Kent and Medway Mental Health NHS Trust

Patient Safety Incident Response Framework (PSIRF) Policy

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DOCUMENT TRACKING SHEET

Patient Safety Incident Response Framework (PSIRF) Policy

Version	Status	Date	Issued to/approved by	Comments
1.0	Final	Oct 2024	Quality Committee	
2.0	Final	August 2025	TWPS&MR Group	Full review, significant changes made throughout document Approved

REFERENCES

NHS England (2019) Mental Health-Related Homicide – Information for Mental Health Providers. Available at: Information-for-Mental-Health-Providers_V4.0.pdf (england.nhs.uk)

NHS England (2019) The NHS Patient Safety Strategy: Safer culture, safer systems, safer patients. Available at: https://www.england.nhs.uk/wp-content/uploads/2020/08/190708_Patient_Safety_Strategy_for_website_v4.pdf

NHS England (2021) NHS Patient Safety Strategy: Progress so far. Available at: NHS England » NHS patient safety strategy priorities for leaders and patient safety specialists

NHS England (2022) Patient Safety Incident Response Framework and supporting guidance. Available at: NHS England » Patient safety learning response toolkit

NHS England (2022) Safety action development guide. Available at: https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-Safety-action-development-v1.1

NHS England (2022) SEIPS Quick Reference Guide and Work System Explorer. Available at: B1465-SEIPS-quick-reference-and-work-system-explorer-v1-FINAL-1.pdf

NHS England (2025) Being fair tool. Supporting decision making for patient safety incidents referred to workforce, and ensuring that staff are not treated unfairly after a patient safety incident. Available at: https://www.england.nhs.uk/publication/being-fair-tool/

NHS Kent and Medway (2024) Patient Safety Incident Response Framework (PSIRF) Oversight Policy. Available at: Microsoft Word - KM ICB PSIRF Oversight Policy v.2 APPROVED.docx

RELATED POLICIES/PROCEDURES/protocols/forms/leaflets

Claims Management Policy	KMPT.CorG.014.05
Duty of Candour – Being Open Policy	KMPT.CorG.018.06
Freedom to Speak Up Policy	KMPT.HR.002.09
Learning from Deaths Policy	KMPT.CliG.156.04
Learning from Experience Policy	KMPT.CorG.011.08
Kent and Medway Patient Safety Incident Response Framework (PSIRF) Oversight Policy	N/A
Patient Safety Incident Response Plan	N/A
Patient Safety Partner Policy	KMPT.CliG.232.01

Policy and Procedure for Listening and Responding to Concerns and Complaints	KMPT.CorG.019.08
Safeguarding Adults Policy	KMPT.CliG.006.09
Safeguarding Children and Young People Policy	KMPT.CliG.030.06

SUMMARY OF CHANGES

Date	Author	Page	Changes (brief summary)
July 2025	EH		Full update made to the document following alteration in expected practice from the implementation of the PSIRF. Updates made to reflect work as done within the organisation and additional information added to provide guidance to staff on practical application. Removal of information relating to Duty of Candour and referral to policy.

CONTENTS

1 INTRODUCTION

1.1 This policy supports the requirements of the Patient Safety Incident Response Framework (PSIRF) and sets out Kent and Medway Mental Health NHS Trust's (or, the trust's) approach to developing and maintaining effective systems and processes for responding to patient safety events and issues for the purpose of learning and improving patient safety. The policy is based on NHS England's Patient Safety Incident Response Framework (PSIRF).

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

1.3 This policy supports development and maintenance of an effective patient safety event response system that integrates the 4 key aims of the PSIRF:

1.3.1 Compassionate engagement and involvement of those affected by patient safety events.

1.3.2 Application of a range of system-based approaches to learning from patient safety events.

1.3.3 Considered and proportionate responses to patient safety events and safety issues.

1.3.4 Supportive oversight focused on strengthening response system functioning and improvement.

1.4 This policy should be read in conjunction with the below documents:

1.4.1 Claims Management Policy

1.4.2 Freedom to Speak Up Policy

1.4.3 Learning from Deaths Policy

1.4.4 NHS England Patient Safety Incident Response Framework supporting guidance

1.4.5 Patient Safety Incident Response Plan (PSIRP)

1.4.6 Patient Safety Partner Policy

1.4.7 Policy and Procedure for Listening and Responding to Concerns and Complaints

1.4.8 Safeguarding Adults Policy

1.4.9 Safeguarding Children and Young People Policy

1.5 The terms patient safety events and patient safety incidents are used interchangeably within this document. They refer to situations requiring further exploration where there is opportunity to learn from practice (Safety-I and Safety-II approach[1]), or those that are unintended or unexpected, which could have or did lead to harm for 1 or more individuals receiving healthcare.

[1] Safety-II is defined as 'a state where as much as possible goes right'. This is in comparison to Safety-I, which is 'where as few things as possible go wrong'. The focus in Safety-II is on positive practice.

2 WHO DOES THIS POLICY APPLY TO?

2.1 This policy applies to all staff, whether they are employed by the trust permanently, temporarily, through an agency or bank arrangement, are students on placement, are party to joint working arrangements or are contractors delivering services on the trust's behalf.

2.2 Although this policy primarily affects clinical, operational, governance, and patient safety staff, any staff member may become involved in a patient safety event during their employment with the trust.

3 SCOPE

3.1 This policy is specific to patient safety event responses conducted solely for the purpose of learning and improvement across all clinical services within the trust.

3.2 Responses under this policy follow a systems-based approach. This recognises that patient safety events result from multiple interactions between systems. Responses do not take a 'person-focused' approach. Under the PSIRF, actions or inactions of people or 'human error' will not be stated as the cause of an event.

3.3 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.

3.4 Information from a patient safety event response process can be shared with those leading other types of responses or reviews, but other processes should not influence the remit of a patient safety event response. Such processes as those listed below are therefore outside of the scope of this policy:

3.4.1 Claims handling

3.4.2 Human resources investigations into employment concerns

3.4.3 Professional standards investigations

3.4.4 Information governance

3.4.5 Estates and facilities concerns

3.4.6 Financial investigations and audits

3.4.7 Safeguarding concerns

3.4.8 Coronial inquests, and criminal investigations

3.4.9 Complaints (except where a significant patient safety concern is highlighted)

For clarity, the trust considers these processes as separate from any patient safety investigation/review, however, in rare circumstances, a learning response may raise concerns about an individual's conduct or fitness to practise. It is in these specific circumstances the being fair decision-making tool can help decide what next steps to take.

3.5 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 event response.

4 DUTIES AND OVERSIGHT

4.1 Trust Board

4.1.1 To ensure that systems and processes are in place to undertake suitable and sufficient reviews following patient safety events and to evidence learning afterwards. They will receive assurance from the Quality Committee through summary and exception reporting.

4.1.2 To demonstrate leadership in the trust's learning and open culture, supporting being fair principles and the implementation of PSIRF.

4.1.3 To ensure that staff feel safe to report issues, with the knowledge that the information they share will be treated respectfully and taken forward appropriately.

4.1.4 Individual members of the Board may be required to attend Immediate Management Review meetings and/or contribute to learning responses and reviews following high-profile patient safety events.

4.2 The Quality Committee

4.2.1 The purpose of the Quality Committee is to provide the Board with assurance concerning all aspects of quality and safety relating to the provision of care and services in support of getting the best clinical outcomes and experience for patients. This will primarily be achieved by review of the service line patient safety report.

4.2.2 Improvement plans will be monitored to provide assurance of implementation and efficacy.

4.3 The Trust Wide Patient Safety and Mortality Review Group

4.3.1 This group is chaired by the Chief Nurse (or their deputy) and meets every other month. It will undertake an initial review of the service line patient safety report on behalf of the Quality Committee at each regular meeting.

4.3.2 The purpose of the group is to oversee patient safety Quality Account priorities and progress, receive reports, monitor and challenge the area of patient safety.

4.3.3 The effectiveness of the Patient Safety Incident Response Plan will be monitored and updates will be provided to the Quality Committee.

