Kent and Medway
NHS and Social Care Partnership Trust

Patient Safety Incident Response Framework Policy

Document Reference No.	KMPT.CorG.176.01
Replacing document	Management and Investigation of Serious Incidents Policy: KMPT.CorG.020.08
Target audience	All staff
Author	Central Investigation Team Manager
Group responsible for developing document	Trust Wide Patient Safety and Mortality Review Group
Status	Authorised
Authorised/Ratified By	Trust Wide Patient Safety and Mortality Review Group
Authorised/Ratified On	September 2024
Date of Implementation	September 2024
Review Date	April 2025
Review	This document will be reviewed prior to review date if a legislative change or other event otherwise dictates.
Distribution date	October 2024
Number of Pages	19
Contact Point for Queries	kmpt.policies@nhs.net
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DOCUMENT TRACKING SHEET

Patient Safety Incident Response Framework Policy

Version	Status	Date	Issued to/approved by	Comments
0.1-0.4	Draft	Jun 2024	Central Investigation Team Manager	Template provided by NHSE
0.5	Draft	Jul 2024	Chief Nurse Interim Director of Quality & Safety	
0.6	Draft	Jul 2024	Kent & Medway Integrated Care Board	
0.7	Draft	Aug 2024	Chief Nurse Interim Director of Quality & Safety	Revisions following KMICB feedback
0.8	Draft	Aug 2024	Kent & Medway Integrated Care Board	Minor revisions Approved 13/09/2024
0.9 0.10	Draft	Aug 2024 Sept 2024	Trust Wide Patient Safety & Mortality Review Group Kent, Surrey & Sussex Provider Collaborative	Sent for consultation to stakeholders, including Patient Safety Partner Approved by Chair's Action TWPS&MRG on 17/09/2024
0.11-0.13	Final drafts	Sept – Oct 2024	Interim Director of Quality & Safety	Minor revisions and completion of equality impact assessment
1.0	Final	Oct 2024	Quality Committee	For assurance

REFERENCES

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NHS England (2021) A just culture guide. Supporting consistent, constructive and fair evaluation of the actions of staff involved in patient safety incidents. Available from: https://www.england.nhs.uk/wp-content/uploads/2021/02/NHS_0932_JC_Poster_A3.pdf

NHS England (2021) NHS Patient Safety Strategy: Progress so far: 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 from: NHS England » Patient safety learning response toolkit

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

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RELATED POLICIES/PROCEDURES/protocols/forms/leaflets

Patient Safety Incident Response Plan	
Duty of Candour – Being Open Policy	KMPT.CorG.018.06
Patient Safety Partner Policy	KMPT.CliG.232.01
Policy and Procedure for Listening and Responding to Concerns and Complaints	KMPT.CorG.019.06
Learning from Experience Policy	KMPT.CorG.011.08
Learning from Deaths Policy	KMPT.CliG.156.04

SUMMARY OF CHANGES

Date	Author	Page	Changes (brief summary)

CONTENTS

1 INTRODUCTION

1.1 This policy supports the requirements of the Patient Safety Incident Response Framework (PSIRF) and sets out Kent and Medway NHS and Social Care Partnership Trust's (KMPT, or, the trust's) 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 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 four 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 our current patient safety incident response plan, which is a separate document setting out how this policy will be implemented.

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 the 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)

3.5 For clarity, the trust considers these processes as separate from any patient safety investigation/review. 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.

3.6 The trust will ensure the leads for different investigation/review processes work together to ensure each response seeks to deliver the intended outcomes and complement each other, rather than duplicating scope or omitting key work.

4 DUTIES AND OVERSIGHT

4.1 KMPT 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 Just Culture 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 high profile patient safety event learning responses and reviews.

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 Quality Digest.

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 Quality Digest 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

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 initiate 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 or trust priorities as outlined within the Patient Safety Incident Response Plan, 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 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, possible high profile cases, homicides and child deaths. It will be led by the Chief Nurse or deputy. Panel members are expected to prioritise attendance when requested and convened, or to appoint a deputy to attend.

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

4.7 Patient Safety Peer Review Meeting

4.7.1 This meeting will be attended by members of the patient safety team (PST) and the Head of Patient Safety, and is designed to ensure impartiality, timeliness of learning and report writing and communication with those involved is being maintained.

