Guy's and St Thomas' NHS Foundation Trust

Patient Safety Incident Response Plan (PSIRP)

Contents

1 Introduction

Our first Guy's and St Thomas' (GSTT) Patient Safety Incident Response Plan (PSIRP) went live across the Trust on 4th December 2023 and set out how we would respond to patient safety incidents within the PSIRF. This identified a set of Trust Priority Incidents that required improvement plans as were considered a common and/or high source of risk for the Trust, requiring a more proportionate response under PSIRF. Eight (8) Trust Priority Incident types were recommended based on analysis of patient safety events from 2018-2022.

Since the timeframe of our last incident analysis, the Trust has merged and re-organised, as well as grown in its approach to and understanding of PSIRF. As this was the first PSIRP developed and implemented at the Trust, a review of the plan within the ensuing 2 years was agreed. The aim of this review was to consider the effectiveness of our overall plan, identify improvements to build on our successes to date and, more importantly, consider if additional or current PSIRP priority improvement areas are required.

Our initial PSIRP focused primarily on overall Trust Priority areas and resulted in utilising existing Trust groups or committees who developed improvement plans and tried to take improvement work forward in addition to their existing extensive agendas, scope and responsibilities. Feedback from the groups has also highlighted the challenge in providing multiple assurance routes across each Trust Priority group and impacting incident response decision making, particularly if that incident theme is not of concern in that specific group or directorate. We have confirmed each Clinical Group has its own incident profiles and demographics, whereby there are not 'one size-fits-all' incident themes pertinent to all Clinical Groups.

Our new PSIRP accounts for the areas of highest risk and priority action across the Trust and has also enabled Clinical Groups to identify areas they wish to focus on in patient safety, for specific improvements that are tailored to their respective directorate, patient and incident cohorts. In turn, this should mean more meaningful improvement, more control over how PSIRF is applied across Clinical Groups, and more effective, proportionate responses to patient safety incidents.

Our 2nd Patient Safety Incident Response Plan (PSIRP) sets out how Guy's and St Thomas' NHS Foundation Trust (GSTT) intends to respond to patient safety incidents over the following 24 months. We will remain flexible and consider the specific circumstances in which patient safety issues and Incidents occurred and the needs of those affected. This plan sits alongside our Trust Incident Management policy to guide responses to patient safety incidents.

There are many ways to respond to a patient safety incident. This document covers learning responses undertaken solely for the purpose of organisational learning and improvement. These responses are protected from processes that seek to determine legal liability, assign blame, assess professional

conduct/competence/fitness to practise, investigate criminality, or establish cause of death. Other types of response may be required to address specific issues or concerns, for example complaints management, claims handling, human resources investigations into employment matters, professional standards investigations, coroner's inquests, or criminal investigations. The principal aims of these processes differ from those of a patient safety response and are outside the scope of this Plan.

Some patient safety incidents in healthcare require a specific type of response as set out in policies or regulations. These responses include mandatory Patient Safety Incident Investigation (PSII) in some circumstances or review by, or referral to, another body or team, depending on the nature of the Incident.

The Systems Engineering Initiative for Patient Safety (SEIPS) framework is used within all PSIRF Learning Responses to understand outcomes within complex systems and to support the analysis of incidents and safety issues more broadly. Learning Responses explore decisions or actions as they relate to the situation. The method is based on the premise that actions or decisions are consequences, not causes, and is guided by the principle that people are well intentioned and strive to do the best they can.

2 Our services

Guy's and St Thomas' NHS Foundation Trust is registered with the Care Quality Commission to provide services in the following locations:

- St Thomas' Hospital
- Guy's Hospital
- Evelina London Hospital
- Royal Brompton Hospital
- Harefield Hospital
- Guy's and St Thomas' NHS Foundation Trust Adult Community Services
- Guy's Cancer Queen Mary's Hospital
- Royal Brompton & Harefield Hospitals Specialist Care-Wimpole Street
- Pulross Intermediate Care Centre
- Amputee Rehabilitation Unit (ARU) Lambeth Community Care Centre
- New Cross Gate Dialysis Unit
- Camberwell Dialysis Unit
- Lane Fox REMEO Respiratory Centre
- Tunbridge Wells Kidney Treatment Centre
- Borough Kidney Treatment Centre
- Minnie Kidd House

3 Definitions

Patient Safety Incident: are any unintended or unexpected Incident which could have, or did, lead to harm for one or more patients receiving healthcare.

