Patient Safety Incident Response Plan (PSIRP)

Contents

1 Introduction

This 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 18 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 we can respond to an incident. This document covers responses conducted solely for the purpose of system learning and improvement and 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. Responses are conducted for the sole purpose of learning and identifying improvements that reduce risk and/or prevent or significantly reduce recurrence.

Responses are insulated from remits that seek to determine avoidability/preventability /predictability; legal liability; blame; professional conduct/competence/fitness to practise; criminality; or cause of death. Other types of response exist to deal with specific issues or concerns. Examples of such responses include complaints management, claims handling, human resources investigations into employment concerns, professional standards investigations, coroner's inquests or criminal investigations. The principle aims of each of these responses differ from the aims of a patient safety response and are outside the scope of this Plan.

Some 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.

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.

Trust Priority Incident: are patient safety Incidents that are aligned to our improvement priorities and which have a robust improvement plan monitored and tracked by a trust wide quality committee, Clinical Group or Directorate.

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.

Multi-disciplinary team (MDT) Review: The multidisciplinary team (MDT) review 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: 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.

Structured Judgement Review: is a case note review methodology that blends traditional, clinical-judgement based review methods with a standard format. This approach requires reviewers to make safety and quality judgements over phases of care, to make explicit written comments about care for each phase, and to score care for each phase. The result is a relatively short but rich set of information about each case in a form that can also be aggregated to produce knowledge about clinical services and systems of care.

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.

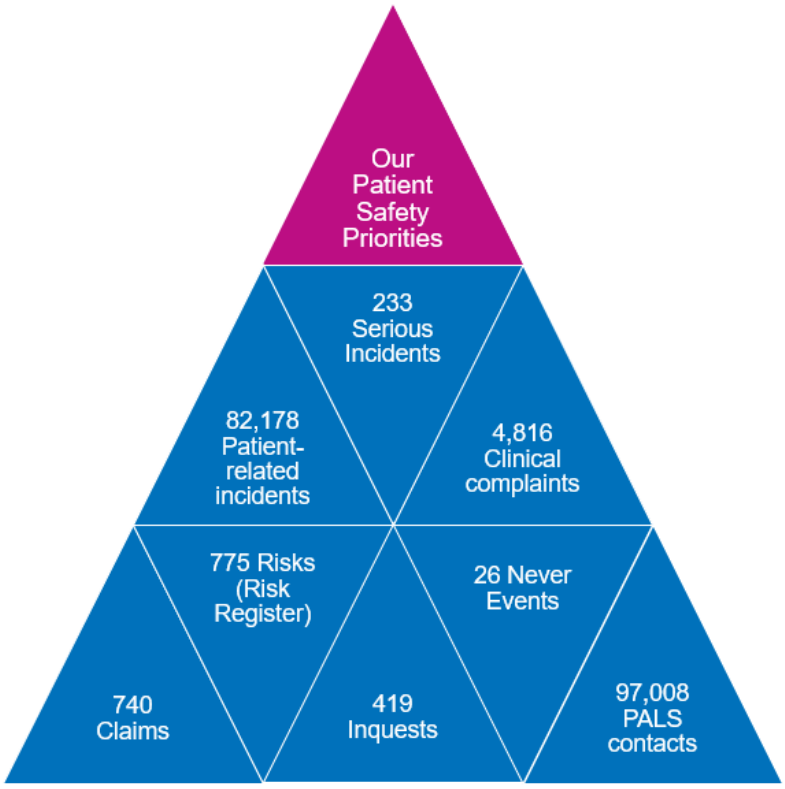
4 Defining our patient safety incident profile

4.1 Data sources:

Patient safety issues for Guy's and St Thomas' NHS Foundation Trust have been identified and profiled using the following data sources:

- Patient Safety incidents reported between 01/04/2018-31/12/2021
- Thematic analysis of quantitative and qualitative data (Listing reports from GSTT Incident Reporting System)
- Key themes from Complaints/PALS/Claims/Inquests
- Key themes identified from specialist safety & quality committees (e.g. AIP, Falls, MSC)
- Themes from Learning from Deaths
- Review of Corporate Risk Register

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 improvement priorities.