4.7.2 It allows a safe space for investigators to discuss progression, obstacles and concerns that may require further escalation. Additionally, the meeting space supports the team to ensure non-biased approaches to investigation/learning reviews and apply both just culture and systems-based approaches.

4.8 Expert Groups

4.8.1 These groups, such as the Medication Review Group and physical health group, will routinely monitor the number and types of patient safety events arising from their specialty and ensure appropriate actions are taken, and external reports are made.

4.9 Directorate Governance Leads, Directorate Senior Leadership & Management Teams

4.9.1 Directorate senior leadership and management teams are responsible for ensuring that staff complete InPhase reports for any possible patient safety event.

4.9.2 Governance leads are responsible for ensuring that directorate reviews take place, and that events are triaged daily to the most appropriate pathway (Appendix A).

4.9.3 If an event is identified to be presented at Patient Safety Incident Decision Panel, governance leads are responsible for working with clinical teams to ensure that InPhase reports are good quality, enabling the panel to make a reasonable decision.

4.9.4 Senior leadership and governance leads are responsible for reviewing completed learning reports, and ensuring appropriate attendance at learning review meetings. They will also attend IMR meetings when appropriate, and ensure appropriate attendance from others as required.

4.9.5 Leadership and management teams will ensure that Duty of Candour is completed within legal timeframes, and Compassionate Engagement is always adhered to for patient safety events within PSIRF. This includes ensuring support for staff involved, regardless of their status.

4.9.6 Directorates are responsible for developing, implementing and monitoring local improvement plans, 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 directorate processes.

4.10 **Patient Safety Team**

4.10.1 To ensure all assigned after action review (AAR's), thematic review and patient safety incident investigation (PSII) reports are completed in line with agreed timeframes. Keep patients and families updated where this is not possible.

4.10.2 To facilitate AAR meetings following a patient safety event.

4.10.3 To seek appropriate expert advice (internally or externally) for learning reviews where required.

4.10.4 To ensure the involvement of patients/families/carers and staff in learning reviews, throughout the process. Keep in line with Duty of Candour regulations, Compassionate Engagement principles and Just Culture throughout.

4.10.5 To identify key staff involved and ensure that they are aware that PSIRF and the learning response is a learning review process not focused on 'blame' or individuals.

4.10.6 To share learning review findings, and usually the report, with the patient/family/staff, except in exceptional circumstances such as at police request or where doing this may increase the risk to the patient (such as in some domestic abuse cases).

4.11 **Chief Nurse (Designated Board Member Lead for Patient Safety)**

4.11.1 To take responsibility 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 appraised of patient safety events that are externally reportable, such as to the Care Quality Commission (CQC), NHSE/I, commissioners and others.

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

4.11.3 To take responsibility for alerting the Chief Executive of high profile cases or those that risk organisational reputation.

4.11.4 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.

4.12 **Director of Quality and Safety**

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

4.13 **Head of Patient Safety**

4.13.1 To quality check learning reviews completed by the patient safety team, or ensure a deputy is appointed when not available.

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

4.13.3 To ensure IMR meetings are appropriately organised, to attend the meeting, and make sure notes are sent out within one working day of the meeting.

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

4.14 Patient Safety Specialists

4.14.1 Patient Safety Specialists have been appointed by the trust and they are responsible for attending update meetings from NHS England/Improvement, developing and embedding the Patient Safety Strategy for the trust, updating the trust, and ensuring that investigation/ learning review processes are embedded within the trust.

4.14.2 They are also responsible for ensuring that adequate support is provided to the investigation/ learning review process and for ensuring that staff are trained in line with the patient safety syllabus.

4.15 All Staff

4.15.1 To report any incidents/events/risk issues on InPhase that would warrant further review or investigation.

4.15.2 To contribute fully to any learning response or review/investigation process in an open and honest manner.

5 OUR PATIENT SAFETY CULTURE

5.1 A key priority within the trust strategy is to create a culture where our people feel safe, equal and can thrive. This priority is very much aligned to the patient safety culture sought to deliver the PSIRF, so the trust is committed to working towards a move from a retribution approach and instead to promote a fair, just and learning culture.