4.4 The Learning Review Group

4.4.1 This group is chaired by the Chief Nurse (or their deputy) and meets monthly.

4.4.2 It will review the outputs from all learning responses to consider emerging themes and trends. This review may lead to additional improvement working groups being recommended or current groups standing down. This intelligence will be reported through the trust and contribute to the development of future Patient Safety Incident Response Plans.

4.5 The Patient Safety Incident Decision Panel (the panel)

4.5.1 The panel is chaired by the Director of Quality and Safety, the Chief Nurse or Deputy Chief Nurse (or their deputy) and meets weekly.

4.5.2 The purpose of the panel is to review patient safety events that may require further review or a further learning response, such as an After Action Review, Thematic Review, or Patient Safety Incident Investigation. Decisions will be made in line with national requirements or local priorities as outlined within the Patient Safety Incident Response Plan (PSIRP), or as a proportionate response to the event.

4.5.3 To identify a responsible member to escalate to trust executives and the communications team when a patient safety event is recognised as likely to attract publicity, and/or has been or may be in social media, and/or may require their consideration and escalation to others. This must also include identification of responsibility for the duty of candour with the family/patient involved and notifying the family/patient if a case is likely to attract media publicity.

4.6 Immediate Management Review (IMR) Panel

4.6.1 To determine actions for high-profile cases, potentially high-profile cases, homicides/attempted homicides and child deaths, or cases likely to attract media/social media attention. Led by the Chief Nurse or deputy, panel members are expected to prioritise attendance when requested, or to appoint a deputy to attend.

4.6.2 To make decisions regarding immediate actions required and appropriate liaison and escalation. The note taker will ensure a record of the meeting is sent within 3 working days to enable prompt actions.

4.6.3 Further information on the IMR can be found in section 14 and appendix D.

4.7 Expert Groups

4.7.1 These groups, such as the medication review group and physical health group, will routinely monitor the number and types of patient safety events relevant to their speciality and ensure appropriate actions are taken, and external reports are produced when required.

4.8 Directorate Governance Leads, Directorate Senior Leadership & Management Teams

4.8.1 Responsible for ensuring that staff report patient safety events, using the incident management system (InPhase).

4.8.2 Ensuring that directorate reviews take place each working day, and that events are triaged to the most appropriate pathway (appendix A).

4.8.3 Where required, directorates must ensure immediate actions are taken to ensure the safety of patients, the public and staff, and the identification of measures needed to mitigate the problem until further review is possible. This may include, for example, withdrawing equipment or monitoring a procedure.

4.8.4 Ensuring compliance with the Duty of Candour policy and the compassionate engagement principle of the PSIRF, including staff support.

4.8.5 Working with clinical teams to ensure that information within the incident management system (InPhase) and the Patient Safety Incident Decision Panel (the panel) supporting form is of good quality, to support the panel decision.

4.8.6 Ensuring that relevant subject matter experts (e.g. physical health team or pharmacy team) are invited to the panel and/or allowed to contribute to the review, to support decision making when required.

4.8.7 Ensuring staff attendance at safety discussions and learning response meetings.

4.8.8 Attending IMR meetings and ensuring appropriate attendance from others as required.

4.8.9 Reviewing completed learning responses for factual accuracy.

4.8.10 Responsible for developing, implementing and monitoring local improvement plans and safety actions, and sharing learning with staff. They will provide evidence of learning, such as service improvements and implementation of best practice. Escalation of any urgent issues should take place through local directorate processes.

4.9 Patient Safety Team

4.9.1 To ensure all assigned learning responses are completed within the timeframes agreed with those involved.

4.9.2 To seek appropriate expert advice (internally or externally) for learning responses where required.

4.9.3 To ensure compassionate engagement of those involved in learning responses, in line with Duty of Candour regulations, compassionate engagement and being fair principles.

4.9.4 Provide support to directorate governance teams where required, to identify the most appropriate learning response.

4.9.5 Participate in the patient safety team peer review meeting and engage in peer review of learning responses.

4.9.6 To collate trust-wide actions and inform senior management, who will determine action ownership.

4.10 Chief Nurse (Designated Board Member Lead for Patient Safety)

4.10.1 Responsible for ensuring all patient safety events are managed and investigated appropriately according to trust policy and meet all external requirements. This includes sharing learning, ensuring that the Chief Executive and Trust Board are apprised of patient safety events that are externally reportable.

4.10.2 To ensure learning is demonstrable and evidenced, with good practice shared across the trust.

4.10.3 To take responsibility for alerting the Chief Executive and relevant external bodies of high-profile cases or those that risk organisational reputation.

4.10.4 To chair, or appoint a deputy, for all Immediate Management Reviews (IMRs), the Trust Wide Patient Safety and Mortality Review Group, and the Learning Review Group.

4.11 Director of Quality and Safety

4.11.1 To chair, or appoint a deputy, for the Patient Safety Incident Decision Panel.

4.11.2 Allocate trust-wide actions arising from the Patient Safety Incident Decision Panel and IMRs.

4.12 Head of Patient Safety

4.12.1 To quality check learning responses, reviews and investigations completed by the patient safety team, or ensure a deputy is appointed when required.

4.12.2 To ensure appropriate escalation for high-profile events or other areas of particular concern, such as an alleged homicide and/or reputational concerns.

4.12.3 To ensure IMR meetings are appropriately organised, attend IMRs, and ensure notes are sent out in 3 working days of the meeting.

4.12.4 To monitor patient safety activity and escalate when concerns arise or timescales cannot be met.

4.13 Patient Safety Specialists

4.13.1 Patient Safety Specialists support the local implementation of the NHS Patient Safety Strategy and development of a patient safety culture, safety systems and improvement activity.

4.13.2 Within the trust, they are responsible for attending update meetings from NHS England/Improvement and ensuring that investigation/learning response processes are embedded, adequate support is provided to the investigation/learning response process and that staff are trained in line with the patient safety syllabus.

4.14 All Staff

4.14.1 To report any safety events or risks using the incident management system (InPhase).

4.14.2 To engage openly and honestly in learning responses.

4.14.3 To apply Duty of Candour and/or compassionate engagement principles.

4.14.4 Utilise and engage with relevant support services as required.

5 OUR PATIENT SAFETY CULTURE

5.1 Our key aim is to create a culture where our people feel safe, equal and can thrive. The trust is committed to working towards a systems-based approach to learning to promote a being fair, just and learning culture.

5.2 The trust values (caring, inclusive, curious and confident) represent how we show up every day for our patients, communities, partners and each other, supporting the trust to create a culture where every interaction and decision is an opportunity to improve.

5.3 Alongside the opportunities to learn from safety events, a Safety-II approach will be adopted. Positive experiences from patients, families, carers and staff will be identified and shared to support the trust in learning from excellence.

5.4 Compassion, understanding and engagement of those affected by patient safety events will remain a high priority and are key to the success of the PSIRF. A collaborative approach to learning from safety events and good practice is vital in driving improvements. This will continue to increase transparency and openness amongst our people to report events and allow for wider engagement.

5.5 Patient safety learning responses will be undertaken for the purpose of learning, and identifying system-wide improvements.

6 PATIENT SAFETY PARTNERS

6.1 Patient Safety Partners (PSPs) are a key element to ensuring the successful implementation of the PSIRF within the trust. The trust has engaged with a range of internal and external stakeholders to identify specific functions for PSPs to support the implementation of the PSIRF within the trust; the role will be reviewed in line with the PSIRF Policy and plan review, to ensure it continues to provide the greatest impact for patient safety improvement within the trust.

6.2 The focus for PSPs will be:

6.2.1 Proportionate responses to patient safety events.

6.2.2 Utilising lived experiences to make meaningful changes in improving care.

6.2.3 Participate priority improvement programmes.

6.3 PSPs will be encouraged to both equally challenge actions that are unlikely to, and suggest solutions that may lead to, sustainable quality improvement within the trust. Please see the development and training section for further details on the support to be offered.

6.4 PSPs will also be invited to attend the Trust Wide Patient Safety and Mortality Review Group and trust learning events to share findings from reviews of all sources of patient safety insight, agree the priority areas for quality improvement, and have oversight of the outputs from the panel and the Learning Review Group.

