Turning Point Patient Safety Incident Response (PSIR) Plan

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Introduction

Turning Point Patient Safety Incident Management Plan (PSIR Plan)

The Turning Point PSIR Plan outlines our systems-based approach to learning from safety events and incidents and how it may be tailored proportionately for locally commissioned NHS services. It aligns with the NHS' **Patient Safety Incident Response Framework (PSIRF)**, which is embedded in our national **Incident Management Policy** and applies across all Turning Point services,

This plan specifically addresses 'in-scope' services where:

1. The **NHS Standard Contract** is in place, and
2. Services are **locally commissioned by NHS commissioners** to apply PSIRF.

As Turning Point is not an NHS Trust, we follow the guidance *"Applying the Patient Safety Incident Response Framework outside of NHS trusts"*, allowing for local flexibility and proportionality in implementation.

The document also introduces our approach to developing a **Patient Safety Improvement Profile (PSIP)**, aligned with PSIRF and our Incident Management Policy. It clearly distinguishes between national governance responsibilities and locally commissioned, local service-level (and local system-level) implementation, particularly in relation to PSIP development, PSIRF implementation, and commissioner engagement.

This tailored approach, along with our overarching policy, has been formally endorsed by the **West Yorkshire Integrated Care Board (WYICB)**, Turning Point's Lead ICB.

Our services

Turning Point is a leading national provider of services across learning disability, mental health, public health, and substance use, working with a broad range of commissioners, including the NHS. We deliver high-quality, accredited care, earning sector leading CQC ratings and recognition from royal colleges.

Importantly, our local services work in close collaboration with system partners and local patient safety teams to embed learning at every level. This local partnership-driven approach ensures that local safety insights are shared, acted upon, and translated into meaningful improvements. By **working together within local systems**, we help create services that are safe, responsive, adaptive, and continually improving to meet the evolving needs of the communities we serve.

Defining our patient safety incident profile

Our patient safety incident profile for PSIRF purposes is developed proportionately and maintained at a **local service and local-system level**, in collaboration with **local-system partners**. This ensures that the profile reflects the specific local context, local risks, and local priorities of our service and the communities we serve.

Following our **Incident Management Policy**, we apply structured learning methodologies—such as **After-Action Reviews (AARs)** and **Patient Safety Incident Investigations (PSIIs)**—to support deeper analysis and practical learning from safety events. We draw on a wide range of data sources, including **Vantage incident reports**, feedback, complaints, claims, and audit findings, to identify the types, frequency, and severity of patient safety incidents. This analysis is conducted proportionately, reflecting the scale and complexity of each service, and is aligned with locally commissioned priorities to ensure relevance and responsiveness to local system needs., and in line with **locally commissioned priorities**.

For PSIRF purposes, the development and ongoing review of our incident profile is conducted locally, as commissioned, within **local contract management processes**, ensuring regular oversight and responsiveness to emerging risks in the local system. While this work is locally led, it is supported by access to Vantage incident management dashboards, operational governance support and **organisational oversight at a national level**, ensuring alignment with broader patient safety objectives and the principles of the Patient Safety Incident Response Framework (PSIRF) including voluntary reporting via the Learning From Patient Safety Events (LFPSE) system, in collaboration with local system partners.

Defining our patient safety improvement profile

At Turning Point, our commitment to patient safety is embedded in every aspect of our service delivery and transformation agenda. We recognise that our patient safety improvement profile is shaped by a combination of reactive learning from local and aggregated incidents and proactive initiatives. These efforts are designed to reduce harm, enhance service user experience, and build a culture of openness and continuous improvement.

Current Improvement and Transformation Work

- **Implementation of Vantage**: Our new incident and accident management system has been developed to align with PSIRF principles. Phase 2 includes integration with the NHS Learning from Patient Safety Events (LFPSE) system via API, and a direct feed from the MHRA to support timely alerts and responses.
- **Policy and Procedure Review**: We have updated our Incident Management Policy and associated documents to reflect PSIRF requirements proportionately. These updates ensure clarity in roles, responsibilities, and processes across NHS and non-NHS services.
- **Training and Capability Building**: We have expanded our internal learning repository to include PSIRF-specific resources for all services and guidance on accessing E-LFH and HSSIB training courses. Our training covers the requirements of the Patient Safety Syllabus and accommodates local service flexibility needs.
- **Learning from Incidents and Near Misses**: We have strengthened our incident reporting and learning systems to ensure timely (live) analysis and dissemination of learning based on systematic recording of learning responses and actions taken.
- **Learning Dissemination**: Our systems allow for more systematic capture and dissemination of local learning outcomes. All service managers have robust incident management dashboards and access to substantial operational and organisational support. We will disseminate learning through through line management structures and thematic governance groups—including the Medicines Optimisation Group, Safeguarding Group, and National Mortality Group—ensuring learning informs practice across all levels of the organisation.

