Sciensus

Patient Safety Incident Response Plan

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Note: Where present, right border lines within this document indicate paragraphs modified during the latest review of this Policy.

1. Foreword

The introduction of the Patient Safety Incident Response Framework by NHS England has provided Sciensus with an exciting opportunity to support the continued evolution of a safety culture in healthcare. We are in year two of the full implementation and have already reported on the learnings from year one. The spirit of PSIRF is to focus on understanding how incidents happen, so we can learn more effectively and provide safer care for our patients.

As an organisation we are committed to creating a just and psychologically safe culture, where our employees feel empowered and supported to report safety concerns without fear of retribution or blame. To show consistency and commitment in our approach, Sciensus have implemented PSIRF across all services, and across all four nations of the United Kingdom.

Sciensus have equipped its employees with training and skills to take a systems-based approach to investigation to drive real and measurable improvement. Rather than simply focusing on what went wrong, we will examine all components of the care system to identify where change and improvement is needed. We are committed to working and engaging with our employees, patients and their families to ensure everyone is involved with incident responses and developing safety actions to improve our services.

This is now our second incident response plan, in which we recognise that work will continue to ensure the principles of PSIRF are embedded throughout the organisation. We have created a foundation of trust where employees can speak out, and will continue to reflect upon our safety data, learning responses, patient and employee feedback and safety improvement plans to ensure our focus is always learning and improvement.

I commend this plan to you and the continued strengthening of the way we work together to drive quality improvement across the organisation.

Professor Sir Jonathan Asbridge

Chief Clinical Officer

2. Purpose

This Patient Safety Incident Response Plan (PSIRP) describes how Sciensus intends to respond to, and learn from, patient safety incidents reported by Sciensus employees, patients and their families and carers over the next 12 to 18 months. Our plan will continuously evolve as Sciensus learns from its experiences as we work under the Patient Safety Incident Response Framework (PSIRF), adopted in January 2025.

Our plan will describe the data analysis and triangulation undertaken, to look at the types of patient safety incidents which have occurred to identify any themes, including national and local priorities, and outline how Sciensus will respond to ensure proportionate and meaningful learning is the focus.

Our plan will improve Sciensus' effectiveness when it comes to the investigation of, and learning from patient safety incidents by:

Adopting a 'systems thinking' approach to identify system gaps and themes which contribute to patient safety incidents, rather than looking for a single point of failure or apportion unfair blame to individuals or employees.	**Involving patients, families and Sciensus employees in learning response activities, to reflect their voice and work together to develop meaningful safety improvement actions.**
Focussing continuous improvement efforts on those identified themes and system gaps to drive measurable improvement using patient safety incident data.	**Ensuring learning responses and applicable safety improvement actions are shared across Sciensus to promote openness and transparency and demonstrate true learning from patient safety incidents.**

2.1. Aims and Objectives

By adopting the Patient Safety Incident Response Framework and associated Patient Safety Incident Response Plan, Sciensus aims to:

Improve the safety and quality of the care and service that we provide to our patients.	**Effectively measure improvement initiatives based on learning from incident responses via a robust overarching clinical quality governance structure.**
Embed a climate that supports a Just Culture where people are not punished for actions, omissions or decisions commensurate with their experience and training, but where gross negligence, wilful violations and destructive acts are not tolerated.	**Improve the experience for patients, their families and carers, and Sciensus employees wherever a patient safety incident or the need for a Patient Safety Incident Investigation (PSII) is identified.**
Respond to patient safety incidents purely from a patient safety perspective, with an appropriate and proportionate learning response.	**Support and involve patients, their families and carers, and Sciensus employees with Patient Safety Incident learning responses for better understanding of the issues and contributory factors, promoting Duty of Candour.**
Ensure appropriate resource is focused on effective learning and improvement to identify systemic contributory factors and themes, in order to develop system improvement action plans.	**Ensure our learning responses focus on a high-quality response to patient safety incidents, with the implementation of meaningful safety improvement actions that lead to demonstrable change.**

2.2. Our Values

2.3. Scope

A Patient Safety Incident is any unintended or unexpected incident which could have, or did, lead to harm for one or more patient's receiving healthcare. This plan covers responses conducted solely for the purpose of systemic learning and improvement. There is no remit to apportion blame or determine liability, preventability, or cause of death in a learning response conducted for the purpose of learning and improvement.

