and skin cancer, as well as aiming to maintain short waiting times of less than 6 weeks at each clinic location. SCDS hold AQP community contracts with Sussex ICB, Kent, and Medway ICB; as well as holding a rolling community contract with Frimley ICB and providing subcontracted clinical services for many of our local acute trusts.

SCDS uses the services of My Skin Doctor to assist with triage of routine referrals. SCDS uses tele-dermatology technology into pathways of care to enable patient's skin conditions to be assessed remotely and safely.

Defining our patient safety incident profile

The range of services provided by the services includes surgical removal of skin lesions and skin cancers, systemic treatment of inflammatory conditions and treatment of skin conditions with Phototherapy, PDT and Laser. Patient safety risks can be identified in all these treatment regimes, however using the organisational data commencing April 2022, we were able to determine specific areas of risk to patients from incidents and complaints reported.

Data Sources

The organisation implemented a quality compliance software called Radar Healthcare in April 2023. Prior to April 2023, incidents and complaints were recorded on incident reporting templates, Clinical Governance reports and KPI dashboards. Radar provides a comprehensive quality management system for the organisation by monitoring events, risks, workforce compliance, documents, audits and scheduled tasks. The events module of the software records:

- All incidents (clinical, non-clinical, safeguarding etc. equivalent to the trust 'DATIX' system)
- Complaint/plaudits
- Data governance breaches

Data sources also included incidents identified and reported internally, as well as communication from ICB's, GP surgeries and patients themselves with reports of incidents. In preparation of the PSIRF plan data between April 2019 to Sept 2023 was included in the review.

Stakeholder engagement

In preparation for the implementation of PSIRF, we have read through online discussions and guidance documents, and joined webinars made available on the local and national trust websites. The patient safety plan and policy has been shared with the ICB patient safety team for further guidance and support. As part of our patient safety response plan, we will engage with the relevant ICB's quality and safety team during patient safety incident investigations as stipulated in the response plan. In addition, the service engages with the ICB at contract review meetings where quality performance and patient safety is a standing agenda point. More regular feedback to the ICB occurs in the form of KPI and clinical governance reports. The Quality & Safety team will be invited to participate in one learning response every 6 months. Medical Clinics will co-operate fully in investigations led by the ICB or the Trust partners.

Feedback from users of the service has also been considered in determining the patient safety profile. SCDS engages with local trust hospitals where subcontracts are held, during incident investigations. Clinicians and GP's that refer into the service are made aware of patient safety incidents and are involved in the investigation when required. Medical Clinics Limited run 3 post grad training sessions per year where all members of staff are invited to attend either virtually or face to face with patient safety learning and improvement being discussed at this forum.

The organisation commits to open communication and transparency with patients and will acknowledge when things don't always go according to plan. Patients/service users are informed of incidents that affect them in a manner that they understand. This communication may also extend to face to face meetings or consultations should the need arise and if requested by the patient or family.

Organisational Safety Culture

Medical Clinics Limited incident management policy requires that all employees report incidents they may be aware of or involved in. Currently, incidents can be and are reported by any member of the team. Incidents are reported directly onto Radar, or to a senior member of the team who then logs the event on Radar. The importance and commitment the organisation places on patient safety is evidenced by the speed with which concerns and incidents are handled. Stakeholders are involved immediately and issues are escalated to Clinical Directors without delay.

The organisation supports a just culture approach to reporting and investigating incidents by reviewing applicable processes during the investigation, and determining if there are any gaps or changes needed. We appreciate that human factors play a significant role in why incidents occur and will take these into consideration when investigating incidents. Employees involved in patient safety incidents will be offered support if needed through the investigation processes by Line Managers and can reach out to Mental Health first aiders for support. We also understand that it is important for employees to fell they have a voice and will actively engage with them to know their concerns and consider suggestions for improvements raised on patient safety matters. If employees feel uncomfortable raising these in person, they have the ability to record concerns and improvement ideas on Radar for the attention of the Service manager and/or Line Manager.

Staff will be made aware about just culture environment and human factors. Employees have been enabled with access to Radar Healthcare as a platform to report incidents. Incidents may also be reported verbally for staff working in clinic locations where IT access is not always available. This accessibility has enhanced incident management processes by providing a consistent approach to incident reporting across the organisation.

Defining our patient safety improvement profile

To enable an understanding of our patient safety profile, we needed to review and analyse incident reporting templates and data reports from Radar. A comprehensive review of all incidents between April 2019 and Sept 2023 was undertaken by the Quality and Safety Manager and the results presented to the Patient Safety Team. The following key areas identified were agreed with the Patient Safety Team to be included in the patient safety improvement profile:

1. Specimen handling errors
2. Wound complication/wound infections
3. Admin errors resulting in harm or risk to patient safety
4. Data breaches

Managers at all levels of the organisation have implemented improvement initiatives based on areas of incidents relating to patient safety, organisational risks, and complaints. In April 2023, a Quality improvement log was created to record of all improvement initiatives undertaken by within the organisation. ***More recently, it has been possible to log QIP's as an event on Radar Healthcare.*** Majority of the improvement initiatives logged related to updating and / or streamlining processes which ultimately impacted positively on patient safety.

The following improvement plans relating to these key areas as well as other areas of patient safety were initiated.

