Patient Safety Incident Response Policy

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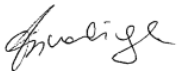
	NAME	TITLE	SIGNATURE	DATE
Author	Indra Sivalingam	Quality & Safety Manager		1 Nov 2025
Authoriser	Anna Baldwin	NHS Operations Director		4 Nov 2025

Contents

Purpose

This policy supports the requirements of the Patient Safety Incident Response Framework (PSIRF) and sets out Medical Clinics Limited's approach to developing and maintaining effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety.

"Patient safety incidents are any unintended or unexpected incidents which could have, or did, lead to harm for one or more patients receiving healthcare" (NHS England)

The PSIRF advocates a co-ordinated and data-driven response to patient safety incidents. It embeds patient safety incident response within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management.

This policy links to the existing other existing policies in the organisation:

- Incident Management Policy
- Health and Safety Policy
- Complaints Policy

This policy also supports development and maintenance of an effective patient safety incident response system that integrates the four key aims of the PSIRF:

- 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 system functioning and improvement.

Scope

This policy is specific to patient safety incident responses conducted solely for the purposes of learning and improvement across Medical Clinics Limited. Any response that seeks to find liability, accountability or causality is beyond the scope of this policy.

We will clearly distinguish between learning-focused patient safety responses and processes related to accountability or liability (for example HR, regulatory or legal processes). Where parallel processes are required, they will be coordinated but kept formally separate, and the scope of the patient safety response will not be altered to serve disciplinary, regulatory, or legal purposes. Therefore, response types that are outside the scope of this patient safety incident response plan include complaints, human resources investigations, professional standards investigations, coronial inquests, criminal investigations, claims management, financial investigations and audits, safeguarding concerns, information governance concerns and estates and facilities issues, as other processes exist for that purpose. The principle aims of each of these responses differ from those of a patient safety response.

Information from a patient safety response process can be shared with individuals/teams leading other types of responses as listed above, but these processes should not influence the remit of a patient safety incident response.

Our patient safety culture

Incident reporting is an integral part of good risk and strategic management. Patient safety is at the forefront of the organisation's values, beliefs and norms. Reporting of patient safety events is highly important, and as such incident management is emphasised across the organisation as an essential means of enhancing patient safety through learnings derived from patient safety events. Medical Clinics Limited adopts a culture of 100% reporting and encourages all employees to report all categories of events (complaints, incidents and concerns) without fear of victimisation. Staff are encouraged to seek guidance from a senior member of staff if unsure of the reporting process. The organisation's supports a culture of transparency and fairness and will always listen and support staff to speak up. This is done by putting the emphasis of incident investigations on learning and continuous improvement and not on individuals. The PSIRF guidance emphasises learning from what goes *right* as well as what goes wrong.

Responses under this policy follow a systems-based approach which recognises that patient safety is provided by interactions between various components and not from a single component. Responses do not take a 'person-focused' approach where the actions or inactions of people, or 'human error', are stated as the cause of an incident. There is no remit to apportion blame or determine liability, preventability or cause of death in a response conducted for the purpose of learning and improvement. Proportioning blame to individuals is discouraged, with the focus of investigations being processes and not people.

The organisation continues to train individuals involved in patient safety incident investigations, while also making them aware of the differences between patient safety incident responses, legal and HR processes. These types of investigation are separately undertaken but do involve the assistance of relevant team members e.g. HR Manager, to provide specialist advice to ensure staff are not unfairly exposed to disciplinary action. The NHS Just Culture Guide will be a valuable tool to facilitate discussions between managers and staff involved in incidents. Disciplinary action will only be taken if actions are identified as intentional to cause harm or gross misconduct.

The following systems are in place where all staff can record patient safety-related issues, concerns and incidents, and enables open and transparent reporting in a secure environment:

a) Radar, a quality compliance software is accessible to all employees and provides a platform for electronic capturing of all incidents, complaints and concerns.
b) The organisation's Whistleblowing and Addressing Workers Concerns policy ensures employees can speak up regarding concerns and includes the ways in which they may do this.

