Patient Safety Incident Response Framework

Policy

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Primary Eyecare

Contents

Purpose....3
Scope....4
Our Patient Safety Culture....6
Addressing Health Inequalities....7
Engaging and Involving Patients, Families and Staff Following a Patient Safety Incident....8
Patient Safety Incident Response Planning....9
Resources and Training to Support Patient Safety Incident Response....10
Our Patient Safety Incident Response Plan....11
Reviewing our Patient Safety Incident Response Policy and Plan....12
Responding to Patient Safety Incidents - Reporting....13
Patient Safety Incident Response Decision-Making....15
Responding to Cross-System Incidents/Issues....16
Timeframes for Learning Responses....17
Oversight Roles and Responsibilities....18
Complaints and Appeals....19

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Purpose

Introduction to the Primary Eyecare Services Patient Safety Incident Response Policy

This policy supports the requirements of the Patient Safety Incident Response Framework (PSIRF) and sets out our 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. We are committed to responding to all Patient Safety Incidents (PSIs) to continually improve the safety of our services.

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 supports development and maintenance of an effective response system that integrates the four key aims of the PSIRF. patient safety incident

- 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

The organisation holds a separate Complaints policy, which may be deployed alongside this policy in the event of a PSI.

Patient Safety Culture

PSIRF recognises the important of structures in place for employees and patients involved in PSIs. Patient safety culture has been a main priority throughout the development of our PSIRF policy.

Engagement

Primary Eyecare Services has adopted a collaborative and structured approach to establishing and embedding its PSIRF response across the organisation. Our understanding of PSIRF continues to mature as part of routine governance and patient safety activity, supported by ongoing dialogue on how the framework is applied in practice. This approach has been informed through engagement with our lead PSIRF commissioner, collective input from all commissioners, and sustained internal review across clinical, governance and quality assurance teams, ensuring a consistent and organisation-wide approach to learning and improvement.

Scope

System Overview of Primary Eyecare Services

Primary Eyecare Services is a lead provider of NHS extended eye care services, providing services across 30 Integrated Care Boards (ICBs), in collaboration with 51 Local Optical Committees (LOCs). We offer 253 service pathways, providing high-quality, accessible eye care to patients in their local communities. These services are delivered across over 2,500 optometry practices with care delivered by more than 6,000 clinicians, ensuring the delivery of high-quality eye care across the country.

This policy is specific to patient safety incident responses conducted solely for the purpose of learning and improvement across our three core pillars of service delivery:

Core Services Delivered Through Optometry Practices

- Urgent Eye Care Services
- Cataract Services
- Glaucoma Services
- Children's Pathways
- Health Inequalities/Hard to Reach Groups – these include eye care for people with learning disabilities, autism and for patients with low vision
- Community Eye Care Services

Clinical Services Delivered by Primary Eyecare Services to Support and Enable Local Optometry Practices to Deliver our Core Delivery Model

- Telemedicine Services
- Clinical Triage/Referral Services
- Glaucoma Monitoring

Non-Clinical Support Services

- We provide a variety of non-clinical services, which support the delivery of our clinical services

Aims

There are four strategic aims of PSIRF that form the basis of this policy. These are aligned with our purpose, 'Working together with optometry practices and patients to deliver excellent eye care in all the communities we service'. Our core values are aligned in the table on page 5.

Responses under this policy follow a systems-based approach. This recognises that patient safety is an emergent property of the healthcare system: that is, safety is provided by interactions between 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 in a response conducted for the purpose of learning and improvement. Other organisations and processes, exist for that purpose and are outside the scope of this policy. Information from a patient safety response process can be shared with those leading other types of responses, but other processes should not influence the remit of a patient safety incident response.