7 ADDRESSING HEALTH INEQUALITIES

7.1 Addressing health inequalities is an organisational priority and will feature in a range of quality improvement and quality assurance processes. This will include but not be limited to the implementation of the PSIRF.

7.2 Some of our communities are the most deprived and within these, there is a greater risk of suicide than the rest of the county. We have a crucial role in working with our partners on joint initiatives to reduce suicide and self-harm within our localities. We also need to work closely with our partners to support the physical health and wellbeing of people across our communities, to improve the local life expectancy.

7.3 The trust has implemented the Patient and Carer Race Equality Framework (PCREF). This is a framework, supporting mental health trusts to address racial inequalities in access, experience and outcomes for people from diverse ethnic, racial and cultural backgrounds. The PST will share data with the Equality, Diversity and Inclusion (EDI) team to support the analysis and identification of health inequalities in experience and outcomes.

7.4 Patient safety responses will continue to consider health inequalities through a variety of routes, including:

7.4.1 Outcomes for patients across a range of specific characteristics to ensure any unwarranted variation is identified as an area for improvement.

7.4.2 Specific support needs to encourage engagement in patient safety responses from all patients, focusing on what each person can add to the learning process and collectively removing any barriers to participation.

8 ENGAGING AND INVOLVING PATIENTS, FAMILIES AND STAFF FOLLOWING A PATIENT SAFETY EVENT

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

8.2 All those affected will be treated with respect, dignity, openness, and transparency at all times following a patient safety event.

8.3 The PSIRF supporting guidance (engaging and involving patients, families and staff following a patient safety incident) provides 4 steps of engagement which should be followed by staff engaging with patients/families or carers following a patient safety event, where a learning response is being completed.

8.4 Further information can be found in the Duty of Candour – Being Open Policy and compassionate engagement guidance.

9 PATIENT SAFETY INCIDENT RESPONSE PLANNING

9.1 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. These are referred to as local priorities.

9.2 The trust Patient Safety Incident Response Plan (PSIRP) provides full details for when learning responses are indicated.

9.3 To capture learning from deaths, Structured Judgement Reviews (SJRs) will be undertaken. This methodology blends traditional, clinical judgement-based review methods with a standard format to make safety and quality judgements over phases of care. An SJR will not usually be required if it has already been determined that a Patient Safety Incident Investigation (PSII) or After Action Review (AAR) will be undertaken, to maintain proportionality. Where a thematic review is being completed, an SJR may not be required; however, this will be considered on a case-by-case basis by the panel. Existing communication channels will be utilised to ensure there is no duplication. The Learning from Deaths Policy contains further information on SJRs.

9.4 Our patient safety incident response plan (PSIRP)

9.4.1 Our plan sets out how the trust intends to respond to patient safety events 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.

9.4.2 A copy of the trust's current PSIRP can be found on the trust's public internet page and staff intranet page.

9.5 Reviewing our patient safety incident response policy and plan

9.5.1 Our PSIRP 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.

9.5.2 Updated plans will be published on our website, replacing the previous version.

9.5.3 A rigorous planning exercise will be undertaken every 4 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.

10 REPORTING PATIENT SAFETY EVENTS

10.1 Patient Safety Vs Non-Patient Safety

10.1.1 The Learn from Patient Safety Events (LFPSE) service is a national NHS system for the recording and analysis of patient safety events that occur in healthcare. The lists below set out examples of categories which meet LFPSE reporting (patient safety incidents) requirements and those that do not (non-patient safety incidents). A diagram of the below can be found in appendix G.

10.1.2 Patient Safety Incidents (PSI)

a) Violence/aggression to patients
b) Patient slips, trips and falls
c) AWOLs
d) Medical devices
e) Medication incidents
f) Complication or deterioration
g) Treatment/procedure
h) Poor discharges
i) Self-harm
j) Pressure ulcers

10.1.3 Non-Patient Safety Incidents (Non-PSI)

a) Staff IG incidents
b) Staff slips, trips and falls
c) Violence and aggression against staff
d) IT equipment
e) Theft – not related to a patient
f) Damage to trust property
g) Estates/facilities issues
h) Security

10.2 Patient safety incident reporting

10.2.1 All patient safety incidents requiring reporting to the Learn from Patient Safety Events (LFPSE) service will be recorded on the trust incident management system (InPhase). This record can be completed by any member of trust staff, usually by the team or individual who identified the event.

10.2.2 From the point of identification, incidents must be recorded on the trust incident management system (InPhase) as soon as reasonably practicable, and in all instances by the end of the next working day.

10.2.3 The report must include:

a) An accurate description
b) Correct information about the patient (including but not limited to demographics, diagnoses and medication) as identified in the electronic patient record
c) Accurately identified causes
d) Accurate levels of harm
e) Descriptions of all immediate actions taken to mitigate risk
f) Fully completed required fields
g) Supporting evidence where applicable e.g. photographs, emails, documents

10.2.4 The report must not include:

a) Any patient or staff identifiable information in the free text boxes or outside of the relevant fields
b) Opinions or views not supported by fact

10.3 Review of reported patient safety events

10.3.1 All patient safety events reported on the trust incident management system (InPhase) will be reviewed each working day by the directorate governance team. The purpose of this initial review is to ensure information contained

within the report adheres to requirements set out in section 10.2.3 and 10.2.4, above.

10.3.2 Directorate senior leadership teams and governance teams will determine the appropriate pathway as set out in appendix A. Those deemed to require an AAR, thematic review or PSII will be referred to the panel.

10.4 Sharing information with other organisations

10.4.1 If an event is reported on the trust incident management system (InPhase) and it is identified as belonging to another organisation, the incident management system (InPhase) team will share a PDF summary with the relevant organisation. See appendix B for additional information.

10.5 Reporting to the CQC

10.5.1 Events meeting the below criteria must be reported to the CQC:

a) the death of a patient, where the death relates directly to the event rather than to the natural course of the patient's illness or underlying condition (where the patient has died within 12 months of last contact/discharge)
b) cases where patients have died in acute organisations, but mental health services contributed to the death
c) any homicide/attempted murder involving a trust patient as either the victim or alleged perpetrator
d) any safeguarding event that has occurred relating to neglect of a child/ren under the care of a patient open to the trust
e) a never event
f) where a patient has experienced harm or prolonged psychological harm
g) RIDDOR reportable incidents (shared via the Health and Safety Executive).

10.6 The Mortality Review Manager is responsible for completing an event notification form. This is then shared with the CQC by the Compliance and Assurance Manager.

10.7 Completed learning responses for events meeting the above criteria are shared with the CQC by the Compliance and Assurance Manager.

11 PROCESS FOR RESPONDING TO PATIENT SAFETY EVENTS

11.1 Responding to cross-system events/issues

11.1.1 All events reported by partner organisations that require review within the trust will be shared via the PST and added to the trust incident management system (InPhase). Managerial review will be completed by the relevant team within one week and action taken internally as required (appendix B).

11.1.2 The sharing of events will always be coordinated between PST and PST across organisations as agreed by the relevant commissioner and communities of practice. The trust will work closely with other providers, stakeholders and commissioning bodies to ensure clear sharing lines.

11.1.3 Where an event overlaps with another provider and is deemed to require a PSIRF learning response, a joint investigation will be completed. The recommendation for response type will be considered internally (by the panel)

and then negotiated with the other organisation to agree on a clear response route and terms of reference.

11.1.4 If it has been agreed that a PSIRF learning response will be completed involving more than 1 organisation, the PST will be responsible for making and maintaining contact with the other organisation/s.

11.1.5 Where it is unclear which organisation should lead, this will be referred to the commissioners.

11.2 Patient safety incident response decision-making

11.2.1 Directorates should escalate events that meet national requirements or local priorities for discussion at the panel. A Safety-II approach can also be considered for exploration, so learning can be identified and shared from good practice. A panel supporting form (appendix C) must be completed by the directorate prior to discussion at the panel.

11.2.2 The panel is chaired by the Director for Quality and Safety and/or Deputy Chief Nurse and is held weekly. A member of the PST will take the minutes. The purpose of the panel is to determine the most proportionate response.

