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|  | Organisation logo |

Patient safety incident response policy

Effective date:

Estimated refresh date:

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|  | **NAME** | **TITLE** | **SIGNATURE** | **DATE** |
| **Author** |  |  |  |  |
| **Reviewer** |  |  |  |  |
| **Authoriser** |  |  |  |  |

**On completion of your final report, please ensure you have deleted all the blue information boxes.**

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| NHS providers should use this template when developing their local patient safety incident response policy, adding extra sections as required.  When completing this template, you should make it clear whether:   * Your patient safety incident response policy links to related policies in place at your organisation, such as the incident reporting policy, risk management policy, safety improvement policy/plan and clinical governance policy. You should provide links or references to all the related documentation; content does not need to be repeated here but should be clearly referenced.   **or**   * Your patient safety incident response policy is an overarching policy for patient safety management in your organisation. If so, this document should include detail for relevant aspects of incident management in your organisation, including patient safety incident reporting and safety improvement monitoring.   **General writing tips**  Your patient safety incident response policy must be published on your website. It should:   * be accessible to a wide audience * use clear and simple everyday English whenever possible * explain technical terms or avoid them altogether * use lists where appropriate * be written in short sentences * avoid use of jargon and excessive abbreviations.   **Guidance boxes** provide information for completing sections, including where further information can be found.  **Standard text** is provided for some sections. You may want to amend this and add content to support local requirements. |

Contents

[Purpose 4](#_Toc106014094)

[Scope 5](#_Toc106014095)

[Our patient safety culture 7](#_Toc106014096)

[Patient safety partners 8](#_Toc106014097)

[Addressing health inequalities 9](#_Toc106014098)

[Engaging and involving patients, families and staff following a patient safety incident 10](#_Toc106014099)

[Patient safety incident response planning 11](#_Toc106014100)

[Resources and training to support patient safety incident response 11](#_Toc106014101)

[Our patient safety incident response plan 12](#_Toc106014102)

[Reviewing our patient safety incident response policy and plan 12](#_Toc106014104)

[Responding to patient safety incidents 14](#_Toc106014105)

[Patient safety incident reporting arrangements 14](#_Toc106014106)

[Patient safety incident response decision-making 14](#_Toc106014107)

[Responding to cross-system incidents/issues 15](#_Toc106014108)

[Timeframes for learning responses 15](#_Toc106014109)

[Safety action development and monitoring improvement 15](#_Toc106014110)

[Safety improvement plans 16](#_Toc106014111)

[Oversight roles and responsibilities 17](#_Toc106014112)

[Complaints and appeals 18](#_Toc106014113)

# Purpose

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| **Notes**  Provide a brief overview of the purpose of your policy.  Note that the policy is based on [NHS England’s Patient Safety Incident Response Framework (PSIRF).](https://www.england.nhs.uk/patient-safety/incident-response-framework/)  Standard text is provided. You may want to amend this. |

This policy supports the requirements of the Patient Safety Incident Response Framework (PSIRF) and sets out **[organisation’s name]** approach to developing and maintaining effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety.

The PSIRF advocates a co-ordinated and data-driven response to patient safety incidents. It embeds patient safety incident response within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management.

This policy supports development and maintenance of an effective patient safety incident response system that integrates the four key aims of the PSIRF:

* compassionate engagement and involvement of those affected by patient safety incidents
* application of a range of system-based approaches to learning from patient safety incidents
* considered and proportionate responses to patient safety incidents and safety issues
* supportive oversight focused on strengthening response system functioning and improvement.