Primary Eyecare Services Value	PSIRF Strategic Aim
Patient Centred: at the heart of everything we do is the provision of safe, effective and compassionate eye care provided to the highest standards always putting patient's interests, preferences and priorities first.	Improve safety and care provided to patients.
Inclusive: bringing innovation into our work with national and local stakeholders, partners and colleagues aiming for the betterment of community eye care provision. Enhance overall safety and resilience within the community while engaging compassionately with patients, their families and carers.	Improve the experience for patients, their carer's and wherever a PSI or the need for a PSI investigation is identified.
Sustainable: improve the use of valuable healthcare resources to meet patients immediate and long-term needs. Evolve services to be safe, effective and adaptable to meet patient's needed.	Improve the use of valuable healthcare resources.
Collaborative: bringing innovation into our work with national and local stakeholders, partners and colleagues aiming for the betterment of community eye care provision.	Improve the working environment for staff in relation to their experiences of PSI and investigations.
Trusted: Acting with integrity and honestly, to be accountable and responsible in everything we do.	Openness, honesty and integrity are overarching aims throughout PSIRF.

Our Patient Safety Culture

Primary Eyecare Services promotes a 'no-blame' safety culture. This approach facilitates continuous learning and improvement, focusing a good practice.

This is an organisational approach that emphasises learning from errors, near-misses, complaints, issues and incidents without assigning blame or punitive actions to individuals involved. This culture recognises that errors can often result for complex system failures rather than individual negligence, and it focuses on understanding and improving the systems to prevent occurrences.

There are a variety of actions we have taken:

Leadership Commitment: Senior Leaders champion a culture of safety and actively support a blame-free environment.

Open Communication and Reporting: encouraging all staff providing services to report error, omissions without fear of retribution.

Learning and Improvement: we focus on learning from incidents rather than attributing blame.

Non-Punitive/Systems Focused Approach: focus on identifying how systems and processes can be improved to prevent future occurrences.

Continuous Education and Training: regular training is provided to staff enhance their skills and understanding of safety protocols.

Patient-Centred Focus: a culture which encourages involvement of patients and their carer's and acknowledges the potential for error, while working to prevent them.

Transparent Communication: open communication about safety concerns, incidents and the changes made to improve patient safety.

Accountability for Systems: responsibility is shared with a focus on improving systems and processes rather than singling out individuals.

Addressing Health Inequalities

Primary Eyecare Services is accessible to the wider population. We have a strong record of supporting ICB's nationally with the development and implementation of local strategies to reduce health inequalities.

Addressing health inequalities is a priority within Primary Eyecare Services and feature across the services we deliver through the implementation of PSIRF and through our Continuous Quality Improvement Plan (CQIP).

Patient safety responses will consider a variety of health inequalities considering:

- Outcomes from patients with a range of characteristics to consider variation
- Removing barriers to participation in our services and implementing learning outcomes

We collaborate with primary care and secondary care colleagues and work with local and national organisations to raise awareness and improve access to eye care. We also engage with patients and representatives to understand how services can be tailored to meet the specific needs of local populations.

Primary Eyecare Services collaborates with both SeeAbility and Royal National Institute for Blind People (RNIB), with initiatives to improve the care patients receive.

Engaging and Involving Patients, Families and Staff Following a Patient Safety Incident

The 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 priorities 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.

Involvement of Patients, Families and Carers Following Incidents

The core values embedded within the involvement of patients; families are carers following incidents are:

- Respect
- Dignity
- Openness
- Transparency

Engagement with patients, families and carers is in line with our duty of candour policy. We ensure that patients are informed when things go wrong, why they have gone wrong and the steps we are taking to mitigate any issues, both immediately and in the future.

Compassionate Engagement

An additional component of patient safety culture is compassionate engagement. Compassionate engagement includes understanding and open dialogues with patients, families and employees. Employees within the quality team have undertaken further training to develop our understanding of compassionate engagement.

In response to evolving patient safety within the organisation, Primary Eyecare Services has a Continuous Quality Improvement Plan (CQIP). Our CQIP is informed by feedback from patients, families and carers. Our CQIP delivers our continuous cycle of quality assurance assessments across the organisation, informing our approach to quality and governance.

Our CQIP is implemented by our quality team with the aim to enhance patient safety and continuously learn from patients, families and carers following incidents. The quality team will monitor outcomes from our CQIP and evolve our approach to patient safety as required.

Support for employees following a patient safety incident includes line manager support as required. We have wellbeing support available to our staff through our employee health and wellbeing offering.