By making staff aware of the organisation's expectations regarding patient safety matters and PSIRF requirements, we will be reinforcing a just culture environment within the organisation. In addition to this, staff training on Freedom to Speak up and Just Culture will raise further

awareness on these topics. Different levels of training will be made available to core staff, managers and senior leaders on the Freedom to Speak Up in Healthcare e-learning for health platform.

To develop an effective patient safety incident response system that integrates the four key aims of the PSIRF, the organisation endeavours to:

1. Engage with patients and/or their family members during an investigation, to listen to their concerns and involve them in learnings or improvements where possible as a patient safety partner.
2. Supporting staff involved in incidents by using a just culture approach. Acknowledge that staff may need support when incidents reviews are undertaken by providing resources for assistance with mental health needs where needed and keeping them updated with the progress of the investigation.
3. Use the patient safety incident profile and incident data to determine the best possible response proportionate to the impact of the incident.
4. Learning from incidents and using these as opportunities for improvement, sharing learnings with staff and patients, while also including them in improvement initiatives where relevant.

Learnings from patient safety events will be communicated by providing feedback at team meetings and where relevant to the whole organisation via newsletters. Learnings are shared between partner organisations i.e. Trust and Private partnerships. Clinical Governance reports sent to ICB's monthly include reports of patient safety incidents and complaints. Reporting incidents to Regulators and other stakeholders takes place as required e.g., ICB's, LFPSE platform and CQC. All reports and learnings are communicated without disclosing confidential patient details.

Patient Safety Partners

Due to the organisation's current risk and patient safety profile, Medical Clinics Limited ***does not require*** the services of a designated patient safety partner at this stage. This position will be reconsidered during the review of this policy and if there are changes to the organisation's patient profile. Patient engagement will be done on an individual basis and patient's will be given the option of having a friend or family member representative as support during this process. Patients and family members also have the option of using patient advocacy to support them through the process. The organisation can also identify a Clinical Lead to oversee the investigation process to take on the role as a patient advocate. This process will be overseen by the Operations / Services Manager and treating doctor. In the event of the patient not wanting to see the same clinician, arrangements can be made with another senior Clinician. The Operations/Service manager will lead the investigation and will be the point of contact for the patient should they have any concerns, require any additional information or treatment.

Patients are encouraged to be a part of their own care with discussions being held by the clinical team on treatment options that would be best suited. To understand the patient's perspective on this, we have included the following questions in the patient satisfaction survey: *'Did you feel you were involved as much as you wanted to be in decisions about your care and treatment?'*
The organisation's contact details are included in all correspondence to the patient and are also available on the Medical Clinics, SCDS and Laser and Skin websites.

Addressing health inequalities

Health inequalities are unfair and avoidable differences in health across the population, and between different groups within society. These include how long people are likely to live, the health conditions they may experience and the care that is available to them. The organisation does not discriminate between patients and ensures that patients from all social groups have equitable access to treatment. All patients referred follow the same triage pathway using a set of referral and treatment criteria.

Data collected from patient records and surveys help us determine specific characteristics of our patients, e.g., disability levels and vulnerable patients, access to local clinics, as these groups are also more likely to experience challenges in accessing care. The following questions from part of the patient satisfaction survey and assist in monitoring health inequalities:

'Are your day-to-day activities limited because of a health problem or disability which has lasted (or is expected to last) at least 12 months? Include any issues/problems related to old age. What is your age group? What gender group are you?; What is your ethnic group?'