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.
Core Project 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.

During the stakeholder and PSIRP drafting process we have faced a number of organisational challenges including preparation for implementing a new transformational health record system called EPIC, continuing to develop as a merged organisation and industrial action that have affected our ability to engage more closely with our frontline staff through specific staff forums. We have however shared, involved and discussed with the specific commitees and groups that have significant clinical representation. We have also conducted a safety culture survey to provide a baseline of the perceived culture that will enhance the information already obtained through the national staff survey. In addition the confirmed improvement priorities have been developed from the incidents our staff report, further reflecting we are responding to their raised concerns.

Prior to updating this response plan, after 18 months we will conduct staff forums to seek views and assurance on the patient safety response framework and the effectiveness of this plan. This will ensure our future plan hasfurther enhanced engagement on the improvement priority areas.

Our new health record system aligned to our incident reporting system will transform the ability to review incidents against protected characteristics and identify if there are any health inequalities through analysis of incidents, complaints and other patient feedback. Where appropriate we will explore further areas highlighted in our recent 2022 staff survey within our Patient Safety Incident Investigations (PSII) such as staff burnout, equality, diversity and inclusion and health inequalities. Any information and learning from these will be included in subsequent response plans.

5 Defining our patient safety improvement profile

The Trust reviewed incident data from the last 3.5 years 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 (see section 4 above).

This 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 Priority Incidents that we will focus on for the next 12-18 months.

Trust Priority Incidents	Rationale	Outline plan	Improvement Committee/Group
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)	16% of the overall trust-wide patient-related incidents and the most common type of patient safety Incident. 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 (in this quarter) related to opiate usage in patients with acute or chronic renal impairment resulting in opiate toxicity.	Close monitoring and review through Medchart including protocols and training and integration with Epic health record. Insulin medicines management improvement workstream initiated and supported by Diabetes Committee Outpatient dispensing improvement plan, inpatient dispensing robots and management of stock levels. Working group for improvement on VTE prophylaxis and anticoagulation omissions	Medicines Safety Committee (MSC)

Falls – inpatient	6,193 patient-related incidents were reported, representing 8% of the overall trust-wide patient-related incidents. Although patient falls and resulting harm is 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.	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.	Trust Falls Group
Pressure Ulcers (Reduction in pressure ulcers acquired whilst in trust care)	6,428 patient-related incidents were reported in this modified category, representing 7.8% of the overall trust-wide patient-related incidents. Pressure Ulcers independently represent a high volume of trust-wide patient-related incidents resulting in low harm.	Clear trust wide pressure ulcer 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.	Tissue Viability Team
Clinical Complications (surgical errors as a result of systemic failure to conduct safety checklist)	A combined total of 536 patient-related incidents were reported in this modified category. 16% of incidents resulted in a moderate and above degree of harm (86). These represent the highest cohort of duty of candour applicable harms. We have reported some never events related to this category involving the Surgical Safety Checklist process and oxygen and air ports.	Surgical Safety Group to continue to work on strengthening compliance and delivery following the surgical safety checklist with robust checks. The Quality and Assurance Directorate will work with Clinical Groups to provide assurance the actions from safety alerts are embedded.	Surgical Safety Group (SSG) Patient Safety Committee (PSC)

