

Norfolk Primary Care

Primary Care Patient Safety Strategy: Our Statement



*Putting patient safety central to quality
improvement and learning*

October 2026

Contents

Foreword	3
Background	4
Our Commitment to Patient Safety: Our Vision and Pledge	5

Foreword

Since the publication of our 2024/25 Patient Safety Strategy, Norfolk Primary Care has continued to strengthen its commitment to delivering safe, effective, and compassionate care. Patient safety remains at the heart of everything we do, underpinning our clinical practice, governance arrangements, and continuous improvement activities.

Over the past year, we have successfully implemented the Patient Safety Incident Response Framework (PSIRF), embedding a systems-based, learning-focused approach to the management of patient safety incidents across all services. This significant milestone has enabled us to move beyond a traditional investigatory model and towards one that prioritises understanding, improvement, and the reduction of future harm through meaningful organisational learning.

As the national patient safety landscape continues to evolve, we recognise the importance of ensuring that our strategy remains responsive to emerging evidence, recommendations, and best practice. Our Patient Safety Strategy considers the recent upgrade of patient safety and public health to a ministerial responsibility, in light of the Thirlwall Inquiry recommendations.

We aim to ensure that our patient safety approach continues to promote a culture of openness, transparency, professional curiosity, and timely escalation of concerns, whilst further strengthening the systems, processes, and accountability that support safe patient care.

As we move forward, we remain committed to fostering a 'just culture' in which staff feel empowered to speak up, incidents are viewed as opportunities for learning, and patients remain central to all safety improvements. Through collaboration, continuous learning, and a steadfast focus on quality, we will continue to develop a safer healthcare environment for our patients, staff, and wider communities.



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Background

The [NHSE Primary Care Patient Safety Strategy](#) promotes a culture of continuous learning, improvement, and system-wide collaboration in the management of patient safety incidents. Central to this approach is the recognition that effective patient safety relies on open reporting, meaningful investigation, shared learning, and the active involvement of both patients and staff. The strategy places significant emphasis on fostering a just culture, supporting staff wellbeing, and ensuring that learning from incidents is translated into tangible improvements in care.

Following the publication of the Thirlwall Inquiry and its recommendations, patient safety has received enhanced national focus, including the strengthening of ministerial oversight and accountability for patient safety within the healthcare system. These developments reinforce the importance of organisational learning, robust governance, early identification of risks, effective speaking-up cultures, and transparent reporting mechanisms. Norfolk Primary Care (NPC) is committed to ensuring that its patient safety arrangements continue to align with emerging national expectations and recommendations arising from the Inquiry.

NPC has successfully implemented the Patient Safety Incident Response Framework (PSIRF), embedding a systems-based, compassionate, and learning-focused approach to patient safety incident response across all services. Through PSIRF, the organisation seeks to understand how and why incidents occur, identify opportunities for improvement, and reduce the risk of future harm rather than focusing solely on assigning blame.

In support of this approach, NPC utilises the Learning from Patient Safety Events (LFPSE) service to record and share patient safety events, enabling local, regional, and national learning, where appropriate and relevant. Through collaboration with stakeholders, commissioners, provider organisations, and system partners, NPC is committed to strengthening patient safety governance, enhancing learning from incidents, and supporting continuous quality improvement across the organisation and the wider health and care system.

This Patient Safety Strategy sets out how NPC will continue to develop a culture of safety, openness, learning, and improvement, ensuring that patients remain at the centre of all patient safety activities and that the organisation remains responsive to national policy developments, emerging risks, and best practice.

Our Commitment to Patient Safety: Our Vision and Pledge

At Norfolk Primary Care (NPC), patient safety is fundamental to everything we do.

Quality Domain	Key To Success
Patient Safety 	Success in patient safety is achieved through a strong organisational culture that prioritises learning, openness, and continuous improvement. This includes robust clinical governance arrangements, proactive risk identification and management, effective incident reporting and learning, and adherence to evidence-based policies and standards. Ongoing staff training, clear communication, and engagement with patients and partners further support the delivery of safe care and the prevention of avoidable harm.

As a patient-centred organisation, we place patients, their families, carers, and advocates at the heart of our decision-making, ensuring that their experiences and outcomes drive continuous improvement in the services we provide. Equally, we recognise that high-quality, safe care can only be delivered when staff are supported, valued, and empowered to contribute to a positive safety culture.