5.2 Alongside the opportunities to learn from unintended safety events, a Safety-II approach[1] will be adopted and positive experiences from patients, families, carers and staff will be identified and shared as the trust is committed to learning from excellence.

5.3 Compassion, understanding and engagement of those affected by patient safety events will remain high priority and is a key driver to the success of PSIRF. A collaborative approach to learning from safety events and good practice is vital in driving the improvements for patients and families and this approach will also be adopted by all staff. This will continue to increase transparency and openness amongst our people to report events and allow for wider engagement.

5.4 Patient safety learning responses will be undertaken for the sole purpose of learning and identifying system wide improvements; they are not to apportion blame, liability or define preventability or cause of death.

5.5 Further focus on just and learning culture will ensure staff are treated fairly following patient safety events and ensuring errors or omissions in care are understood primarily as an organisational responsibility.

[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.

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 PSIRF within the trust; the role will be reviewed at annual intervals to ensure it continues to provide the greatest impact for patient safety improvement within the trust.

6.2 Initial focus for Patient Safety Partners will centre around:

6.2.1 Proportionate response to patient safety events.

6.2.2 To utilise lived experiences to make meaningful changes in improving care.

6.2.3 Support to input into 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 support to be offered.

6.4 All Patient Safety Partners 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 Patient Safety Incident Decision 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 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 Patient safety responses will continue to consider health inequalities through a variety of routes. These routes will consider:

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

7.3.2 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.

7.3.3 During recruitment of Patient Safety Partners, consideration will be given to diversity and where gaps in partners with specific characteristics are identified, active recruitment will be led to ensure diversity in this key stakeholder group.

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 patients and families will be treated with respect, dignity, openness, and transparency at all times, including following a patient safety event.

8.3 All patient safety events/incidents will be reported utilising the trust incident reporting and management system, InPhase.

8.4 Patients, and families as appropriate, will be provided with full details of the patient safety event. They will be offered support initially by the clinical team involved in their care and then by a trained learning response facilitator or the patient safety team (PST) who will support them throughout the learning response process. As well as meeting our regulatory and professional requirements for Duty of Candour (DoC), our trust aims to be open and transparent with those affected by a patient safety event because it is the right thing to do.

8.5 Support for staff following a patient safety event will initially be through line manager support, but access to the trust wellbeing support and occupational health will always be available. Any staff who feel unfairly treated following a patient safety event will be encouraged to discuss with their directorate HR employee relations advisor, their senior managers, or to contact the trust Freedom to Speak Up Guardian. Where the patient safety team are aware of such concerns, advice will be sought as to the most appropriate channel to direct these in order to support the member of staff. Staff can also access support from relevant professional bodies, staff side and unions.

8.6 Contact with patients and/or families should be as soon as possible after the event. This shows the patient and/or family that we care. It also allows early learning to be captured. We should work with patients, families and staff throughout the review and response process, and actively seek their views.

8.7 Individual needs must be considered and adaptations made as far as possible. This could include, for example, interpreters, disability and accessibility needs, cultural needs, and advocacy.

8.8 There are occasions when involving patients and/or families may not be possible (or may need to be delayed). Examples might be when patients are too unwell and/or families cannot be involved for specific reasons, such as in criminal cases if the police will not permit contact, or a patient and/or family member may be put at more risk as in cases relating to domestic abuse. This decision will be made by the Patient Safety Incident Decision Panel and recorded on InPhase.

8.9 We recognise the impact on families, friends and staff following a mental health related homicide is traumatic and life changing. Following an event of this kind, NHS England's principles and recommended activities will be followed to support existing processes and structures to continue providing meaningful support to those affected.

9 PATIENT SAFETY INCIDENT RESPONSE PLANNING

Please see process flowchart in Appendix A.

9.1 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.

9.2 The trust Patient Safety Incident Response Plan (PSIRP) provides full details and trigger points for the learning responses, which will be implemented using Systems Engineering Initiative for Patient Safety (SEIPS) methodology.

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. The trust's SJR process will remain unchanged. An SJR will not be required to be completed if it has been determined that a Patient Safety Incident Investigation (PSII) will be undertaken, in order to maintain proportionality. Existing communication channels will be utilised to ensure there is no duplication. See the Learning from Deaths Policy for further information on SJRs.

9.4 The timescales set out below are a guideline and will be determined by the complexity of the individual event requiring review/investigation.