Responses covered in this Plan include:

• Patient Safety Incident Investigations (PSIIs)

• Patient Safety Reviews (PSRs)

Complaints management, claims handling, human resources investigations into employment concerns, professional standards investigations, coroners' inquests, or criminal investigations relate to specific issues or concerns. The principle aims of each of these responses differ from the aims of a patient safety learning response and are therefore outside the scope of this plan.

It is noted that the Patient Safety Incident Response Framework is an NHS England requirement. However, by following its principles, it also meets the requirements of the Health and Social Care Northern Ireland Procedure for the Reporting and Follow up of Serious Adverse Incidents (2016), and the Healthcare Improvement Scotland, A National Framework for Reviewing and Learning from Adverse Events in NHS Scotland (2025). Therefore, will be adopted for all of the devolved nations.

3. Definitions

After Action Review (AAR)	A tool used to debrief an event to understand what took place, why it happened the way it did, and how to improve on it.
Just Culture	A just culture considers wider systemic issues where things go wrong, enabling professionals and those operating the system to learn without fear of retribution.
Learning Response	Tools and guides, or other system-based equivalents, to explore the contributory factors to a patient safety incident or cluster of incidents, and to inform improvement.
Multi-Disciplinary Team (MDT)	A group of health and care staff who are members of different professions, that work together to make decisions regarding the care and treatment of patients and service users.
Never Events	Patient safety incidents that can cause harm (or have the potential to do so) and are "wholly preventable because guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and have been implemented by healthcare providers" [NHS Improvement 2018].
Patient Safety Incident Investigation (PSII)	A PSII is undertaken when an incident or near-miss indicates significant patient safety risks and potential for new learning.
PSIRF	Patient Safety Incident Response Framework.
PSIRP	Patient Safety Incident Response Plan.
SEIPS	"Systems Engineering Initiative for Patient Safety" is a framework that can be used in understanding inter-relationships across the structures, processes and outcomes in health care.
Stakeholders	Individuals or key groups representing patients, staff and those providing services to enable care.
Statutory Duty of Candour	A regulatory requirement for care providers to be open and transparent with service users and includes situations where things have gone wrong with care or treatment. The requirements span communication, support, truthfulness, and an apology.
Swarm Huddle	Used to identify learning as soon as possible after a patient safety incident to quickly analyse what happened, how it happened and decide what needs to be done to reduce risk.
Systems Thinking	A mindset of ensuring that an investigation explores the multiple interacting contributory factors across the care system.
Thematic Analysis	The process of examining and assigning codes to text (e.g. incident narratives), in order to identify and group information into common themes. This assists in the interpretation across a range of inter-related data and can support learning across multiple investigations.

4. Responsibilities

Individual roles and responsibilities under the Patient Safety Incident Response Framework are defined within the Patient Safety Incident Response Policy.

5. Defining Our Safety and Improvement Profile

5.1. Our Service Models

Bloods Only
Clinical Study – Nursing Only
Continuous Nurse Administration Only
Delivery – On Demand Supply + Nurse Training
Delivery – Regular Supply + Continuous Nurse Administration
Delivery – Regular Supply + External Nurse Training
Delivery – Regular Supply + Nurse Injection Admin + Patient Support Programme
Delivery – Regular Supply + Nurse Training
Delivery – Regular Supply + Nurse Training + Patient Support Programme
Delivery – Regular Supply + Patient Support Programme
Delivery Only – On Demand Supply
Delivery Only – Regular Supply
Early Supported Discharge
Helpline Only
Intravenous Antibiotics
Nurse Training Only
Provider Transition Pathway – Pharma
Switch Referral – Delivery Only
Stores and Nursing Only
Stores Only