We are committed to creating an environment where patients, staff, and partners work together to identify risks, learn from patient safety events, and implement meaningful improvements. Through compassionate engagement with all individuals affected by patient safety incidents, we seek to ensure that learning is shared openly across the organisation and with system partners to strengthen patient safety across the wider health and care system.

NPC has successfully implemented the Patient Safety Incident Response Framework (PSIRF), embedding a systems-based, learning-focused approach to patient safety incident response. Our investigations are designed to understand how and why incidents occur, recognising both positive practice and opportunities for improvement. We use insights gained from patient safety events to improve systems, processes, and the quality of care delivered, rather than focusing on individual blame.

Through the implementation of PSIRF, the principles of the NHS England Primary Care Patient Safety Strategy, and the learning arising from the recommendations of the Thirlwall Inquiry, NPC will continue to strengthen its approach to patient safety, quality, governance, and organisational learning. We are committed to fostering a culture that encourages speaking up, professional curiosity, transparency, and the timely escalation of concerns, recognising that these are essential components of safe and effective healthcare.

These activities are supported through NPC's Clinical Governance Framework, which

provides clear oversight, accountability, and assurance for patient safety across the organisation. The Patient Safety Incident Response and Learning Group is responsible for reviewing patient safety incidents, investigation findings, emerging themes, organisational learning, and the progress of improvement actions. The Group is a sub-group of and reports to the Quality & Safety Committee, which provides strategic oversight of quality, patient safety, risk management, and regulatory compliance. The Quality & Safety Committee, in turn, reports directly to the NPC Board, ensuring that patient safety remains a core organisational priority with clear lines of governance, scrutiny, and accountability at every level.

Through these governance arrangements, NPC ensures that learning from patient safety events is systematically embedded into practice, monitored for effectiveness, and shared across services and system partners. This structure supports transparency, organisational learning, and continuous improvement, enabling the Board to maintain assurance that lessons identified lead to meaningful and sustainable changes in care delivery.

To support the development of a strong patient safety culture, all NPC staff, both clinical and non-clinical, are expected to complete the [NHS Patient Safety Syllabus training](#) appropriate to their role. This promotes a shared understanding of patient safety principles, human factors, systems thinking, and continuous improvement, ensuring that every member of staff understands their role in maintaining and enhancing patient safety.

We are committed to fostering a positive safety culture by ensuring staff have opportunities to share their experiences, views, and suggestions for improvement. Staff are encouraged to participate in both the annual NHS General Practice Staff Survey and our internally led staff survey, providing valuable feedback on workplace culture, wellbeing, communication, leadership, and patient safety. Survey findings are reviewed and used to inform quality improvement initiatives, workforce development, and patient safety priorities, helping to ensure staff feel listened to, valued, and empowered to contribute to safer patient care.

The Freedom to Speak Up (FTSU) framework is embedded across the organisation and forms a key component of our approach to patient safety and staff wellbeing. We are committed to creating an environment where all staff feel psychologically safe and confident to raise concerns, share ideas, and speak up about issues that may affect patient care, quality, safety, or the working environment. Staff are supported to raise concerns through a range of channels, including access to designated Freedom to Speak Up Guardians, with assurance that concerns will be handled confidentially, fairly, and without fear of detriment. Feedback from speaking up activity is used to promote organisational learning, strengthen our safety culture, and drive continuous improvement.

NPC promotes a 'Being Fair' culture, supported by the [NHS England Being Fair Framework](#). This approach encourages a balanced and compassionate response when things go wrong, focusing on understanding the systems and factors contributing to an event while supporting accountability, learning, and improvement. It recognises that most patient safety incidents result from complex interactions within systems rather than the actions of individuals alone.

We believe that every member of staff has a role to play in improving quality and designing safer systems of care. By working collaboratively with patients, colleagues, commissioners, and system partners, we will continue to strengthen our safety culture, improve patient experiences and outcomes, and ensure that learning from patient safety events leads to meaningful and sustainable improvements across all NPC services.

Through openness, continuous learning, robust governance, and a commitment to improvement, NPC will strive to deliver the safest possible care for our patients while supporting a compassionate and inclusive environment for everyone who uses and delivers our services.



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