# Scope

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| **Notes**  This policy relates to responses to patient safety incidents that are solely for the purpose of learning and improvement. Any response that seeks to find liability, accountability or causality is beyond the scope of this policy.  For completeness, you may wish to list (or reference) all the response types that are outside the scope of your patient safety incident response plan (eg complaints, human resources investigations, professional standards investigations, coronial inquests, criminal investigations, claims management, financial investigations and audits, safeguarding concerns, information governance concerns, and estates and facilities issues). Reference other incident reporting and response guidance as required.  You can use this section to describe how learning response methods can be used to support learning and improvement in relation to other non-patient safety incident types, providing their application complies with any wider requirements.  Standard text is provided. You may want to amend this. |

This policy is specific to patient safety incident responses conducted solely for the purpose of learning and improvement across **[describe/list the organisation(s)/service(s) covered by this policy].**

Responses under this policy follow a systems-based approach. This recognises that patient safety is an emergent property of the healthcare system: that is, safety is provided by interactions between components and not from a single component. Responses do not take a ‘person-focused’ approach where the actions or inactions of people, or ‘human error’, are stated as the cause of an incident.

There is no remit to apportion blame or determine liability, preventability or cause of death in a response conducted for the purpose of learning and improvement. Other processes, such as claims handling, human resources investigations into employment concerns, professional standards investigations, coronial inquests and criminal investigations, exist for that purpose. The principle aims of each of these responses differ from those of a patient safety response and are outside the scope of this policy.

Information from a patient safety response process can be shared with those leading other types of responses, but other processes should not influence the remit of a patient safety incident response.

## Our patient safety culture

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| **Notes**  Use the [PSIRF preparation guide](https://www.england.nhs.uk/publication/patient-safety-incident-response-framework-and-supporting-guidance) to complete this section.  Describe:   * how your organisation promotes a climate that fosters a just culture and any work planned or underway to improve safety culture * what is being done to support open and transparent reporting * what is being done to support the development of a just culture. |

## Patient safety partners

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| **Notes**  Describe how you engaged (and will continue to engage) patient safety partners in your patient safety incident response policy and plan development and maintenance. For example, in:   * oversight committees * design and development of incident response processes including engagement and involvement.   See also the [Framework for involving patients in patient safety guidance](https://www.england.nhs.uk/publication/patient-safety-incident-response-framework-and-supporting-guidance). |

## Addressing health inequalities

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| **Notes**  In this section describe how your patient safety incident response processes support health equality and reduce inequality.  For example:   * How applying a more flexible approach and intelligent use of data can help identify any disproportionate risk to patients with specific characteristics, and how this information informs patient safety incident response. * How you explore and respond to issues related to health inequalities as part of the development and maintenance of your patient safety incident response policy and plans. * How the tools you use to respond to patient safety incidents prompt consideration of inequalities, including when developing safety actions. * How you will engage and involve patients, families and staff following a patient safety incident with consideration of their different needs. * How you will uphold a system-based approach (not a ‘person focused’ approach) and ensure staff have the relevant training and skill development to support this approach. This will support the development of a just culture and reduce the ethnicity disparity in rates of disciplinary action across the NHS workforce. |

# Engaging and involving patients, families and staff following a patient safety incident

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| **Notes**  Refer to the [Engaging and involving patients, families and staff following a patient safety incidents guidance, patient safety incident response standards and the PSIRF preparation guide](https://www.england.nhs.uk/publication/patient-safety-incident-response-framework-and-supporting-guidance) to complete this section  Provide an overview of how those affected by patient safety incidents will be engaged, including their involvement in a learning response.  You should consider aligning this section with the Engaging and involving patients, families and staff following a patient safety incident guidance.  Describe how Duty of Candour will be upheld.  If you’re working towards meeting the patient safety incident response standards you should note how you plan to develop further the foundations of a system that supports compassionate engagement and involvement of those affected (in line with those standards).  Standard text is provided. You may want to amend this. |

The PSIRF recognises that learning and improvement following a patient safety incident can only be achieved if supportive systems and processes are in place. It supports the development of an effective patient safety incident response system that prioritises compassionate engagement and involvement of those affected by patient safety incidents (including patients, families and staff). This involves working with those affected by patient safety incidents to understand and answer any questions they have in relation to the incident and signpost them to support as required.

