**King's College Hospital NHS Foundation Trust patient safety incident response policy – 2023-2026**

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|  | **NAME** | **TITLE** | **DATE** |
| **Author** | Andy Wilmer | Associate Director of Patient Safety | 5th October 2023 |
| **Reviewer** | Róisín Mulvaney | Director of Quality Governance | 30th October 2023 |
| **Reviewer** | Rantimi Ayodele | Deputy Chief Medical Officer | 30th October 2023 |
| **Authoriser** | Leonie Penna | Chief Medical Officer |  |

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# Purpose & Scope

## Purpose

This policy is an overarching policy for patient safety management at King's College Hospital NHS Foundation Trust including acting as the Trust’s Patient Safety Incident Response Policy in line with the NHS Patient Safety Incident Response Framework (PSIRF).

The purpose is to describe how the organisation proactively identifies patient safety issues, learns from every day work and good care and sets out the organisations approach to developing and maintaining effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety.

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

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

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

## Scope

The scope of this policy incorporates the organisation’s approach to delivery of the NHS Patient Safety Strategy (insight, involvement and improvement), including implementation of the Patient Safety Incident Response Framework (PSIRF).

Incident management approaches detailed in this policy are specific to patient safety incident responses conducted solely for the purpose of learning and improvement across King's College Hospital NHS Foundation Trust. Methodologies and approaches outlined in this policy may be used for non-patient safety incident types (e.g. staff safety, information governance) however the management and learning from these incident types are outside the scope of this policy.

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

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

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

# Patient safety culture

King's College Hospital NHS Foundation Trust promotes a patient safety culture through;

* Promoting a just and restorative approach to patient safety incidents
  + Using a systems-based approach to respond to and learn from patient safety incidents which focus on how the design of the wider-system in which staff work creates challenges to the delivering of care.
  + Ensuring HR policies prevent the automatic suspension or any other disciplinary process for staff affected by a patient safety incident.
  + Ensuring disciplinary processes related to patient safety are overseen by staff with an understanding of patient safety, system factors and just and restorative practice (e.g. trained oversight leads).
  + Ensuring improvement plans following an incident do not focus on individuals affected, including individual reflection or re-training.
* Compassionate engagement and support
  + Ensuring engagement, involvement and support of all people affected by patient safety incidents is the number one priority for any response.
  + Ensuring systems are in place to support, or at the minimum to signpost to support services, people affected by patient safety incidents.
  + Promoting the meaningful involvement of patients and families in how the organisation learns and improves following a patient safety incident.
  + Proactively identifying and answering questions of people affected.
* Open and transparent reporting
  + Facilitating the recording of patient safety events by staff affected by them, or those who become aware of them.
  + Promoting the transparent recording of patient safety incident information within the organisation and wider system only for the purpose of developing meaningful insight and supporting the delivery of effective improvement work.
* Focusing on system-wide improvement
  + Ensuring the delivery and evaluation of effective and sustainable improvement work is at the forefront of governance and oversight processes rather than performance management or focus on individuals.
  + Promoting collaboration on patient safety improvement projects across organisational boundaries.

The organisation is committed to ongoing safety culture improvement activities in-line with the NHS Patient Safety Strategy. This includes the use of;

* recognised safety culture assessment tools
* the NHS England safety culture guide (and other materials produced by the NHS Safety Culture Programme Group) once published nationally to provide insight and inform improvement in safety culture.
* the use of safety culture metrics within NHS staff survey to triangulate data regarding staff experience/safety and data on diversity and drive improvements in culture and addressing inequalities.
* collaboration between patient safety, workforce and wellbeing teams.

# Involvement

## Patient safety partners

The organisation is committed to engaging Patient Safety Partners in providing valuable challenge and insight from a patient’s perspective in;

* The implementation and ongoing development of our Patient Safety Incident Response Policy and Patient Safety Incident Response Plan.
* The design of safer healthcare at all levels of our organisation
* Relevant patient safety and quality related committees.
* Improvement plans and projects.

The Trust is also committed to the wider principles of involving patients in patient safety outlined in the Patient Safety Strategy.

## Addressing health inequalities

The organisation’s patient safety incident response processes support health equality and reduce inequality through;

* Implementation of the Learn from Patient Safety Events (LfPSE) service to facilitate capture and analysis of equalities data sets in relation to patient safety incidents. Periodic analysis of data to identify disproportionate risk to patients with specific characteristics will be carried out to inform the organisations Patient Safety Incident Response Plan development.
* Annual research into the experience of people affected by patient safety incidents to identify areas for improvement regarding support and engagement resources.
* The use of system-based incident responses carried out by staff with systems and human factors training to prompt consideration of health inequalities when identifying insight and in the co-production of improvement plans (e.g. developing safety actions or using quality improvement methodologies).
* Proactive identification of support and engagement needs of people affected when responding to a patient safety incident.
* The use of safety culture metrics within the NHS staff survey to support the triangulation with data regarding staff experience/safety and data on diversity.
* Utilisation of a system-based approach (not a ‘person focused’ approach) when responding to patient safety incidents (led by staff with appropriate training and overseen by leaders with the relevant systems understanding) to support the development of a just and restorative culture reduce the ethnicity disparity in rates of disciplinary action across the NHS workforce.

