KSS Patient Safety Incident Response Policy

Policy name	KSS Patient Safety Incident Response Policy		
Policy lead	Emma Parkhe, Executive Officer		
Approved by	KSS Board of Trustees (TBA)	**Version No.**	1.0

Version number	Revision Date	Nature of Revision	Next Review Due
1.0	October 2023	Document created with help of NHS England Templates.	October 2024
1.1	6/12/23	Policy Approved by the Board of Trustees and authority delegated to CGSD for future reviews and monitoring of performance against policy.	December 2024

Audience	All Service Delivery Staff
Public facing policy (yes/no)	Yes

Policy Statement

KSS is committed to continuously striving for excellence with regards patient safety, building on the foundations of a safer culture and safer systems so our patients are protected from avoidable harm.

KSS is committed to adopting the NHS Patient Safety Incident Response Framework (PSIRF) as a tool for developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.

Purpose

This policy supports the requirements of the Patient Safety Incident Response Framework (PSIRF) and sets out KSS' 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.

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

There is no remit to apportion blame or determine liability, preventability or cause of death in a response conducted for the purpose of learning and improvement. Other processes, such

as claims handling, human resources investigations into employment concerns, professional standards investigations, coronial inquests and criminal investigations, exist for that purpose.

The principle aims of each of these responses differ from those of a patient safety response and are outside the scope of this policy.

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

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

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

- compassionate engagement and involvement of those affected by patient safety incidents.
- application of a range of system-based approaches to learning from patient safety incidents.
- considered and proportionate responses to patient safety incidents and safety issues.
- supportive oversight focused on strengthening the way the systems work.

Background and Scope

In 2015, NHS England published the Serious Incident Framework, building on previous work produced in collaboration with the National Patient Safety Agency. The ostensible purpose of the Framework was to inform the process of serious incident management. Stated priorities included the provision to learn from serious incidents, to provide support for victims, families and staff in a transparent manner, and to clearly lay out any organisational accountability.

However, it soon became evident that the expectations laid out in the 2015 document were difficult to deliver as resources were heavily focussed on investigation rather than improvement.

The PSIRF is a key part of the revised NHS patient safety strategy, first published in 2019. It was created to help healthcare organisations establish a safety management system that embeds the key principles of a patient safety culture to focus on understanding how incidents happen, rather than apportioning blame, allowing for more effective learning and improvement, and ultimately safer care for patients.

PSIRF removes the 'serious incident' threshold for investigation but requires that healthcare providers develop a patient safety incident response plan with input from a wider stakeholder group including patients, frontline staff, senior staff and board members.

The PSIRF is a contractual requirement under the NHS standard contract and as such is mandatory for services provided under that contract.

Definitions	
Staff	Any individual who works for KSS in any capacity including Emeritus staff and those working on a full-time, part-time, temporary, secondment, or line share basis.
Patient Safety	The avoidance of unintended or unexpected harm to people during the provision of health care.
PSIRF	A national framework applicable to all NHS activity commissioned outside of primary care. Building on evidence gathered and wider industry best-practice, the PSIRF is designed to enable a risk-based approach to responding to patient safety incidents, prioritising support for those affected, effectively analysing incidents, and sustainably reducing future risk.
PSIRP	Our local plan sets out how we will carry out the PSIRF locally including our list of local priorities. These have been developed through a co-production approach with the divisions and specialist risk leads supported by analysis of local data.
Health Inequalities	Avoidable differences in health outcomes between groups or populations, including those with protected characteristics, socio-economic disadvantage, vulnerable groups and geographical inequality.
Health Disparities	A particular type of health difference that is closely linked with social, economic and/or environmental disadvantage. Health disparities are said to adversely affect groups of people who have systematically experienced greater obstacles to health.
Just Culture	A system of shared accountability where KSS and individuals are responsible for their actions and learn from errors. It does not punish individuals for actions that are consistent with their experience and training, but does not tolerate gross negligence, wilful violations or destructive acts. A Just Culture fosters a psychologically safe environment where errors are reported and explored without blame.
Those Affected	Includes staff, families and bystanders in the broadest sense and members of KSS staff involved in the patient safety incident; that is: the person or patient to whom the incident occurred, their family and close relations, and KSS staff involved. Family and close relations may include parents, partners, siblings, children, guardians, carers, and others who have a direct and close relationship with the individual to whom the incident occurred.