This information gives us an idea of the diversity of the patients accessing care in Dermatology. Medical Clinics Limited, addresses inequalities in the following areas by adopting certain measures as detailed below:

- The availability of services in patient's local area – The organisation runs clinics at numerous locations across Sussex, Surrey and Kent, and are therefore able to offer patients appts closer to their homes. Patients would then have to travel a shorter distance and are more likely to keep to their appointment.
- Access to transport – Patients who are vulnerable have the option of contacting the NHS patient transport service to assist with travel to appointment destinations.
- Language barriers – the organisation makes use of translator services for hearing impaired and foreign language translation.
- Patients that did not attend their appointment are offered a second chance to reschedule their appointment.
- Patients not brought to their appointment by the carer– a phone call is made to the patient and their appointment is rescheduled.

- Patients anxious about treatment/diagnosis – phone calls from the patient are routed to the relevant team member to assist. If the patient is known to suffer from anxiety, they are also given a longer appointment time slot.

Consistent with the PSIRF focus on inequalities, we will use inequalities data (including deprivation, ethnicity, disability and access indicators) to:

- ***identify whether certain groups experience different types or rates of patient safety incidents***
- ***prioritise learning responses where there is evidence of unequal impact***
- ***ensure improvement actions do not inadvertently widen inequalities.***

Engaging and involving patients, families and staff following a patient safety incident

PSIRF recognises that learning and improvement following a patient safety incident can only be achieved if supportive systems and processes are in place. It supports the development of an effective patient safety incident response system that prioritises compassionate engagement and involvement of those affected by patient safety incidents (including patients, families and staff). This involves working with those affected by patient safety incidents to understand and answer any questions they have in relation to the incident and signpost them to support as required. See NHS England's 'Engaging and involving, patients, families and staff following a patient safety, incident supporting guidance:

Those affected by patient safety incidents may have a range of needs (including clinical needs) as a result, and these must be met where possible. This is part of our duty of care. While we cannot change the fact that an incident has happened, it is always within our means to compassionately engage with those affected, listen to, and answer their questions and try to meet their needs. Engaging with those affected by a patient safety incident substantially improves our understanding of what happened, and potentially how to prevent a similar incident in future. Patients, their family members and carers may be the only people with insight into what occurred at every stage of a person's journey through the healthcare system. Not including those insights could mean an incomplete picture of what happened is created.

Staff have important contributions to make about their experience of the incident and the working environment at the time and should be supported to share their account. Staff must be given the opportunity to speak freely in a non-threatening environment without fear of repercussion. Staff must have the ability to have a colleague present for support and should also be able to access support from mental health first aiders. Managers must identify if the incident has affected staff morale or wellbeing in any way and look at ways to support the team through this.

Apologies should be meaningful and need to demonstrate understanding of the potential impact of the incident on those involved, and a commitment to address any questions and concerns. Ideally, an apology communicates a sense of accountability for the harm experienced, but not responsibility for it ahead of investigation. Getting an apology right is important – it sets the tone for everything that follows. Apologising is also a crucial part of the Duty of Candour, and we will comply with all legal requirements related to the Duty of Candour.

A legal Duty of Candour reinforces our principles of being open and involving our patients in the delivery of their care as part of our Just and Learning Culture. The Duty of Candour requires that healthcare providers make sure that patients or service users are told openly, honest and in a timely manner when mistakes happen which are believed to have caused significant harm. If a patient lacks capacity to decide regarding their own care or is deceased, then we should involve their families, or those close to them, in these discussions.

We are committed to talking to our patients, service users, families and carers at a very early stage to allow us all to understand what has happened and, where necessary, learn to prevent harm happening again as a way of improving the safety of our future patients and service users

Each approach is individualised. Engagement and involvement should be flexible and adapt to individual and changing needs. Timing is sensitive as some people can feel they are being engaged and involved too slowly or too quickly, or at insensitive times. Those affected must be treated with respect and compassion. Everyone involved in a learning response should be treated respectfully. There should be a duty of care to everyone involved in the patient safety incident and subsequent response, and opportunities must be provided for open communication and support through the process. Guidance and clarity are provided at each stage of the investigation as patients, families, and healthcare staff can find the processes that follow a patient safety incident confusing. Therefore, all communications and materials need to clearly describe the process and its purpose and not assume any prior understanding.

