Patient safety incident response plan 2026/27

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Introduction

The NHS Patient Safety Strategy was published in 2019 and describes the Patient Safety Incident Response Framework (PSIRF), a replacement for the NHS Serious Incident Framework which changes how the NHS responds to patient safety incidents with increasing focus on how incidents happen.

PSIRF does not mandate investigation as the only method for learning from patient safety incidents; nor does it prescribe what to investigate. PSIRF supports organisations to respond to incidents in a way that maximises learning and improvement rather than basing responses on arbitrary and subjective definitions of harm.

There are many ways to respond to an incident, and this document covers responses conducted solely for the purpose of systems-based learning and improvement.

Everyturn will ensure the four key aims of PSIRF are included in all responses where appropriate:

1. Compassionate engagement and involvement of those affected by patient safety incidents
2. Application of a range of system-based approaches to learning from patient safety incidents
3. Considered and proportionate responses to patient safety incidents
4. Supportive oversight focused on strengthening response system functioning and improvement.

Purpose

This patient safety incident response plan sets out how Everyturn intends to respond to patient safety incidents over a period of 12 to 18 months. The plan is not a permanent rule that cannot be changed. We will remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected.

Our Services

Everyturn provides the following range of services:

- Specialist Nursing Services

- Stepdown services from hospital
- NHS Talking Therapies
- Community Services
- Crisis Support
- Children & Young Persons (CYP) services
- Mental Health First Response Services (MHFRS)

Our locations

Talking Therapies	Nottingham and Nottinghamshire
	Derby and Derbyshire
	Peterborough
	Wirral
24-hour specialist adult care	Coalway Lane, Gateshead
	Jubilee Mews, Newcastle
24-hour specialist older adult care	Alderwood, Gateshead
Dementia care	Briarwood, Gateshead
	Pinetree Lodge, Gateshead
Community Crisis Support	Newcastle, Sunderland, North Tyneside, South Tyneside, Northumberland, Teesside
Community Mental Health and recovery support	Newcastle, North Tyneside, South Tyneside, Northumberland, Teesside
Children & Young Person Services	Gateshead & Newcastle
Stepdown beds from hospital	Woodland House, Bromley
Mental Health First Response Services (MHFRS)	Newcastle

Further information about our organisation can be found on the Everyturn website https://www.everyturn.org/

Defining our patient safety incident profile

The patient safety incident profile has been developed using multiple sources to identify the patient safety concerns most prevalent and pertinent to our organisation, a review of activity, insights and resources was considered to define our incident profile. This included triangulate of information from a wide range of sources including:

- Incidents reported: 2024/25
- Complaints, compliments and feedback
- Claims and legal cases
- Coroner's inquest findings
- National Patient Safety Alerts
- Clinica audit findings
- Accreditation reports
- Workforce shortages

The organisation will incorporate wider patient perspectives into our future patient safety incident response planning through meaningful engagement with our patients, families and carers involved in patient safety incident responses over the next 12 - 18 months.

Defining our patient safety improvement profile

Our patient safety improvement profile has been identified and agreed via insights from our patient safety incident profile and quality improvement work underway and planned. This is not an exhausted list and our processes for centralising and formalising our quality improvement activity will also aid future development of our improvement profile.

The current top local priorities are:

	Transformation and Improvement Priorities	Focus	Specialty
1	Learning Organisation	Strengthening systems for learning from incidents, improving feedback loops, and embedding a culture of continuous safety improvement to reduce repeat harm	All services

2	Journey to CQC Outstanding	Addressing identified safety and quality gaps within Specialist Nursing services, with a focus on safe care delivery, governance, and assurance	Specialist Nursing services
3	Clinical Strategies	Standardising clinical approaches and reducing unwarranted variation in care to improve safety outcomes across services	All services
4	Development of service user experience & engagement	Enhancing involvement of service users in care planning and safety-related decision making to improve outcomes and reduce risk	All services

	Incident types	Specialty
1	Disruptive / Aggressive Behaviour	All services
2	Falls	Older People's services
3	Self-harm	All services
4	Information governance / data breaches	All services
5	Physical illnesses and deterioration	Specialist Nursing Services
6	IT system failures	All services
7	Safe Staffing	All services

Our Patient Safety Incident Response Plan

The table below details the response methods which will be used for issues / incidents identified in the section 'Defining our patient safety incident profile'. The type of response to an event will depend on:

- the views of those affected, including patients and their families
- what is known about the factors that lead to the incident(s)
- whether improvement work is underway to address the identified contributory factors
- whether there is evidence that improvement work is having the intended effect/benefit
- if an organisation and its ICB are satisfied risks are being appropriately managed.

Local Requirements		
Patient safety incident type or issue	**Planned response**	**Anticipated improvement route**
Falls	Falls rapid review tool to identify if an individual learning response may be required (where there is potential for new learning or significant concern). Falls learning response tool to be used where indicated.	Create local safety actions and feed these into the clinical leads and operational groups.
Physical illnesses and deterioration	Local review by service to identify if an individual learning response may be required (where there is potential for new learning). Oversight by clinical governance to consider tool to be used (After Action Review (AAR), Case/Peer Review, Learning Team, Thematic Review)	Create local safety actions and feed these into the clinical leads and operational groups.
Information governance / data breach issues	Local review by service to identify if an individual learning response may be required (where there is potential for new	Create local safety actions and feed these into Information Governance Committee and operational groups.

	learning). Oversight by information governance to consider tool to be used (After Action Review (AAR), Case/Peer Review, Learning Team, Thematic Review)	
Disruptive / Aggressive Behaviour	Local review by service to identify if an individual learning response may be required (where there is potential for new learning). Oversight by information governance to consider tool to be used (After Action Review (AAR), Case/Peer Review, Learning Team, Thematic Review)	Create local safety actions and feed into operational, H&S and peoples groups
Self-harm (excluding deaths)	Local review by service to identify if an individual learning response may be required (where there is potential for new learning). Oversight by clinical governance to consider tool to be used (After Action Review (AAR), Case/Peer Review, Learning Team, Thematic Review)	Create local safety actions and feed into clinical leads and operational groups
Incidents of any harm level or category not listed above where potential for new learning is identified or significant concern	After Action Review, Case/Peer Review, Thematic Review	Create local safety actions and feed these into existing workstreams where applicable and into PSIRP future planning.

National Requirements		
Patient safety incident type or issue	**Planned response**	**Anticipated improvement route**
Unexpected deaths which may be due to problems in care / Never Events	All unexpected deaths to have a rapid review completed initially to identify areas of concern. Patient Safety Incident Investigation (PSII) to be completed if applicable to criteria.	Respond to recommendations as required and feed actions into the system improvement plan/quality improvement strategy


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