National and Regulatory Incident: are patient safety Incidents that require a specific type of response as set out in national policies or regulations. These responses will include an internal trust patient safety Incident Investigation or review by or referral to another body or team, depending on the nature of the Incident.

Patient Safety Incident Investigation: A patient safety incident investigation (PSII) is an in-depth investigation undertaken when an incident or near-miss indicates significant patient safety risks and potential for new learning. A PSII investigation uses the Systems Engineering Initiative for Patient Safety (SEIPS) framework to understand outcomes within complex systems and which can be applied to support the analysis of incidents and safety issues more broadly. Investigations explore decisions or actions as they relate to the situation. The method is based on the premise that actions or decisions are consequences, not causes, and is guided by the principle that people are well intentioned and strive to do the best they can. The goal is to understand why an action and/or decision was deemed appropriate by those involved at the time. PSII's look at work as done and include safety I and safety II.

Investigation: to examine, study or inquire into an incident, event or process systematically. Any investigation undertaken at GSTT has the aim of examining the system and not individuals. This includes what works well and where there are potential safety gaps to a system or process.

After Action Review (AAR): is a structured facilitated discussion of an Incident, the outcome of which gives individuals involved in the Incident understanding of why the outcome differed from that expected and the learning to assist improvement. AAR generates insight from the various perspectives of the MDT and can be used to discuss both positive outcomes as well as incidents.

Patient Safety Pathway Review (PSPR): The Patient Safety Pathway Review (PSPR) supports health and social care teams to: identify learning from multiple patient safety incidents; agree the key contributory factors and system gaps in patient safety incidents; explore a safety theme, pathway, or process; and gain insight into 'work as done' in a health and social care system.

Swarm Huddle: Swarm-based huddles are used to identify learning from patient safety incidents. Immediately after an incident, staff 'swarm' to the site to quickly analyse what happened and how it happened and decide what needs to be done to reduce risk

Case Note Review: Case note review is a method used to determine whether there were any problems in the care provided to a patient within a particular service. It is undertaken routinely to learn and improve in the absence of any particular concerns about care. This is because it can help identify problems where there is no initial suggestion anything has gone wrong. It can also be done where concerns exist, such as when bereaved families/carers or staff raise concerns about care.

Incident Review Meeting (IRM): An Incident Review Meeting is a multidisciplinary team meeting focused on reviewing what is known about an incident at that time, which considers whether:

- whether the contributory factors are sufficiently understood,
- whether the incident presents a meaningful opportunity for learning and
- whether the level of risk to patients warrants a formal learning response.

This meeting is completed to review incidents of concern and to decide collectively if a PSIRF Learning Response is required.

The different learning responses available should be discussed with a collective decision and rationale for the one chosen

Never Event: (NE): are incidents that are wholly preventable because guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. Full details of each Never Event can be accessed via NHS England Website or our Trust Quality and Assurance Intranet Page.

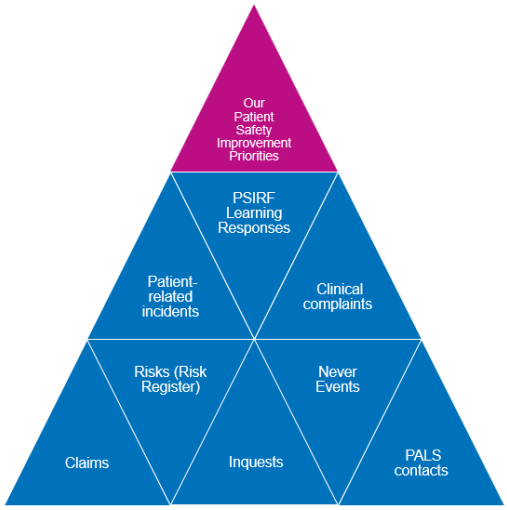
4 Defining our Patient Safety Incident Response Plan (PSIRP) and Trust Improvement Priorities

4.1 Data sources:

Our Patient Safety Incident Response Plan (Version 2) and Trust Improvement Priorities have been identified and profiled using the following data sources:

- Patient Safety incidents reported between April 2024-March 2025
- Thematic analysis of quantitative and qualitative data (Listing reports from GSTT Incident Reporting System)
- Key themes identified from specialist safety & quality committees (e.g. AIP, Falls, MSC)
- Review of the Trust Risk Register
- Review of incidents and improvement work against our 1st/initial PSIRP

Incident types, recurrence and severity were explored, together with careful consideration of safety improvement opportunities and knowledge, together with plans and interventions already in place. The diagram below shows the data sources for informing our Trust improvement priorities.



