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Patient Safety Incident Response Plan (PSIRP) 2023/25

KIMS HOSPITAL

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FOREWORD FROM OUR HOSPITAL DIRECTOR

Patient Safety

Keeping patients safe during their care and treatment should be at the heart of every health system. There have been some outstanding achievements and progress in creating a more positive safety culture. However, in such a complex system incidents still occur and it is vital that we learn and change as a result.

What is the National Picture

Prior to the pandemic, there were significant achievements in reducing the prevalence of specific types of patient harm. The concerted efforts of healthcare workers and the impetus provided by national campaigns, led to dramatic reductions in rates of hospital-acquired MRSA and C. Difficile infections, and major improvements in outcomes for people with Venous Thromboembolism (VTE, or blood clots in the veins) and hip fractures.

These examples show how data can provide not only a means of measuring improvements, but also the stimulus for acting in the first place, when high levels of harm or unwarranted variation exist. Progress in creating a more positive safety culture amongst the workforce is also evident in the data. There has been a welcome increase in the proportion of staff feeling that their organisation acts to prevent the same incident from happening again, and in staff feeling that they are treated fairly when incidents occur – that said, national surveys reveal that one in four healthcare workers do not feel secure raising concerns about unsafe clinical practice, and two in five still do not feel they would be treated fairly in such circumstances.

The NHS Patient Safety Strategy 2019 describes the Patient Safety Incident Response Framework (PSIRF) as "a foundation for change" and as such, it challenges us to think and respond differently when a patient safety incident occurs.

What are we focusing on at KIMS Hospital

Over the past year our teams have continued to navigate a variety of changes and challenges related to moving through the pandemic and living with Covid-19.
Our primary focus remains on providing safe, outstanding, quality care and I am enormously proud of the team at KIMS Hospital for the contribution they have made to our patients and continued success of the organisation.
We continue to engage with our NHS colleagues to support the high demand for healthcare, not only through the post pandemic recovery plan but in our continued commitment to supporting the delivery of patient choice across Kent.
We have focused this year on enhancing a JUST CULTURE building upon the SPEAKING UP FOR SAFETY programme already embedded by introducing sharing the learning meetings and strengthening our Medical Divisional meetings. I was therefore delighted that our colleagues within the Care Quality Commission recognised this during our unannounced visit in January 2023.

"Staff relayed that KIMS is a good organisation and that they felt proud to work here. Staff spoke highly of the culture of openness where patients, their families and staff could raise concerns without fear and that transparency in learning from incidents was shared. They cited that the service managed patient safety incidents and near misses well, with thorough investigations involving patients and families, shared learning and evidence of changes in practice, and those patients received apologies, honest information, and suitable support."

We continue to develop accessibility to KIMS Hospital across the region and are proud of the service developments we have implemented at Sevenoaks Medical Centre. We remain committed to expanding these and during the coming year we are working to develop this further through the integration of our LycaHealth site in Orpington, and through continued investment in upgrading our imaging equipment.

Looking Ahead

We have continued our quality improvement journey, identifying opportunities across the organisation and successfully driving these forward using task and finish focus groups. Quality Improvement groups include Management of Formalin, Improving Thromboprophylaxis, Blood sampling and Wound Management in the outpatient setting. As these groups were underway they have not been included in our safety priorities and are monitored through the governance committee structure. We have invested significantly in our patient safety and quality team this year to ensure we are able to respond swiftly to opportunities to learn and improve the care we provide. Our Director of Infection & Prevention in collaboration with our Consultant Microbiologist and Infection Prevention Lead, have reviewed the way we learn from infection reviews and will be adopting the systems approach to learning recommended nationally. Therefore, I am confident that with the implementation of the Patient Safety Incident Response Framework (PSIRF) we are well placed to embrace the opportunities this provides to support learning and the improvements in safety a new framework provides.