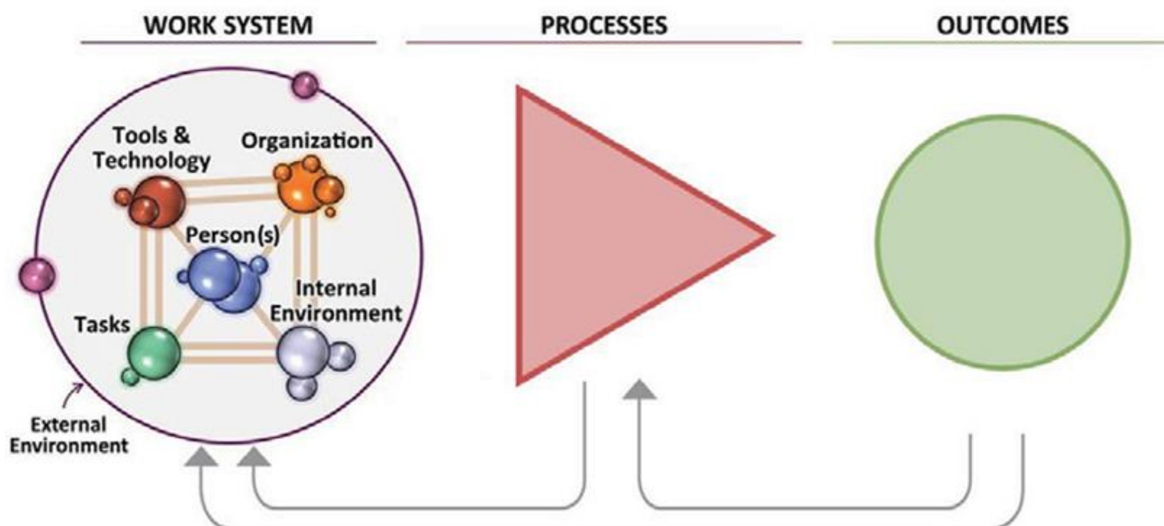
Patient Safety Incident Response Planning

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. Beyond nationally set requirements, organisations can explore patient safety incidents relevant to their context and the populations they serve rather than only those that meet a certain defined threshold.

Primary Eyecare Services PSIRF plan provides full details including:

- Investigation with the core Systems Engineering Initiative for Patient Safety (SEIPS) framework

We implement SEIPS protocol as a methodical and systematic process to identify the specific factors that contributed to a patient safety incident. SEIPS is not about a blaming people: it is about systems and processes. Our SEIPs model seeks to understand the underlying causes and environmental context which led to a patient safety incident occurring, strengthening systems in place of meeting the objective of fully securing patient safety. We follow the process below when SEIPS.



Resources and Training to Support Patient Safety Incident Response

Resource

We have reviewed roles and completed a workforce gap analysis within our organisation. This led to an updated internal structure bringing together patient safety and compliance roles within the organisation to form our quality team.

This team focuses on patient safety, enabling our organisation to continue to improve the quality of services we deliver while leading the delivery of PSIRF.

The team has extensive experience and training in healthcare quality improvement and patient safety principles to ensure that this framework aligns with regulations and standards, whilst mitigating risks associated with patient safety incidents.

Our quality team structure will be reviewed at least annually in line with our patient safety profile.

Our Patient Safety Incident Response Plan

Our plan sets out how Primary Eyecare Services intends to respond to patient safety incidents. We will remain flexible and consider the specific circumstances in which each patient safety incident occurred and the needs of those affected.

Response Evaluation

Patient safety incidents within Primary Eyecare Services will follow five categories:

- Swarm Huddle
- Patient Safety Incident Investigation
- Safety Improvement Plan
- After Action Review
- Thematic Review

Swarm Huddle: A meeting to explore an incident in a non-punitive way and deliver learning. It is a facilitated discussion on an incidents or event to analyse what happened, how it happened and decide what needs to be done immediately to reduce risk. It enables understanding and expectations of all involved and allows for learning to be captured and shared more widely.

Patient Safety Incident Investigation (PSII): A patient safety incident investigation is undertaken when an incident or near-miss indicates significant patient safety risks and the potential for new learning. Investigations explore decisions or actions as they relate to the situation. The method is based on the premise that actions as they relate to the situation. The method is based on the premise that actions or decisions are consequences, and not causes.

Safety Improvement Plan: A safety improvement plan will be identified during a patient safety incident response. We will capture necessary actions and implement a safety improvement plan to reduce future risk. This supports our aim of continuous quality improvement and gives the organisation the opportunity to develop our PSIRF response framework.