For our initial PSIRP, the Trust reviewed incident data from 2018-2022 resulting in analysis of 82,178 patient safety incidents. This included Never Events, Serious Incidents, harm and no harm incidents. The trends and themes from these incidents were triangulated with complaints, patient experience, mortality, claims and inquest data and live risks on the Trust Risk register.

Building on this, for our 2nd PSIRP, the Trust reviewed incident data from April 2024-March 2025

along with, thematic analysis of quantitative and qualitative data (from the GSTT Incident Reporting System), key themes identified from specialist safety & quality committees (e.g. Surgical Safety, Falls, Medicines Safety), themes from Learning from Deaths, review of Corporate Risk Register and review of incidents and improvement work against our 1st/initial PSIRP.

Following Trust-wide and Clinical Group incident analysis, it was identified that we needed to move away from set 'Trust-wide only' priorities to a more 'improvement first' approach that focuses on areas that mean the most to clinical groups as well as key risk and quality objectives in the Trust.

A more focused set of Trust Improvement Priorities (no longer labelled as 'Trust-wide improvement plans') that outline the key patient safety areas of focus have been identified. Whilst a representation of the highest areas of risk for GSTT, they do not mandate a single approach for all services and our 2nd PSIRP encourages clinical groups to focus on further improvement areas that may fall outside or in addition to these improvement priorities.

The below improvement areas reflect the highest sources of risk Trust-wide analysis and feedback, requiring a more proportionate response and central senior management-led QI focus, most aligning to an existing corporate or clinical improvement programme:

1) Administrative / Patient Pathway Related Safety

2) Medication

3) Surgical Safety

4) Patient Falls

5) Maternity

Findings from this data was produced into a full data profile, shared and discussed with Clinical Groups and the specific Trust quality committees for specialist input. It was also shared and approved by the Trust Risk and Assurance Committee. Through the review and the thematic analysis of our data, we have identified the following Trust Improvement Priorities that we will focus on for the next 24 months:

Trustwide Improvement Priority	Rationale	Outline plan	Improvement Committee/Group
Administration errors (Patient pathway administration errors – systemic failure to refer and or act on referral from internal or external)	Administrative / Patient Pathway Related Safety' (hereby referred to as 'Admin') is a high-risk theme based on frequency, impact and types of response. 'Admin' incidents affected all clinical groups proportionately, as well as being one of the highest sources of risk and the biggest risk register theme across the Trust. Data analysis showed an ongoing link to the Epic system and processes, as well as suggestions the current Admin PSIRP had other underlying themes. Whilst a common area of risk for all groups, Cancer & Surgery identified a need for improvement around lost to follow-up, and ISM around ambulatory improvement workstream.	Administration Safety Oversight Group in place to address the themes, trends and contributory factors that lead to incidents. Improvement plan identified aiming to: To prevent harm as a result of administrative process and functions for patient referral and tracking. Outcome measure: 1. Number of incidents reported with harm as a result of administrative function/process. 2. Reduction in re-booking of patients for clinics or treatment Key work streams in place will be monitored and developed to reduce harm and ensure risk of further harm reduced to minimum possible.	Administration Excellence Programme
Falls – inpatient	Patient falls were identified as a medium source of risk, although more specific to certain clinical groups rather than a complete Trust-wide theme. Due to still being one of the most commonly reported incidents and due to risk, a Trust-wide PSIRP was indicated, with a focus on ISM & HLCC due to their incident profiles. Although patient falls and resulting harm is	Clear trust wide falls prevention improvement plan based on learning from incident investigations and actions. This improvement plan will cover the trust and where required be specific to each Clinical Group trends/themes. Improvement plan identified aiming to: To ensure all admitted patients receive high quality falls management for the duration of	Trust Falls Group