Richard Dimblebee, Hospital Director, KIMS Hospital June 2023

INTRODUCTION

The Serious Incident Framework provided structure and guidance on how to identify, report and investigate an incident deemed to meet a nationally dictated criterion. The primary methodology used was root cause analysis which was resource heavy and tended to focus on problems and were reported to cause staff to feel blamed. PSIRF in contrast is best considered as a learning and improvement framework with the emphasis placed on the system and culture that support continuous improvement in patient safety through how we respond to patient safety incidents.

THE SCOPE OF PSIRP AND KIMS HOSPITAL'S VISION

There are many ways to respond to an incident.
This Patient Safety Incident Response Plan (PSIRP) is our plan to meet the requirements of PSIRF. There is no remit within this plan or PSIRF to apportion blame or determine liability, preventability or cause of death in a response conducted for the purpose of learning and improvement. It is outside the scope of PSIRF to review matters to satisfy processes relating to complaints, HR matters, legal claims and inquests.
This plan explains the scope for a systems-based approach to learning from patient safety incidents. We will identify incidents to review through nationally and locally defined patient safety priorities. An analysis of which is explained later within this document. This plan is a live, evolving document and will be reviewed at least annually with our Integrated Care Board.

One of the underpinning principles of PSIRF is for organisations to use their resources in a different way to respond more effectively to patient safety incidents, by using different methods to explore system issues to gain more insight and reduce blame.

Carrying out reviews for the right reasons can and does identify learning. Removal of the serious incident process does not mean "do nothing", it means respond in the right way depending on the type of incidents and associated factors.

PSIRF recognises the need to ensure we have support structures for staff and patients involved in patient safety incidents. Part of which is the fostering of a psychologically safe culture shown in our leaders.

Key points

PSIRF is:

- NOT an investigation framework;
- Serious incidents no longer feature;
- Sets out new approach to achieve effective learning and improvement following patient safety incidents;
- Embeds patient safety incident response within a wider system of improvement;
- Supports a significant shift in safety culture;
- Prompts a move away from a reactive and bureaucratic approach to safety to a more proactive approach.

SYSTEM OVERVIEW OF KIMS HOSPITAL

KIMS Hospital is the largest independent hospital in Kent providing prompt, safe, quality care for our patients.

Our hospital services offer access to excellent healthcare to patients who wish to self- fund their care in an independent centre or through the use of private health insurance. In addition, we are commissioned by Kent and Medway Integrated Care Board with over 350 GP practices, covering a population within Kent of 1.8 million. In the governance year 2022/23 KIMS Hospital saw in excess of 9,000 inpatient and day surgery patients.
The hospital has reviewed its governance structure in 2022 and celebrates the fact we are fortunate to have the support of main board members, patient forum representatives and external lay experts as part of our key governance committees.

The Quality and Governance Team

The form and function of the team has been reviewed and with significant investment in both increased numbers of staff alongside additional training in patient safety & PSIRF. The team champion and support the implementation of this response plan.

Core patient safety activities undertaken at KIMS Hospital include:

- ✓ Risk Management
- ✓ Clinical Audit
- ✓ Quality Improvement
- ✓ Patient Experience
- ✓ Health and Safety
- ✓ Monitoring and responding to national safety alerts
- ✓ Review and monitoring of NICE guidance implementation
- ✓ Benchmarking through national systems e.g. National Joint Registry
- ✓ Thematic reviews of incidents for learning purposes

The operational 'work-as-done' for these patient safety activities is predominantly owned by our colleagues on the front-line, however, we always adopt our unique KIMS Hospital ONE TEAM approach.