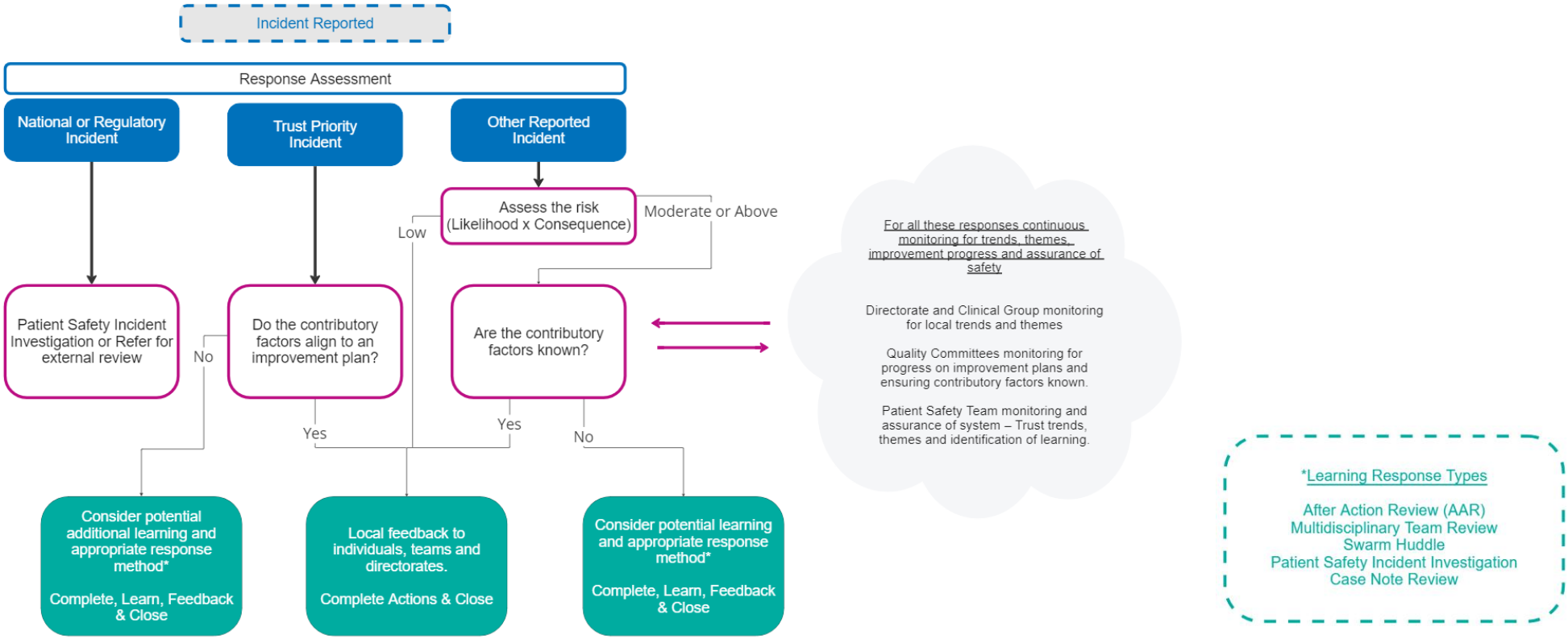
Patient deterioration including Sepsis (systemic failure to identify and act on sepsis or systemic failure to identify the deteriorating patient and act appropriately)	1,065 patient-related incidents were reported in this modified category which is formed from merging two GSTT Datix categories: Delays in Clinical Care; Treatment & Diagnosis, representing 5.6% and 4.7%, respectively, of the overall trust-wide patient-related incidents. 5.7% (61) of incidents resulted in high harm (moderate harm, severe harm & death). The trust data analysis highlighted an issue with communication (7% of incidents reported) that was reported as a category. This is not a harm category in itself but communication is a cause of harm/near miss and therefore further work on effective communication for handover and escalation is required.	Improvement plan and tracking for consistent observations taken and recorded as per policy that includes increased frequency and escalation when flagged. Compliance with the sepsis screening for identifying sepsis early and subsequent implementation of the sepsis bundle for treatment. Progress to the improvement plan will be tracked at each Directorate and Clinical Group. Handover and escalation communication tools and consistent approach will be developed and monitored. This includes handover from surgical patients to Intensive Care, transfer between wards/departments and intra hospital transfer.	Surgical Safety Group Acutely ill Patients Group (AIP) Patient Safety Committee (PSC)
Diagnostic results (follow up and action for result by clinicians)	1,995 patient-related incidents were reported in this modified category. 96% of incidents resulted in low or no harm (including death – not incident related) (1930). Most harms come from staff not reviewing results as opposed to delays in undertaking/ordering them or receiving the results (no/low harm mostly)	Ensuring the new Apollo health record system is designed and established to ensure results are requested, acknowledged and actioned Continuous training and development for staff using the new health record system	Patient Safety Committee (PSC)
Administration errors (Patient pathway administration errors – systemic failure to refer	3,938 patient-related incidents were reported in this category, representing 4.8% of the overall trust-wide patient-related incidents. 93% of patient-related incidents were reported as no harm (no	Administration Safety Oversight Group established to address the themes, trends and contributory factors that lead to incidents. Improvement plan including training needs for	Patient Safety Committee (PSC)