	relatively low for a large organisation there is still improvement to reduce to minimal harm. There is a balance between rehabilitation/mobilisation and fall protection and with robust risk assessment compliance and subsequent actions we can ensure all done possible to prevent a fall.	their inpatient stay.	
Medications Omitted and delayed medicines for high risk drugs (insulin, opioids and anticoagulants). Administration of medicines – wrong dose for high risk medicines (insulin, opioids and anticoagulants)	Remains one of the highest reported incident types. Risk on corporate risk register on aseptic dispensing for chemotherapy (national issue). Trend of incidents reported resulting in omitted doses or overdose of insulin (10 times over dose in one case), secondary to incorrect device (standard parenteral syringe used to draw up insulin rather than an insulin syringe) Trend of moderate harm incidents reported related to opiate usage in patients with acute or chronic renal impairment resulting in opiate toxicity.	Improvement plan identified aiming to: • Reduce the number of omitted and delayed doses to patients for drugs on the critical drugs list. • Reduce harm to patients by eliminating 'wrong dose' errors. • Reduce harm to patients from incorrect prescribing and administering of insulin, anticoagulant medication and Opioids. • Improve compliance with controlled drug (CD) management through robust systems followed consistently in practice	Medicines Safety Committee (MSC)
Surgical Safety	Surgical Safety identified as medium source of risk and high priority improvement area. Incidents including Never Events continue to occur with a significant percentage resulting in moderate harm or above.	Improvement plan identified aiming to: • Implement a robust safety process that reduces the risk of never events occurring as much as reasonably practicable throughout the perioperative pathway. • Compliance to the sequential standards outlined in the National Safety Standards	Surgical Safety Group (SSG)

		for Invasive Procedures (NatSSIPs2): 1. Consent and procedural verification 2. Team Brief 3. Sign In 4. Time Out 5. Implant use6. Reconciliation of items 7. Sign Out 8. Debrief and handover	
Maternity	Maternity improvement programme, identified as Trust priority and area of risk, with focus on PPH, Bladder Care, Escalation & Hypoglycaemia.	Improvement plans identified aiming to: **Postpartum haemorrhage (PPH)** • Identification of women at risk by appropriate history taking and risk documentation. • Ensuring preparedness and prevention strategies for women identified as high-risk. • Early recognition and quantification of blood loss with timely escalation. • Ensuring all staff know what actions to take in the event of postpartum haemorrhage. • Provide parents with appropriate information following severe PPH **Bladder care** • Reduce urinary retention post birth • Improve overall bladder care for inpatients **Escalation/MEWS** • **Improve early recognition of the acutely**	Maternity Board

		unwell during pregnancy and immediate postnatal period by systematically following national MEWS pathway of escalation. • Discussing EPIC and MEWS parameters • Identifying mothers at risk by appropriate-MEWS score and escalation • Timely recording and escalation • Ensure all staff know what actions to take to measure the 6 physiological parameters, record this on EPIC, and escalate appropriately. • Teach and regularly review with staff, and ensure staff are aware of the appropriate immediate actions. **Hypoglycaemia:** • Identifying babies at risk by appropriate history taking, recording of birthweights/ centiles and effective handover between clinical area. • Initiating early skin to skin contact and feeding for all babies.	

In addition, clinical groups have also identified more bespoke areas of focus within these priority areas or different areas of focus that reflect areas of risk more specific to each clinical group. It is expected that these clinical group improvement areas will flex across services and are not intended to be exhaustive; the improvement priorities below provide an overview of the improvement underway across each clinical group, now that PSIRF has released time from 'investigation' to more proactive improvement for patient safety.