To prepare our staff at KIMS Hospital for PSIRF, we launched patient safety syllabus training for all staff in November 2022. Our weekly communications bulletin 'HOT TOPIC' was utilised to launch PSIRF and explained to staff how the Serious Incident Framework (SIF) was being replaced by the new Patient Safety Incident Framework (PSIRF) and of our strategy to transition to this. Staff were signposted to Level 1 training through Health Education England and all Executives commenced Senior Leader Level training. Those with patient safety responsibilities at a more senior level completed Level 2 training, enabling them to develop skills to undertake a fresh style of systematic review for learning. A review at the end of 2022/23 revealed over 95% of all staff had completed the Level 1 safety training. In order to strengthen our capabilities in 2023/24 Level 2 training is now mandated for all roles holding a professional registration.

Training is planned in readiness to undertake the new style Patient Safety Incidents Investigations (PSII), following the national guidance.

SITUATIONAL ANALYSIS OF PATIENT SAFETY ACTIVITY 2019-2023

In order to identify our patient safety profile, the Quality and Governance Team have triangulated data from 2019-2023 including:

- ✓ Patient Safety Incidents reported within Datix™
- ✓ Complaints relating to clinical care and treatment
- ✓ Quality dashboard data
- ✓ Clinical and Non-Clinical Audit results
- ✓ Outcome of Coroner's Inquests
- ✓ 2022 Patient Notification Exercise, summary of learning

In addition to a thematic review of this data, this was sense checked by undertaking brief conversations with a variety of staff from across the organisation asking them the simple question "What are the top 3 safety issues you see here at KIMS Hospital?" An example of the staff met were Clinical Nurse Specialists, Directors, Doctors, Theatre staff, Governance Leads, Committee members and Facilities staff.

Patient Safety Activities	Activity	Definition	Number 2019-March 2023	Number Last governance year 2022/23
National Priorities	Never Events	Incident meeting criteria for Never Events framework and reported to STEIS as a SIRI	4	1
	Incidents meeting Serious Incident Criterion	Incident meeting criteria for SIRI	47	14
KIMS Hospital Priorities	Patient Safety Incident Reviews	Including moderate harm incidents meeting the requirement for Statutory Duty of Candour, not meeting SIRI criteria	54	36
	Patient Safety Incident Validation	Patient safety incidents of low/no harm requiring validation at department/ward level	5899	1160
	Coroner's Inquest	A legal process to determine the cause of death involving patient safety incidents	2	1
	Thematic Review identifying trend requiring improvement work	Following review, a trend is noted in patient safety incidents where harm is being caused repeatedly within a department, service or process	4	4
	Patient Recall following identification of a trend	The overall objective of a patient recall is to limit or mitigate the harm to patients and provide a clear focus for their ongoing care.	1	1
	Complaints and concerns received relating to clinical care and treatment	Complaints offer a rich source of learning to help improve services for everyone.	110	17
	Audit results demonstrating the need for improvement work monitored though Quality Dashboard	Clinical audit is a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria.	12	4

OUR SAFETY PRIORITIES 2023-2025

Through our analysis of our patient safety insights we have determined 3 patient safety priorities we will focus on for the next two years.

Priority	Key Theme	Key risks from activity	Proposed methods to both improve safety and learn from incidents
1 Provision of safe surgery/ interventional procedures	Prevention of Never Events. The organisation has reported and investigated 4 Never Events in the time period reviewed. Audit of WHO have showed inconsistencies in departments outside Theatres.	Never Events are different from other serious incidents as the overriding principle of having the Never Events list is that even a single Never Event acts as a red flag that an organisation's systems for implementing existing safety advice/alerts may not be robust.	Achieving Association for Perioperative Practice (AfPP) Accreditation in November 2023 was testament to the ONE TEAM approach of the Theatre/Endoscopy staff. This accreditation recognises the hard work on implementing standards aimed at improving safety. Each of our priorities will be implemented using a Task & Finish group methodology led by a clinical leader not directly involved in the area. The group will have clinical and non-clinical experts and a wide range of relevant stakeholders. If a Never Event occurs an immediate SWARM huddle will be called to review facts and support staff. This will be investigated as a Patient Safety Incident Investigation (PSII) using the new methodology which is systems based.