Ongoing improvement work will be carried out to identify and address inequalities utilising the NHS patient safety inequalities handbook to inform the organisations use of diversity data and effectiveness of improvement projects. This work will be carried out in conjunction with the safety culture improvement described above.

## Patient safety education and training

### Patient safety syllabus

* Available via LEAP for KCH staff and online via the [e-learning for healthcare website](https://www.e-lfh.org.uk/programmes/patient-safety-syllabus-training/) for other partners and stakeholders.
  + Levels
    - Level one
      * *Essentials for patient safety* aimed at all NHS staff
      * *Essentials of patient safety for boards and senior leadership teams* (for senior leaders and executive teams)
    - Level two
      * *Access to practice* aimed at clinical and non-clinical staff who have an interest in understanding more about patient safety or who want to go on to access the higher levels of training.
      * *Sector specific sessions* available on completion of access to practice. Options are Mental Health, Primary Care, Acute Care, Maternity Care, Management and Administration – to be selected based on the trainee’s role.
    - Levels three to five (are currently in development nationally and will be first rolled out to Patient Safety Specialists).

### PSIRF Training

**Learning response lead training**

|  |  |
| --- | --- |
| Training/development requirement | How to access |
| Formal training and skills development in **learning from patient safety incidents.** | Via KCH Patient Safety Team for in house one day response lead training. |
| Completed level 1 (essentials of patient safety) and level 2 (access to practice) of the patient safety syllabus. | Available via LEAP for KCH staff and online via the [e-learning for healthcare website](https://www.e-lfh.org.uk/programmes/patient-safety-syllabus-training/) for other partners and stakeholders. |
| Undertake continuous professional development in incident response skills and knowledge | Courses such as those offered by the [Health Services Safety Investigation Branch](https://www.hssib.org.uk/education/nhs-courses/) are recommended, particularly those focusing on specific methodologies such as after action reviews and thematic reviews. |
| Network with other leads at least annually to build and maintain their expertise. | Learning response lead forum. |
| Contribute to a minimum of two learning responses per year. | To be monitored via the ‘response lead’ field within InPhase. |

**Patient safety incident investigation lead**

|  |  |
| --- | --- |
| Training/development requirement | How to access |
| Have completed learning response lead training (or equivalent) and requirements as above. | As above |
| Formal training and skills development in patient safety incident investigation skills, application and using the national patient safety incident investigation template. | Via KCH Patient Safety Team for in house half day patient safety incident investigation lead training.  HSSIB Level 2 in Safety Investigation/ A systems approach to investigating and learning from patient safety incidents courses. |

**PSIRF engagement lead training**

|  |  |
| --- | --- |
| Training/Development requirement | How to access |
| Formal training in **involving those affected by patient safety incidents** in the learning process. | Via KCH Patient Safety Team for in house one day engagement lead training. |
| Completed level 1 (essentials of patient safety) and level 2 (access to practice) of the patient safety syllabus. | Available via LEAP for KCH staff and online via the [e-learning for healthcare website](https://www.e-lfh.org.uk/programmes/patient-safety-syllabus-training/) for other partners and stakeholders. |
| Undertake continuous professional development in engagement and communication skills and knowledge | Courses such as those offered by the [Health Services Safety Investigation Branch](https://www.hssib.org.uk/education/nhs-courses/) are recommended, particularly HSSIB Involving those affected by patient safety incidents in the learning process training. |
| Network with other leads at least annually to build and maintain their expertise. | Engagement lead forum. |
| Contribute to a minimum of two learning responses per year. | To be monitored via the ‘engagement lead’ field within InPhase. |

**PSIRF oversight lead training**

|  |  |
| --- | --- |
| Training/Development requirement | How to access |
| At least **two days**’ formal training and skills development **in learning from patient safety incidents** AND **one day** training in **oversight of learning from patient safety incidents**. | Via KCH Patient Safety Team for in house one day oversight lead training. |
| Completed level 1 (essentials of patient safety) and level 1 (essentials of patient safety for boards and senior leadership teams) of the patient safety syllabus. | Available via LEAP for KCH staff and online via the [e-learning for healthcare website](https://www.e-lfh.org.uk/programmes/patient-safety-syllabus-training/) for other partners and stakeholders. |
| Undertake continuous professional development in incident response skills and knowledge. | Courses such as those offered by the [Health Services Safety Investigation Branch](https://www.hssib.org.uk/education/nhs-courses/) are recommended covering incident response skills (as per learning response leads above) or patient safety incident response framework oversight training). |
| Network with other leads at least annually to build and maintain their expertise. | Oversight lead forum. |

### Duty of Candour training

Training and guidance to support staff with delivering the statutory requirements for Duty of Candour available via;

* Engagement lead training as above.
* NHS Resolutions offers guidance on the importance of being open and honest and when and how to say sorry.
  + [Duty of candour animation - NHS Resolution](https://resolution.nhs.uk/resources/duty-of-candour-animation/)
  + [Read saying sorry (duty of candour) - NHS Resolution](https://resolution.nhs.uk/resources/saying-sorry/)
* Additional duty of candour training arranged regularly by the Associate Medical Director (Risk and Governance).
* Guidance on individual patient safety incidents can be sought from the Patient Safety Team and/or Corporate Medical Director (Quality, Governance and Risk).