Clinical Group Improvement Priorities				
Improvement Priority	**Cancer & Surgery**	**Evelina London Women & Children**	**Heart, Lung & Critical Care**	**Integrated Specialist Medicine**
Medication	■	■	■	
Falls	■			
Admin		■	■	
Patient Self-endangerment				■
Pressure Ulcers	■			
Delayed Pathology Lab Results and Lost Samples		■		
Surgery Delays & Cancellations			■	
Delays in Clinical Care			■	

Key points on control and assurance are:

- Clinical Groups have determined how their local priorities are managed and overseen. This can be individual improvement plans/driver diagrams, or tracked through assurance reporting or trackers into your CG committees / new or existing groups. Improvement work should be fluid.
- Assurance will first and foremost be discussed and owned at Clinical Group level – wherever and however decided within clinical group governance structures. Should align to how each clinical group monitor improvement actions and gain assurance.
- Showcasing of learning will report into the Learning for Improvement Group (LfIG); suggested 3 improvement spotlights per year (one group every 4 months) to showcase learning, improvement and patient safety initiatives for each clinical group. This can be taken from existing assurance arrangements or papers in place.
- Trust improvement priorities will continue to be executive or centrally led (e.g. COO for Admin Excellence, CNO for Falls, Chief of Surgery for surgical safety), with revamped groups and continued reporting into LFIG. Continued engagement and buy in from Groups required to ensure we maintain focus, naturally depending on whether the priorities align and address key risk areas for clinical groups. Trust Priority actions may differ from a Group/Directorate, so local adaptation or additional focuses can be initiated locally depending on need.

4.2 Stakeholders:

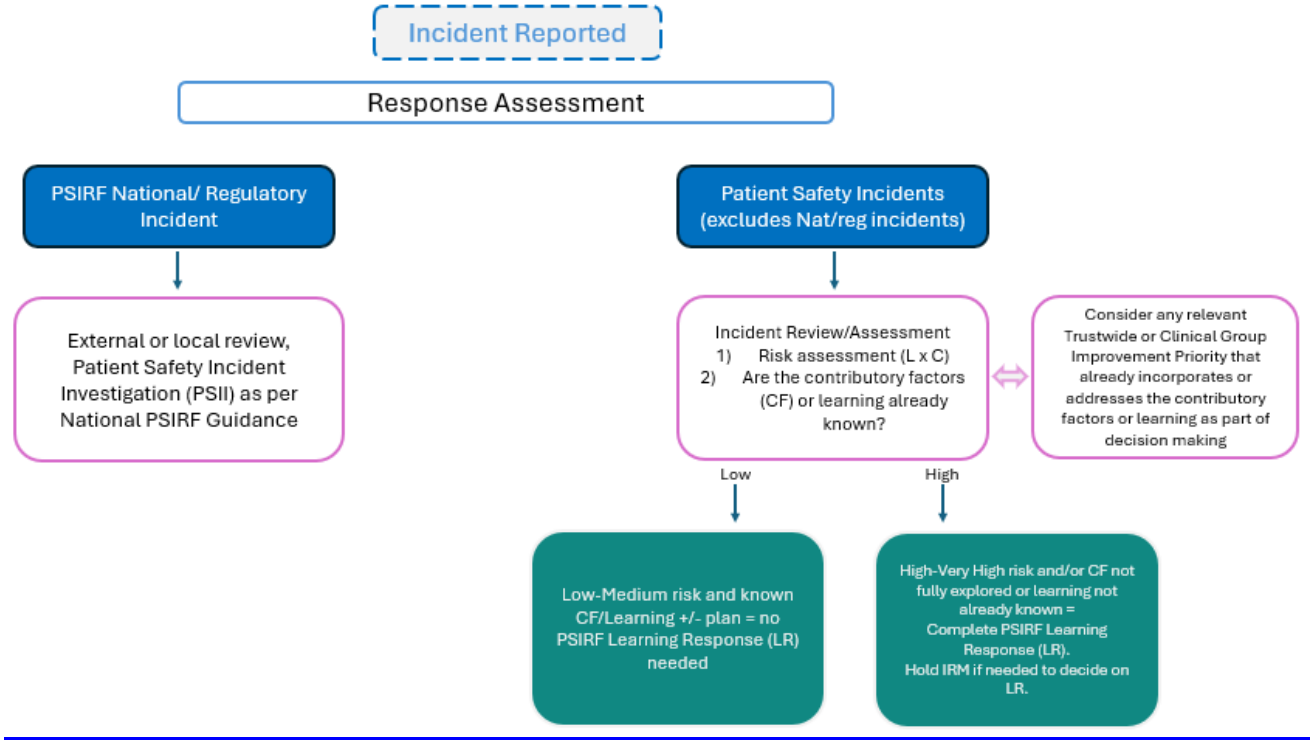
Identifying our patient safety issues at Guy's and St Thomas' NHS Foundation Trust was a collaborative process involving the following stakeholders:

