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|  | Organisation logo |

Patient safety incident response plan

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 plan, adding extra sections as required.  If guidance relating to the specific headings exists in any of your other policies or procedures, you do not need to repeat it here but do clearly reference it.  **Note:** Before completing this template, you must have undertaken work to understand your organisation’s capacity to respond to patient safety incidents – that is, resources and training. This work should include workforce gap analysis (see [PSIRF preparation guide](https://www.england.nhs.uk/publication/patient-safety-incident-response-framework-and-supporting-guidance)) of the numbers and training of staff with a specific role in patient safety incident response, as well as how other staff will be expected to support such responses.  **General writing tips**  You must publish your patient safety incident response plan on your website. It should:   * be accessible to a wide audience * use clear, 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 can amend this and add content to support local requirements. |

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# Introduction

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| **Notes**  Provide a general introduction to your plan, including any background information and a statement of rationale.  Standard text is provided. You may want to amend this. |

This patient safety incident response 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 rule that cannot be changed. We will remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected.

# Our services

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| **Notes**  Organisations deliver different services and pathways and there are often organisations within organisations – see [PSIRF preparation guide](https://www.england.nhs.uk/publication/patient-safety-incident-response-framework-and-supporting-guidance).  To help ensure the shape and structure of your plan reflects patient safety concerns for the variety of services your organisation offers, start by mapping your services. Describe how you did this and the output of this activity. |

## Defining our patient safety incident profile

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| **Notes**  Describe how you identified and agreed the patient safety issues most pertinent to your organisation.  You should include the following sub-sections:   * stakeholder engagement – who did you collaborate with to define your patient safety incident profile and how were they involved? * data sources – specify the data you have reviewed and the timeframe (two to three years of data should provide a good patient safety incident profile).   Describe the services covered by your plan and include or signpost to guidance for specific services/departments as required. |

## Defining our patient safety improvement profile

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| **Notes**  Describe how you identified and agreed your patient safety improvement profile.  Provide a consolidated list of all improvement and service transformation work with an impact on patient safety underway or planned across your organisation (this should describe relevant national, regional and locally driven improvement and service transformation programmes). |

## Our patient safety incident response plan: national requirements

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| **Notes**  List the patient safety incident types that must be responded to according to national requirements (see Appendix A: National event response requirements in the [Guide to responding proportionately to patient safety incidents](https://www.england.nhs.uk/publication/patient-safety-incident-response-framework-and-supporting-guidance)).  You may find the below table helpful for documenting how you intend to respond, by patient safety incident type.  When developing your plan, consider how you will use learning from each nationally required response to inform improvements. You may wish to describe this as shown in the table below or in the ‘Safety action development and monitoring improvement’ and ‘Safety improvement plans’ sections of your [Patient safety incident response policy](https://www.england.nhs.uk/publication/patient-safety-incident-response-framework-and-supporting-guidance). |

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| **Patient safety incident type** | **Required response** | **Anticipated improvement route** |
| Eg incidents meeting the Never Events criteria | PSII | Create local organisational actions and feed these into the quality improvement strategy |
| Eg death thought more likely than not due to problems in care (incident meeting the learning from deaths criteria for patient safety incident investigations (PSIIs)) | PSII | Create local organisational actions and feed these into the quality improvement strategy |
| Eg incident meeting Each Baby Counts criteria | Referred to Healthcare Safety Investigation Branch for independent patient safety incident investigation | Respond to recommendations as required and feed actions into the quality improvement strategy |

# Our patient safety incident response plan: local focus

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| **Notes**  Determine the appropriate response methods for the other issues/incidents listed in ‘Defining our patient safety incident profile’ above.  Based on the findings from your service mapping exercise you should consider whether it is more appropriate to include one table for your organisation or to create individual tables for specific services.  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.  Refer to the [PSIRF preparation guide](https://www.england.nhs.uk/publication/patient-safety-incident-response-framework-and-supporting-guidance) for further detail on how to define your patient safety incident response plan.  The type of response will depend on:   * the views of those affected, including patients and their families * capacity available to undertake a learning response * what is known about the factors that lead to the incident(s) * whether improvement work is underway to address the identified contributory factors * whether there is evidence that improvement work is having the intended effect/benefit * if an organisation and its ICB are satisfied risks are being appropriately managed.   You should note improvement programmes that relate to issues in your patient safety profile - that is, be clear where there are improvement efforts already underway in relation to recognised patient safety issues to support consideration and justification of the learning response types.  You may find the below table helpful for documenting how you intend to respond, by patient safety incident type or issue.  When developing your plan, you should consider how you will use learning to inform improvements. You may wish to describe this as shown in the table below or in the ‘Safety action development and monitoring improvement’ and ‘Safety Improvement plans’ sections of your [Patient safety incident response policy](https://www.england.nhs.uk/publication/patient-safety-incident-response-framework-and-supporting-guidance). |

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| **Patient safety incident type or issue** | **Planned response** | **Anticipated improvement route** |
| [insert incident type or issue] | [insert method] | Eg create local safety actions and feed these into the quality improvement strategy... |
| [insert incident type or issue] | [insert method] | Eg build case for new improvement plan... |
| [insert incident type or issue] | [insert method] | Eg inform ongoing improvement efforts... |