Everyone affected by a patient safety incident (patients, staff, families) should have the opportunity to be listened to and share their experience. The opportunity to be listened to is also part of restoring trust and repairing relationships between organisations and staff, patients, and families. The approach must be collaborative and open. An investigation process that is collaborative and open with information, and provides answers, can reduce the chance litigation will be used as a route for being heard.

Accepted subjectivity as everyone will experience the same incident in different ways. No one truth should be prioritised over others. Strive for equity - organisations may differ from patients, families, and healthcare staff in what they consider is the appropriate response to a patient safety incident. The opportunity for learning should be weighed against the needs of those affected by the incident.

Martha's Rule – Right to Escalate Concerns

Medical Clinics Limited supports the implementation of Martha's Rule, ensuring that patients, families and carers are able to escalate concerns about a patient's clinical condition or safety at any time.

All patients and families will be informed that they can:

- ***raise concerns directly with any member of staff,***
- ***request an urgent senior clinical review,***
- ***ask for a second opinion or reassessment if they feel the patient's condition is worsening, or their concerns have not been adequately addressed.***

Staff must respond to such concerns immediately and compassionately, ensure the patient is reviewed promptly by an appropriately senior clinician, and document all actions taken. Any escalation made under Martha's Rule will be recorded on Radar and reviewed as a patient safety event, with outcomes feeding into our learning response system and improvement programmes.

Patient safety incident response planning

PSIRF supports organisations to respond to incidents and safety issues in a way that maximises learning and improvement, rather than basing responses on arbitrary and subjective definitions of harm. Staff will be allocated the time away from Clinical activities to review and investigate incidents without the added responsibility of clinical duties. This will allow staff to be more focussed to consider all aspects of the investigation. Clinics will be covered by additional resources should this be required.

Resources and training to support patient safety incident response

The role of incident investigation leads lies with Operational, Service and Practice Managers. A multi-disciplinary team approach is adopted depending on the nature of incident. Additional resources will be included to provide relevant expertise i.e. Clinical Leads, HR Manager. The analysis of incidents is done by the Quality & Safety Manager.

The Quality & Safety Manager will provide training on Incident investigation and the various incident response types. Training will be done by on an ad hoc basis and will cover reporting of incidents on Radar. Training requirements will be reviewed concurrently with this policy. Incident investigators will also be required to attend PSIRF update webinars. Different levels of training will be made available to core staff, managers and senior leaders on the Freedom to Speak Up in Healthcare e-learning for health platform.

Our patient safety incident response plan

Our plan sets out how Medical Clinics Limited intends to respond to patient safety incidents over a period of 12 to 18 months. The plan is not a permanent set of rules that cannot be changed. The plan remains flexible and considers the specific circumstances in which each patient safety incident occurred and the needs of those affected. The plan provides guidance on reporting of certain types of incidents; however, a collaborative team approach is still required.

Reviewing our patient safety incident response policy and plan

Our patient safety incident response plan is a 'living document' that will be appropriately amended and updated as we use it to respond to patient safety incidents. We will review the plan every 12 to 18 months to ensure our focus remains up to date; with ongoing improvement work our patient safety incident profile is likely to change. This will also provide an opportunity to re-engage with stakeholders to discuss and agree any changes made in the previous 12 to 18 months. Updated plans will be published on the Medical Clinics Limited and SCDS websites.

A rigorous planning exercise will be undertaken every four years and more frequently if appropriate (as agreed with our integrated care board (ICB)) to ensure efforts continue to be balanced between learning and improvement. This more in-depth review will include reviewing our response capacity, mapping our services, a wide review of organisational data (for example, patient safety incident investigation (PSII) reports, improvement plans, complaints, claims, staff survey results, inequalities data, and reporting data) and wider stakeholder engagement.