Stakeholder	Involvement
Staff	Through incidents reported on the Trust incident reporting system.
Trust Patient Safety Team	The team conducted the data collection and initial analysis to socialise further. This team also triangulated the data and responded to any comments, feedback and challenges.
Clinical Groups	Clinical groups were asked to provide detailed feedback, analysis and recommendations to ensure that the proposed incident profiles aligned with the current incidents and improvement work ongoing in their areas
Board Executives	The proposed incident profiles were presented to the Trust Board (executive & non-executive) for oversight and comment.
Trust-wide Quality Committees	The proposed incidents profiles were socialised across all trust-wide quality committees for comment, challenge and feedback. Alignment with ongoing and future plans for improvement work.
Tissue Viability Leads; Patient Falls Leads; Adult Community Leads	The proposed incident profiles were shared with specialists within the Trust for expert feedback, comment and challenge. Further conversations occurred to ensure that the data collected represented the actual ongoing incidents reported within the area to further support the data profiles.
Patient Experience Team; Patient Advise Liaison Services (PALS); Patient Resolution	Provided data based upon patient feedback, experiences and complaints to ensure that the patient voice was acknowledged and included within the thematic analysis provided – further socialisation of this data to ensure that expert opinions were acknowledge.
Legal and Claims; Preventing Future Death Reports; Risk Register	Provided additional data to enable a thematic review and triangulation with the proposed incident profiles— further socialisation of this data to ensure that expert opinions were acknowledge.

5 Responding to Incidents

5.1 Responding to reported Incidents overview

The chart below outlines the Trust response to reported Incidents (incidents) occurring within the trust. Each step and those responsible is described in further detail within the Trust Incident Management policy. To ensure resource to focus on improvement is available the response to Incidents must be proportionate. The ongoing monitoring and assessment of trends and themes will provide the assurance and confidence that we are responding appropriately and proportionately to patient safety Incidents.



5.2 Responding to National or Regulatory Incidents

These are patient safety incidents that require a specific type of response as set out in national policies or regulations. These responses include internal trust PSIRF Learning Responses or review by or referral to another body or team, depending on the nature of the incident. The table below sets out the nationally mandated responses for national Incidents that are planned for the next 24 months:

Table A1: Events requiring a specific type of response as set out in policies or regulations

Event	Action required	Lead body for the response
Deaths thought more likely than not due to problems in care (incidents meeting the learning from deaths criteria for PSII)[5]	Locally-led PSII	The organisation in which the event occurred
Deaths of patients detained under the Mental Health Act (1983) or where the Mental Capacity Act (2005) applies, where there is reason to think that the death may be linked to problems in care (incidents meeting the learning from deaths criteria)	Locally-led PSII	The organisation in which the event occurred
Incidents meeting the Never Events criteria 2018, or its replacement.	Proportionate learning response	The organisation in which the Never Event occurred

[5] Unless the death falls under another more specific category in Table A1, in which case that response must be followed.

Event	Action required	Lead body for the response
Mental health-related homicides	Referred to the NHS England Regional Independent Investigation Team (RIIT) for consideration for an independent PSII Locally-led PSII may be required	As decided by the RIIT
Maternity and neonatal incidents meeting Healthcare Safety Investigation Branch (HSIB) criteria or Special Healthcare Authority (SpHA) criteria when in place	Refer to HSIB or SpHA for independent PSII See also Appendix B	HSIB (or SpHA)
Child deaths	Refer for Child Death Overview Panel review Locally-led PSII (or other response) may be required alongside the panel review – organisations should liaise with the panel	Child Death Overview Panel
Deaths of persons with learning disabilities	Refer for Learning Disability Mortality Review (LeDeR) Locally-led PSII (or other response) may be required alongside the LeDeR – organisations should liaise with this	LeDeR programme
Safeguarding incidents in which: • babies, children, or young people are on a child protection plan; looked after plan or a victim of wilful neglect or domestic abuse/violence	Refer to local authority safeguarding lead Healthcare organisations must contribute towards domestic independent inquiries, joint targeted area inspections, child safeguarding practice reviews, domestic homicide reviews and any other safeguarding reviews (and inquiries) as required to do so by the local safeguarding partnership (for children) and local safeguarding adults boards	Refer to your local designated professionals for child and adult safeguarding