After Action Review (AAR): AAR is a method of evaluation that is used when outcomes of an activity or event have been particularly successful or unsuccessful. It aims to capture learning from these tasks to avoid failure and promote success for the future. Within the organisation we are using it to ensure that all actions resulting from a PSI are appropriately managed.

Thematic Review: A thematic review aims to identify patterns in data to help answer questions, show links or identify issues. Thematic reviews can sometimes use a combination of qualitative data and quantitative data. We deliver eye care services to patients identified as low risk and do not deliver surgical care, hence our risk profile is different to many other large providers.

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 at least every 12 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 period.

Updated plans will be published on our website, replacing the previous version.

A rigorous planning exercise will be undertaken every four years and more frequently if appropriate 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 wider 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 - Reporting

How to Report a Patient Safety Incident

Primary Eyecare Services encourages the reporting of any concerns. Our dedicated quality team are trained to manage concerns appropriately in alignment with our complaints policy and PSIRF.

Patient safety incidents can be reported to us by:

- Patients
- Families
- Carers
- Organisations

Patients, Families and Carers

Patients, families and carers can contact our quality team directly via the online feedback form accessible on our website or by emailing quality@primaryeyecare.co.uk, through the 'blue bubble' function connected to our IT system.

Sub-Contractor Practices

Sub-contractor practices must have in place and maintain staff suitably trained and competent in emergency preparedness, resilience and response. Staff providing services in sub-contractor practices can report any patient safety incident to Primary Eyecare Services by emailing quality@primaryeyecare.co.uk through the 'blue bubble' function connected to our IT system blue or by contacting the clinical lead for their area.

All patient safety incidents must be reported to the organisation within 24 hours and where possible, the same day. The flowchart below demonstrates the process for subcontractor practices to notify the organisation in the event of any patient safety.

Internal teams are encouraged to report incidents to the following email addresses:

quality@primaryeyecare.co.uk

Internal Reporting

All incidents and issues are reported by the Head of Quality to the Director of Quality and Governance at the least quarterly, along with an overview of mitigating actions. The report also contains the following items:

- Service issues
- Significant event
- Patient safety incident
- Whistleblower allegations
- Freedom to speak up instances
- Complaints
- Safeguarding concerns
- Information governance breach
- Personal data breach

The Director of Quality and Governance reports to the board quarterly, this includes trend analysis, allowing us to disseminate learning to implement safety and quality improvement.

Primary Eyecare Services complies with all regulatory reporting requirements.

External Reporting

The Head of Quality will notify the coordinating commissioner of all patient safety incidents. This will include an initial assessment which will include but not limited to the information below:

- Date of incident
- Date identified
- Incident site
- Non-identifiable patient details e.g. sex, age
- GP Practice
- Duty of Candour
- Degree of harm
- A description of the issue
- Immediate action taken by the organisation – including any action to resolve any harm or minimise any further harm to the patient
- Any other actions identified

The organisation will agree reporting timetables with the coordinating commissioner and provide interim updates as required.

Primary Eyecare Services will report patient safety incidents onto Learning from Patient Safety Events (LFPSE).

Patient Safety Incident Response Decision-Making

Duty of Candour

In line with the statutory Duty of Candour, where a PSI has resulted in serious harm or death, Primary Eyecare Services will be open, transparent and honest with the patient and, where appropriate, those close to them. We will ensure timely and compassionate communication, including a clear explanation of what is known at the time, an acknowledgement where things have gone wrong, and a sincere apology.

We will respect and uphold the patient's wishes regarding information sharing and involvement of others, ensuring confidentiality is maintained at all times. Support will be offered to patients, families and carers throughout the process, recognising the emotional impact such incidents may have.

Duty of Candour conversations and actions will be appropriately documented and form part of our learning response under PSIRF, ensuring transparency, reflection and organisational learning. This approach reinforces our commitment to a just culture, focused on learning, improvement and maintaining trust with our patients.

Responding to Cross-System Incidents/Issues

There may be cases where more than one organisation is involved in the care and service delivery where a patient safety incident has occurred.