9.5 Patient safety event learning responses will fall into four main categories, which are explored in further detail below:

9.5.1 Rapid Reviews (two types: Rapid Review A – huddle/debrief or Rapid Review B – Multidisciplinary Team (MDT))

9.5.2 Thematic Reviews

9.5.3 After Action Reviews (AARs)

9.5.4 Patient Safety Incident Investigations (PSIIs)

9.6 Rapid Reviews/Local Learning Responses

Led by the relevant directorate, learning response documentation will be completed by the chair/lead facilitator. The trust templates will be used to document the review. These reviews will be completed and documentation and/or information uploaded to InPhase within two weeks of the incident being reported. All local learning responses will identify any immediate safety actions required. These will be shared with key stakeholders via established directorate governance processes. The initial trigger for a further learning response will most commonly be made via the directorate governance process however, this can also be initiated by any member of the senior leadership teams, Chief Nurse, Director of Quality and Safety or Head of Patient Safety. Referral to the Patient Safety Incident Decision Panel must be made within one week of completing the Rapid Review.

9.6.1 Rapid Review A: Huddles/Debrief

A huddle is designed to start as soon as possible after a patient safety event occurs to quickly analyse what happened, how it happened, and decide what

needs to be done to reduce risk. A debrief allows the participants to reflect on a project, an activity, an occurrence, or an event. It usually covers action items relating to a task, any obstacles that arose, individual learnings and findings, relevant progress, or subsequent actions.

9.6.2 **Rapid Review B: MDT Reviews**

The MDT Review is suited for community services who can incorporate learning and identify actions through their existing processes on a weekly basis or sooner if possible, to review an element of practice, often between professional groups or teams. Also described as reviewing 'work done against work as imagined' or the policy/practice gap. These facilitated reflective sessions can be completed even if the specifics of the patient care cannot be recalled, and reflection is based on current practice more generally. This approach is suited where an event may have been identified several weeks or months after it happened or when there is more than one similar event. For effective reflection, these sessions will aim to include a wide range of multi-professional staff both involved in the event and involved in the general aspects of work discussed.

9.7 Thematic Reviews

For events of a reoccurring type and/or with reoccurring errors or omissions, or to assess a current or emerging risk, a thematic review will be completed by the patient safety team (PST). The review must be started as soon as possible after the Patient Safety Incident Decision Panel has identified a need for the review and should ordinarily be completed within 1 to 3 months of their start date. No review should take longer than 6 months. Findings will be shared at the Learning Review Group.

9.8 After Action Reviews (AARs)

9.8.1 After Action Reviews (AARs) are most suited to consider the patient's journey through the trust and consider the specific factors that led to errors or omissions in care. The AAR will focus on care provided, reviewing the specifics of this patient's care. This may include a range of different aspects of learning within a single patient's journey.

9.8.2 These facilitated reflective sessions will benefit from close time proximity to the event(s) and involving those staff that were involved in the event and leading the service at the time. Please see the development and training section for further details on support to be offered facilitators.

9.8.3 AARs will completed in line with the PSIRP and will be an option for further investigation and decided through the Patient Safety Incident Decision Panel. Once the decision is made to complete an AAR, the responses should be completed within no more than four weeks and reports submitted within a further one week. This entire process should not exceed 8 weeks from when the event was reported.

9.8.4 The session should take 30 minutes to one hour and all staff involved should be given sufficient notice (usually two weeks) before the date it will take place to minimise non-attendance. Staff are expected to adjust their work schedule in order to attend.

9.9 Patient Safety Incident Investigations (PSIIs)

9.9.1 PSIIs will be completed for all patient safety events meeting national or local priorities as set out in the PSIRP.

9.9.2 Other events will be investigated via PSII where the Patient Safety Incident Decision Panel considers the potential learning to be of a significant level and complexity to require an extensive investigation, to allow the required quality improvement activities.

9.9.3 Where a PSII for learning is indicated, the investigation must be started as soon as possible after the patient safety event is identified and should ordinarily be completed within 1 to 3 months of their start date. No local PSII should take longer than 6 months. The time frame for completion of a PSII will be agreed with those affected by the event, as part of the setting of terms of reference, provided they are willing and able to be involved in that decision. A balance must be drawn between conducting a thorough PSII, the impact that extended timescales can have on those involved in the incident, and the risk that delayed findings may adversely affect safety or require further checks to ensure they remain relevant.