### General patient safety, system thinking and human factors training

Wider patient safety training for all staff through the NHS patient safety syllabus (available via LEAP for KCH staff and online via the [e-learning for healthcare website](https://www.e-lfh.org.uk/programmes/patient-safety-syllabus-training/) for other partners and stakeholders).

In person, in house training will be developed and delivered through the life of this policy.

# Patient safety insight

Patient safety incidents and responses are one source of insight into the safety of the system. The organisation also utilises other approaches to gain insight into system safety and drive improvement activities. The organisation is committed to not only investing resources in patient safety incident responses and improvement activities, but also pro-active patient safety approaches to predict and prevent harm before it occurs.

These approaches include;

## Learning from everyday work (safety II)

A safety II approach considers everyday work rather than retrospectively determining why things go wrong. A safety II approach considers the normal working of the system (work as done) including its strengths and vulnerabilities. It considers the how people get the job done in practice, how the system supports and inhibits getting the job done and the compromises and workarounds required to adapt to competing demands and resource limitations. It provides insight into how closely work as imagined (by leaders) or prescribed (in policies or guidelines) actually reflects normal practice and where the system needs to be improved or where guidelines should be adapted to be more realistic and/or flexible.

This aligns with a systems approach to responding to patient safety incidents, particularly when responding to, or improving, a theme of incidents.

## Learning from excellence (good care)

Patient safety events relating to good care that can be learned from are recorded via the Learning from Patient Safety Events service on InPhase.

Appreciative enquiry can be used to learn from what went well, to understand strengths in the system and how they can be built on. Patient safety themes can be captured through the good care reporting to allow triangulation of insight and thematic analysis.

## Identifying emerging themes

Whilst robust safety profiling work has been carried out to develop our plan, it is recognised that currently under recognised, new, emerging, or escalating issues are likely to develop.

The organisation will utilise a variety of approaches to identify these themes as early as possible and allocate resource to understanding their contributory factors and implementing improvement plans.

* The use of Statistical Process Control (SPC) charts to monitor changes and variations in themes and findings associated with patient safety incidents and their responses.
* Monitoring of underlying themes and issues at a safety theme level within Trustwide safety improvement groups.
* Proactive approaches such as horizon scanning, risk management, safety II and use of external sources of insight such as National Patient Safety Alerts and HSIB investigations to identify issues which have not yet led to significant safety challenges within the organisation.
* The use of a variety of data sources to assess potentially emerging issues such as sense checking quantitative data with qualitative insight and vice versa.

## Proactive patient safety risk identification and management

The effective proactive identification of potential risks or hazards to patient safety are an imperative element of the organisation’s management and should be managed in line with the Trust’s Risk Management Strategy.

Staff are supported and encouraged to identify and escalate potential risks or hazards through the roll out of the Patient Safety Syllabus and improving safety culture and particularly psychological safety. The organisation has a minimal appetite for risks that impact on quality of care and patient safety and as such risks and hazards identified must be mitigated effectively to prevent patient harm.

The Trust will utilise horizon scanning to identify potential patient safety issues proactively as a result of internal or external changes.

## Triangulation of a wide range of sources of insight

The organisation recognises that insight derived through patient safety incident reporting and responses is just one source of insight into system performance and patient safety risks, and a source that is primarily reactive. The organisation is committed to utilising other sources to provide a more rounded insight and to identify and resolve potential patient safety risks before they materialise. This insight will be a combination of quantitative and qualitative analysis.

|  |  |
| --- | --- |
| **Internal** | **External** |
| **Quality sources**   * Patient experience and feedback (complaints, PALS contacts, patient experience reports) * Legal (inquests and clinical negligence claims) * General Practice Quality Alerts * CQC (Inspections, enquires and whistle-blowers) * Freedom to Speak Up contacts * Quality Assurance (Quality Assurance Framework, MEG Audits) * Risk Registers * Clinical Audit * Integrated Quality Reports * Quality Scorecard * Infection Control audits and observations * Mortality (mortality monitoring, mortality and morbidity meetings, medical examiner reviews) | **Regional/Network**   * Collaboration across South East London and relevant clinical networks (e.g. Major Trauma Network) * South London Patient Safety Collaborative (Health Innovation Network) improvement programmes |
| **Qualitative sources**   * Learning from everyday work/observational studies * Escalation of concerns and hazards by front line staff * Quality Improvement contacts and coaching | **National**   * National Patient Safety Alerts * NHS England LFPSE data analysis * Health Services Safety Investigations Body (HSSIB) investigations * Learning from Patient Safety Events Insight * National Patient Safety Improvement Programmes * NHS Resolutions/ Getting It Right First Time (GIRFT) litigation data pack |
| **Performance sources**   * EPIC * Operational performance (waiting lists etc.) | **International**   * World Health Organisation |
| **Safety culture and experience sources**   * NHS Staff Survey * KCH Quarterly Pulse Survey * Safety Culture assessments * The National Education and Training Survey * Research into the experience of people affected by patient safety incidents |  |