1. Specimen handling errors and wound complications – action plans are specific depending on the nature of the incident. Communication of the errors to all clinical staff is key to raise awareness, ensure learnings and change in practice. Where a trend is suspected, the team will investigate in more detail and agree on actions to be taken.
2. Wound complications - Changes have been made to the wound advice form given to patients to highlight dates for suture removal and signs to look out for to identify wound complications, and details on who to contact.
3. Admin errors – several improvements have been recorded e.g. Upgrading of letter templates, lab forms, blood forms, changes to admin teams roles.
4. Data breach - a clock was inserted on the company's intranet site and is reset when a new breach is reported. Staff are thus made aware of the frequency of these events.

As an organisation, we learn from incidents, as well as from good and positive care. Many improvements have been derived from simply needing to improve a process and these are shared across the organisation as well as with stakeholders.

Other improvements linked to patient safety include:

1. Updated 'Was not brought' Protocol to include nursing home patients and more contact with GP and Patient Parent/Care home which has resulted in improved safeguarding and overall view of WNB patients.
2. Introduction of letter templates to facilitate outgoing letters to GP's and patients, improving communication and preventing delays in care.
3. Phototherapy referral linked directly to tasks – team is immediately informed preventing delayed / missed referrals.
4. Use of pando app for patient images – secure method of sharing images.
5. Information lacking for potential phototherapy patients - put together a letter for potential phototherapy patients for the secretaries to send out with the patients' clinic letter with essential information.
6. Updated Isotretinoin protocol to include changes to national guidelines – enhances patient safety.
7. ***Policies developed to ensure equity in access of care and compliance with the AIS standards.***

Medical Clinic's patient safety priorities for ***2025/2026 remain unchanged and*** include:

1. Reduction in would complications that have resulted in extended care.
2. Improving specimen handling and labelling.
3. Reduction in admin / typing errors that have resulted in delays to patient care.

Our patient safety incident response plan: National requirements

Patient safety incident type	**Required response**	**Anticipated improvement route**
All incidents meeting the Never Events criteria	Patient Safety Incident Investigation (PSII) [This is an in-depth investigation which will be completed by a Patient Safety Lead. It will explore systems thinking and will identify improvement actions that aim to prevent the incident from happening again]	Create local organisational actions including reporting process to ICB and LFPSE
Death (incident meeting the learning from deaths criteria for patient safety incident investigations (PSIIs))	PSII	Create local organisational actions including reporting process to ICB and LFPSE

Our patient safety incident response plan: Local focus

Based on PSIRF guidance, the following learning response types will be used when investigating incidents. These response types will be based on the impact of patient safety as a result of the incident i.e. no impact, minor, major, significant, catastrophic. The risk rating of this incident can also be taken into consideration when determining the response types. In addition, the response type will be agreed by the manager leading the investigation, following consultation with the patient safety team.

After Action Review - this is a more in-depth local investigation that takes place within 5 days of the incident occurring. The aim is to capture what happened, the learning and any actions. The incident will be added to Radar

Thematic Review - This can be undertaken when there are a number of similar incidents across an area. This involves reviewing the incidents for any cross-cutting themes, and looking at the wider picture, including overall patient safety data and metrics.

Hot Debrief - This is a locally led review of the incident within 24 hours of the incident occurring. The aim is to discuss what happened and any immediate learning. It will be added to the Radar for review of themes. This is also an opportunity to support staff and enable them to ask any questions at the time of the incident. This may help to address any initial concerns staff may have.

Concern – This is an event on Radar which will be relevant for minor incidents with no impact on patient safety where no in depth investigation is necessary.

Although PSIRF promotes a systems-based approach to safety investigation, the organisation is required under ISO standards to determine the root cause(s) of safety-related non-conformities. In these cases, Root Cause Analysis (RCA) will be undertaken as the method for identifying underlying causes and implementing corrective actions.

The table below provides incident responses to the top incident types affecting patients and services. Where required a thematic review will be undertaken when trends are identified for incident types with similar themes.

Patient safety incident type or issue	**Planned response**	**Anticipated improvement route**
Specimen handling errors	Record incident on Radar. Conduct an After-Action Review (AAR) if there has been a delay in patient care and /or breach of pathway. Include the learning outcomes and any actions taken.	Share learnings for reflection and improvement. Implement actions for any gaps identified.
Wound complications/infections	Record incident on Radar. Conduct an After-Action Review (AAR) if complication or infection has resulted in additional treatment and referral to secondary care. Record incident details on Radar, Include the learning outcomes and any actions taken.	Monitor for trends relating to treating clinician/nurse, type of procedure/surgery, clinic location.
Data Breach	Record incident on Radar. Conduct an After-Action Review (AAR) Record incident details on Radar, report to Data Protection Officer (DPO). Include the learning outcomes and any actions taken.	Training and awareness

Admin delays	Record incident on Radar. Conduct an After-Action Review (AAR) Record incident details on Radar, Include the learning outcomes and any actions taken.	Create an action plan for each incident based on findings from individual investigations. Monitor for trends and implement a quality improvement plan where necessary.

Learning outcomes arising from patient safety incidents will be shared across the organisation where appropriate through team discussions, meetings and training platforms. Learning outcomes and opportunities for improvement that involve outsourced services e.g. laboratories, GP practices, will also be shared with these teams.

This patient safety incident response plan is not a permanent rule and may be changed upon the discretion of management, depending on the circumstances surrounding an event. Medical Clinics Limited will remain flexible and consider the specific circumstances in which patient safety issues and incidents occur and the needs of all those affected. This plan has been aligned to the organisation's Incident Management Policy, which will be the organisation's overarching policy for incident management.