11.2.3 Expert opinions from specialists should inform whether the practice that led to an event met local and national policies, processes and standards.

11.2.4 Initial learning should be included on the supporting form (appendix C). If trust-wide learning is identified, the panel chair is responsible for identifying an appropriate lead and/or route for disseminating this learning.

11.2.5 When it is unclear whether a patient safety event meets the national requirements or local priorities, the panel will seek advice from the Patient Safety Specialists, Chief Nurse/Chief Medical Officer or deputy or nominated person.

11.2.6 To ensure proportionality with learning responses, the panel will consider a thematic review for all events where there is a recurring event type, similar initial findings or when an emerging risk has been identified.

11.2.7 The panel or IMR will identify any event which appears to meet the requirement for external reporting. This will be documented following discussion.

11.2.8 The patient safety team's business continuity plan should be referred to during periods of high pressure.

12 LEARNING RESPONSES

12.1 PSIRF supports organisations to respond to events 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 events relevant to their context and the populations they serve rather than only those that meet a certain defined threshold.

12.2 Under the PSIRF, the trust has agreed on 5 types of learning responses to be used following patient safety events. These are based on those recognised and recommended by NHS England (NHSE):

12.2.1 Rapid Reviews (RRs)

12.2.2 After Action Reviews (AARs)

12.2.3 Patient Safety Incident Investigations (PSIIs)

12.2.4 Structured Judgement Reviews (SJRs)

12.2.5 Thematic Reviews (TRs)

12.3 Some patient safety events will not require a formal learning response and can be managed locally by teams and services, so learning and rationale can be evidenced. Directorate governance teams can contact the PST for advice on determining the most appropriate and proportionate response.

12.4 The trust has identified 4 pathways to be used following a patient safety event. These are detailed in the table below. Further information relating to the completion of learning responses (pathways 3 and 4) is set out in the following sections.

Pathway	When required	Response Required	Lead
1	Event and contributory factors are well understood. National/local improvement plans, targeted at contributory factors, are being implemented and monitored for effectiveness. Clear this does **not** meet national requirements or local priorities.	Local management review on incident management system (InPhase), recording the rationale for pathway 1.	Directorate
2	Event and contributory factors are well understood. National/local improvements are minimal. Clear this does **not** meet national requirements or local priorities.	Information/detail required from the team/service involved or reporter to record what happened, why, and any learning or improvements, to be recorded on the incident management system (InPhase).	Directorate
3	Event and contributory factors are not well understood. Unclear whether national requirements/local priorities are met. Further exploration is required. Local to team/service. Deemed the most proportionate response by the panel or during conversation with PST. When an IMR is required.	Rapid Review, to be recorded in the relevant section of the incident management system (InPhase).	Directorate
4	When national requirements or local priorities are met (as set out in the PSIRP). When a new trend or theme is identified, requiring further exploration. Deemed the most proportionate response by the panel	AAR PSII Thematic review	PST

12.5 Rapid Review (pathway 3)

12.5.1 A rapid review is undertaken by staff in the directorate where further exploration is needed to understand what happened and why promptly and without delay. Rapid reviews are also required before an IMR (see section 14).

12.5.2 Rapid reviews must be undertaken as soon as possible after the event. This should be no more than 2 weeks of the event taking place (within the same shift if possible) or 1 week of the decision at panel. A resource pack is available for facilitators and attendees on the PSIRF staff intranet page.

12.5.3 These are arranged directly by the team or service involved or the directorate governance team. They can take place in person or virtually.

12.5.4 The rapid review section on the incident management system (InPhase) must be completed by an agreed attendee (usually the facilitator or note taker). The report is then shared with those involved, the directorate governance team and the senior leadership team for review. This review process is specific to each directorate and is set by them.

12.5.5 If, following the rapid review, it is agreed by the directorate senior leadership team and governance team that the event requires further exploration, or the system issues identified are outside of the sphere of control of the team/directorate, the governance team must escalate this to the panel. The panel supporting form (appendix C) must be completed and submitted before the panel. If a rapid review and/or IMR has been undertaken prior to the panel, existing information can be used for the supporting form to avoid duplication. A member of the directorate must attend to present facts and a summary of the findings.

12.5.6 A rapid review is not required if:

a) There is existing improvement work in place within the organisation, which will address or has addressed the contributory factors identified.
b) The issues or system problems are well understood and are managed locally – consider how the efficacy of this management is being monitored; a learning response may be required if improvements are not seen over time.
c) The Patient Safety Incident Response Plan (PSIRP) identifies an alternative learning response.
d) It has been agreed between the directorate and the PST that it should be escalated directly to the panel. This may be required due to the complexity or significance of initial findings.

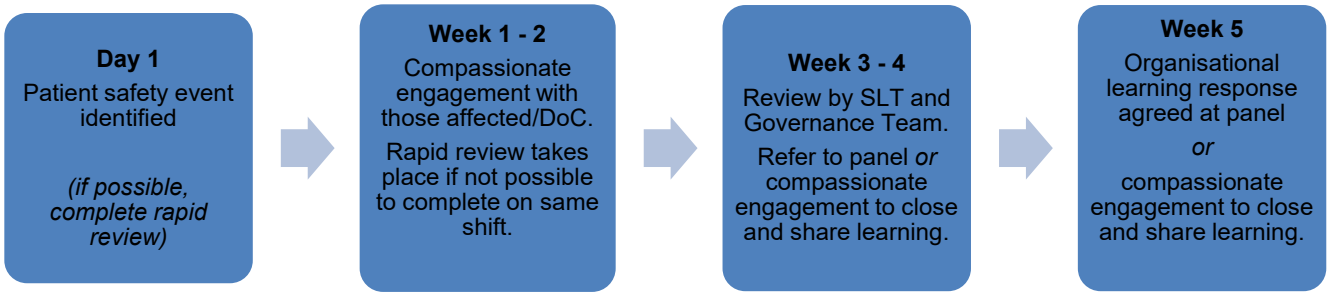
12.5.7 Those attending and those affected should be advised how and when they will receive relevant updates and appropriate support if required. Supporting information for those involved in a rapid review is available on the trust intranet.

12.5.8 The patient or family must be informed of the event and review process using the NHS England guidance document - Engaging and involving patients, families and staff following a patient safety incident.

12.5.9 The table below sets out a summary of rapid review:

Timeframe (from being aware of event)	Duration	Attendees	Facilitator/Lead
ASAP – ideally same shift. Within 2 weeks of event or 1 week of panel decision Before IMR	30 minutes approx.	All those directly involved.	Member of staff who has attended rapid review training session (provided by PST) *or* Senior team member or member of the governance team.

12.6 The below sets out the process and timeframes:



12.7 After Action Review (AAR) (pathway 4)

12.7.1 After Action Reviews (AARs) are most suited to consider a complex journey or involvement with multiple services, teams or providers and the specific factors that led to an outcome. The AAR will focus on care provided, reviewing the specifics of the patient's care. This may include a range of different aspects of learning within a single patient's journey.

12.7.2 These facilitated reflective sessions will benefit from close time proximity to the event(s) and involve those staff who were involved in the event and leading the service at the time. AARs will be completed in line with the PSIRP and will be an option for further investigation where necessary. An AAR is undertaken only when identified as a proportionate response following discussion at the panel and is not usually indicated when a rapid review has already been completed.

12.7.3 A competent and trained facilitator will be assigned to undertake the AAR. This will be arranged by the PST with the support of the directorate governance team and/or manager/team leader. The date, time and location (including whether this is virtual or in person) is determined by the organiser in conversation with those required to attend.

