



Position Statement

Development of Patient Safety Governance within Practice Plus Group Health in Justice Services – March 2026

Practice Plus Group's (PPG) Health in Justice (HiJ) directorate began implementing the Patient Safety Incident Response Framework (PSIRF) in 2023 as one of the early adopters ahead of the national requirement for providers to transition. Since the introduction of PSIRF, we have undertaken a programme of work to embed the framework across our prison, immigration removal and non-custodial health care services. This has involved developing governance structures, investigation methodologies and learning processes designed to support proportionate responses to patient safety incidents while ensuring that meaningful learning is identified and translated into improvements in care.

In August 2025, PPG HiJ directorate further strengthened its patient safety governance arrangements through the centralisation of the Patient Safety Team. The purpose of this change was to improve organisational oversight of patient safety incidents across services, enhance the consistency and quality of incident management and investigation, and strengthen the organisation's ability to identify emerging safety themes across multiple sites.

As PSIRF was embedded in practice and the organisation's approach matured, internal review indicated that the application of proportionality in some cases had tended toward the least intensive investigation approach when decisions were taken at an individual level. While this reflected the intention of PSIRF to avoid unnecessarily burdensome investigations, it was recognised that this approach could risk limiting opportunities for deeper system learning and may not always provide the level of analysis helpful to external processes such as coronial review.

In response, the organisation has strengthened its governance arrangements to support more consistent and balanced decision-making regarding the appropriate level of investigation. A weekly national decision-making forum has been introduced to review medium to high-risk patient safety incidents and determine appropriate level of learning response i.e., whether a Patient Safety Incident Investigation (PSII) or other structured review methodology is required.

In addition, senior clinical leaders now provide quality assurance and sign-off for all patient safety incident investigations to ensure appropriate clinical scrutiny, learning and response to incidents.

The organisation has also introduced a centralised process to cross-reference learning from external review mechanisms, including Prisons and Probation Ombudsman investigations and independent clinical reviewer reports, ensuring that learning identified through external processes is considered alongside internal incident reviews.

The centralisation of the Patient Safety Team has enabled a more structured approach to reviewing learning from individual patient safety incidents and identifying emerging themes across services. Learning identified through incident reviews is now considered through strengthened national



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governance forums, including Patient Safety Incident Response Group and National Quality Assurance governance structures.

In addition, we are prioritising improvements in the quality and consistency of patient safety investigations and reporting. Training, guidance and support are being provided to staff involved in investigations to strengthen capability in systems-based investigation methodologies and improve the clarity and quality of investigation reports.

As part of strengthening governance arrangements, we also established a HiJ Triage Professional Decisions Panel (PDP) in early 2025. The PDP provides multidisciplinary oversight and guidance where concerns arise relating to professional practice or fitness to practise. The panel enables cases to be reviewed holistically with senior clinical input and supports proportionate and consistent decision-making regarding professional conduct concerns.

The PDP operates alongside the organisation's patient safety governance arrangements and is closely connected. Where concerns relating to professional practice arise during the review of patient safety incidents, these may be escalated to the PDP for further consideration. Similarly, matters considered within the PDP may highlight wider system risks or learning which are then reviewed through the Patient Safety Team's governance processes.

PPG recognises that PSIRF learning responses and coronial investigations serve different but complementary purposes. PSIRF focuses on organisational learning and improvement through systems-based review, while coronial processes seek to establish the circumstances surrounding an individual death, including matters relating to causation.

In line with [guidance](#) issued by NHS England and the Chief Coroner in early 2026, PPG aims to ensure that its patient safety investigation processes support organisational learning while also providing clear factual information and context where required to assist coronial processes.

These developments form part of an ongoing programme of work to strengthen patient safety governance within our HiJ services and to ensure that incident responses are consistent, proportionate and focused on identifying meaningful system learning. The organisation will continue to review and strengthen its patient safety processes to support safer care for patients across all HiJ settings.

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Deputy Director of Nursing and Quality

5th March 2026