## Insight, improvement and assurance strategy

Patient safety incident responses complement these wider approaches to patient safety as per this strategy;

# Patient safety incidents

## Patient safety incident response planning

The organisation will 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. In addition to nationally set requirements, we will set out our priorities specific to the key patient safety issues relevant to the organisation in our plan, and review these regularly to ensure they remain relevant.

The Trust will take a proportionate approach to its response to patient safety incidents to ensure that the focus is on maximising improvement. Where we are confident that where contributory factors are already well understood and effective improvement work is underway we will ensure resource is utilised to support those affected and continue the improvement work rather than re-investigating known issues.

We will undertake planning of our current resource for patient safety response and our existing safety improvement workstreams. We will identify insight from our patient safety and other data sources both qualitative and quantitative to explore what we know about our safety position and culture.

Our patient safety incident response plan will detail how this has been achieved as well as how the Trust will meet both national and local focus for patient safety incident responses.

## Resources and training to support patient safety incident response

The organisation will work towards full compliance with the NHS England patient safety response standards regarding the training and time allocation for response, engagement and oversight roles. The organisation will initially be pragmatic and flexible in its approach to resource allocation to ensure responses can still take place and that resource with relevant training and dedicated time can be utilised to add the most value.

### Learning response leads

Learning response leads are staff with;

* + training in responding to patient safety incidents.
  + an understanding of systems thinking and human factors.
  + skills and competencies to undertake learning responses across the organisation.
  + the ability to communicate complex matters in difficult situations, compile qualitative and quantitative information and summarise and present complex information in a clear and logical manner.
  + dedicated time within their role or job plan to undertake learning responses.
  + an appropriate level of seniority and influence in the organisation; at band 8a (or equivalent) and above.

Learning response leads will;

* + lead on a minimum of two learning responses to patient safety incidents per year. Learning responses may be any of the system based methodologies indicated within our incident response plan.
  + lead learning responses within dedicated paid time.
  + ensure learning responses are completed to a high standard and in line with the principles of just and restorative practice, systems thinking and compassionate engagement.
  + work with, or act as, engagement leads to ensure staff, patients and families affected by a patient safety incident are proactively supported and meaningfully involved in learning responses.
  + ensure learning responses identify system based improvement ideas and/or safety actions and are appropriately discussed and communicated with those responsible for their implementation and evaluation.

The organisation will;

* develop its resources to ensure each Care Group has staff with the appropriate training and support to undertake other types of learning responses, with access to staff with relevant response lead training for coaching and support.
  + develop capacity within Site and Corporate Teams, as well as those with a subject matter expertise in a specific patient safety theme.
  + ensure learning responses are not led by staff who were involved in the patient safety incident itself or by those who directly manage those staff.
  + ensure that learning responses are not undertaken by staff working in isolation and that processes are in place to source the input of subject matter experts, whether clinical experts or systems thinking/human factors experts.
  + develop a dedicated resource of staff with enhanced training to lead patient safety incident investigations.

### Engagement leads

Engagement leads are staff with;

* + training and competencies in supporting and involving staff, patients and families affected by patient safety incidents.
  + skills in communicating and engaging with patients, families, staff, and external

agencies in a positive and compassionate way, including skills in listening and hearing the distress of others in a measured and supportive way.

* + the ability to recognise when those affected by patient safety incidents require onward signposting or referral to support services.

Engagement leads will;

* + lead on engaging people affected (staff, patients and families) by patient safety incidents to ensure people affected are proactively supported and meaningfully involved in learning responses.
  + lead on engagement activities in a minimum of two learning responses to patient safety incidents per year.
  + support learning response leads to incorporate the experiences, perspectives and suggestions of people affected, and to summarise them using accessible language.
  + contribute to the development of staff, patient and family support processes, resources and pathways.

The organisation will;

* develop its resources to ensure each Care Group has staff with the appropriate training, skills and capabilities to compassionately engage people affected by patient safety incidents.
* develop internal and external resources and mechanisms for support of people affected (whether staff, patients or families).
* ensure staff affected by patient safety incidents are afforded the necessary managerial support and be given time to participate in learning responses.
* ensure all Trust managers work within just and restorative culture principles and utilise other teams such as the wellbeing team to ensure that there is a dedicated staff resource to support such engagement and involvement. Care Group and Site oversight processes will ensure that managers work within this framework to ensure psychological safety.

