PHOENIX HEALTH SOLUTIONS LTD

PATIENT SAFETY INCIDENT RESPONSE POLICY & PLAN

	PSIRF Policy & Plan Phoenix Health Solutions Ltd
Date:	**1.6.2026**
Review Date:	**June 2028**
Version	**2**
Executive Lead	**Medical Director**
Approved By	**Executive Management Group**

1. Introduction

Phoenix Health Solutions Ltd (PHS) is committed to providing safe, effective and patient-centred care.

Patient safety is the avoidance of unintended or unexpected harm arising from healthcare. When incidents occur, PHS is committed to responding in a compassionate, proportionate and learning-focused manner.

This Patient Safety Incident Response Policy and Plan describes how PHS will respond to patient safety incidents in accordance with the NHS Patient Safety Incident Response Framework (PSIRF).

The policy supports an open and just culture that promotes learning, improvement and patient safety.

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2. Purpose

The aims of this policy are to:

- Improve patient safety outcomes.
- Ensure incidents are responded to proportionately.
- Promote organisational learning.
- Involve patients, families and staff in investigations.
- Support a culture of openness and transparency.
- Meet statutory and regulatory requirements.

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3. Scope

This policy applies to:

- All permanent employees.
- Agency and temporary staff.
- Consultants and clinicians working on behalf of PHS.
- Contractors and subcontractors.
- Students and volunteers.

The policy applies to all PHS services including:

- Audiology
- Ophthalmology
- Physiotherapy
- Gastroenterology

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4. PSIRF Principles

PHS adopts the four principles of PSIRF:

Compassionate Engagement

Patients, families, carers and staff affected by incidents will be treated with respect and compassion and involved in the response process wherever appropriate.

Systems-Based Learning

Investigations will seek to understand the factors contributing to incidents and identify opportunities for improvement.

Proportionate Responses

Responses will be tailored to the circumstances, complexity and learning potential of each incident.

Effective Governance

Learning and improvement actions will be monitored through the Executive Management Group.

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5. Our Services

Phoenix Health Solutions aims to provide safe, effective and responsive healthcare services.

Services currently include:

- Adult Hearing Services
- Ophthalmology
- Physiotherapy
- Gastroenterology

PHS also works with subcontracted providers where applicable and maintains shared arrangements for incident reporting, learning and governance.

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6. Patient Safety Incident Profile

PHS reviews patient safety incidents, complaints, audits and feedback to identify areas of risk and opportunities for improvement.

Current themes identified from incident analysis include:

Clinical Documentation

- Incomplete patient records.
- Missing theatre documentation.
- Delayed completion of records.

Access and Delays

- Clinic cancellations.
- Clinic rescheduling.
- Delays to treatment.

Patient Experience

- Complaints relating to communication.
- Concerns regarding professionalism.
- Patient dissatisfaction.

Clinical Risk

- Procedural incidents.
- Follow-up delays.
- Consent-related concerns.

The patient safety profile will be reviewed annually by the Executive Management Group using incident reports, complaints, audits, patient feedback, staff feedback and LFPSE data and updated when new risks emerge.

Patient Safety Priorities 2026-2027

Following review of incident reports, complaints, audits, patient feedback and governance discussions, Phoenix Health Solutions has identified the following patient safety priorities for focused learning and improvement during 2026-2027:

Priority Area	Reason for Inclusion
Clinical Documentation	Recurring themes relating to incomplete records and documentation compliance
Access and Delays	Delays to treatment caused by clinic cancellations and rescheduling
Communication and Patient Experience	Complaints relating to communication and professionalism
Follow-Up and Care Pathways	Ensuring timely review, follow-up and continuity of care

These priorities will be reviewed annually by the Executive Management Group and may be amended where new risks, learning themes or service changes emerge.

PHS will use a range of learning responses proportionate to the nature of incidents and opportunities for learning and improvement identified.

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7. Patient Safety Incident Response Plan

PHS will use a range of learning responses depending on the nature and severity of the incident.

Incident Type	Response
Near miss	Local review and learning
Low harm incident	Incident review
Repeated incidents	Thematic review
Moderate harm incident	Clinical review
Significant patient safety concern	Patient Safety Incident Investigation (PSII)
Nationally mandated investigations	PSII

PHS recognises that not all patient safety incidents require a formal Patient Safety Incident Investigation (PSII). The most appropriate response will be selected according to the learning potential, complexity and circumstances of the incident.

The chosen response will focus on understanding contributing factors and identifying opportunities for improvement.

The Medical Director and Operations Manager will determine the most appropriate response based on:

- Actual or potential harm.
- Complexity of the incident.
- Opportunities for learning.
- Potential for wider system improvement.

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8. Patient Safety Investigation Methods

PHS may utilise:

Incident Review

A review undertaken to understand what happened and identify learning.

Clinical Review

A review of care provided against accepted standards.

After Action Review (AAR)

A structured discussion following an incident to identify learning.

