Implementation Plan for Eyecare Medical's Patient Safety Incident Response Policy December 2025

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Note	

Eyecare Medical: 18-Month Patient Safety Incident Response Implementation Plan (PSIRP 2025–2026

Purpose

This 18-month plan sets out how Eyecare Medical will operationalise its *Patient Safety Incident Response Policy (2025)*, embedding the NHS England Patient Safety Incident Response Framework (PSIRF).
Our aim is to strengthen governance, develop a compassionate and fair culture, and ensure learning from incidents leads to measurable improvement in patient safety and experience.

Introduction

This patient safety incident response plan sets out how **Eyecare Medical** 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

1. Description of Services

Eyecare Medical provides a range of community-based and secondary ophthalmic services across the Northwest – contracted with Cheshire and Merseyside and Derbyshire. Services include:

- Diagnostic and treatment services for retinal disease, including macular degeneration and diabetic retinopathy
- YAG laser post cataract treatment
- Minor eye conditions
- Community ophthalmology consultation and shared care with hospital trusts

Our patient population includes older adults and individuals with sensory impairment, low vision, and multiple comorbidities.

Defining our patient safety incident profile

2. Defining Our Patient Safety Incident Profile

2.1 Data Sources and Timeframe

To define our patient safety incident profile, we reviewed **18 months of data** including:

- Reported patient safety incidents (internal Datix system)
- Complaints and compliments
- Claims and near-miss events
- Clinical audit findings
- Patient feedback and Friends & Family Test comments
- National Ophthalmology Dataset benchmarking

2.2 Stakeholder Engagement

Our key stakeholders include::

Patients, families and carers.

Internal staff and leaders: Frontline staff including nurses, doctors

Management : Medical directors and manager and governance leads

External partner: ICB representatives, CQC inspectors, regulatory bodies - RCO, GMC, NMC

Workshops and review meetings were held to interpret trends, review themes, and agree priorities using PSIRF guidance.

Consideration is being given to creating a patient engagement working group in 2026.

2.3 Identified Incident Themes

Analysis identified the following recurring themes within past 18 months: June 2024 - Dec 2025

- **Medication errors** (particularly relating to intravitreal injections) 0 incidents
- **Delays in follow-up** or review of patients with chronic eye disease 1 incident
- **Communication breakdowns** between clinical and administrative pathways 1 incident
- **Access barriers** for patients with sensory impairment or language needs 0 incidents
- **Clinical documentation and consent process variation** 2 near misses

Defining our patient safety improvement profile

3.1 Identifying Priorities

Our patient safety improvement profile was determined by triangulating incident data, complaints, and quality metrics, alongside national patient safety priorities.
Local workshops agreed priorities based on *frequency, severity, and potential learning value.*

3.2 National Patient Safety Priorities

Eyecare Medical will respond to the following **national priorities** in line with NHS England PSIRF guidance:

Our patient safety incident response plan: national requirement

Patient safety incident type	Required response	Anticipated improvement route
Incidents meeting the Never Events criteria: Wrong eye treated	PSII- reported to LfPSE	Led by PSIRF learning response lead. Completed within 1-3 months from their start date. Reviewed by Patient Safety Group or Medicines Management group and reported and to and reviewed by Clinical Governance Committee. ICB Quality lead invited to meeting to review.
Death thought more likely than not due to problems in care (incident meeting the learning from deaths criteria for PSIIs)	PSII reported to LfPSE	Very unlikely to occur in services provided by ECM. If this did occur, investigation would be led by PSIRF learning response lead and completed within 1-3 months from their start date. Response reviewed by patient Safety Group or Medicines Management group and reported and to and reviewed by Clinical Governance Committee ICB Quality lead invited to meeting to review.