5.2. Our Data Sources

Patient Safety risks for our organisation captured over 2025 were reviewed and defined by creating a safety profile from various data sources. Data sources utilised for our safety profile included:

- Patient Safety incident data
- Formal complaints
- Information Governance risks with a patient safety impact
- Duty of Candour and serious incidents involving moderate or severe harm
- Deaths within 30 days of systemic anti-cancer treatment
- Invoice queries
- Near miss error logs for dispensary and pharmacy
- Whistleblowing
- Organisational abuse allegations (Safeguarding)
- Legal / compensation claims

Incident/event types, recurrence, common themes, and risk of harm were explored alongside any safety improvement intervention projects already in place. The development and definition of our safety profile was led by the Patient Safety Team. Responsible leads and data owners were consulted during profile development to ensure meaningful analysis and understanding of the data underpinning our response plan. This data has enabled Sciensus to identify the types of incidents/events that are impacting our patients the most, and where we need to learn and prevent such events from recurring in the future.

5.3. 2025 PSIRF Learning Responses Demands

National priority investigations:	Volume:
Incidents meeting the ‘Never Events’ criteria published by NHS Improvement in 2018	0
‘Learning from Deaths’: Death thought more likely than not due to problems in care (incident meeting the learning from deaths criteria for patient safety incident investigations (PSIIs))	0
Notifiable safety incidents meeting the statutory ‘Duty of Candour’	0
Local priority investigations:	
AAR	19
Swarm huddle	16
Thematic review	2
MDT review	24
SEIPS	11
Observational study	2
Pressure ulcers acquired during the provision of homecare	2

Suspected or confirmed catheter-related bloodstream infections during the provision of Sciensus care/treatment	18

5.4. Identified Patient Safety Themes

The information below describes our organisation's top patient safety themes alongside key sub-themes and known insights identified through our safety profile analysis. For this exercise and to understand key themes across different services, safety data was reviewed within the dispense and delivery and nursing services.

5.4.1. Dispense and Delivery Services

Patient Safety Theme	Key Sub-Themes	System Insights
Dose(s) Omitted or Delayed - Medication Not Available To Patient	Prescribing – no prescription written	Late prescriptions received from referring hospital Trusts is a consistent top risk accounting for 83% of dispense and delivery service patient safety incidents.
	Patient Services – unable to contact patient	Patient Services have been unable to contact the patient to arrange a delivery of medication, resulting in an omitted or delayed dose of medication. This is the second most prevalent patient safety risk within dispense and delivery services, accounting for 4% of patient safety incidents.
	Delivery failure – patient not in to receive	Within top three patient safety risks for dispense and delivery services and 3% of reported patient safety incidents. A delivery is attempted within the allocated time window, but the patient is not available to accept it.
	Delivery Not Confirmed with Patient	Identified as top internal patient safety risk, with 55% of these incidents relating to Analytics – systemic themes of SMS deliveries not being arranged in line with patient stock levels, and patient call tasks not opening or being completed.
	Unclassified delivery failures	Themes include deliveries being scheduled despite being over delivery capacity or having no available delivery capacity.
Medication error > Medication administered. (Dose not omitted/delayed)	Prescription services - Prescription / Order Data Entry	Consistent top internal trend for medication incidents. Top themes relating to transcription of medication details (drug name, drug brand, strength, formulation, dose in units, dose frequency or delivery frequency) from the prescription, which has not been identified in the downstream checks and thereby has resulted in a medication supply error to the patient.

		The top 3 near misses reported within Prescription Services involved transcription, approval, and front-end accuracy check. Consistent trend within invoice queries during the same time period.