Learning Response	Learning facilitated in response to an event, most often an adverse one.

Policy Application

Our Patient Safety Culture

KSS defines a positive safety culture as one where the environment is collaboratively crafted, created, and encouraged so that everybody (individual staff, teams, patients, service users, families, and carers) can flourish to ensure brilliant, safe care by:

1. Continuous learning and improvement of safety risks
2. Supportive, psychologically safe teamwork
3. Enabling and empowering speaking up by all

In preparing this policy we have taken into consideration the six themes identified in the NHS safety culture, learning from best practice.

i. Leadership

KSS recognises the key role of a compassionate and skilled leadership team and the positive role this has when developing patient safety culture. Our strategic and cultural framework, the KSS Way, outlines what we do to deliver on our purpose of saving lives and ensuring the best possible patient outcomes. We do this by staying true to our values of being Caring; Trusted; Dedicated; Innovative and Collaborative. We stay committed to what we believe in, how we treat people, and how we behave in order to deliver on our purpose. We ensure we have the right skills, including leadership skills, at the right levels to ensure a compassionate workforce, with a zero tolerance to bullying and harassment and with a high priority placed on staff wellbeing and creating a psychologically safe workplace.

KSS leaders work hard to build trusting relationships, reach mutual understandings, build rapport, encourage open and inclusive communications with regular personal contact, in order to surface and resolve any conflict.

KSS supports the principles of Just Culture where incidents, including complaints and claims, can be reported and investigated in a non-punitive and supportive environment. This is to ensure that investigations identify whether the actions of individuals were due to systems failures or whether the individual knowingly committed a reckless intentional unsafe or criminal act. This culture is not only seen through policies and procedures but evidenced by the high incidence of incident reporting, which is reviewed on a quarterly level to ensure trends being understood.

ii. Continuous learning and improvement

KSS has a good record of continuous learning and improvement, where staff are supported to raise and address concerns, in focusing upon good practice that is shared, then replicated within and beyond organisational boundaries. This ensures that staff feel empowered to report

and discuss patient safety incidents openly and confidently, knowing that, when an investigation is required, it will be handled in a non-punitive and supportive environment.

This principle is set from the Board and is central to the KSS' leadership approach. All meetings are to be held with this key principle at its core and staff are reminded through one-to-one engagements, at case reviews and clinical governance sessions. Any engagement with those affected in a patient safety incident shall be carried out with compassion and understanding.

KSS is committed to sharing the learning from patient safety incidents both internally and externally. Alongside the opportunities to learn from incidents, KSS is committed to learning from excellence and doing this through the reporting of excellence and reflecting on opportunities to ensure we fulfil our purpose of saving lives and ensuring the best possible patient outcomes.

KSS are fully committed to quality training, including crew resource management and human factors, which includes a full day during staff induction.

KSS will keep up to date with the NHS Patient Safety Syllabus and ensure that staff receive appropriate training to ensure patient safety remains at the heart of what we do.

iii. Measurement and systems

KSS appreciates the importance of understanding whether staff feel valued and able to speak up. This is measured through regular staff surveys, including shorter pulse surveys, workshops and feedback groups, using an independent body where it is felt necessary to do so.

HR management also sits under our Corporate Services division, which gives an independent oversight to staff turnover and HR processes.

KSS measure the number of incidents, incident to staff ratio and trends in incident reporting to ascertain staff confidence and the state of our safety culture.

KSS has adopted the Systems Engineering Initiative for Patient Safety (SEIPS) model (Carayon et al., 2006) in learning from patient safety incidents.

iv. Teamwork and Communication

KSS has a "One Team" approach to our successes and key to that is understanding that every member of staff contributes to the lifesaving work we do, a principle that is measured at each staff survey. This is reinforced through staff-led groups and activities.