Workforce Wellbeing and Safety Culture: Recognising the link between staff wellbeing and patient safety, we are investing in psychological safety, supervision, and leadership development to foster a culture where staff feel safe to speak up and learn

Our patient safety incident response plan: National requirements

The national event response requirements and the PSIRF *Guide to responding proportionately to patient safety incidents* are fully reflected (as applicable) in Turning Point's Incident Management Policy and supporting documents. Turning Point's national governance structures provide **strategic oversight and coordination of patient safety improvement work**. These include the Quality Risk and Assurance Group, Practice Governance Group, National Mortality Group, National Safeguarding Group, Medicines Optimisation Group, and Information Security Group. These groups are responsible for:

- Identifying and monitoring national trends in incidents and risks
- Developing and reviewing risk reduction strategies
- Supporting services with policy, training, and learning resources
- Ensuring consistency in the application of incident management (including PSIRF principles) across the organisation

Turning Point's national Incident Management Policy is the overarching framework that embeds PSIRF principles across all services, ensuring consistency in incident response, learning, and improvement.

Our patient safety incident response plan: Local focus

Turning Point's local **services will work together with commissioners and local patient safety teams to develop the most appropriate model** for their services within the local systems, considering the national PSIRF guidance: *Applying the Patient Safety Incident Response Framework outside of NHS trusts*.

At the local service level, PSIP development is tailored to the specific risks, contractual obligations, and operational context of each service and will be routinely incorporated into a single "Service Improvement Plan." Local teams, including Operations Managers and Regional Managers, are responsible for:

- Reviewing incident data and learning outcomes from Vantage
- Engaging with clients, families, and frontline colleagues
- Identifying service-specific safety priorities
- Agreeing PSIP priorities with commissioners through contract monitoring and reporting arrangements
- Ensuring alignment with local safeguarding, mortality governance, and quality assurance processes

- Reporting applicable incidents via the Learning From Patient Safety Events (LFPSE) system, in collaboration with local system partners and arrangements.

* n.b. "Service Improvement Plan" may have different names in some services, due to local variations.

Local Services – Key Roles

Engagement with local commissioners and local systems to identify system priorities and actions will develop via local contract monitoring processes (noting national oversight) via key local roles – ensuring a local focus.

Based on the requirements of the NHS Standard Contract role of **Patient Safety Specialist** is designated by the relevant business unit, and agreed nationally with the Lead Integrated Care Board (ICB), whilst the role of **Learning Response Lead** is **designated at the service level, as locally commissioned** and negotiated with the commissioning Integrated Care Board (ICB). These are not national roles but support the local systems and local implementation of the NHS Patient Safety Strategy. This approach aligns with NHS England's guidance for non-NHS Trust providers, which emphasizes that PSIRF implementation should be locally led and proportionate, allowing system partners to co-design systems that nurture patient safety improvement rather than compliance with centrally mandated measures.

Turning Point's Service Managers and Locality Managers are responsible for:

- Fulfilling the PSIRF Patient Safety Specialist requirements locally, including local implementation of the Patient Safety Syllabus.
- Reviewing incident data and learning outcomes using Vantage
- LFPSE reporting (as applicable)
- Ensuring compassionate engagement with those affected by incidents
- Identifying and agreeing local PSIP priorities with commissioners through contract monitoring and reporting
- Maintaining a Service Improvement / Action Plan that encompasses the local PSIP priorities

Monitoring and Review

Turning Point's incident management is embedded within a dynamic and responsive governance framework, coordinated through its Risk and Assurance Department. This includes the **Quality Risk and Assurance Group, National Mortality Group** and our **Operational Management Groups.**.

These groups provide **ongoing oversight** of incidents, trends, and learning responses. Through regular review cycles and integrated reporting mechanisms, they ensure that:

- **Incident trends are continuously monitored**, enabling timely identification of emerging risks.
- **Learning is routinely captured and disseminated** across the organisation to inform practice and policy.
- **Risk reduction strategies are actively implemented and reviewed** to ensure effectiveness and sustainability.

Turning Point's Safety Incident Management Plan ('PSIR Plan') will be **routinely reviewed** in conjunction with the review of Turning Point's Incident Management Policy (bi-annually or as needed, if sooner) and communicated with the Lead ICB.

Escalation of Local ICB Feedback via the Lead ICB

Where feedback, concerns, or unresolved issues arise from local Integrated Care Boards (ICBs) that cannot be resolved through routine contract monitoring or local governance mechanisms, Turning Point will escalate these matters via its designated Lead ICB, currently West Yorkshire ICB.

This approach aligns with NHS England's guidance on quality risk response and escalation, which encourages proportionate, collaborative resolution of system-level concerns and supports the role of Lead ICBs in coordinating cross-system learning and oversight. The Lead ICB acts as a strategic conduit between local services and national governance, ensuring that persistent or complex issues—particularly those with implications for patient safety, equity, or system-wide learning—are addressed through appropriate escalation pathways.

This may include engagement with NHS England regional teams where necessary, in line with the National Quality Board's escalation framework and the PSIRF oversight specification.

References

Key Guidance Documents:

- NHS England: Applying PSIRF outside NHS Trusts - Patient Safety Learning Response Toolkit
- PSIRF Preparation Guide
- Turning Point Incident Management Policy
- NHS England – Patient Safety Specialists - Requirements for Patient Safety Specialists