5.4.2. Cancer

Patient Safety Theme	**Key Sub-Themes**	**System Insights**
Access / admission / transfer / discharge	Unplanned admission / transfer to specialist care unit	Unwell patients transferred into a hospital setting for further management. Top themes resulting in admissions include infection (37%) disease related symptoms (26%) and other comorbidities (15%).
Dose(s) Omitted or Delayed - Medication Not Available To Patient	Dispensing - Missing Item, Prescribed, Entered but Not Dispensed	Unable to compound chemo/immunotherapy due to equipment failure within the compounding unit. These events affect multiple patients at a time and due to treatment length, geographical location and nursing capacity patients can experience treatment delays. 37% of medication incidents attributed to unit equipment failures.
Reported Patient Death	Death within 30 days of systemic anti-cancer treatment (SACT)	Of the 87 deaths reported within the cancer service in 2025, 24% were within 30-days of treatment. Individual and collective mortality case reviews have been conducted, with the following themes identified: ➢ Documentation / assessment of response to treatment ➢ Assessment of fitness for treatment including performance status ➢ Assessment and escalation of deterioration
Infection - cross / healthcare associated	Suspected or confirmed catheter-related bloodstream infection	Whilst incidents of this nature are low volume, the risk for patient harm is high. Investigation findings have included: ➢ Inconsistent audit practices across regions ➢ Poor delayed wound healing following portacath insertion

5.4.3. Early Supported Discharge

Patient Safety Theme	Key Sub-Themes	System Insights
Patient Accident	Slips, trips, falls	Unwitnessed patient falls on service with varying degrees of harm, infrequently as the result of internal error. Reported falls account for 21% of all patient safety incidents within ESD services. Exploration of falls across all nursing services have identified themes of inconsistencies between services of when to risk assess and appropriate signposting, developing opportunities for improvements within this area.
Pressure Ulcer	Acquired during NHS care Acquired during homecare	47 pressure ulcers reported across 2025, with 2 acquired during the provision of homecare. Investigation findings from homecare acquired pressure ulcers identified a common theme of patients declining daily visual assessment of pressure areas.

5.4.4. On Demand (Nursing Services excluding Cancer and Early Supported Discharge)

Patient Safety Theme	Key Sub-Themes	System Insights
Treatment / procedure - delay / failure	Omitted dose - poor venous access	Consistent top trend of abandoned/rescheduled treatments due to failed peripheral cannulation making up 36% of all on demand nursing patient safety incidents. The top therapy area reporting failed cannulation is Enzyme Replacement (Lysosomal Storage Disorders).
Medication error (medication administered)	Drug administration error	Identified themes from incident data and investigations have included: ➢ Induction dosing of biologic drugs not administered ➢ Errors in reconstitution of medicine, such as incorrect fluid volume. ➢ Failure to check prescription. ➢ Failure to check medicine labels.

5.5. Existing Service Improvement Projects

To identify and agree our patient safety improvement profile, the top safety risks highlighted above were individually scrutinised and shared amongst key stakeholders to understand what improvement and service transformation projects are currently underway or planned across the organisation. To do this, reviews have been conducted of business-wide transformation projects, change control and CAPA documents, local improvement initiatives and action plans, and Patient Safety Improvement Group (PSIG) outcomes.

Where improvement work relates to identified patient safety issues, we must consider the balance of effort between ongoing improvement work and additional learning responses to individual incidents. Where an incident type is well understood – for example incidents of a particular type have been thoroughly investigated and improvement plans targeted at these contributing factors are implemented and monitored – resources may be better directed at continuing improvement rather than repeated investigation or using another type of learning response. Through this work, we have identified where additional learning responses would be beneficial to our organisation as part of our response plan.