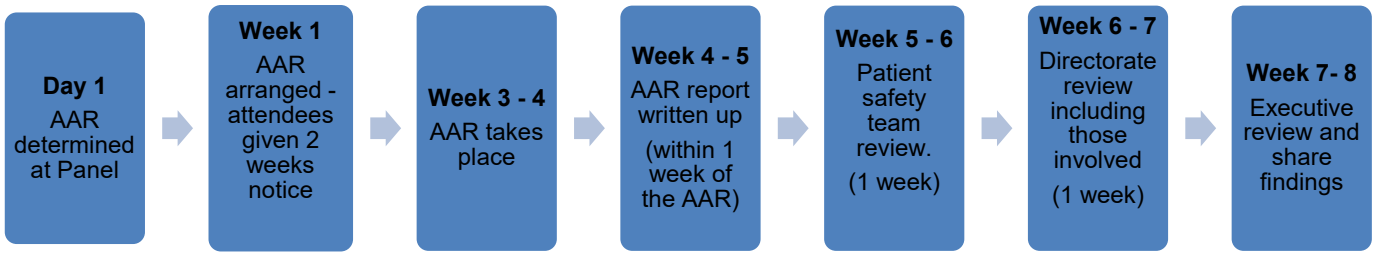
12.7.4 All staff involved should be given sufficient notice (usually 2 weeks) before the date it will take place to maximise attendance. Staff are expected to engage in the learning response and attend the AAR when invited.

12.7.5 It is the responsibility of the line manager or team leader to support staff members to be able to attend the AAR. This may involve coordinating shift patterns or allowing staff to take time back if the AAR is held outside of their regular working hours.

12.7.6 Following completion of the AAR, the facilitator will produce a report using the locally adapted NHSE AAR report template, which is held by the PST. There may be occasions where some analysis is required and it is deemed more

appropriate by the PST to write up the learning using a PSII template. If following the AAR if it felt by the PST that a national requirement is met, another response may be indicated as outlined in the PSIRP. Learning identified within the AAR will be summarised by the facilitator and shared with the directorates.

12.7.7 The below sets out the process and timeframes:



12.8 Patient Safety Incident Investigation (PSII) (pathway 4)

12.8.1 A PSII is undertaken only when indicated in the PSIRP or identified as a proportionate response following discussion at the panel. The trust will liaise with those affected and jointly consider the level of involvement those individuals would like to have in the process as per the principles of compassionate engagement.

12.8.2 Where a PSII is indicated following panel discussion, it must be started as soon as possible and should ordinarily be completed in 1 to 3 months. No local PSII should take longer than 6 months. In exceptional circumstances (e.g. cases requiring external review or input), longer timeframes may be required.

12.8.3 In all cases, the timeframe for completing a PSII will be discussed and agreed with those affected by the event.

12.8.4 PSIIs will be led by a competent and trained member of the PST, and supported by expert advisors and specialists from clinical and/or operational teams, as required.

12.8.5 All PSIIs will require final approval by the Executive Medical Director and/or Chief Nurse and/or Director of Quality and Safety and/or nominated deputy.

12.9 Thematic review (pathway 4)

12.9.1 A thematic review will be completed by the PST for events of a recurring type, with similar initial findings, to assess a current or emerging risk, or when findings from other learning responses identify a theme.

12.9.2 The review must be started as soon as possible after the panel has identified a need for the review and should ordinarily be completed in 1 to 3 months of its start date. No review should take longer than 6 months.

12.9.3 A thematic review is undertaken when identified as a proportionate response following discussion at the panel, and used to support learning and improvement.

12.9.4 Where patients or families request a copy of the thematic review, this will be redacted by the Information Governance team before being shared to ensure that any identifiable information is removed.

13 COMPLAINTS AND APPEALS

13.1 The trust is focused on quality improvement and supporting those affected by patient safety incidents, therefore it is expected that all actions to support a proportionate and thorough response following a patient safety event will be delivered. This process should be fully inclusive of the considerations for those affected by the incident. However, where patients and/or families/friends do not feel the response to the patient safety incident has been appropriate or that they have not been supported appropriately, a right to raise a concern or complaint will remain.

13.2 All people affected by a patient safety event who wish to raise a concern or complaint can do so via Patient Advice and Liaison Service (PALS) and Complaints by emailing kmmh.pals@nhs.net

13.3 The trust webpage has further information about raising a concern or making a complaint.

14 HIGH PROFILE PATIENT SAFETY EVENTS AND IMMEDIATE MANAGEMENT REVIEW (IMR)

14.1 When the patient safety event is potentially a high profile event, the case must be escalated to the Head of Patient Safety or the Director of Quality and Safety as soon as it is known. They will then alert the Chief Nurse. A high profile or potentially high profile event is any patient safety event that is: a homicide or attempted homicide, a child death, or otherwise likely to attract media (including social media) interest and/or significant public interest.

14.2 The Head of Patient Safety will appoint a member of the PST to join a member of the directorate's governance team in completing an initial review using a template (appendix E). This must be completed as soon as possible after the event has been identified. At least one of the reviewers must be available for the immediate management review (IMR) meeting.

14.3 The Head of Patient Safety (or nominated deputy) will arrange the IMR. This should be held within 5 working days of the event being identified.

14.4 A rapid review must be held before the IMR to ensure initial fact-finding and immediate learning is identified.

14.5 There is a standard attendance list (appendix D). Additional attendees will be determined by the Director of Quality and Safety and/or Head of Patient Safety as required.

14.6 The Chief Nurse (or nominated deputy) will chair the IMR. A member of the PST will take notes and these will be sent to the attendees in 3 working days, to allow for actions to be completed promptly.

14.7 The Chief Nurse (or nominated deputy) will be responsible for escalating high-profile cases to the CQC, NHSE/I, commissioners, and/or any other agencies as required.

14.8 The commissioners must inform NHSE/I of critical situations where there is significant risk to patient and/or staff safety, which might include:

14.8.1 Unexpected death or suicide of patient whilst in care that could require an independent investigation

14.8.2 Allegation of abuse or assault whilst in care by either patient or staff that could require an independent investigation

14.8.3 Negative media publication with reputational impact that may require senior management briefing

15 TRAINING AND AWARENESS

15.1 Resources and information to support those involved in a learning response are available on the trust intranet and website.

15.2 All staff are required to complete a local patient safety e-learning module, available via iLearn, focusing on the essentials for creating patient safety.

15.3 Health Education England patient safety syllabus modules (Access to Practice One, Access to Practice Two and Patient Safety in the Mental Health Sector) are available on iLearn and recommended for all staff at band 7 and above, who may be asked to support or lead in learning responses.

15.4 Patient Safety Partners will be supported to access the patient safety syllabus education and provided with professional patient safety supervision via the Director of Quality and Safety. The aim will be to support PSPs to transfer their individual experience and expertise to complement the trust's patient safety responses.

15.5 AAR facilitators must have completed specialised training via the Health Services Safety Investigation Body (HSSIB) module.

15.6 Those leading PSII and thematic review learning responses will be educated in the SEIPS methodology and attend networking sessions within the trust to provide peer supervision and learning.

16 EQUALITY IMPACT ASSESSMENT SUMMARY

16.1 The Equality Act 2010 places a statutory duty on public bodies to have due regard in the exercise of their functions. The duty also requires public bodies to consider how the decisions they make, and the services they deliver, affect people who share equality-protected characteristics and those who do not. In the trust the culture of Equality Impact Assessment will be pursued in order to provide assurance that the trust has carefully considered any potential negative outcomes that can occur before implementation. The trust will monitor the implementation of the various functions/policies and refresh them in a timely manner in order to incorporate any positive changes. The Equality Impact Assessment for this document can be found on the Equality and Diversity pages on the trust intranet.

16.2 The Human Rights Act 1998 sets out fundamental provisions concerning the protection of individual human rights. These include maintaining dignity, ensuring confidentiality and protecting individuals from abuse of various kinds. Employees and volunteers of the trust must ensure that the trust does not breach the human rights of any individual the trust comes into contact with.