Event	Action required	Lead body for the response
• adults (over 18 years old) are in receipt of care and support needs from their local authority • the incident relates to FGM, Prevent (radicalisation to terrorism), modern slavery and human trafficking or domestic abuse/violence		
Incidents in NHS screening programmes	Refer to local screening quality assurance service for consideration of locally-led learning response See: Guidance for managing incidents in NHS screening programmes	The organisation in which the event occurred
Deaths in custody (eg police custody, in prison, etc) where health provision is delivered by the NHS	Any death in prison or police custody will be referred (by the relevant organisation) to the Prison and Probation Ombudsman (PPO) or the Independent Office for Police Conduct (IOPC) to carry out the relevant investigations Healthcare organisations must fully support these investigations where required to do so	PPO or IOPC
Domestic homicide	A domestic homicide is identified by the police usually in partnership with the community safety partnership (CSP) with whom the overall responsibility lies for establishing a review of the case	CSP

5.3 Responding to Patient Safety Incidents

Patient Safety Incidents include any Incident that is not a national/regulatory incident.

<table>
<tr><td colspan="3">Patient Safety Incident</td></tr>
<tr><td colspan="3">↓</td></tr>
<tr><td colspan="3">Response Assessment</td></tr>
<tr><td colspan="3">Assess the risk of the incident (Likelihood x Consequence)</td></tr>
<tr><td colspan="2">Low-Medium Risk (Likelihood x Consequence)
↓</td><td>High-Very High Risk (Likelihood x Consequence)
Consider if the contributory factors and learning are clear and known. Consider any existing improvement work.
↓</td></tr>
<tr><td colspan="3">Response Action</td></tr>
<tr><td>Incident unlikely to require a PSIRF Learning Response
↓
Provide local staff and team feedback and close the event.
Inform patient/NoK in line with Being Open and DoC Policies.
If concerns remain, local teams should consider a case note review or incident review meeting.</td><td>Contributory factors and learning are well understood +/- there is existing improvement work
↓
Incident unlikely to require a learning response.
Provide local staff and team feedback.
Inform patient/NoK in line with Being Open and DoC Policies.</td><td>Contributory factors and learning are <u>not</u> well understood +/- there is not existing improvement work
↓
Incident will require a PSIRF Learning Response</td></tr>
<tr><td colspan="3">For all these incidents there will remain ongoing monitoring to ensure trends and themes from reported incidents are tracked, and improvements required are identified and addressed where resources available</td></tr>
</table>

5.4 Engaging and Involving Patient's, Families and Staff

The Patient Safety Incident Response Framework promotes systematic, compassionate, and proportionate responses to patient safety incidents, anchored in the principles of openness, fair accountability, learning and continuous improvement – and with the aim of learning how to reduce risk and associated harm.

The term engagement describes what GSTT will do to communicate with and involve people affected by a patient safety incident in a learning response. This will include discussion and actively engaging with patients, families, and healthcare staff to seek their input to the response and develop a shared understanding of what happened. Compassionate engagement describes an approach that prioritises and respects the needs of people who have been affected by a patient safety incident. Involvement is part of wider engagement activity but specifically describes the process that enables patients, families, and healthcare staff to contribute to a learning response.[1]

Patients and families provide a unique and meaningful insight into patient safety Incidents and their involvement and contribution to a learning response can help to develop a relationship of openness and trust, leading to respect for how the organisation responds to safety Incidents. All GSTT staff should demonstrate compassionate interactions with patients and families following a safety Incident.

It is important to note that in some cases a learning response may not be required for an individual patient safety Incident if risks are already being appropriately managed and improvement work is ongoing to address the known contributory factors. For these cases the response will ensure those affected are engaged as outlined in the Engaging and Involving Patients, Families and Staff following a Patient Safety Incident Guidance.