Thematic Review

Review of recurring incidents or trends.

Audit

Review of compliance and effectiveness of care processes.

Patient Safety Incident Investigation (PSII)

A systems-based investigation used where significant learning may be gained.

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9. Patient and Family Involvement

PHS recognises the importance of involving patients and families following patient safety incidents.

Patients and families will be:

- Informed when incidents occur.
- Offered opportunities to share their perspective.
- Kept updated during investigations.
- Informed of findings and learning outcomes.
- Supported throughout the process.

Patient involvement will be tailored to individual wishes and needs.

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10. Staff Involvement and Support

PHS recognises that staff may be affected by patient safety incidents.

Staff will be:

- Supported throughout investigations.
- Encouraged to speak openly.
- Treated fairly and respectfully.
- Provided with opportunities to contribute to learning.

PHS promotes a just culture where learning is prioritised over blame.

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11. Duty of Candour

PHS will comply with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Where the statutory duty of candour applies, PHS will:

- Inform affected patients and families.
- Offer an apology.
- Explain known facts.

- Explain any investigation process.
- Provide written follow-up.
- Maintain appropriate records.

Compliance will be monitored through governance arrangements.

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12. Incident Reporting Arrangements

All staff have a duty to report:

- Patient safety incidents.
- Near misses.
- Hazards and risks.
- Concerns affecting patient safety.

Incidents must be reported promptly to the Operations Manager and/or Medical Director.

Where required, incidents will be reported through:

- LFPSE (Learn from Patient Safety Events Service)
- Care Quality Commission (CQC)
- Integrated Care Board (ICB)
- Commissioners

All incidents will be reviewed for learning opportunities.

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13. Learning and Improvement

PHS is committed to learning from all incidents.

Learning may result in:

- Process improvements.
- Policy updates.
- Additional training.
- Clinical audits.

- Service redesign.

All actions arising from investigations will:

- Be documented.
- Have a named lead.
- Have a completion date.
- Be reviewed for effectiveness.

Learning will be shared with staff through team meetings, governance discussions and training sessions. Learning themes identified through LFPSE reporting will be reviewed and shared with staff where relevant.

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14. Subcontractor Arrangements

PHS works collaboratively with subcontracted providers.

Subcontracted providers are expected to:

- Report incidents promptly.
- Cooperate with investigations.
- Share learning outcomes.
- Participate in governance discussions where required.

Learning from incidents involving subcontracted services will be reviewed jointly and actions monitored through governance processes.

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15. Governance and Oversight

Executive Management Group

The Executive Management Group is responsible for:

- Reviewing patient safety incidents and trends.
- Monitoring investigations.
- Reviewing learning and improvement actions.
- Ensuring compliance with PSIRF principles.

- Reviewing the Patient Safety Incident Response Plan annually.
- Providing organisational oversight of patient safety.

Medical Director

The Medical Director is the Executive Lead for Patient Safety and is responsible for:

- Clinical oversight.
- Escalation of serious concerns.
- Supporting investigations.
- Ensuring learning is embedded.

Operations Manager

The Operations Manager is responsible for:

- Incident management processes.
- LFPSE reporting.
- Monitoring action plans.
- Supporting investigations and reviews.

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16. Equality, Diversity and Inclusion

PHS will ensure patient safety investigations and responses are undertaken fairly and without discrimination.

Consideration will be given to:

- Protected characteristics.
- Health inequalities.
- Communication needs.
- Accessibility requirements.

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17. Review of the Patient Safety Incident Response Plan

The Patient Safety Incident Response Plan will be reviewed annually by the Executive Management Group.

The plan may also be reviewed earlier where:

- Significant patient safety incidents occur.
- New services are introduced.
- Significant changes occur within existing services.
- National guidance changes.
- New patient safety risks or learning themes emerge.

Any amendments to the plan will be approved by the Executive Management Group.

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18. Monitoring and Review

Activity	Frequency
Incident Review	Monthly
Governance Review	Bi-Monthly
LFPSE Reporting Review	Monthly
Action Plan Monitoring	Quarterly
Patient Safety Profile Review	Annually
PSIRF Plan Review	Annually
Policy Review	Every 2 years

This policy and plan may be reviewed earlier where significant organisational, regulatory or patient safety changes occur.

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19. Associated Documents

- Incident Reporting Policy
- Complaints Policy
- Duty of Candour Policy
- Risk Management Policy
- Safeguarding Policy
- Freedom to Speak Up Policy
- NHS England PSIRF Guidance

20. References

References

- NHS England Patient Safety Incident Response Framework (PSIRF)
- NHS England Patient Safety Incident Response Standards
- Learn from Patient Safety Events (LFPSE)
- Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
- Regulation 20 – Duty of Candour

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21. Approval and Version Control

Version	Date	Author	Summary of Changes
1.0	January 2024	Allison Jex	Original Policy
2.0	January 2026	Allison Jex	Updated to align with PSIRF and Executive Management Group governance structure