Our weekly communication, Dispatch, ensures key messages can be communicated to all staff regularly and staff are all invited to contribute before each publication. All Service Delivery staff meet regularly in two teams to discuss learning and train together, ensuring learning from patient incidents.

v. Psychological Safety

KSS recognises that great teamwork starts with psychological safety i.e., a belief that you can speak up and/or make genuine mistakes without retribution. Staff become more creative,

resilient and motivated when they feel safe, and our leadership teams work to encourage and develop this principle across KSS.

vi. Inclusion, diversity and narrowing healthcare inequalities

KSS supports a zero-tolerance approach to all forms of discrimination and are proud to have a workforce who are able to be their authentic selves. This extends to our patients and their families. We need to ensure that our service is designed to treat all patients with the same level of excellence, irrespective of gender, race, disability, age, sexual orientation, religion, belief, gender reassignment, pregnancy and maternity or marital or civil partnership status.

We will keep up to date with reports that highlight areas of inequality that require attention and focus on how that translates to learnings for our service, including building trust with the wider communities where there is need to do so.

Patient and Staff Safety Partners

KSS is proud of its engagement with staff and former patients. We actively engage staff at all levels in the patient safety review will recruit formal patient safety partners to work alongside us, which will be recruited with addressing health inequalities in mind.

KSS is committed to designing systems and processes that meet the needs of those affected to produce meaningful learning and improvement. A key part of this commitment introduces Patient Safety Partners; empowering patients and their carers to be involved in their own safety, as well as being partners alongside staff in improving patient safety in KSS.

The main role of the Patient Safety Partner is to ensure that the patient voice is heard within KSS, with the core purpose of improving safety and quality. The following are examples of work that Patient Safety Partners would be involved with:

- Membership of the Patient Safety Review Panel
- Review and analysis of safety related information
- Involvement in patient safety-related projects
- Participation in investigation oversight groups

Our Patient Safety Partners will be fully supported in their role and will be provided with ongoing supervision and support. They will also receive training, so they are best able to support patient safety in our area.

Addressing Health Inequalities

KSS recognises that health inequalities can be experienced by people grouped by a range of different factors including:

- Socioeconomic status and deprivation
- Sharing certain protected characteristics, as defined by the Equalities Act 2010
- Belonging to vulnerable or excluded groups of society
- Geography

KSS is aware of the growing awareness of intersectionality i.e., inequalities based on an overlap of several protected characteristics creating further systems of disadvantage.

KSS recognises that everyone has their own individual experience of discrimination, oppression, and treating everyone equally does not take account of the fact that some individuals are more disadvantaged than others. Equity is required to provide equality of opportunity.

These principles will be at the centre of our PSIRF framework as we strive to ensure everyone's voice is heard equally and we recognise that each patient's journey is different. This means we will offer specific support to encourage engagement to add to our learning processes and to constructively remove any barriers to participation.

During the recruitment of our Patient Safety Partners, consideration will be given to diversity, identifying gaps with specific characteristics, and actively recruiting from this community.

Proactively, KSS seeks to continue engaging with the wide variety of communities we serve to understand any resistance to seeking help, share key life-saving messages and training. This includes initiatives such as community CPR and defibrillation awareness.

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

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 plan 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 support in answering any questions they might have in relation to the incident and signpost or providing them to support as required.

KSS is committed to developing its Patient and Family Aftercare Service to continue to support those affected by signposting the most appropriate help and guidance, as we continue to offer pastoral care and arrange visits in answering potential questions.

KSS recognises that the involvement of colleagues and partner agencies at the earliest opportunity and throughout an investigation is fundamental when responding to a patient safety incident and is committed to a process of openness and transparency throughout, underpinned by robust information sharing agreements and processes.

Patient Safety Incident Response Planning

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

The KSS plan will be published on the KSS website and will reflect:

- A thorough analysis of relevant organisational data

- Collaborative stakeholder engagement
- A clear rationale for the response to each identified patient safety incident type.

Resources and training to support patient safety incident response

To allow effective learning from Patient Safety Incidents and ensure actions leading to sustainable improvements, KSS will ensure those involved in responses have adequate capacity and competency.