5.5 Duty of Candour & Notifiable Safety Incidents

If a patient safety Incident is confirmed as being a notifiable safety Incident then Statutory Duty of Candour (DoC) will apply. This requires us to discharge Verbal and Written DoC as well as share the outcome of the patient safety Incident. Patients and families will be involved as part of the learning response. For cases where DoC applies and no investigation required as part of the response framework we will

complete the DoC requirement through a written response and include the existing improvement plan and provide some information, assurance and explanation on what approach was or wasn't taken and why. Full details will be within the Trust Incident Management policy.

5.6 Just culture

Involving staff in the investigation of safety Incidents is a key priority for GSTT to ensure a that culture of fairness, openness and learning is promoted and supported, empowering all staff to speak up and be part of learning and recommendations. Through the new approaches in how we will respond to safety Incidents, wider systemic issues will be considered when learning for improvement, ensuring all staff working with, and in our systems can be open and honest in the knowledge investigations are not about individuals, thus removing the fear of blame or retribution.

5.7 Cross-System Learning Responses

Learning responses will generally be managed by local Trusts to facilitate the involvement of people affected and those responsible for delivery of the services. However, if GSTT, another Trust or the South East London Integrated Care Board (SEL ICB) within the Integrated Care System (ICS) identify that a cross learning response is required a shared agreement on the lead and delivery of this response and subsequent improvement will be confirmed with the SEL ICB.

Sub-contractors:

Sub-contractors are responsible for applying a suitable response, review or investigation method and must share these, the findings and actions with GSTT. This should be set out clearly in any SLA with the sub-contractor.

6 Continuous Improvement and Assurance of Effectiveness

6.1 Management and Identification of Trust Improvement Priorities

The process for managing new improvement work identified through Incidents, risk assessment, learning from deaths, inquests, claims clinical audit and outcomes and patient feedback (such as complaints or patient surveys) must be continuous.

The priority Incidents and subsequent improvement plans detailed in this document have been developed from triangulated data over the last three years. These will be the focus over the next 24 months however other safety issues will continue to be identified from patient safety Incidents. New safety issues will be discussed and confirmed through the Trust governance structures.

6.2 Assurance and Monitoring of Effectiveness to Patient Safety Incident Response Plan

Improvement plans and effectiveness will be monitored through the relevant quality committees. Incident assessment and responses will be monitored by the Directorate & Clinical Group governance processes and by the Trust Patient Safety Team horizon scanning and trend review work which will be escalated to the relevant teams or committees as required.

Assurance and improvement from the learning methods and the safety culture will be managed by the Patient Safety Team under the Quality and Assurance directorate. This will include seeking feedback from staff using the learning methods, safety culture results and staff survey results. Learning and changes will be managed through discussion with key stakeholders, training and improvements to the Incident Management policy.

Regular sampling of reported Incidents and the response action taken will be conducted and feedback to individual teams and Clinical Groups on the outcome of these assurance checks.

Regular update reports will be created for Committee and Board review and assurance. Contents may vary, but will likely include data on:

- Patient safety Incident reporting trends and themes (from incident reporting system)

- Duty of candour compliance monitoring
- Findings from Incident responses including PSIIs
- Progress against the PSIRP (assurance of process monitoring)
- Progress on Improvement Plans
- Benchmarking with national reporting – Learning from Patient Safety Events (LFPSE)

7 Risks of the Patient Safety Incident Response Plan

The Patient Safety Incident Response Framework (PSIRF) and our Patient Safety Incident Response Plan (PSIRP) has transformed how we respond to incidents. There are however key risks that have been discussed and acknowledged as a Trust. The three main risks are listed below and these will be continually monitored and assessed through the quality governance structures;

- Resource capacity and engagement from staff to deliver on the improvement plans for all the priority incident areas. Without the focus on the improvement plans the benefit and ethos of the PSIRF model will be not be achieved.
- The engagement and understanding from patients and their families on the investigation response types used or the lack of investigation if directly linked to an improvement priority. Patients and families may expect full investigations as with the previous serious incident framework.
- The availability and engagement of staff to complete the investigation response type within an effective timescale.

8 Document History

Document History		
Date	**Comments**	**Approved by**
April 2023	Original version	PSC
March 2026	2nd Version	TRAC