### Oversight leads

Oversight leads are staff with;

* leadership responsibilities involving the oversight of patient safety incident responses.
* training and skills in learning from patient safety incidents and in oversight of learning from patient safety incidents.
* abilities to constructively challenge the strength and feasibility of safety actions to improve underlying system issues.
* abilities to recognise when safety actions following a patient safety incident response do not take a system-based approach.

Oversight leads will;

* lead on the oversight of patient safety incidents responses in line with the patient safety incident response standards.
* ensure people affected (patients, families, and staff) are being/have been compassionately engaged, supported and meaningfully involved to gain system insight and generate improvement ideas.
* robust processes are in place to determine proportionate responses to patient safety incidents.
* ensure learning responses are system based and in line with just and restorative practices.
* ensure oversight and governance processes and meetings focus on enabling and monitoring improvement in the safety of care.
* support the collaboration with internal and external partners in incident response and improvement.
* be curious to identify potential areas for improvement through proactive measures and the triangulation of a wide range of insight sources to gain a clear understanding of system safety.

The organisations will

* Develop resources to ensure each Care Group and Site Executive have at least one senior leader with the appropriate oversight lead training and skills to meaningfully ensure the principles of this policy and our plan are being upheld.
* Develop oversight roles at Group level, particularly for Patient Safety Specialists and Board members with a responsibility for Patient Safety.

## Our patient safety incident response plan

Our Patient Safety Incident Response Plan is available [on our Trust website](https://www.kch.nhs.uk/about/corporate-information/our-standards-of-care/patient-safety-incident-response-framework-psirf). This plan was developed through the PSIRF implementation roadmap, overseen by the Trust’s PSIRF Implementation Steering Group. The plan was informed by patient safety incident data, triangulation with multiple other sources and stakeholder engagement with Care Groups and other groups.

Our plan sets out how King's College Hospital NHS Foundation Trust intends to respond to patient safety incidents over a period of 12 to 18 months. The plan is not a permanent set of rules that cannot be changed. We will remain flexible and consider the specific circumstances in which each patient safety incident occurred and the needs of those affected, as well as the plan. This policy reaffirms the commitment to;

* ensuring people affected are compassionately engaged and supported in any patient safety incident response.
* determining considered and proportionate responses to patient safety incidents, and the investment of resource in improvement activities above investigation or other learning responses where the system vulnerabilities are already known.
* oversight functions which focus on the above and facilitate collaborative, effective improvements.

## Reviewing our patient safety incident response policy and plan

Our patient safety incident response plan is a ‘living document’ that will be appropriately amended and updated as we use it to respond to patient safety incidents.

A six-monthly assessment of the effectiveness of the plan, including the learning response methodologies used will be carried out.

We will fully 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 review process will also include;

* Analysis of data to identify disproportionate risk to patients with specific characteristics.
* Research into the experience of people affected by patient safety incidents to identify areas for improvement regarding support and engagement resources.
* Review of a sample of learning responses completed using HSIB’s Learning Response Review and Improvement Tool.

This will also provide an opportunity to re-engage with stakeholders to discuss and agree any changes made in the previous 12 to 18 months. Updated plans will be published on our website, replacing the previous version.

A rigorous planning exercise will be undertaken every three 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. This process will lead to updates of this policy.

## Responding to patient safety incidents

### Patient safety incident reporting arrangements

Patient safety events, including patient safety incidents, will be recorded internally through the Trust’s local incident management system linked to NHS England’s Learn from Patient Safety Events (LfPSE) service. All staff in the organisation, including contractors, have a duty to ensure patient safety incidents which they are affected by, witness or become aware of are recorded through the Trust’s LRMS.

Processes for selecting the appropriate response are detailed in our plan covering Care Group, Site and Trust oversight and support. These processes cover the criteria for how and when patient safety incident response decisions need to be escalated from Care Group to Site Executive level and from Site Executive level to Trust Board level.

Incidents requiring a cross-system response will be managed as per section 5.2.3 below.

Statutory and national policy requirements for external reporting are managed through the relevant LfPSE fields within our local incident management system. The Trust will continue to follow national guidance regarding the recording of any incidents subject to patient safety incident investigations (PSIIs) on the national Strategic Executive Information System (StEIS).

### Patient safety incident response decision-making

Response selection and resource allocation processes are described within the organisation’s patient safety incident response plan.

Proactive planning of resource allocation for patient safety incident investigations is also described within the current plan, however the organisation is aware that a level of flexibility and need to react to emerging issues requiring response resource is also required.

### Responding to cross-system incidents/issues

Patient safety incidents requiring a cross-system learning response will be identified by;

* + Site Executive oversight (including via Care Group local review and escalation) of incident responses to consider where cross-system learning responses may be indicated – with support in facilitating via Site Executives, King’s and ICB Patient Safety Specialists and King’s Patient Safety Team.
  + Trust Executive oversight of cases potentially requiring patient safety incident investigations – with support in facilitating via King’s Executive and King’s and ICB Patient Safety Specialists.
  + The Trust will engage with the ICB to consider the coordination of learning responses at the appropriate level of the system and/or by the most appropriate system partner as per the ICB’s PSIRF plan and policy.