9.9.4 In exceptional circumstances, a longer timeframe may be required for completion of the PSII. In this case, any extended timeframe should be agreed between the trust and those affected.

9.9.5 PSIIs will be led by the investigators within the PST and supported by expert advisors and specialists as required from clinical and/or operational teams. Please see the development and training section for further details on support to be offered facilitators.

9.9.6 The trust will liaise with those affected by patient safety incidents and jointly consider the level of involvement those individuals would like to have in the investigation process. This consideration will be led by the Central Investigation Team (CIT) Manager.

9.9.7 All PSIIs will require final approval via the trust Executive Medical Director and/or Chief Nurse and/or Director of Quality and Safety.

9.10 Our patient safety incident response plan (PSIRP)

9.10.1 Our plan sets out how the trust intends to respond to patient safety events over an initial period of 6 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.

9.10.2 A copy of the Trust's current PSIRP can be found on the trust internet page.

9.11 Reviewing our patient safety incident response policy and plan

9.11.1 Our PSIRP is a 'living document' that will be appropriately amended and updated as we use it to respond to patient safety incidents. The plan will initially be reviewed at 6 months locally, then with the commissioners at 12 months, and at least annually after that to ensure the plan is current and proving effective in learning and improving.

9.11.2 With ongoing improvement work, our patient safety event 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 months.

9.11.3 Updated plans will be published on our website, replacing the previous versions.

10 RESPONDING TO PATIENT SAFETY EVENTS

10.1 Patient safety event reporting arrangements

10.1.1 All patient safety events/incidents will be reported on InPhase locally by the team that identified the event. The team should complete the InPhase report as soon as possible. It is recognised that in some instances this may not be immediate, in which case the team should complete the InPhase report as soon as they are able to, and in all cases by the end of the next working day.

10.1.2 All patient safety events will initially be reviewed by the governance team or the identified manager for the location that the event was reported in. This initial review will ensure that the information reported within the incident form is accurate and complete. Focus will be given to ensure:

a) Accurate description of the event
b) Patient and staff identifiable information is only included in the appropriate sections of the form and is accurate and as described on the electronic patient record
c) Accurate cause groups have been identified
d) Accurate harm level has been identified
e) All immediate actions/mitigations taken are recorded
f) All incident fields have been completed

10.1.3 Following completion of the incident form, any further investigation or review can be triggered. The governance team or manager can indicate the need for a local/rapid review, or consider escalation to the Patient Safety Incident Decision Panel.

10.1.4 Directorates will have daily review mechanisms in place to ensure that patient safety events can be responded to proportionately and in a timely fashion. This should include consideration of and prompting to service teams where DoC or compassionate engagement applies.

10.2 Patient safety incident response decision-making

10.2.1 The Patient Safety Incident Decision 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 group is to review incidents that may require further exploration, such as a thematic review, AAR or PSII.

10.2.2 Expert opinion from specialists must be sought to determine whether practice that led to an event did not meet local and national policies, processes and standards.

10.2.3 When it is unclear if a patient safety event meets the criteria to be reviewed as a PSII or one of the PSIRP priorities, the panel will seek advice from the Chief Nurse or another director as relevant.

10.2.4 To drive efficiency within investigations/learning responses, learning and quality improvement, the panel will first consider thematic review for all events that note a reoccurring event type, reoccurring error or omission in care, or if an emerging risk has been identified.

10.2.5 Events that require an individual review will be escalated for discussion at the panel. This will include events that identify errors or omissions in care that have not previously been understood and have further learning potential. The meeting will identify the most proportionate response. Outcomes will be shared with the Learning Review Group.

10.2.6 A PSII will be initiated as per the specific criteria described earlier in this policy, but also for any events where the panel considers the potential learning to be of a significant level and complexity to require an extensive investigation to allow the required quality improvement activities.

10.2.7 The panel will identify any event which appears to meet the requirement for reporting externally. This will be to allow the trust to work in a transparent and collaborative way with our commissioners or regional NHS teams if an incident meets the national criteria for PSII or if supportive co-ordination of a cross system learning response is required. This will be documented following discussion at the Patient Safety Incident Decision Panel.