The Patient Safety Incident Responses will fall into the following main categories:

- After Action Review: a structured and facilitated group discussion after any activity or event that has been particularly successful or unsuccessful.
- A Multi-disciplinary Team Review: an in-depth process of input from several different disciplines in identifying learning from multiple patient safety incidents and explore improvement themes, pathways or processes. These may involve collaborating with key stakeholders outside of Team KSS, involved in the patient journey and care. An MDT review is to be facilitated by a trained and competent investigation lead with the learning recorded in a standardised manner.
- A Patient Safety Incident Investigation: an in-depth review of a single patient safety incident or cluster of events to understand what happened, and how. The goal is to understand why an action and/or decision was deemed appropriate by those involved at the time. A PSII is required where an incident results in moderate or severe harm to patient resulting in a statutory duty of candour. The PSII is to inform thematic analysis of ongoing patient safety risks and use to build a case for a new improvement plan or inform ongoing improvement efforts. The PSII is to be carried out by a trained and competent investigation lead with the learning recorded in a standardised manner.
- A no/low harm patient safety incident: to result in a validation of the facts at a local level through a thematic review, also to inform ongoing patient safety risks and improvement efforts. The thematic review is to be carried out by a trained and competent investigation lead with the learning recorded in a standardised manner.

KSS has the following staff to support and facilitate the PSIRF framework:

- Executive Officer with responsibility for patient safety, quality improvement and compliance
- Head of Risk and Safety (Executive Director Service Delivery)
- PSIRF trained Investigators Leads
- PSIRF trained Engagement Leads
- PSIRF trained Oversight Leads
- AAR trained conductors

There is a pool of trained investigators who can undertake comprehensive investigations, however the majority have a substantive clinical or governance role, time will be allocated within job plans to complete investigations.

All staff are required to complete mandatory patient safety training levels 1 and 2 which covers the basic requirements of reporting, investigating, and learning from incidents.

Our patient safety incident response plan

The Patient Safety Incident Response Plan (PSIRP) has been created based on a patient safety risk profile of previous incidents, stakeholders such as internal staff, patients and/or their families, carers or other organisations including other Air Ambulance Services and the local Ambulance Service NHS Trust. The plan sets out how KSS prioritises a co-ordinated, data-driven approach to patient safety incidents, responding compassionately and proportionately to these. KSS remains flexible in considering the specific circumstances in which patient safety issues and incidents occur and the needs of those affected.

KSS, working closely with colleagues in the aviation industry, has historically valued a system and processes approach in learning from incidents. KSS is committed to continuing to improve its culture in engaging compassionately with those involved in patient safety incidents, applying lessons learnt on a system-wide level, responding considerately and proportionately, with a supportive oversight focusing on system improvement.

Our plan sets out how KSS 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. It remains flexible and considers the specific circumstances in which each patient safety incident occurred and the needs of those affected.

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. We will review the plan every 12 to 18 months to ensure our focus remains up to date and our priorities are still aligned; with ongoing improvement work our patient safety incident profile is likely to change. This will also provide an opportunity to re-engage with stakeholders to discuss and agree any changes made in the previous 12 to 18 months.

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

A rigorous planning exercise will be undertaken every four years and more frequently if appropriate (as agreed with our integrated care board (ICB)) to ensure efforts continue to be balanced between learning and improvement. This more in-depth review will include reviewing our response capacity, mapping our services, a wide review of organisational data (for example, patient safety incident investigation (PSII) reports, improvement plans, complaints, claims, staff survey results, inequalities data, and reporting data) and wider stakeholder engagement.

Responding to patient safety incidents

Patient safety incident reporting arrangements

Patient safety incident reporting will follow SD SOP 06 Incident Reporting and Investigation.

We recognise that staff must continue to feel supported and able to report any incidents or concerns in relation to patient safety, whilst promoting a system of continuous improvement within the fair and just culture.

Patient safety incident response decision-making

Through the PSIRF implementation journey, the Patient Safety Review Panel is to become central in ensuring the dissemination of patient safety incident learning across KSS. This panel is a diverse group, representing different work systems including staff, patients, service delivery clinical operations managers, Associate Medical Directors, equipment manager, patient safety lead and executive oversight. The review panel is to meet every eight weeks to review patient safety incidents, collate and summarise learning, as well as communicate this across all systems internally and externally.

In addition to the above bi-monthly meeting, the review process can be initiated through any Trustee of the Clinical Governance and Service Delivery Committee, Chief Executive, Executive Director of Service Delivery, Executive Medical Director or the Deputy Medical Director.

Responding to cross-system incidents or issues

All incidents recommended for external review, following initial managerial review, will be shared via the Patient Safety Lead. The sharing of incidents will always be coordinated between patient safety to patient safety team across organisations. KSS will work closely with NHS Partners to ensure clear communication channels, all underpinned by the appropriate information sharing agreements, to avoid an unnecessary delay in undertaking effective investigations.