6. Our Patient Safety Incident Response Plan

6.1. National Requirements

Patient safety incident type	Required response	Anticipated improvement route
Incidents meeting the 'Never Events' criteria published by NHS Improvement in 2018. Events applicable to services delivered by Sciensus include: *5. Administration of medication by the wrong route* *6. Overdose of insulin due to abbreviations or incorrect device* *12. Transfusion or transplantation of ABO-incompatible blood components or organs* *14. Scalding of patients*	Patient Safety Incident Investigation (PSII)	Create local organisational actions and share these at quality and governance forums. Review within Patient Safety Improvement Groups. Please see 6.4 for implementation and monitoring of safety actions.
'Learning from Deaths': Death thought more likely than not due to problems in care (incident meeting the learning from deaths criteria for patient safety incident investigations (PSIIs))		

6.2. Local Focus

Listed below are our organisation's local patient safety incident priorities identified from the safety and improvement profiling work undertaken. The criteria for selection as a local priority included:

- Incidents/events identified that commonly occurred within patient safety incident data and other safety data sources,
- Areas where there is reduced confidence that our organisation has comprehensive insight into systemic contributing factors,
- Areas where there is insufficient evidence to demonstrate that current improvement and service transformation projects underway have effectively reduced risks.

Our local priorities will be reviewed throughout the lifespan of this plan as continued improvement work is undertaken and the organisation becomes more confident under the principles of the incident response framework.

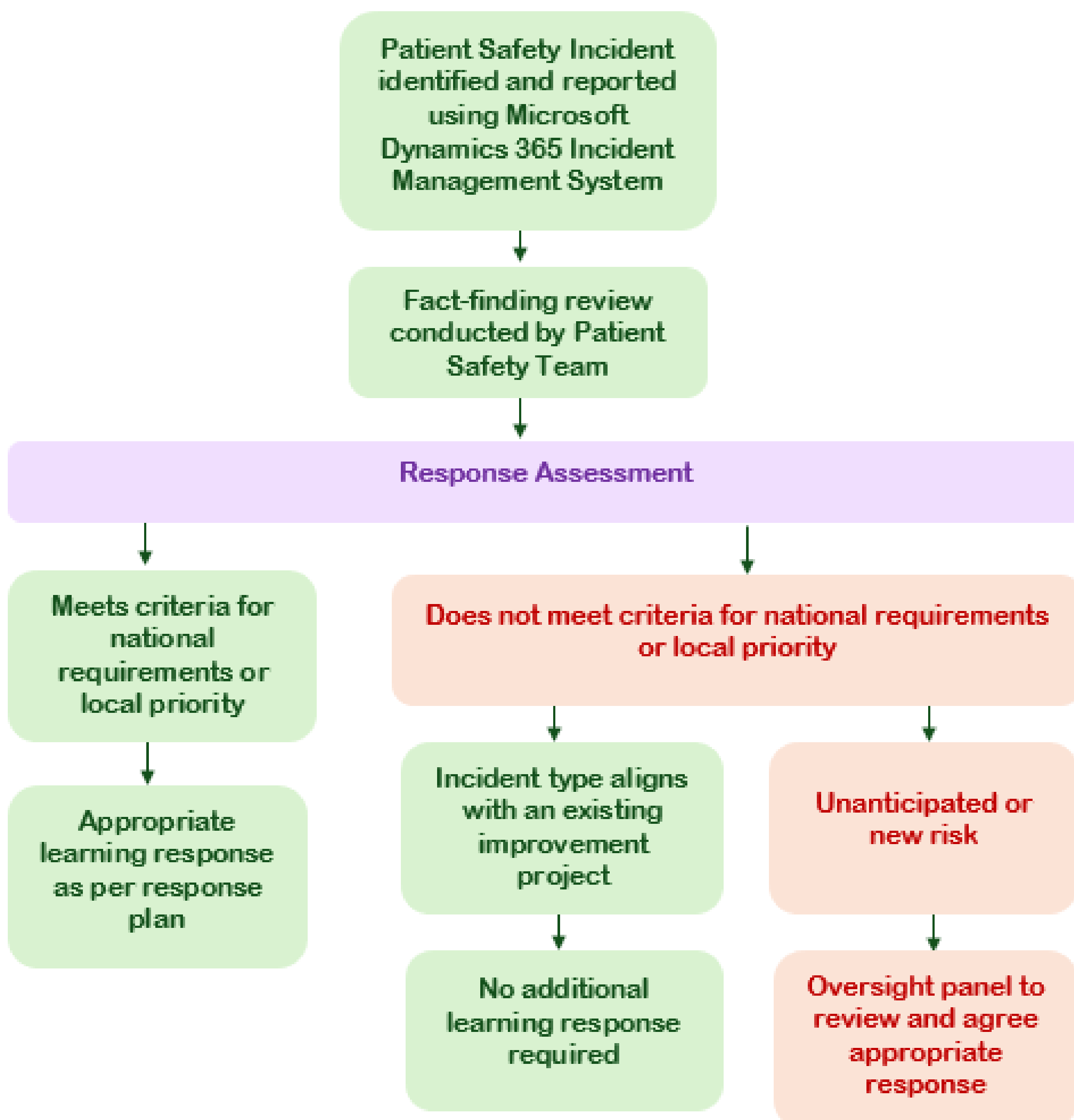
Patient safety incident type or issue	Planned response	Anticipated improvement route
Notifiable safety incidents as defined by the Care Quality Commission: 1. *It must have been unintended or unexpected.* 2. *It must have occurred during the provision of a regulated activity.* 3. *In the reasonable opinion of a healthcare professional, already has, or might, result in death, or severe or moderate harm to the person receiving care.*	Patient Safety Incident Investigation (PSII)	Create local organisational actions and share these at quality and governance forums. Review within Patient Safety Improvement Groups. Please see 6.4 for implementation and monitoring of safety actions.
Delivery Not Confirmed with Patient *Patient safety incidents of missed/delayed doses due to failures within analytic services*	Further exploration is required via thematic analysis. Aim of thematic analysis to understand common links and themes within a cluster of events or incidents and seek to understand the barriers and contributory factors using a systems-based approach.	Data collated from thematic reviews will be used to support ongoing improvement initiatives and development of safety actions. Review within Patient Safety Improvement Groups. Please see 6.4 for implementation and monitoring of safety actions.
Unclassified delivery failures *Patient safety incidents of missed/delayed doses due to a failed delivery, where*		