Priority	Key Theme	Key risks from activity	Proposed methods to both improve safety and learn from incidents
2 Responding well to clinically changing conditions	Thematic review of SI reports demonstrated elements of learning relating to the management of a deteriorating patient, recognition and responding to signs of SEPSIS and effective utilisation of NEWS2. Audit results of NEWS2 show lack of compliance against the relevant standard. When sense checking with staff, this theme also appeared.	Failure to detect and respond to patient clinical deterioration is associated with increased hospital mortality and risk of adverse events that are known to be preventable. Early recognition and response to deteriorating patients by health professionals is fundamental for optimal patient outcomes.	Review and refinement of the audit methodology for NEWS2. Review of the NEWS2 Policy and chart to ensure meets KIMS Hospital unique escalation process. Review of the Deteriorating Patients Policy. Introduction of Clinical On-Call. Staff education regarding the management of a deteriorating patient in a ward setting. Review of enhanced care provision. If an event occurs where there is possible delays or effective management of a critically ill patient, a case review will be undertaken and if areas for learning are identified an After-Action Review (AAR) will be facilitated.

Priority	Key Theme	Key risks from activity	Proposed methods to both improve safety and learn from incidents
3 Effective discharge	Incidents, audits, complaints, risk register and sense checking with staff revealed a trend related to our discharge processes. Lack of consistency in relation to provision of information, effective communication with GP's and advice and education regarding medication.	Ineffective or delayed information from the hospital to the primary care provider could negatively impact continuity of care. In addition, good quality pain management that patients understand helps recovery and return to health. There are risks related to both of these as identified through our review which can lead to re-admission and disrupted patient pathways.	A review of the discharge process to identify opportunities for improvement involving patient education process and information provision. Audit of the discharge process and actions taken where evidence appears there are areas for improvement. Implement electronic discharge to GP. Complaint investigations and review of comments within patient satisfaction survey. AAR if there is evidence of a potential for learning.

HOW WE WILL RESPOND TO PATIENT SAFETY INCIDENTS

Deciding what to investigate through a Patient Safety Incident Investigation (PSII) process will be a flexible approach, informed by the local and national priorities. Our objective is to facilitate an approach that involves decision making through a "convening authority" approach that is commonly used in the military and aviation to commission investigations.

We will use existing structures to support the process of decision making. Incidents are reviewed on a daily basis at KIMS Hospital and where relevant, discussed at the daily safety huddle, the 10@10, to ensure immediate sharing of learning.

Where the information indicates the incident may meet either national or local priorities, a case review is undertaken the same day and escalated to the Chief Nurse/ Registered Manager using the Incident Decision Making Tool. A meeting is convened attended by the Chief Nurse, Clinical

Manager responsible for the area and the Head of Quality, Governance and Patient Safety and where necessary the Medical Director. The group review the facts to ensure:

1. The patient is safe and is being suitably supported.
2. The staff are being supported in line with our JUST CULTURE with compassion and kindness.
3. If the incident meets the criteria it is internally escalated to the Board and reported to the relevant external agency.
4. The most appropriate tool is employed to elicit learning with the lead reviewer identified.

The process will be described in detail in the associated policies, particularly in new policies that describe Patient Safety Incident Investigations, Patient Safety Incident Responses and involving patients in discussions about incidents, learning and improvement.
National guidance recommends that 3-6 investigations per priority are conducted per year.

Patient Safety incidents that must be investigated under PSIRF

1. Never Events
2. Deaths more likely than not due to problems in care. This can be identified through an incident and/or the learning from deaths process.

Apart from the "must investigate" points above, the decision to carry out a Patient Safety Incident Investigation should be based on the following:

- the patient safety incident is linked to one of KIMS Hospital Patient Safety Priorities that were agreed as part of the situational analysis;
- the patient safety incident is an emergent area of risk. For example, a cluster of patient safety incidents of a similar type or theme may indicate a new priority emerging. In this situation, a proactive investigation can be commenced, using a single or group of incidents as index cases.