10.2.8 The panel must identify a panel member to escalate to executive staff and to the communications team when cases are identified which are likely to attract publicity or have been/may be in social media, or which may require their consideration and escalation. The panel will agree responsibility (in conjunction with the executive lead if required) for informing the patient, family and/or carers if the case is likely to attract publicity through media forms. An immediate management review (IMR) will be considered in these circumstances (please see the IMR section for further details).

10.2.9 The panel will receive information from directorates about initial learning from all cases for consideration. When no initial learning has been identified, the directorate senior leadership representative will be responsible for ensuring initial learning is identified and put in place within timeframes agreed by the panel.

10.3 Responding to cross-system events/issues

10.3.1 All events recommended for external review, following initial managerial review, will be shared via the PST. The sharing of events will always be coordinated between patient safety to patient safety team across organisations as agreed by the Multi Agency Review Group and communities of practice. The trust will work closely with other providers, stakeholders and commissioning bodies to ensure clear sharing lines.

10.3.2 All events reported by partner organisations that require review within the trust will be shared via the PST and added to the local incident management system. Managerial review will be completed by the relevant team within one week and any additional reviews will be triggered as with internally reported events. Themes from externally reported events will be drawn out and considered both alongside and within the wider pool of events.

10.3.3 Where patient safety event investigation beyond managerial review demonstrates overlap with another local provider, a joint investigation will be completed. The recommendation for response type will be considered internally and then negotiated with the other organisation to agree a clear response route and terms of reference.

10.4 Timeframes for learning responses

10.4.1 Directorate governance reviews will be undertaken daily to triage and confirm the next pathway.

10.4.2 Local management reviews (pathway 1) and investigation and learning (pathway 2) pathways will be completed within 1 week of an event being reported.

10.4.3 Rapid reviews (pathway 3) will be completed within 1 week of the management investigation and learning being completed (2 weeks from the event being reported).

10.4.4 Thematic reviews will be completed within 1 to 3 months, following agreement at the Patient Safety Incident Decision Panel.

10.4.5 AAR reports will be completed within 8 weeks from the event being reported. This will include submitting the report.

10.4.6 PSIIs will have timescales agreed at the Patient Safety Incident Decision Panel and during engagement with patients and families, with a maximum time period of up to 6 months. The time period agreed will include timescales for investigation/review, identification of areas for improvement and development of an action plan. All stages will be completed within the agreed timescale (6 months maximum) and patients and families must be kept informed of progress.

10.4.7 The table below outlines the submission guidelines for all learning responses:

Learning Response	Timescale from event being reported
Rapid Review	2 weeks
Thematic review	1 to 3 months (as per NHSE guidance)
AAR	8 weeks
PSII	3 to 6 months (as per NHSE guidance)

10.5 Safety action development and monitoring improvement

10.5.1 Through the response and investigation, process areas for improvement will be defined. Following the areas for improvement, safety actions will be developed to address each of these. When developing the safety actions a quality improvement methodology will be utilised to ensure the actions are: clearly defined, describe responsibilities and timescales, aligned to reportable outcome measures, and include a detailed assurance/monitoring process.

10.5.2 Safety actions must be developed with the clinical and operational teams that will implement these actions to ensure ownership of the actions and outcomes.

10.6 Safety improvement plans

10.6.1 Outcomes of learning responses including investigations will be reviewed by the Learning Review Group and safety improvement plans will be developed within all of the improvement governance structures. These improvement plans will be a key focus of the regular thematic reviews within working groups and explore the impact of improvement plans on subsequent events.

10.6.2 There will be a clear alignment between some safety actions falling out of individual patient safety responses and the overarching safety improvement plans; these plans will often lead to the outcome measurement and assurance processes that underpin safety actions.

10.6.3 Safety improvement plans will be considered by the Learning Review Group both to receive progress and assurance regarding existing plans, but also to recommend the need for future improvement plans following review of responses and individual safety actions.

11 COMPLAINTS AND APPEALS

11.1 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.

11.2 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 kmpt.pals.kmpt@nhs.net.

11.3 The trust webpage has further information about raising a concern or making a complaint which is publicly available.