17 MONITORING COMPLIANCE WITH AND EFFECTIVENESS OF THIS DOCUMENT

What will be monitored	*How will it be monitored*	*Who will monitor*	*Frequency*	*Evidence to demonstrate monitoring*	*Action to be taken in event of non-compliance*
Patient safety event reporting	Service line patient safety report	Trust Wide Patient Safety & Mortality Review Group Quality Committee	Every 2 months	Group and Committee minutes	Escalate to directorate Head of Service
	InPhase reports	Patient Safety Incident Decision Panel	All forms on receipt that are required to be reviewed at Panel	Panel notes	Escalate to directorate governance teams
Audit and review findings	Service line patient safety report	Trust Wide Patient Safety & Mortality Review Group Quality Committee	Every 2 months	Group and Committee minutes	Escalate to directorate Head of Service and/or Chief Nurse
	Monthly aggregated reporting	Internal review / approval Groups	Monthly	Group minutes	
Findings from PSIIs	Service line patient safety report	Trust Wide Patient Safety & Mortality Review Group Quality Committee	Every 2 months	Group and Committee minutes	Escalate to directorate Head of Service and/or Chief Nurse
	Monthly aggregated reporting	Internal review / approval Groups	Monthly	Group minutes	
Results from monitoring of improvement plans (implementation & efficacy)	Service line patient safety report	Trust Wide Patient Safety & Mortality Review Group Quality Committee	Every 2 months	Group and Committee minutes	Escalate to Director of Quality & Safety and/or Director of Partnerships & Transformation
Results of surveys and feedback from patients/families on their experiences of	Service line patient safety report	Trust Wide Patient Safety & Mortality Review Group	Every 2 months	Group and Committee minutes	Escalate to Director of Quality & Safety and/or directorate

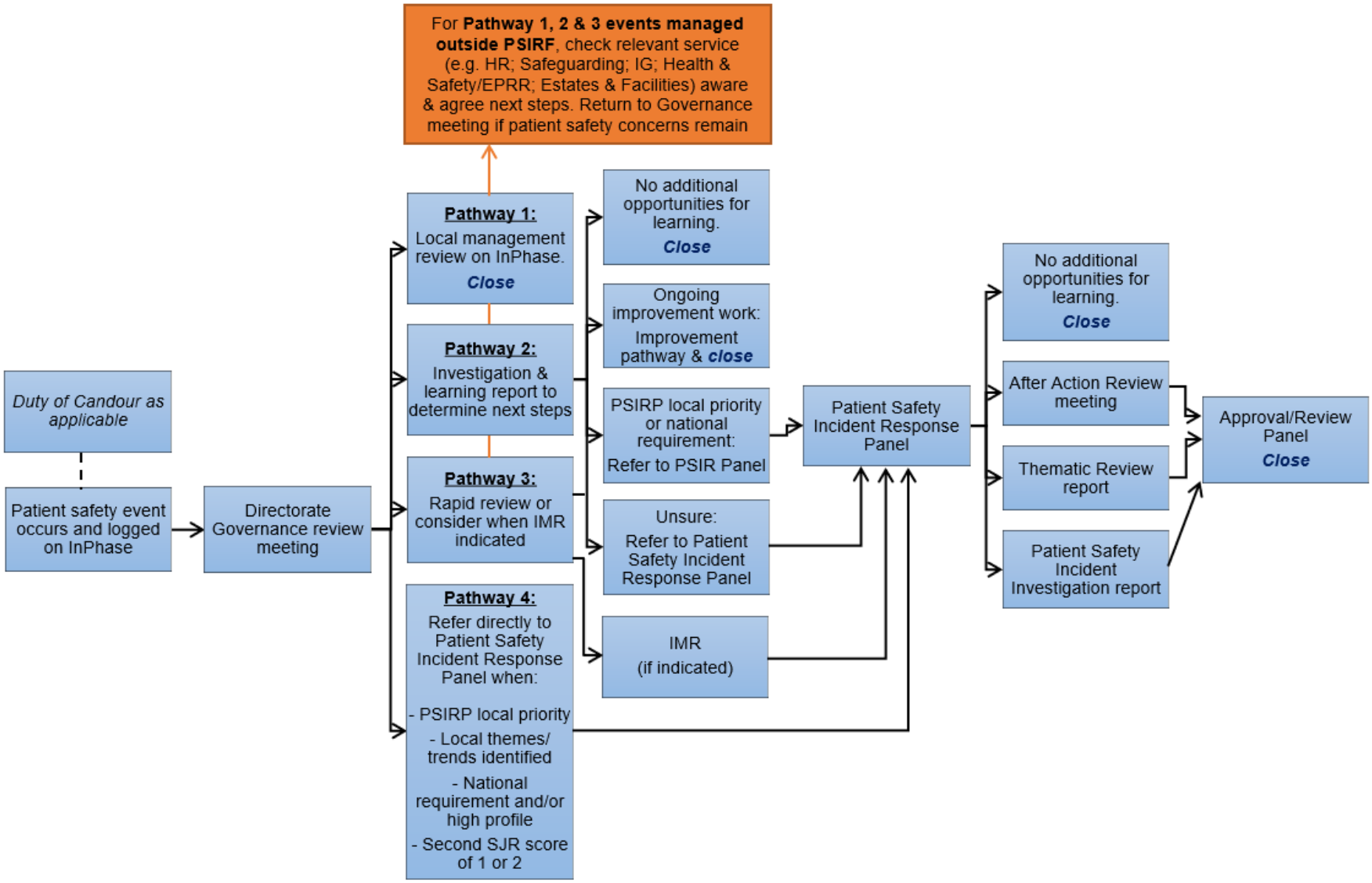
the trust's response to patient safety events		Quality Committee			Head of Service
Results of surveys and feedback from staff on their experiences of the trust's response to patient safety events	Service line patient safety report	Trust Wide Patient Safety & Mortality Review Group Quality Committee	Every 2 months	Group and Committee minutes	Escalate to directorate Head of Service and/or Director of Quality & Safety
Review of the risk register	Service line patient safety report	Trust Wide Patient Safety & Mortality Review Group Quality Committee	Every 2 months	Group and Committee minutes	Escalate to Chief Nurse

18 EXCEPTIONS

18.1 There are no exceptions to this policy.

19 APPENDICES: SUPPORTING DOCUMENTS & FORMS

Appendix A: PSIRF Process Flowchart



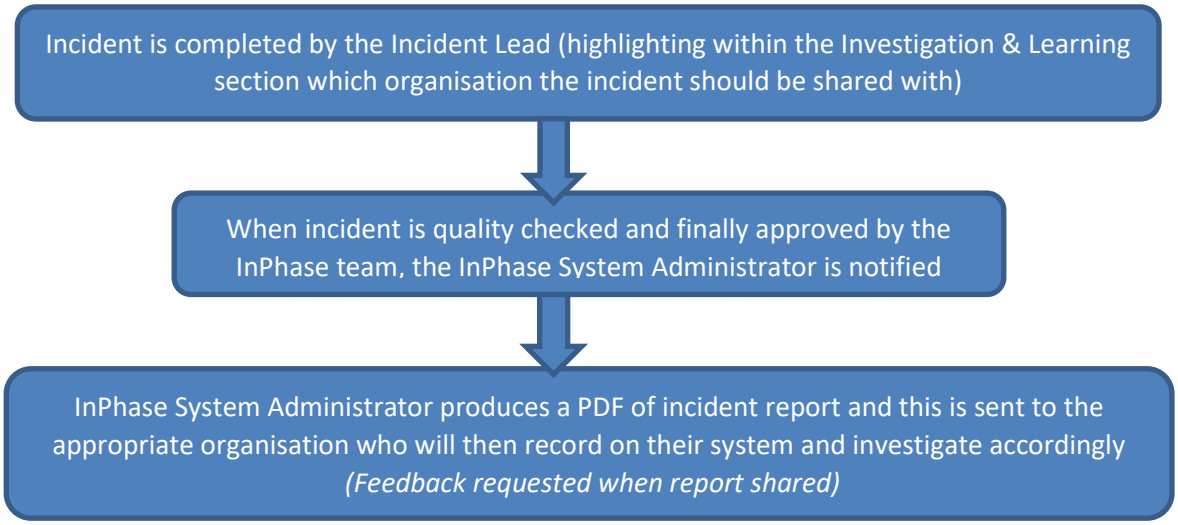
Appendix B: Process for Sharing incidents with other organisations