Incidents that meet the Statutory Duty of Candour thresholds:

There is no legal duty to investigate a patient safety incident. Once an incident that meets the Statutory Duty of Candour threshold has been identified, the legal duty, as described in Regulation 20 says we must:

1. Tell the person/people involved (including family where appropriate) that the safety incident has taken place.

2. Apologise, for example, “we are very sorry that this happened”
3. Provide a true account of what happened, explaining whatever you know at that point.
4. Explain what else you are going to do to understand the events, for example, review the facts and develop a brief timeline of events.
5. Follow up by providing this information and the apology in writing, and providing an update, for example, talking them through the timeline.
6. Keep a secure written record of all meetings and communications.

Patient safety incidents that have resulted in moderate/ severe harm:

These incidents would have automatically been a serious incident under the Serious Incident Framework. It is crucial that these incidents are not routinely investigated using the PSII process, otherwise we will be recreating the Serious Incident Framework.

The routine response to an incident that results in moderate/ severe harm will be to follow the Statutory Duty of Candour requirements. This will both provide insights to thematic learning and provide information about the events to share with those involved. Such incidents where they do not meet either national or local safety priorities will be reviewed on a case by case basis and appropriate tools will be employed to elicit learning, an example of this would be a confirmed post-operative infection where the Infection Prevention Lead Nurse undertakes a post infection review with the Microbiologist. Another example would be our approach to reviewing post-operative thrombosis, where a case review is undertaken by the Quality and Governance Lead and the clinical team for shared learning and any actions for improvement agreed.

<table>
<tr><th></th><th>EVENT</th><th>KIMS Hospital APPROACH</th><th>IMPROVEMENT</th></tr>
<tr><td rowspan="5">NATIONAL PRIORITIES</td><td>Death of a person with Learning Disabilities</td><td>Reported and reviewed by Learning Disabilities Mortality Review (LeDeR)</td><td rowspan="3">Respond to recommendations from external referred agency/ organisation as required.</td></tr>
<tr><td>Safeguarding incidents meeting criteria</td><td>Reported to local safeguarding board</td></tr>
<tr><td>Incidents in screening programmes</td><td>Reported to Public Health England (PHE)</td></tr>
<tr><td>Incidents meeting the Never Event criteria</td><td>SWARM followed by Patient Safety Incident Investigation</td><td rowspan="5">Create local organisational recommendations and actions feeding into patient safety priorities improvement programmes.</td></tr>
<tr><td>Incidents resulting in Death</td><td>Case Review Patient Safety Incident Investigation where deemed necessary</td></tr>
<tr><td rowspan="3">KIMS PRIORITIES</td><td>Provision of safe surgery/interventional procedures</td><td rowspan="3">After Action Review where deemed necessary</td></tr>
<tr><td>Responding well to clinically changing conditions</td></tr>
<tr><td>Effective Discharge</td></tr>
</table>

In addition to the above, trend analysis and thematic reviews are used to monitor learning from low or no harm incidents. Any thematic reviews undertaken will be shared with our ICB. The outcome of such reviews are discussed at the appropriate committee where there is oversight of the learning related to both individual events and themes identified. Where necessary a quality improvement group is established with terms of reference and overseen by the Patient Safety Committee.

Learning can also be identified following good care or through positive feedback. Within the Learning from Patient Safety Events (LFPSE) reporting system there is now an opportunity to formalize this. As part of our launch staff will be engaged and encouraged to report such events. At our governance committees we are including patient stories and the committee discusses the learning from direct feedback or experiences.