We will notify any other providers involved in the patient safety incident and work with the commissioner and any other providers to identify and confirm the most appropriate organisation to take responsibility for coordinating the investigation.

Timeframes for Learning Responses

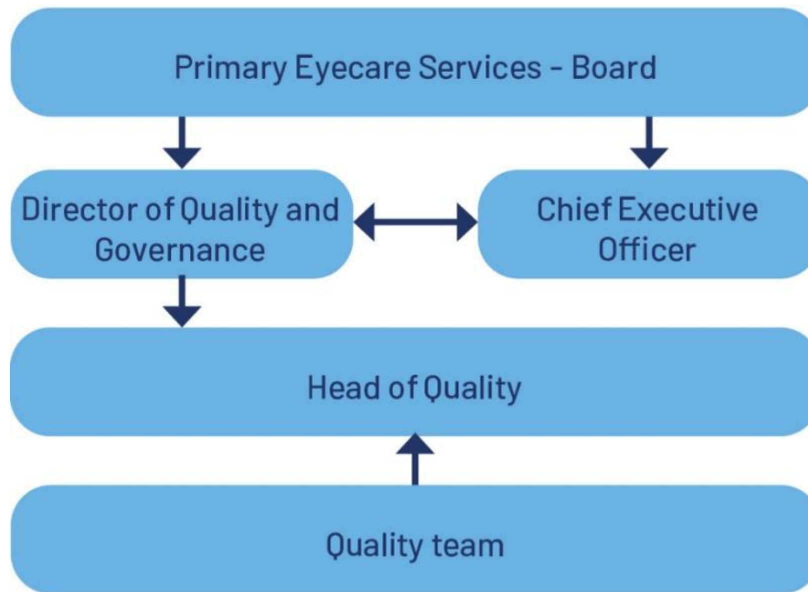
We will work collaboratively with other bodies in managing patient safety incidents. It will:

- Support and train staff in communicating information to patients
- Communicate with commissioners and all relevant bodies as appropriate
- Implement actions as required
- Close cases in a timely manner
- Review and analyse incidents and responses to learn key lessons and embed systemic improvements, in accordance with the organisation's CQIP

The organisation operates the PSIRF plan for driving an appropriate learning experience to improve patient outcomes. This will enable us to ensure quality issues are raised so we can make improvements as required. We will implement any learnings identified to mitigate the risk of a similar incident occurring.

Oversight Roles and Responsibilities

Primary Eyecare Services outlines the organisation specific structures that represent our approach to a comprehensive patient safety system.



Dharmesh Patel is the organisation's named Accountable Emergency Officer. He is responsible for patient safety incident management and reporting to all appropriate bodies. Patient safety is led internally by the Director of Quality and Governance who ensures that incident reporting and management is reported to the Accountable Emergency Officer and the board. This is operationally led by the Head of Quality and delivered by the Quality team.

Oversight of patient safety responses will be under the board of directors and reported quarterly detailing:

- Alignments of patient safety and quality improvement
- Patient safety culture centred around learning for appropriate and proportionate responses
- Learning response methods for cross directorate working
- Governance and reporting structures of PSIs
- Trend analysis overview across all incidents and subsequent outcomes

Oversight of patient safety incident plan and delivery of responses will be led internally by the Head of Quality and Director of Quality and Governance. This will include:

- Thematic analysis of organisational data
- Stakeholder engagement
- Leadership and oversight for PSI responses
- Alignment for response learning and quality priorities within the organisation

All PSIs will be reviewed by the Director of Quality and Governance with oversight from the Accountable Emergency Officer.

Complaints and Appeals

Primary Eyecare Services focuses on continuous quality improvement – it is expected that all actions taken to investigate a proportionate patient safety incident are taken.

Where a patient or their family and friends do not feel like their response has been proportionate, they can raise a concern or complaint.

All individuals affected by a patient safety incident can raise a concern or complaint with the Quality team quality@primaryeyecare.co.uk.

All our Patient Safety Incident responses include details for the local Integrated Care Board and the Health Ombudsman.

Other Relevant Primary Eyecare Services Policies

- Quality Assurance Policy
- Complaints Policy
- Duty of Candour
- Freedom to Speak Up Policy
- Information Governance and Data Management Policy
- Organisational Plan – Making Every Contact Count