Wider patient safety issues, insight or improvement opportunities potentially requiring cross-system collaboration will be identified by;

* + Trustwide patient safety improvement groups monitoring of insight relevant to their theme.
  + The Patient Safety Committee through monitoring of insight sources and identification of emerging themes.
  + Patient Safety Specialists via collaboration with peers across the region (or wider) with facilitation by the ICB.

### Learning response methodologies

Our current Patient Safety Incident Response Plan details our proposed learning response methodology options. It is however recognised that flexibility and adaptability is required to respond most effectively and proportionately to patient safety incidents. Learning responses may utilise one, or multiple, system-based incident response methodologies. Scope is provided by this policy for the use of other system-based learning responses not listed in our plan following discussion with, and approval of, the Patient Safety Team.

### Timeframes for learning responses

A response must start as soon as possible after an incident is identified, and usually completed within one to three months. PSIRF moves away from standardised timescales, in part to avoid performance monitoring of turnaround times over the quality of the insight gained.

Timescales should be agreed for learning responses on a case-by-case basis in conjunction with those affected. However, no learning response should take greater than six months to complete. The time needed to conduct a response must be balanced against the impact of long timescales on those affected by the incident, and the risk that for as long as findings are not described, action may not be taken to improve safety or further checks will be required to ensure the recommended actions remain relevant.

Where those affected by patient safety incidents (or external bodies) cannot provide information, to enable completion within the agreed timeframe (or 6 months), the response leads should work with all the information they have to complete the response to the best of their ability; it may be revisited later, should new information indicate the need for further investigative activity.

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

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

Our plan will detail the processes by which people affected will be supported through both learning and improvement responses.

All incident responses, whether different learning response methodologies or improvement responses should proactively engage people affected, identify support needs and any questions or concerns they have.

It is vital that any learning response values the insight provided by people affected into how the design of the system created an environment in which harm could occur. People affected most be offered the opportunity and supported to have meaningful involvement in any learning response.

Staff affected must be treated in line with just and restorative practice principles and written statements must not be requested or used. Patients and families affected must be given equal opportunity to describe their perspective of the system, and their insight given equal weight to internal sources.

Equally, it is vital that the system findings of any response are shared with people affected to assure them that the system factors are understood, that individual actions were not to blame and that improvement work is underway or will be undertaken to improve the system.

Learning response leads, engagement leads and oversight leads will refer to the PSIRF engaging and involving patients, families and staff following a patient safety incidents guidance to inform how and when to engage and involve people affected.

Details of how compassionate engagement has been carried out should be captured in the relevant sections of the incident record.

### Resources to support people affected by patient safety incidents

Support resources and how to refer or signpost people affected by them will be compiled within the PSIRF intranet page.

The organisation will assess and develop resources to meet the needs of people affected in line with compassionate engagement and involvement principles.

### Duty of Candour

**General principles**

We recognise and acknowledge the significant impact patient safety incidents can have on patients, their families, and carers. Getting involvement right with patients and families in how we respond to incidents is crucial, particularly to support improving the services we provide. Part of this involves our key principle of being open and honest whenever there is a concern about care not being as planned or expected or when a mistake has been made.

Transparent and meaningful compassionate engagement and involvement for all patient safety incidents, regardless of the level of harm, is the right thing to do as well as to meet our regulatory and professional requirements for Duty of Candour [DoC]. The compassionate engagement approaches described above, and in our plan, will fulfil the spirit of the Duty of Candour. Statutory Duty of Candour steps are also described in the compassionate engagement flowchart within our plan.

In addition to the principles of compassionate engagement we will ensure notifiable safety incidents (patient safety incidents where the threshold for statutory Duty of Candour applies – those resulting in moderate or severe physical or psychological harm or fatality) are identified and the required steps are completed, notably the additional requirement to follow up being open conversations in writing.

**Identification of notifiable incident**

Notifiable incidents will be captured through Duty of Candour portals developed within the Trust’s LRMS based on the thresholds described above.

Guidance regarding identifying notifiable incidents and requirements when they are identified can be found on the [CQC website.](https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-20-duty-candour)