INVOLVING PATIENTS, FAMILIES AND CARERS FOLLOWING INCIDENTS

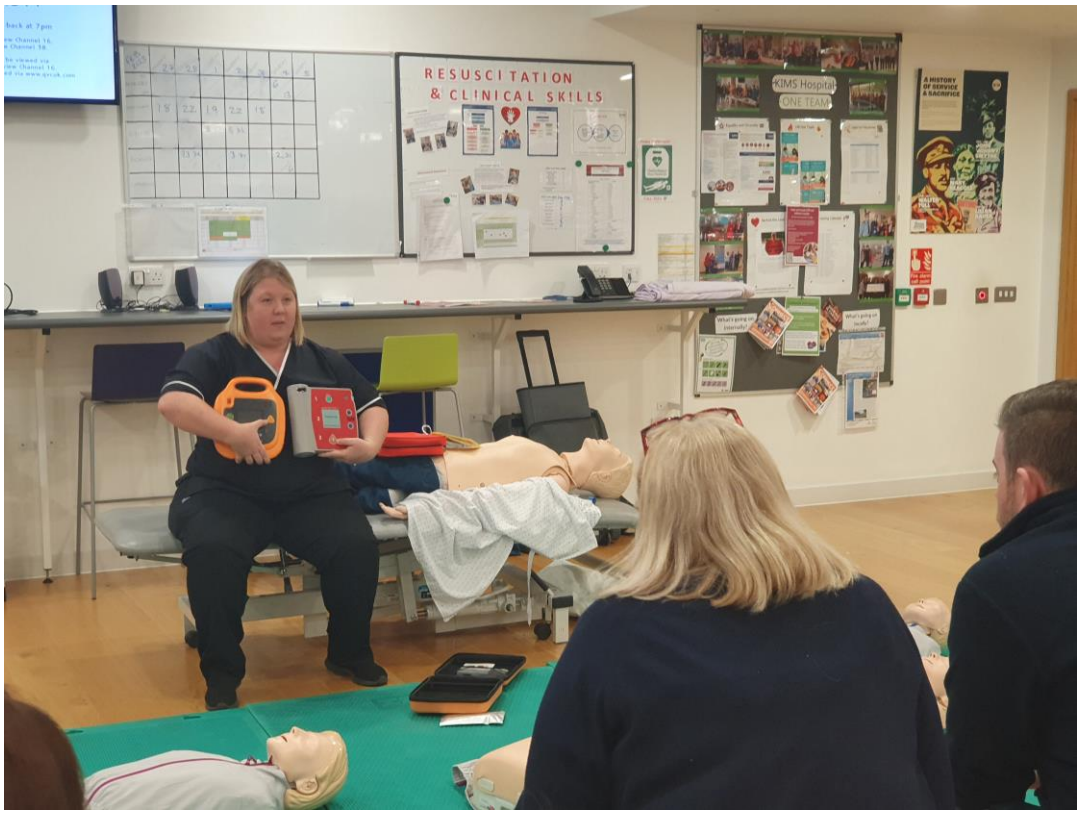
The importance of the involvement of the patient and families in any incident review into their treatment and care cannot be underestimated. It is a recognised National Standard and it is at the heart of what we do at KIMS Hospital. It is our standard practice for our clinical teams to identify a lead responsible to engage and maintain contact with the patient or nominated individual of choice. The rationale for this is to hear the patient/ representative's perspective, address questions within the investigation and provide support. During case reviews or as part of investigations for learning purposes patients and families are invited to contribute to our learning by giving us their thoughts, reflections and providing questions it is important for them to have answered. This is primarily undertaken through the Duty of Candour process. At present we do not have patient safety partners although this is an aspiration however we are very fortunate to have a well-established Patient Forum who work closely with us in the design of patient pathways and the ongoing development of our services.

The Chair of the Patient Forum is a member of the Medical Advisory Committee and Hospital Management Board.

Moving forward we want to strengthen this partnership by inviting a member of the forum to join the Patient Safety Committee. The patient and family voice are vital for both hospital learning from incidents and for putting actions in place to prevent them in the future. The Patient Safety Committee monitors our overarching action plan developed from learning gleaned during incident reviews, therefore involving a patient at the heart of this committee will bring greater accountability and assurance.