Responding to patient safety incidents

Patient safety incident reporting arrangements

The company's Incident Management Policy details the process for reporting of incidents as follows; Employees must report all incidents immediately to their Line Manager. The immediate needs of persons involved in the incident are dealt with and the environment must be made safe to prevent further incidents and to safeguard others. The event must be captured electronically using the Radar Healthcare software, which is accessible to all staff via the Intranet and SystmOne. Incidents must be captured within 3 working days of occurrence to ensure that the data is current, and numbers are allocated for identification and traceability.

All serious clinical incidents will be discussed by senior management and reported to the contract commissioner within 48 hours of the incident occurring. A subsequent 72-hour report will also be sent for reassurance. Managers must ensure that all incidents are investigated within sixty days, and an action plan implemented with appropriate timescales for completion. Reporting to the relevant external bodies e.g. CQC, HSE, RIDDOR, DSPT (including statutory agencies) in the timescales required.

Where there is an agreement between the Organisation and a sub-contractor, the provider/sub-contractor will be responsible for responding to and reporting incidents and will notify the organisation immediately of any serious incidents occurring in respect of any services provided under the service level agreement.

Patient safety incident response decision-making

The Quality & Safety Manager will review all incidents reported on Radar, to ensure accuracy of information captured and request further detail when needed. Analysis of all incidents will be done by the Quality & Safety Manager to determine emerging trends and opportunities for improvement. Complex incidents require a multidisciplinary approach and will be discussed by relevant members of the management team for agreeing on a proportionate response and further actions to be taken. Additional resources required will also be discussed at this point. The team will also take decisions on responding to incidents not listed on the PSIR plan.

Responding to cross-system incidents/issues

The leadership team in the case of organisations without boards, is responsible and accountable for effective patient safety incident management in their organisation. This includes supporting and participating in cross system/multi-agency responses and/or

independent patient safety incident investigations (PSIIs) where required. Incidents requiring cross system learning responses will first be discussed at an operational and senior management level. This committee will agree on escalation of incidents as required by the ICB and PSIRF.

Timeframes for learning responses

Activity	Timescale	Detail
Reporting of incidents	Immediately, or as soon as possible after an incident occurs	Report to Line manager and Operation/Service Manager.
Recording of incidents	Log incident on Radar within 3 working days of the event.	Ensures identification and traceability. Have a record of
Completion of PSII or alternate response types e.g. AAR, concerns.	60 days	Incident investigation with learning outcomes to be completed, as per workflow steps on Radar.

Safety action development and monitoring improvement

Patent safety incident action plans are currently recorded on Radar. Action plans are specific to each incident however corrective actions for similar incidents can be linked on Radar, and this assists with identification of trends and emerging risks. Action plans from incidents are monitored by analysing data from the Radar analytics dashboard and, by using a quality scorecard. Effective action plans will result in a reduction of incidents and the scorecard gives an indication of this by measuring performance against a set target. Trends and learnings from incidents are discussed at monthly meetings. Improvement ideas are recorded on Radar Safety improvements are also communicated via the monthly Quality newsletter.

Safety improvement plans

A quality improvement plan template, incorporating the PDCA cycle has been developed and will be used for large process or system changes, where actions can be monitored and adapted according to need. All improvement ideas generated within the organisation will be recorded on as a Quality Improvement plan on Radar Healthcare. The Quality & Safety Manager oversees the reporting to ensure that ideas and actions are monitored for effectiveness, and that there is a record of all quality improvement initiatives within the organisation. Lessons learned and improvements made following an incident where a patient or service user was or could have been harmed will be shared across the organisation.

Oversight roles and responsibilities

Clinical Director:
The Clinical Directors are responsible for pursuing the aims and objectives of risk management including incident reporting and is involved in serious incident investigation where appropriate

Operations Director, Regional Ops/Service Manager, Clinical Nurse Manager, Line Managers:
It is the Managers' responsibility to ensure incident reporting procedures are in place across the workplace. Regional/Service Manager co-ordinates the incident investigation process and completes the incident investigation on Radar and informs the senior management team within 3 days of the incident happening. Reviews the risk assessment on completion of the investigation and implementation of the action plan. Reviews the actions implemented following an incident for effectiveness. Communicates learnings to the team.