**Fulfilling Duty of Candour requirements**

|  |  |  |
| --- | --- | --- |
| Duty of Candour regulation requirements | How to apply within PSIRF | Timescales |
| Patient safety incident identified, recorded and assessed as a notifiable safety incident under DoC regulations. | * Patient safety incident recorded on Trust’s incident reporting system. * Immediate actions to ensure the safety of those involved, including treating any injuries. * Provide support for people affected (including staff). * PSIRF Panel – initial fact finding and incident assessment as per plan. | As soon as reasonably practicable |
| Tell the relevant person, face-to-face, that a notifiable safety incident has taken place. | * Being open with patient and family. * Proactively identify support needs and questions. |
| Apologise. |
| Provide a true account of what happened, explaining whatever you know at that point. |
| Explain to the relevant person what further enquiries or investigations you believe to be appropriate. | * Improvement response   + advise relevant person that no further learning response/ investigation will be carried out as contributory factors to incident are already well understood and improvement plan in place.   + advise on local and Trustwide improvement actions ongoing.   + answer any outstanding questions. * Learning response (inc. investigations)   + advise planned learning response methodology.   + offer to involve relevant person in learning response. |
| Follow up by providing this information, and the apology, in writing, and providing an update on any enquiries. | * Improvement response   + detail conversation as above in writing and provide/send to relevant person. * Learning response (not inc. investigations) * summarise initial conversation and outcome of learning response. * Patient safety incident investigation * confirm plan for investigation in writing, including meaningful involvement and support elements of PSIRF. * ongoing involvement and engagement of patient/family in investigation. * share outcome of investigation once complete. |
| Keep a secure written record of all meetings and communications with the relevant person. | Record communications, correspondence and meetings within the incident record. |

The Trust will ensure monitoring and escalation processes are in place to ensure both compassionate engagement principles and statutory duty of candour requirements are being fulfilled.

# Improvement

## Safety action development

The Trust will align its processes for the development of safety actions as outlined by NHS England in the safety action development guide (2022). This includes involving people affected, other frontline staff and patients in developing improvement ideas.

Where specific safety actions are identified (i.e. a known or obvious solution to improve the system) they should be assessed and resourced for implementation. These may be carried out at local level (for example on a specific ward, in a specific specialty or Care Group or across a specific pathway), at a Trustwide level (generally linked to a Trustwide patient safety theme and overseen by a Safety Improvement Group) or at a system level (in collaboration with external partners for pathways or safety issues that cross organisational boundaries).

Safety actions will be system-based and address the system rather than attempting to change behaviour (e.g. reminders) or focus on individuals (e.g. reflection, retraining).

## Safety action monitoring

Safety actions must continue to be monitored within the appropriate governance arrangements to ensure they are both implemented and evaluated for their effectiveness and sustainability in improving patient safety.

Oversight processes at Care Group, Site and Trust level (Trustwide Patient Safety Improvement Groups and the Patient Safety Committee) will oversee the implementation and effectiveness of safety actions in their areas. This requires an agreement on outcome and/or process measures at the point a safety action is agreed, and monitoring of these measures to evaluate how changes have impacted on system performance and human wellbeing and whether change has led to an improvement in safety.

Statistical Process Control (SPC) charts are indicated for evaluating many types of improvement measures, and assessing whether a change is an improvement. Flexibility is however given to the selection of appropriate measures, including the use of qualitative insight.

## Safety improvement plans

Safety improvement plans bring together findings from a range of sources of insight, including responses to patient safety incidents. It is expected that improvement plans will be generated at different levels of the organisation, most notably at Care Group and Trustwide safety improvement group levels.

Improvement plans will be developed with the support of the Quality Improvement Team, and as with safety action monitoring above require regular and continuous evaluation of their effectiveness and appropriateness. Improvement plans will be live documents that will adapt to respond to the outcomes of improvement efforts and other external influences such as national safety improvement programmes, regional priorities, and national patient safety alerts. Where the problem and/or solution is not known Quality Improvement methodologies will be used to generate and test ideas.

Through the life of this policy, we will further develop the alignment between the organisation’s patient safety and quality improvement processes and the development of a quality improvement strategy. We will focus patient safety related meetings, committee, groups, and processes on delivering and evaluating improvement activities relevant to their area of specialist topic as per our oversight processes detailed in this policy.

The Patient Safety Committee will oversee the delivery and effectiveness of improvement activities across Care Groups, Sites and Trustwide improvement groups, and support the alignment and collaboration between local, Trustwide and system wide improvement.

The Trust patient safety incident response plan outlines;

* our local priorities for focus of investigation under PSIRF. These were developed due to the opportunity they offer for learning and improvement across areas where there is no existing plan or where improvement efforts have not been accompanied by significant reduction in apparent risk or harm.
* our approach to developing improvement plans, and commissioning improvement projects, at different levels of the organisation.
* our approach to collaborating on improvements with system partners.

## Improvement oversight structure

Our plan will detail the specific improvement groups in place and our improvement oversight structure. The organisation will develop improvement plans and priorities around our cross-cutting patient safety issues and emerging issues as PSIRF is embedded. The organisation will similarly develop processes for supporting and coordinating Site and Care Group specific improvement work around our patient safety priorities, and collaboration with system wide and national improvement plans.