All incidents reported by partner organisations that require review within KSS will be shared via the KSS Patient Safety Review Panel and added to the local incident management system. Managerial review will be completed by the relevant team within 5 working days and any additional reviews will be triggered as with internally reported incidents. Themes from externally reported incidents will be drawn out and considered both alongside and within the wider pool of incidents.

Where incident 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.

Timeframes for learning responses

Learning responses must balance the need for timeliness and capture of information as close to the event as possible, with thoroughness and a sufficient level of investigation to identify the key contributory factors and associated learning for improvement.

We will work with critical partners to establish reasonable timeframes for the delivery of learning responses.

Any learning responses will not be led by the staff who were involved in the patient safety incident itself or, where practical, by those who directly manage those staff.

Staff affected by patient safety incidents will be given time and support to participate in learning responses.

Where necessary, subject matter experts shall be used to facilitate learning responses, providing expertise (either clinical or human factors) and advice.

Safety action development and monitoring improvement

Through the 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.

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

Safety improvement plans

Quality improvement science is about finding out how to improve and make changes in the most effective way, with effective safety improvement plans that are proportionate to the incident or the common themes driving the need for improvement activity.

KSS will manage safety improvement plans through a mixture of approaches, most relevant to the incident or themes. The approach will be decided at the point the safety actions are developed, which is the point the plans will be produced. Such plans may include:

- Creating an organisation-wide safety improvement plan summarising improvement work.
- Creating individual safety improvement plans that focus on a specific part of our service.
- Collectively reviewing output from learning responses to single incidents when it is felt that there is sufficient understanding of the underlying, interlinked systems.
- Creating a wider safety improvement plan to tackle broad areas for improvement.

Complaints

SD SOP 05 Complaints gives a detailed description of the KSS complaints process relevant to our patients, and covers complaints and appeals resulting from an incident, including escalation routes.

Related Documents

SD SOP 24 Patient Safety Incident Reporting Framework Plan
SD SOP 03 Being Open and Duty of Candour
SD SOP 05 Complaints
SD SOP 06 Incident Reporting and Investigation
SD SOP 07 Claims Handling Procedure Clinical and Non-Clinical
SD SOP 16 Risk Management
KSS Policy on Equality (Equity), Diversity and Inclusion

Roles and Responsibilities	
Board of Trustees	Receive any reports from the SDMT, who has delegated responsibility for the application of this policy via the SLT and Clinical Governance and Service Delivery (CGSD) Committee.
Service Delivery Management Team (SDMT)	Responsible and accountable for effective patient safety incident management in KSS. This includes supporting and participating in cross-system/ multi-agency responses and/or independent patient safety incident investigations (PSIIs) where required. Review the number of incidents and trends in incident reporting at each meeting, which act as an indication of staff confidence in the systems KSS has in place.
Chief Executive	Overall Responsibility for patient safety within KSS, including oversight of this plan.
Executive Director Service Delivery	To be the appointed PSIRF executive lead to support the responsibilities contained in this policy.
Executive Officer	Patient Safety Lead, reporting to the PSIRF executive lead. Responsible for chairing the Patient Safety Review Panel.
Clinical Director	Responsible for implementation of an effective training programme.

Further reading and references

NHS England » Patient Safety Incident Response Framework
NHS England » Patient safety learning response toolkit
NICE and health inequalities | What we do | About | NICE
Talking leadership: breakthrough conversations | The King's Fund (kingsfund.org.uk)
Action on patient safety can reduce health inequalities | The BMJ

Monitoring, Compliance and Managing Deviation

This policy is subject to an annual internal audit. Any deviation from policy will be managed within the Policy Deviation process.

Equality Analysis

KSS is committed to creating an equal, diverse and truly inclusive culture where everyone feels welcome and able to be their authentic selves.

We believe that everyone has the right to live without fear or prejudice, and be treated fairly, and with respect and dignity regardless of race, age, gender, disability, sexual orientation, social class, religion and belief.

Our policies all undergo an equality impact assessment as a way of ensuring they do not inadvertently disadvantage anyone and that where possible they proactively advance equality, diversity and inclusion.