Oversight InPhase

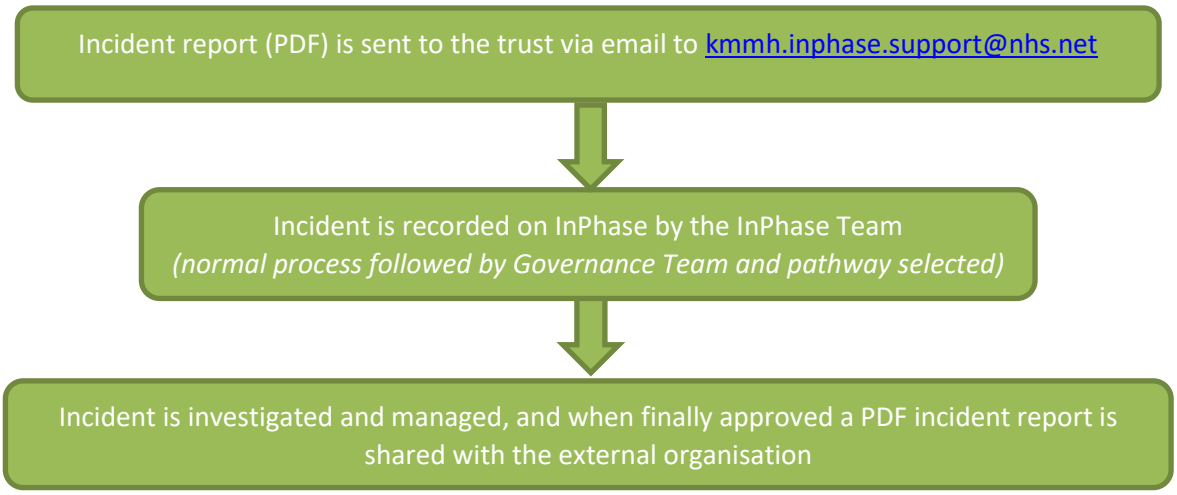
NHS Kent and Medway NHS and Social Care Partnership Trust

PROCESS FOR SHARING INCIDENTS WITH OTHER ORGANISATIONS

- **If an incident logged on InPhase is identified as belonging to ANOTHER ORGANISATION: -**



- **If an incident is identified by ANOTHER ORGANISATION: -**



A tracker of each incident sent externally and/or received is kept within the InPhase Team and all correspondence is attached to the document section with the InPhase record.

Appendix C: Patient Safety Incident Decision Panel supporting form

This form supports decision-making to determine the most proportionate response to patient safety events, in line with the trust Patient Safety Incident Response Plan (PSIRP). If it is determined that another process is required (e.g. Human Resources, Safeguarding, Health and Safety or Inquest) the panel will refer to or request initiation of those processes.

Directorates, please can you:

- Complete sections A and B, then send this form to both **Fiona Delahay** & **kmmh.psinvestigationteam@nhs.net** prior to Tuesday's panel meeting
- Ensure a representative of the relevant Senior Leadership Team (SLT) is in attendance to answer questions
- Ensure those presenting are prepared to verbally summarise sections A and B

Reference (InPhase)			
Event date	Click or tap to enter a date.	**Reported date**	Click or tap to enter a date.
Directorate	Choose an item.	**Service/Team**	
Case presented by			

A. SITUATION AND BACKGROUND

Patient safety event *Include a brief description of the event and relevant background information. What happened? When and where did it happen? Who was involved? What is known and unknown?*
Immediate safety actions *What has been done immediately following the event to ensure safety/put right where possible?*
Directorate Oversight *Who in the SLT is aware of the event/has this been discussed with?*
Subsequent Actions *List any actions taken/planned and monitoring to mitigate risk of recurrence.*
Duty of Candour and Compassionate Engagement

Is the Statutory Duty of Candour applicable?	Choose an item.	Date completed:	Click or tap to enter a date.
Additional information *Detail any reason for delay/name of lead etc. Include information relating to compassionate engagement conversations had as part of the PSIRF.*			

B. ASSESSMENT

Patient Safety Incident Response Plan (PSIRP) applicable?	
National requirement?	*State national requirement met (see PSIRP)*
Local Priority?	*State local priority met (see PSIRP)*
Is it covered by a trust-wide improvement plan or quality improvement work?	*If yes, provide brief description/detail.*
Proposed proportionate response	Choose an item.

Key contacts
List key stakeholders e.g. patient, family, staff directly involved, Heads of Nursing & Quality, Clinical Directors, Service Directors, specialist staff, external experts, etc.

Name	Designation/Role	Consulted for this review *(tick for yes)*
		☐
		☐
		☐
		☐
		☐

Issues and Risks identified on review
Bullet point list – following review of the initial review of the incident, what can we learn? What can we improve? Are there any themes?

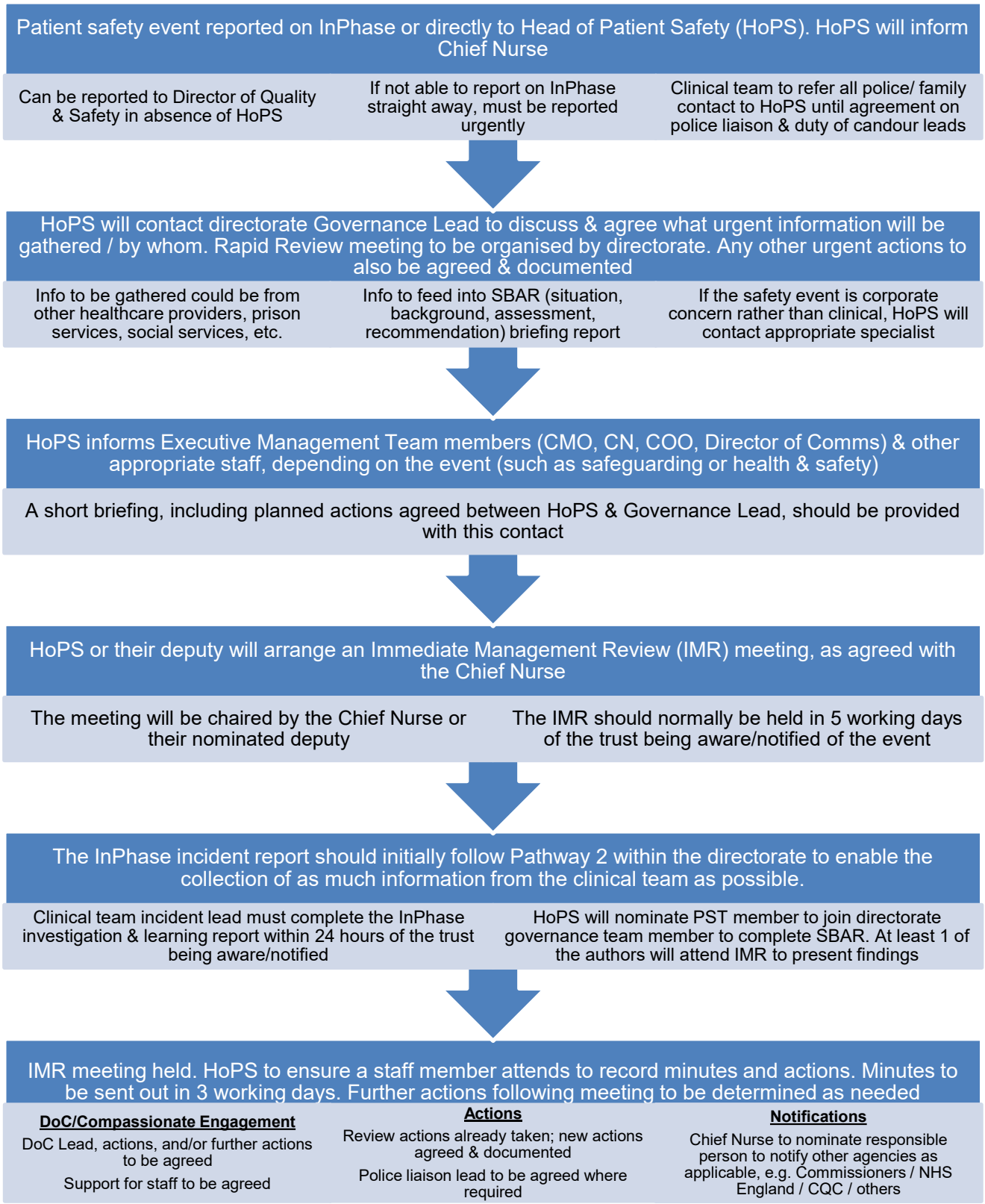
C. RECOMMENDATION

Panel Decision			
Date Presented	Click or tap to enter a date.	**Chair**	
Decision summary *Detail decision made and brief rationale. Include any additional information required and additional organisations/teams to be made aware.*			
Confirmed proportionate response *If thematic review, list other InPhase numbers in summary above.*		Choose an item.	
Anticipated timeframe for completion			