12 HIGH PROFILE PATIENT SAFETY EVENTS LEADING TO AN IMMEDIATE MANAGEMENT REVIEW

12.1 When the patient safety event is potentially a high profile event, and/or likely to attract significant public interest, 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.

12.2 The Head of Patient Safety will appoint a member of the patient safety team (PST) to join a member of the directorate's governance team in completing an initial review using a template form. This must be completed as soon as possible after the event has been identified, and no later than one working day from identification of the event. At least one of the reviewers must be available for the immediate management review (IMR) meeting.

12.3 The Head of Patient Safety (or their deputy) will arrange the IMR. This should be held within one working day of the event being identified where required. The attendance list will be developed with the Director of Quality and Safety. A member of the communications team must be included. If it has been identified that a PSII will be completed, the PST investigator should be available to attend the meeting.

12.4 The Chief Nurse (or their deputy) will chair the IMR. A note taker will be appointed by the Head of Patient Safety. Notes will normally be sent to the attendees within one working day to allow for actions to be completed promptly.

12.5 It may be necessary to appoint an external reviewer/investigator to lead or support the internal review/investigation team. This will be approved by the Chief Nurse.

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

13 IMPLEMENTATION INCLUDING TRAINING AND AWARENESS

13.1 Training and support needs have been identified and a plan has been developed which includes all staff. The PST have delivered team-level and trust-wide training and briefings to support the implementation of PSIRF. Resources have been developed for both staff and patients/families, which will be published on the trust website.

13.1.1 All Patient Safety Partners will be supported to access 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 compliment the trust patient safety response.

13.1.2 To allow effective learning from patient safety events and ensure actions leading to sustainable improvements, it is important to ensure those facilitating or leading learning responses have adequate capacity and competency.

a) AAR facilitators must have completed specialised training. Training will be completed via the Health Services Safety Investigation Body (HSSIB) module or via an internal trust training course led by the PST. All clinical leaders and governance teams will access this training.

b) PSII and thematic review investigators will all be educated in the SEIPS methodology and attend networking sessions within the trust to provide peer supervision and learning.

14 EQUALITY IMPACT ASSESSMENT SUMMARY

14.1 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.

15 HUMAN RIGHTS

15.1 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.

16 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	Quality Digest InPhase reports	Trust Wide Patient Safety & Mortality Review Group Quality Committee Patient Safety Incident Decision Panel	Every two months All forms on receipt that are required to be reviewed at Panel	Group and Committee minutes Panel notes	Escalate to directorate Head of Service Escalate to directorate governance teams
Audit and review findings	Quality Digest Monthly aggregated reporting	Trust Wide Patient Safety & Mortality Review Group Quality Committee Learning Review Group	Every two months Monthly	Group and Committee minutes Group minutes	Escalate to directorate Head of Service and/or Chief Nurse
Findings from PSIIs	Quality Digest Monthly aggregated reporting	Trust Wide Patient Safety & Mortality Review Group Quality Committee Learning Review Group	Every two months Monthly	Group and Committee minutes Group minutes	Escalate to directorate Head of Service and/or Chief Nurse
Progress against the PSIRP	Quality Digest	Trust Wide Patient Safety & Mortality Review Group Quality Committee	Every two months	Group and Committee minutes	Escalate to directorate Head of Service and/or Chief Nurse
Results from monitoring of improvement plans (implementation & efficacy)	Quality Digest	Trust Wide Patient Safety & Mortality Review Group Quality Committee	Every two 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 the trust's response to patient safety events	Quality Digest	Trust Wide Patient Safety & Mortality Review Group Quality Committee	Every two months	Group and Committee minutes	Escalate to Director of Quality & Safety and/or directorate Head of Service
Results of surveys and feedback from staff on their experiences of the trust's response to patient safety events	Quality Digest	Trust Wide Patient Safety & Mortality Review Group Quality Committee	Every two months	Group and Committee minutes	Escalate to directorate Head of Service and/or Director of Quality & Safety
Review of the risk register	Quality Digest	Trust Wide Patient Safety & Mortality Review Group Quality Committee	Every two months	Group and Committee minutes	Escalate to Chief Nurse

17 EXCEPTIONS

17.1 There are no exceptions to this policy.

APPENDIX A PSIRF HIGH-LEVEL DECISION MAKING PROCESS FLOW CHART