Deaths of patients detained under the Mental Health Act (1983) or where the Mental Capacity Act (2005) applies, where there is reason to think that the death may be linked to problems in care	PSII reported to LfPSE	Not relevant to our services
Deaths of persons with learning disabilities	Refer for Learning Disability Mortality Review (LeDeR)	Very unlikely to occur in services provided by ECM. If this did occur, investigation would be led by PSIRF learning response lead and completed within 1-3 months from their start date. Response reviewed by patient Safety Group and reported and to and reviewed by Clinical Governance Committee ICB Quality lead invited to meeting to review.
Mental health-related homicides	Referred to the NHS England Regional Independent Investigation Team (RIIT) for consideration for an independent PSII	Not relevant to our services
Maternity and neonatal incidents meeting Healthcare Safety Investigation Branch (HSIB) criteria or Special Healthcare Authority (SpHA) criteria when in place	Refer to HSIB or SpHA for independent PSII	Not relevant to our services
Child deaths	Refer for Child Death Overview Panel review	Not relevant to our services

Safeguarding incidents in which: • babies, children, or young people are on a child protection plan; looked after plan or a victim of wilful neglect or domestic abuse/violence • adults (over 18 years old) are in receipt of care and support needs from their local authority • the incident relates to FGM, Prevent (radicalisation to terrorism), modern slavery and human trafficking or domestic abuse/violence	Refer to local authority safeguarding lead	Refer to local and national safeguarding leads, investigated at national level and reported through relevant channels and PSII
Incidents in NHS screening programmes	Refer to local screening quality assurance service for consideration of locally-led learning response	Not relevant to our services
Deaths in custody (eg police custody, in prison, etc) where health provision is delivered by the NHS	Any death in prison or police custody will be referred (by the relevant organisation) to the Prison and Probation Ombudsman (PPO) or the Independent Office for Police Conduct (IOPC) to carry out the relevant investigations	Not relevant to our services
Domestic homicide	A domestic homicide is identified by the police usually in partnership with the community safety partnership (CSP) with whom the overall responsibility lies for establishing a review of the case	Not relevant to our services

Our patient safety incident response plan: local focus.

Identifying and learning

Patient safety incident type or issue	Planned response	Anticipated improvement route
1. Delays in follow-up or treatment	Moderate harm incidents in (date of data) related to follow-up delays	Thematic review of scheduling and capacity planning processes
2. Medication safety	% of incidents related to incorrect drug or dose errors	Patient Safety Incident Investigation (PSII)
3. Communication failures	Common theme in both complaints and near-miss reports	After-Action Reviews (AARs) and targeted improvement
4. Consent and documentation	Recurrent learning from audits	Learning review with staff workshops
5. Access inequities	% of incidents involving patients with sensory or communication barriers	Equality impact review and targeted improvement plan

4. Existing Improvement and Transformation Work

Eyecare Medical is already undertaking improvement programmes that align with PSIRF priorities, a shift from root cause analysis to systems orientated approach.

- **Medication Safety Project:** Introduction of triple-check procedure. The patient is checked at every contact throughout the patient journey.
- **Follow-Up and Recall Improvement:** Digital reminders and clinician review workflow updates.
- **Communication Pathway Redesign:** Shared mailbox and escalation process between admin and clinical teams.
- **Patient Experience Programme:** Routine involvement of Patient Safety team in reviewing complaints.
- **Health Inequalities Action Plan:** Identifying patterns of harm by demographic group using NHS Model Health System data.

- **Support:** Compassionate support to all patients and staff directly and indirectly affected including psychological support and access to a counselling programme as ECM recognise the considerable impact that patient safety incidents have on the emotional wellbeing of staff, patients and families and stress involved. This will reduce distress and maintain staff morale and support and the number of investigations.
- **Duty of candour:** Initial verbal apology to the patient and discussion about ongoing investigations and sharing of information followed by a written confirmation of above verbal apology.
- **Significant and new learning:** key focus that enables appropriate implementation of new improvements. Foster learning, empathy and openness.
- **Culture of openness**. To reduce fear of reporting and an open transparent culture.