# Oversight

## Oversight principles

The following principles will be used to guide patient safety incident response oversight processes within Care Groups, Safety Improvement Groups and relevant Trustwide committees;

* People affected (patients, families, and staff) have been **compassionately engaged** and supported.
* Responses are **proportionate** (resource is not used for carrying out learning responses for issues where contributory factors are already well understood and effective improvement work is underway).
* Responses are **system-based** (a system-based methodology has been used, the response has not attempted to find individuals to **blame**, or focused on the actions of people involved, people affected have been engaged to gain system insight, findings and recommendations/areas for improvement are system-based and address the system rather than attempting to change behaviour (e.g. reminders) or focus on individuals (e.g. reflection, retraining).
* **Improvement** is the focus (oversight focuses on enabling and monitoring improvement in the safety of care, continuous monitoring of the progress and effectiveness of improvement work is in place, ongoing improvement projects are in place for known safety priorities).
* **Collaboration** is key (internal and external partners are engaged to support insight and improvement across systems/pathways rather than working in silos)
* **Curiosity** is powerful (oversight processes ask questions to understand rather than to judge, leaders exhibit problem sensing rather than comfort seeking behaviours, patient safety incident insight is triangulated with a mixture of qualitative and quantitative measures to get a clear understanding of safety profile and the effectiveness of the incident response and improvement processes, understanding work as done in practice, why things go well and proactively identifying hazards and risks is crucial).

## Oversight systems

* Care Groups and Corporate Departments
  + Care Group Governance Committees (or equivalent for non-clinical departments) and governance processes will provide oversight of patient safety incident responses in line with the principles above and the patient safety incident response plan.
  + Care Groups/Departments will ensure people affected by patient safety incidents are engaged and supported in a compassionate and open manner, including fulfilling Duty of Candour requirements.
  + Care Groups/Departments will ensure effective improvement plans are in place to address patient safety vulnerabilities specific to their areas, and engage in a collaborative way on wider patient safety improvement work that affects their patients.
* Site Executive Level
  + Site Outstanding Care Boards and other equivalent oversight processes will ensure Care Groups within their remit are following the principles above and the patient safety incident response plan, including compassionate engagement and improvement activities.
  + Site Outstanding Care Boards will support cross Care Group improvement activities, collaboration with internal and external partners and the allocation of response resource.
* Patient Safety Committee
  + The Patient Safety Committee will provide Trust oversight of patient safety incident response system activity and effectiveness and oversight of Trustwide improvement programmes.
  + The Patient Safety Committee will oversee the identifying of emerging or escalating patient safety trends and commission insight and/or improvement resource where required.
  + The Patient Safety Committee will oversee the triangulation of patient safety incident response insight with other sources of insight.
* Group Executives and Board
  + The Executive Lead for Patient Safety (including PSIRF) will review and sign off Patient Safety Incident Investigation reports.
  + The Executive Lead for Patient Safety along with the King’s Executive will provide board level oversight of Patient Safety Incident Investigation reports and the operationalisation of their recommendations.
* Integrated Care Board
  + South East London Integrated Care Board will support collaboration and continuous improvement on both incident responses and system wide improvement plans in line with their patient safety incident response plan and policy.

# Appendices

## Complaints and appeals

1. Appeals by any people affected by a patient safety incident during the response process regarding the response methodology selected or level of compassionate engagement offered should be;
   1. Made directly to the response lead (where known by the people affected).
      1. The response lead should consider the appeal against the Patient Safety Incident Response Plan, particularly weighing up the expected level of new insight versus the resource any response would require.
      2. The response lead should seek advice from a Patient Safety Specialist and/or the Patient Safety Team regarding responding to the appeal.
   2. Made to the Patient Advice & Liaison Service (PALS) as a concern (where the response lead is not known to the people affected).
      1. PALS will pass the concern to a Patient Safety Specialist and/or the Patient Safety Team to ensure the Care Group(s) responsible for the response are aware of both the appeal and the lack of point of contact for the response being offered to the people affected.
2. Complaints regarding either the output of the Trust’s response, or the level of compassionate engagement offered in a completed response should be;
   1. Recorded and managed under the [Patient Complaints process](https://www.kch.nhs.uk/patients-and-visitors/help-and-support/making-a-complaint/)
   2. Responded to by the relevant Care Groups with oversight by the Patient Safety Team to understand the system factors that lead to an unsatisfactory response and any improvements that may be required to the patient safety incident response system.
   3. The complaints and their completed responses should be discussed at the Patient Safety Committee to inform patient safety incident response plan and policy development.

## Record management

* Patient safety incident investigations
  + No written statements from staff affected will be collected. Insight from all people affected will be collected verbally and incorporated into the final report rather than stored as separate records.
  + Investigative approaches and sources of insight gained will be clearly described in the investigation report and incorporated into the analysis and findings rather than stored as separate records.
  + Where insight evidence to provide insight is sought and cannot be incorporated into the final report fully (e.g. timelines from families, CCTV footage or equipment records) they must be saved on the incident record in addition to the final report/document which must also be uploaded on the incident record. Where this is not possible the files should be shared with the Patient Safety Team once the response is complete for filing, with notes to that effect recorded on the incident record.
* Other response types
  + generally the response itself (e.g. completed after action review or observational study) will comprise the entire file and must be recorded or uploaded to the incident record on the Trust’s incident management system.