# Patient safety incident response planning

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| **Notes**  Refer to the [Guide to responding proportionately to patient safety incidents, patient safety incident response standards and the PSIRF preparation guide](https://www.england.nhs.uk/publication/patient-safety-incident-response-framework-and-supporting-guidance) to complete this section  Outline the importance of taking a proportionate approach to patient safety incident response.  Suggested sub-headings for this section are listed below alongside relevant supporting guidance.  Standard text is provided. You may want to amend this. |

PSIRF supports organisations to respond to incidents and safety issues in a way that maximises learning and improvement, rather than basing responses on arbitrary and subjective definitions of harm. Beyond nationally set requirements, organisations can explore patient safety incidents relevant to their context and the populations they serve rather than only those that meet a certain defined threshold.

# Resources and training to support patient safety incident response

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| **Notes**  The [patient safety incident response standards](https://www.england.nhs.uk/publication/patient-safety-incident-response-framework-and-supporting-guidance) describe how patient safety incident responses should be resourced, including the training and competencies those undertaking these responses require.  Describe your capacity to respond and learn from patient safety incidents. This should include the output of your workforce gap analysis (see [PSIRF preparation guide](https://www.england.nhs.uk/publication/patient-safety-incident-response-framework-and-supporting-guidance)): the numbers and training of staff with a specific role in patient safety incident response, as well as expectations for wider staff to support such responses. Any changes made, planned or in progress to improve your capacity to respond and meet national requirements for learning from patient safety incidents should be noted here. |

## **Our patient safety incident response plan**

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| **Notes**  Provide a link to your patient safety incident response plan or combine it with this policy as you see fit. A [patient safety incident response plan template](https://www.england.nhs.uk/publication/patient-safety-incident-response-framework-and-supporting-guidance) is available.  If there are specific plans for different services, they should all be referenced here.  Briefly describe the steps you took to develop your plan, including stakeholder engagement, examining patient safety incident records and safety data, describing safety issues demonstrated by the data, identifying improvement work underway and agreeing response methods.  See Figure 1 and Table 1 in the [Guide to responding proportionately to patient safety incidents](https://www.england.nhs.uk/publication/patient-safety-incident-response-framework-and-supporting-guidance).  Standard text is provided. You may want to amend this. |

## Our plan sets out how **[organisation’s name]** intends to respond to patient safety incidents over a period of 12 to 18 months. The plan is not a permanent set of rules that cannot be changed. We will remain flexible and consider the specific circumstances in which each patient safety incident occurred and the needs of those affected, as well as the plan.

## **Reviewing our patient safety incident response policy and plan**

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| **Notes**  Describe your process for reviewing your patient safety incident response policy and plan.  If you’re working towards meeting [Patient safety incident response standards](https://www.england.nhs.uk/publication/patient-safety-incident-response-framework-and-supporting-guidance) note how you will update you Policy to reflect any changes made. This should include timeframes and a description of the mechanisms to support collaboration and agreement between stakeholders.  Standard text is provided. You may want to amend this. |

Our patient safety incident response plan is a ‘living document’ that will be appropriately amended and updated as we use it to respond to patient safety incidents. We will review the plan every 12 to 18 months to ensure our focus remains up to date; with ongoing improvement work our patient safety incident profile is likely to change. This will also provide an opportunity to re-engage with stakeholders to discuss and agree any changes made in the previous 12 to 18 months.

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 (as agreed with our integrated care board (ICB)) 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 (for example, patient safety incident investigation (PSII) reports, improvement plans, complaints, claims, staff survey results, inequalities data, and reporting data) and wider stakeholder engagement

# Responding to patient safety incidents

# Patient safety incident reporting arrangements

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| **Notes**  Describe your internal and external notification requirements for the reporting of patient safety-related incidents.  You should have an agreed process for relevant teams in the organisation (eg patient safety) to identify and report cross-system issues, so that the organisation can initiate and/or support the relevant response as required.  See [NHS England » Report a patient safety incident](https://www.england.nhs.uk/patient-safety/report-patient-safety-incident/). |