SUPPORTING AND INVOLVING STAFF FOLLOWING INCIDENTS

We have further strengthened our clinical leadership team in 2022/ 23, implementing additional senior clinical roles and as part of our learning culture we have implemented an additional layer of senior clinical support who are always now available on call for advice.



The new role of Clinical Skills Officer has had an incredibly positive influence in the organisation this year working with not only our own staff but strengthening educational support for our university students and working in collaboration with the local NHS Trusts and Ambulance service to facilitate collaborative training exercises across the region. Our Clinical Skills Officer is trained in Human Factors and is involved regularly in de-brief sessions following an event and gives training in this subject.

We have focused on implementing a JUST CULTURE of supportive learning, which our staff identified as an area of improvement through the recent staff pulse survey. Our safety culture received positive feedback, with a large proportion of respondents feeling confident that they could speak up about any safety concerns, and an appreciation of our increased emphasis on learning from incidents. Speaking Up for Safety™ is a focus for our teams and all new employees receive training as part of their corporate induction.
We recognise that many staff will be involved with a patient safety incident at some point in their careers and this can be a traumatic experience. We have a wealth of excellent psychological wellbeing support for all staff. Staff mental health and wellbeing is a key factor in the development of a sustainable, high performing workforce.

Mental health continues to be a focus within the hospital, and within the last year we have trained an additional 10 mental health first aiders to be available, listen to and sign-post employees. We are currently developing a Mental Health strategy and raise awareness of the support that is available through events such as Mental Health Awareness Week.

In order to move towards a compassionate, supportive way of working with colleagues involved in incidents, we no longer request "statements". Staff now meet a trusted colleague or manager to undertake a reflective learning discussion, offering an opportunity for staff to identify any training needs or additional input.

"Thank you for your excellent and comprehensive work and the speed in which you have dealt with this never event. It certainly helped me massively in dealing with it"

Consultant involved in incident 2022

Our Human Resources team are currently reviewing all policies to ensure a JUST CULTURE is at the heart of our HR processes and this is also part of our Practicing Privileges Policy.

The CQC found that the hospital embraced a one team culture, a positive culture that both supported and valued staff, creating a sense of common purpose based on shared values and that this culture was evident during their conversations with staff of all grades.

ROLES AND RESPONSIBILITIES IN THE NEW SYSTEM

Committee	Responsibilities
Quality & Governance Sub-Committee	This committee meets quarterly and reviews safety and quality data providing a forum where members act as a critical friend in seeking assurance that KIMS Hospital has effective structures and processes in place.
Hospital Management Board	This monthly meeting has oversight to review and act as the approval mechanism for risks, PSII and other types of patient safety reviews.
Quality Governance Committee	This quarterly meeting receives both escalation of risk and assurance regarding patient safety activities from committees which bear responsibility for the key areas of patient safety: • Medical Governance • Patient Safety • Patient Experience • Health & Safety • Infection Prevention • Medical Devices • Medication Safety
Patient Safety Committee	This monthly committee is where learning is shared and actions developed in response to audit results and safety reviews are monitored for progress. In addition, the committee monitors compliance with NICE guidance and National Safety Alerts.
Medical Governance Committee	This monthly committee provides a forum to discuss issues related to Consultant practice/ conduct ensuring Consultants are managed in line with KIMS Hospital values, whilst ensuring patient safety is the main priority.
Medical Advisory Committee	The committee meets quarterly and advises the HMB on appropriate frameworks, policies and procedures to support delivery of good medicine and safe and effective clinical care.

TAKEAWAYS

Patient safety is our priority and passion at KIMS Hospital.

We have worked collaboratively to embed a safety culture that reflects our values and vision. We are excited by the opportunities PSIRF provides to help us focus on our safety priorities using the precious resources we have to maximise patient safety.