Appendix D: Immediate Management Review flowchart and agenda

Immediate Management Review (IMR) flowchart

Process for cases that are: high profile, potentially high profile, homicides/attempted homicides, child deaths, or otherwise likely to attract media/social media attention



Immediate Management Review meeting
To be held on Microsoft Teams
Date at X am/pm
InPhase ID XXXXX

Agenda

Invited		
Name	**Job title**	**Initials**
	Chief Nurse (Chair)	
	Deputy Chief Nurse	
	Director of Quality & Safety	
	Head of Patient Safety	
	Patient Safety Administrator (Minutes)	
	Head of Safeguarding	
	Deputy Head of Information Governance & Records Management	
	Deputy Director of Communications & Engagement	
	Deputy Chief Medical Officer (Quality & Safety)	
	Directorate Service Director	
	Directorate Clinical Director	
	Directorate Head of Nursing & Quality	
	Directorate Governance Lead	
	Team General Manager	
	Team Matron	
	Subject experts by invitation	

Apologies		
Name	**Job title**	**Initials**

ITEM	
IMR/25-26/1.	**The patient safety event**
1.1.	**Description of the event**
1.2.	**Background**
1.3.	**Where are the records stored?** *e.g. RiO, Dart, InPhase, meeting minutes, etc.* **Are they secured?** Y/N *(if no, please provide more information)*
1.4.	**Media interest**
IMR/25-26/2.	**Duty of Candour and/or Compassionate Engagement**
2.1.	**Summary of family contact** • Statutory duty of candour (DoC) is *applicable/not applicable*

	• The family *would/would not* like to be involved in investigation
2.2.	**Confirmation of Duty of Candour Lead(s)**
2.3.	**Support for staff**
IMR/25-26/3.	**Liaison with external agencies**
3.1.	**Summary of police contact**
3.2.	**Confirmation of OIC and trust police liaison lead (if required)** ***Please note: Does this case require the Patient Safety Team to contact the police to establish the respective terms of investigation and how we will share findings?***
3.3.	**Liaison with other appropriate groups (e.g. safeguarding)**
IMR/25-26/4.	**Communication with key stakeholders**
4.1.	**Does CQC need to be notified?** Y/N Nominee to complete:
4.2.	**Do commissioners need to be notified?** Y/N Nominee to complete:
4.3.	**Does NHSE/I need to be notified?** Y/N Nominee to complete:
4.4.	**Do any other external agencies need to be notified?** Y/N Agencies to notify: Nominee to complete:
IMR/25-26/5.	**Learning in response to the patient safety event**
5.1.	**Summary of immediate learning, including from rapid review**
5.2.	**Potential areas for further exploration**
5.3.	**Confirmation of where / how immediate learning should be shared**
5.4.	**Confirmation of plan to progress the response**
IMR/25-26/6.	**Any other business**
6.1.	**AOB from attendees**
IMR/25-26/7.	**Date of next meeting (if required): tbc**
IMR/25-26/8.	**Actions to be progressed**
8.1.	**Actions and updates table**

	Action	**Action lead**	**Due date**	**Update**
8.2.	**Postscript notes**			

Appendix E: IMR SBAR form

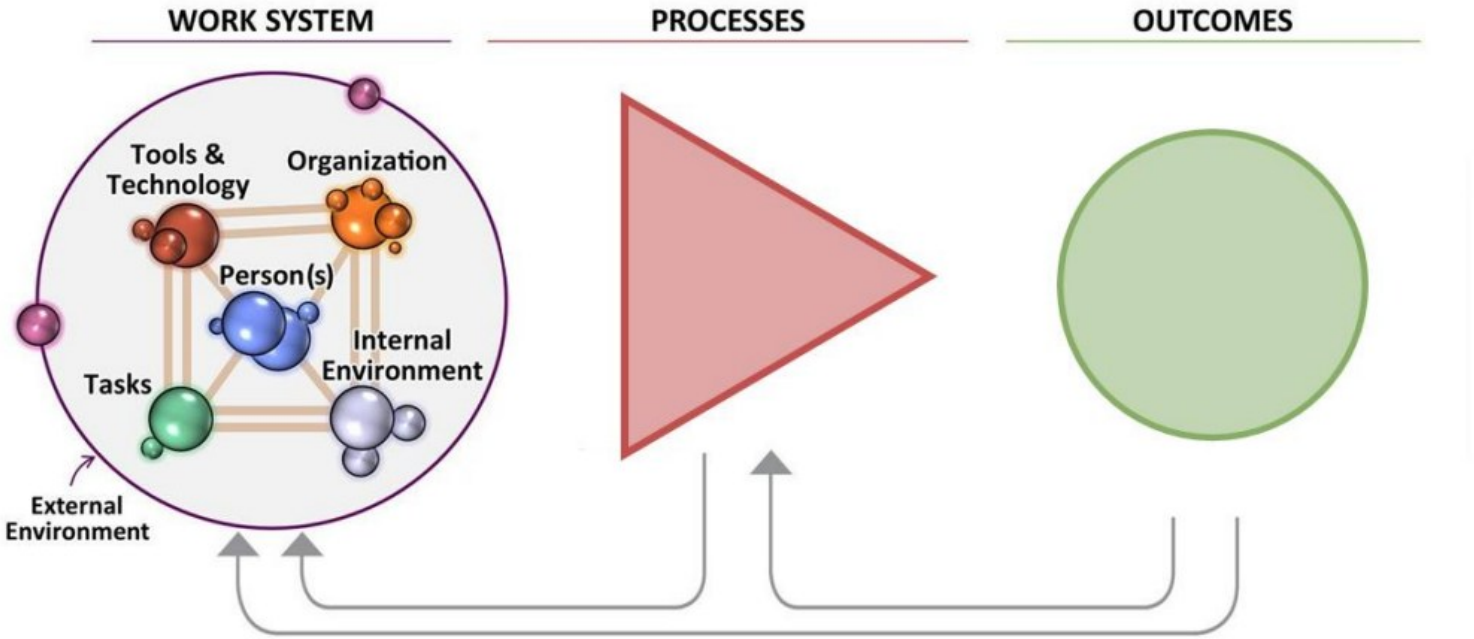
SBAR Report form:

Date:	dd/mm/yyyy	**InPhase:**	hh:mm
Completed by:		**Title:**	
Telephone number:		**Email address:**	
Approved for release by:		**Title:**	

Patient Safety Event– SBAR REPORT		
SBAR is a structured method for communicating critical information requiring immediate attention and action contributing to effective escalation and increased patient safety.		
Safety Event Declared by: Name of Trust / CCG-ICS / NHS England and NHS Improvement		
1.	**Situation** *Describe situation/incident that has occurred.*	
2.	**Background** *Explain history and impact of incident on services / patient safety.*	
3.	**Assessment** *Confirm your understanding of the issues involved.*	
4.	**Recommendation** *Explain what you need, clarify expectations and what you would like to happen.*	
Send to:		**kmmh.psinvestigationteam@nhs.net**

Appendix F: System Engineering Initiative for Patient Safety (SEIPS)

Figure 1. Overview of the SEIPS framework



NHS England (2022) SEIPS Quick Reference Guide and Work System Explorer. Available at: [B1465-SEIPS-quick-reference-and-work-system-explorer-v1-FINAL-1.pdf]

APPENDIX G: PATIENT SAFETY AND NON-PATIENT SAFETY CATEGORIES