# Patient safety incident response decision-making

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| **Notes**  Describe the processes in place locally to decide how to respond to patient safety incidents as they arise, including how decisions take into account your patient safety incident response plan.  Planning supports proactive allocation of patient safety incident response resources, but there will always need to be a reactive element in responding to incidents. A response should always be considered for patient safety incidents that signify an unexpected level of risk and/or potential for learning and improvement but fall outside the issues or specific incidents described in the organisation’s plan.  Describe the following:   * process for identifying emergent issues * method for agreeing a proportionate response * how resources will be allocated to support responses to emergent issues not included in your patient safety incident response plan.   Refer to the [Guide to responding proportionately to patient safety incidents](https://www.england.nhs.uk/publication/patient-safety-incident-response-framework-and-supporting-guidance) for descriptions of methods to capture learning and inform improvement. |

# Responding to cross-system incidents/issues

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| **Notes**  Refer to [Oversight roles and responsibilities specification](https://www.england.nhs.uk/publication/patient-safety-incident-response-framework-and-supporting-guidance).  Describe your process to recognise incidents or issues that require a cross-system learning response, including how you will seek the views of local partners to ensure learning responses are co-ordinated at the most appropriate level of the system. |

# Timeframes for learning responses

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| **Notes**  Describe your process for agreeing how timeframes for different response types will be set.  See [Guide to responding proportionately to patient safety incidents](https://www.england.nhs.uk/publication/patient-safety-incident-response-framework-and-supporting-guidance) for more information |

# Safety action development and monitoring improvement

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| **Notes**  Describe how you use learning from incident responses to inform improvements (see the [Safety action development guide](https://www.england.nhs.uk/publication/patient-safety-learning-response-toolkit)).  Explain how safety actions will be monitored.  Note whether quality improvement and patient safety approaches are aligned (or you are working towards alignment). |

# Safety improvement plans

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| **Notes**  Safety improvement plans bring together findings from various responses to patient safety incidents and issues. They can take different forms. For example, organisations might consider:   * creating an organisation-wide safety improvement plan summarising improvement work * creating individual safety improvement plans that focus on a specific service, pathway or location * collectively reviewing output from learning responses to single incidents when it is felt that there is sufficient understanding of the underlying, interlinked system issues * creating a safety improvement plan to tackle broad areas for improvement (ie overarching system issues).   Describe the approach best suited to your organisation (it may be a mixture of the above). The key is to demonstrate why a specific safety improvement plan approach is the right one for your organisation based on available data, stakeholder views, improvement priorities, patient safety incident profile and insight from patient safety incident responses.  There are no thresholds for when a safety improvement plan should be developed; for example, after completing a certain number of learning responses. The decision to do so must be based on knowledge gained through the learning response process and other relevant data.  Describe how you will support alignment of improvement efforts across the organisation. |

# Oversight roles and responsibilities

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| **Notes**  See [Oversight roles and responsibilities specification and Patient safety incident response standards](https://www.england.nhs.uk/publication/patient-safety-incident-response-framework-and-supporting-guidance) for further information.  Describe your organisation’s approach to oversight. This should include how you meet the relevant [Patient safety incident response standards](https://www.england.nhs.uk/publication/patient-safety-incident-response-framework-and-supporting-guidance).  You may wish to collaborate with your ICB, and other commissioning leads as required, to describe both provider board and ICB oversight functions/processes. Alternatively, ICBs (and other commissioners) may wish to develop their own oversight guidance, which can be referenced here.  Include how you will:   * collaborate and share information with relevant stakeholders, including the ICB, CQC and others – develop this section collaboratively * support continuous development across local systems (eg peer to peer collaboration) and idea generation through local networks (eg patient safety improvement networks, local maternity, and neonatal systems).   Describe how you will monitor improvements made in response to learning from patient safety incidents. |

# Complaints and appeals

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| **Notes**  Provide details and/or links to arrangements for complaints and appeals relating to the organisation’s response to patient safety incidents.  Any links must be to publicly available documents since your patient safety incident response plan will be published on your organisation’s website. |