the 'delivery issue/ reason code has been applied		
Prescription / Order Data Entry- **Patient safety incidents of medicine supply errors due to incorrect transcription, approval, accuracy check or dispensing of a prescription.**		
Unplanned admission / transfer to specialist care unit- **Cancer – severe/unmanageable toxicity and neutropenic sepsis**	To continue to identify learnings from individual and collective case reviews and use open discussion to explore a safety theme, pathway or process via MDT review. To gain insight and establish whether systemic changes are needed.	Incidents/events to be presented monthly to the *'Committee for the Unwell SACT Patient'* to identify learnings and actions for service improvement across the Cancer Directorate. Create local organisational actions and share these at quality and governance forums.
Reported Patient Death- **Deaths within 30 days of systemic anti-cancer treatment (SACT)**		All deaths within 30 days of SACT to be presented to the '*Sciensus Cancer Mortality Review Committee'* (CMRC) to identify learnings and actions for service improvement across the Cancer Directorate. Create local organisational actions and share these at quality and governance forums.
Medication error (medication administered)- **Drug administration error**	SEIPS-based investigation of individual events for prompt learning. Bi-annual thematic analysis to understand common links and themes within a cluster of events or incidents and seek to understand the barriers and contributary factors using a systems-based approach.	Create local organisational actions and share these at quality and governance forums. Review within Patient Safety Improvement Groups. Please see 6.4 for implementation and monitoring of safety actions.
Pressure Ulcer- **Acquired during homecare**	After Action Review Swarm huddle All staff involved to gather after the event and analyse what happened and why to enable insights and	

	reflections and generate prompt learning. Create a common understanding of the event, reflect on successes and failures and identify specific recommendations and group safety actions.	
Infection - cross / healthcare associated- **Suspected or confirmed catheter-related bloodstream infection**	Local systems-based investigation tool underpinned by the SEIPS framework. Bi-annual thematic reviews of completed learning responses to identify common or shared themes.	Create local organisational actions and share these at quality and governance forums. Review within Patient Safety Improvement Groups. Please see 6.4 for implementation and monitoring of safety actions.