5. Learning Response Methods

Learning responses will be proportionate to the level of harm and learning potential:

Response Type	Description	Typical Use
After-Action Review (AAR)	Rapid, team-based reflection	Low to moderate harm or near misses
Patient Safety Incident Investigation (PSII)	Formal systems-based review using human factors approach	Significant harm or complex system failures
Thematic Review	Review of multiple incidents with similar themes	Recurrent or systemic issues
Learning Summaries / Debriefs	Used for learning dissemination and communication	To share insights across teams

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6. Predicted Demand and Resource Availability

Based on annual incident data

- **Anticipated learning responses:** 8 – 12 per year
    - 4 PSIIs
    - 4 AARs
    - 1–2 Thematic Reviews
- **Resources Available:**
    - 1 x Patient Safety Lead (0.4 WTE dedicated)
    - 2 x Learning Response Leads
    - 1 x Engagement Lead
    - Administrative and data support (0.2 WTE)
    - Access to clinical subject matter experts as needed
    - Freedom to Speak Up Lead
- **Oversight:** Medical Director (Accountable Officer) supported by Senior Nurse and Governance Lead
  Resource levels will be reviewed quarterly to ensure capacity meets demand.

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7. Governance and Oversight

- **PSIRF Implementation Group** chaired by the Medical Director
- **Weekly Safety Meetings** for triage and prioritisation
- **Quarterly Governance Reviews** with ICB representation
- **Biannual Plan Reviews** to monitor progress and make adjustments

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8. Monitoring Health Inequalities in Patient Safety

Eyecare Medical will systematically monitor whether patient safety incidents disproportionately affect specific patient groups by:

- Recording **demographic and protected characteristic data** (where available) in incident reporting
- Analysing incidents quarterly to identify disparities
- Discussing findings at Governance Committee with Equality & Diversity Lead

- Implementing targeted improvement actions where inequalities are identified
- Reporting annually to the ICB on equity in patient safety

9. Training, Competency, and Development

- An understanding by all staff involved in PSIRF delivery of the new systems requirements who will complete:
    - **Level 1 & 2 of the NHS Patient Safety Syllabus**
    - **PSII or AAR training** as appropriate to role
- Engagement Leads will receive at least 6 hours of formal training in involving patients and families.
- A **training matrix** will be maintained and reviewed quarterly. See below

Eyecare Medical PSIRF Training Matrix

Training programme	Programme duration	Training education learning provision	All ECM Staff	ECM Staff undertaking incident investigations	ECM Patient Safety Specialist & Engagement Lead	ECM PSIRF Oversight Lead	ECM board management
Patient safety syllabus level 1: Essentials of patient safety for all staff	e-learning 40 mins	• Listening to patients and raising concerns • The systems approach to safety: improving the way we work, rather than the performance of individual members of staff • Avoiding inappropriate blame when things don't go well • Creating a just culture that prioritises safety and is open to learning about risk and safety	✓	✓	✓	✓	✓
Patient safety syllabus level 1: Essentials of patient safety for boards and senior leadership teams	e-learning 40 mins	• The human, organisational and financial costs of patient safety • The benefits of a framework for governance in patient safety • Understanding the need for proactive safety management and a focus on risk in addition to past harm • Key factors in leadership for patient safety				✓	✓

		• The harmful effects of safety incidents on staff at all levels					
Patient safety syllabus level 2: Access to practice	e-learning 40 mins	• Introduction to systems thinking and risk expertise • Human factors • Safety culture		✓	✓	✓	
Oversight of learning from patient safety Incidents (HSSIB)	1 day/ 6 hours	• NHS PSIRF and associated documents • Effective oversight and supporting processes • Maintaining an open, transparent and improvement focused culture • PSII commissioning and planning				✓	
Systems Approach to Learning (HSSIB	2 days / 12 hours	• Introduction to complex systems, systems thinking and human factors • Learning response methods: including interviewing and asking questions, capturing work as done, data synthesis, report writing, debriefs and after-action reviews • Safety action development,		✓			

		measurement, and monitoring					
Involving those affected by Patient Safety Incidents in the Learning Process (HSSIB)	1 day	• Duty of Candour • Just culture • Being open and apologising • Effective communication • Effective involvement • Sharing findings • Signposting and support			✓		
Continuing professional development (CPD)	At least annually	• To stay up to date with best practice (eg through conferences, webinars, etc) • Contribute to a minimum of two learning responses		✓	✓	✓	

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10. Continuous Review and Improvement

- **6-, 12-, and 18-month reviews** to assess progress and effectiveness
- **Annual evaluation** of learning outcomes, trends, and culture measures
- Updates shared with staff, patients, and the ICB via governance reports