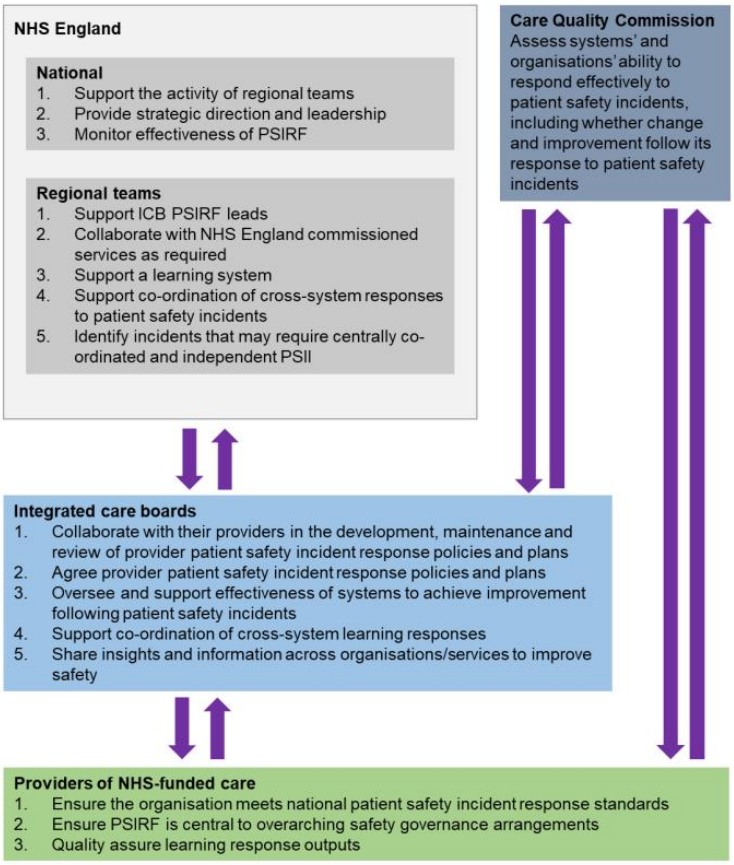
Staff:
All staff (Permanent, Bank, Contracted and Volunteers) are responsible for reporting incidents and assisting in any incident investigations, when necessary. Every member of staff must be aware of the incident reporting policy and procedure and must ensure they are able to access the incident reporting platform on Radar Healthcare.

Quality & Safety Manager:
Oversees the incident management process. Ensures that persons involved in incident reporting and investigation understand their roles and responsibilities and have the capabilities to contribute effectively to the incident reporting process. Reviews information logged on Radar for accuracy and relevance. Extracts and analyses data from Radar for the purposes of identifying trends and areas for improvement. Reports to and liaises with external agencies if deemed appropriate e.g. ICB, CQC, HSE, RIDDOR.

Patient Safety Team:
The Clinical Director is the appointed Patient Safety Manager, and together with the Service Management Team, Clinical Nurse Manager and Quality Lead, form the Patient Safety Team. The team is responsible to ensure overall compliance of the incident management policy as well as the PSIRF policy and PSIRF plan.

Integrated Care Board
The ICB will have oversight on patient safety incidents through sharing of monthly KPI dashboards, clinical governance reports and contract review meetings. An invite will be extended to assist with review and to consult on PSII.

Organisational responsibilities for an effective governance structure



Complaints and appeals

Complaints and appeals relating to the organisation's response to patient safety incidents are available through the company's website. Any concerns or complaints raised about a service provided will be taken seriously and will be managed as such. The organisation encourages patients, families or carers to raise any concerns they may have immediately and at the time they occur by speaking to a member of staff.

Related documents:

Complaints Policy
Incident Management Policy
Duty of Candour Policy
Safeguarding Policy
Patient Access Policy