6.3. Response Assessment

6.3.1. Overarching Response Assessment



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6.3.2. Oversight Panel

In the event of an incident type not meeting the criteria as a national requirement or local priority, or is not aligned with an existing improvement project, an oversight panel will be gathered as soon as is practically possible to review and agree the most appropriate learning or improvement response.

An appropriate response will be decided based upon:

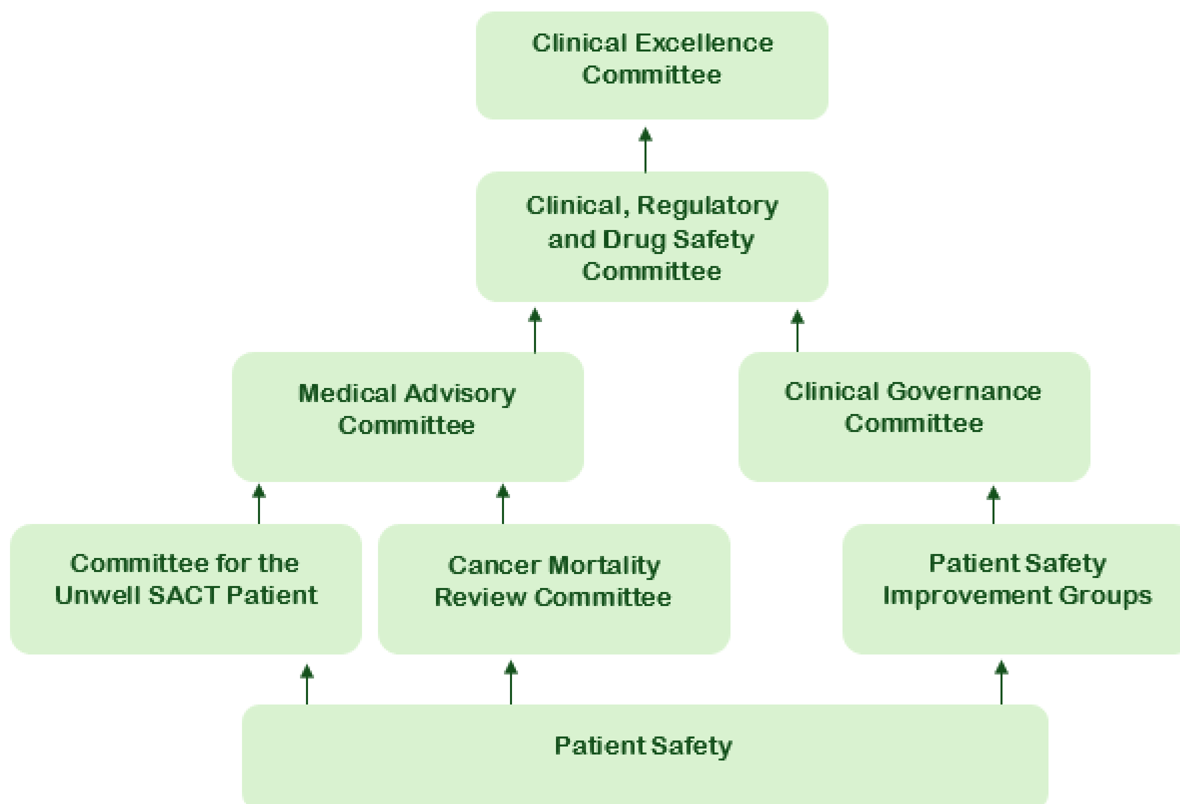
- How well contributing factors to the incident are understood and whether improvement work is already underway,
- Expected potential for learning or new insights,
- The views of those affected, including patients and families,
- Which type of learning response would provide the richest insights,
- Capacity available to undertake a learning response against capacity to implement or inform ongoing improvement work.

6.4. Implementation and Monitoring of Safety Actions

Patient safety learning responses will be used to develop systems-based safety improvement actions and inform the development and effectiveness of ongoing quality improvement projects across the organisation. Safety action development and monitoring improvement is defined within the Sciensus Patient Safety Incident Response Policy. In line with this response plan, Sciensus will ensure:

- Safety actions and recommendations arising from learning response activities are systems-based,
- Trended data from Patient Safety incidents will contribute to and continue to inform ongoing quality improvement work across the organisation,
- Learning responses will inform the implementation and/or development of safety improvement plans, whether at local level or business-wide,
- All quality improvement work informed by Patient Safety data and/or learning responses is continually monitored for progress and effectiveness via continuous improvement and governance leads, including Patient Safety Improvement groups.

6.4.1. Oversight Structure for Governance and Quality



Individual roles and responsibilities of our organisation’s oversight structure are defined within our Patient Safety Incident Response Policy. Oversight responsibilities will focus on:

- Ensuring those affected are engaged and supported,
- Ensuring learning responses are proportionate,
- Ensuring findings and recommendations are systems-based,
- Supporting collaboration with improvement activities.

7. Monitoring Compliance

7.1. Aspects of Compliance or Effectiveness being Monitored

Accuracy and quality of completed Patient Safety incidents to provide assurance of:

- Accurate assessment of degree of harm/patient impact
- Correct incident coding used for data trending purposes
- Contributing factors and risks accurately identified

Accuracy and quality of completed Patient Safety learning responses to provide assurance of:

- Compassionate engagement with those affected
- Application of a systems-based approach to identifying contributing factors
- Systems-based findings and recommendations

7.2. Monitoring Method

Patient Safety incidents are audited using a Patient Safety Incident audit tool developed by the Sciensus in 2020. Audits will continue to be conducted monthly by the Patient Safety Specialist as per existing Patient Safety monitoring processes as defined within internal policy.

Learning responses will be audited using the Health Services Safety Investigations Body (HSSIB) Learning Response Review and Improvement Tool. Audits will be conducted bi-annually by the Patient Safety Specialist, Medication Safety Specialist and Head of Patient Safety. Audit findings will be shared with the Clinical Governance Committee to provide assurance of our commitment to the principles of PSIRF and inform further learning and improvement as a Patient Safety function.

All PSII's will be subject to review and approval via the oversight structure, using the Health Services Safety Investigations Body (HSSIB) Learning Response Review and Improvement Tool to ensure compliance with the principles of PSIRF.

8. Review

This Patient Safety Incident Response Plan (PSIRP) describes how Sciensus intends to respond to, and learn from, patient safety incidents reported by Sciensus employees, patients and their families and carers over the next 12 to 18 months. Our safety profile and local priorities will be reviewed throughout the lifespan of this plan as continued improvement work is undertaken to ensure our focus remains up to date. 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 wide review of organisational data (PSII reports, improvement plans, complaints, staff survey results, inequalities data and reporting data) and wider stakeholder engagement.

More frequent reviews are permitted if deemed necessary by the Document Owner or following change in the Policy or Legislation.

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NHS England (2022) Guide to responding proportionately to patient safety incidents.

NHS England (2022) Patient Safety Incident Response Framework.

NHS England (2022) Patient safety incident response standards.

NHS England (2022) Patient Safety Incident Response Framework Preparation guide.

10. Related Documents

Sciensus Patient Safety Incident Response Policy

Further Sciensus documents, standard operating procedures and policies relating to Patient Safety and PSIRF are available internally to Sciensus staff and employees.