and or act on referral from internal or external)	harm, death – not incident related). The key findings focused on patient tracking and pathway variations resulting in mistakes and lost referrals in the system and follow-up procedures not always being completed/booked which were required for clinical outcomes. Further findings related to referrals through mailboxes being lost or mailboxes not being reviewed or forgotten.	administrative staff identified. Key work streams in place will be monitored and developed to reduce harm and ensure risk of further harm reduced to minimum possible.	
Paediatric (Extravasation Injury)	Paediatrics – Surgery, Theatres & Anaesthesia represented 18.41% (118) of extravasation injury and is the second highest reported directorate; however, it has a decreasing trend over time.	Improvement Plan and monitoring of progress through the Paediatric teams.	Evelina Clinical Group

6 Responding to Incidents

6.1 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. Duty of Candour must be implemented for any Incident meeting the requirement.



6.2 Responding to National or Regulatory Incidents

Some patient safety Incidents 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.

The table below sets out the nationally mandated responses for national Incidents that are planned for the next 12-18months:

Incident	Response Assessment	Response Action
Incidents meeting the Never Events criteria 2018	Assess against any improvement plans. (such as surgical errors from checklist compliance)	Patient Safety Incident Investigation (PSII) Align with improvement plans or if trend/theme submit for trust improvement
Deaths thought more likely than not due to problems in care		
Deaths of patients detained under the Mental Health Act (198 or where the Mental Capacity Act (2005) applies.		
Maternity & neonatal incidents meeting Healthcare Safety Investigation Branch (HSIB) or Special Healthcare Authority (SpHA) criteria		Refer to HSIB or SpHA for independent Patient Safety Incident Investigation (PSII)
Incidents in NHS screening programmes		Refer to local screening quality assurance service for consideration of locally-led learning response
Child deaths		Refer for Child Death Overview Panel review. Locally-led PSII (or other response) may be required alongside the panel review
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
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
Safeguarding incidents meeting criteria		Refer to local authority safeguarding lead.
Deaths in custody		Refer to the Prison and Probation Ombudsman (PPO) or the Independent Office for Police Conduct (IOPC).
Domestic homicide		A domestic homicide is identified by the police

6.3 Responding to Trust Priority (improvement) Incidents

The following incidents (Incidents) are aligned to our improvement priorities and will therefore be referred as Trust Priority Incidents. For each of these there will be a robust improvement plan monitored and tracked by a trust wide quality committee or a Directorate within a Clinical Group. These committees and groups will ensure the contributory factors are known and addressed within the improvement plan. Tracking of the subsequent incident trends and themes against the improvement plan to ensure the plan is appropriate and working is critical. Any Incident reported that could provide additional learning or informing of the plan must be considered for an additional learning response. Patient Safety Incident Investigations should be considered for priority improvement Incidents where the improvement plan requires further development to address the known patient safety issue.

The following table details the response assessment and response action for the reported Incident:

<table>
<tr><th>Trust Priority Incident (aligned to improvement profile)</th><th>Response Assessment</th><th colspan="2">Response Action</th></tr>
<tr><td>Medication Incidents relating to
Omitted and delayed medicines
Administration of medicines – wrong dose
Dispensing delays (inpatient, outpatient and pharmacy aseptic production unit)</td><td rowspan="8">Assess the contributory factors involved in the Incident to identify whether they are well understood and aligned to existing improvement plan.

Consider the potential for learning.</td><td>Contributory factors are well understood and aligned to improvement plan

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Provide local staff and team feedback and close the Incident.

Inform patient/NoK in line with Engaging and Involving Patients, Families and Staff standards and Duty of Candour Policies.</td><td>Contributory factors not aligned to improvement plan and potential additional learning

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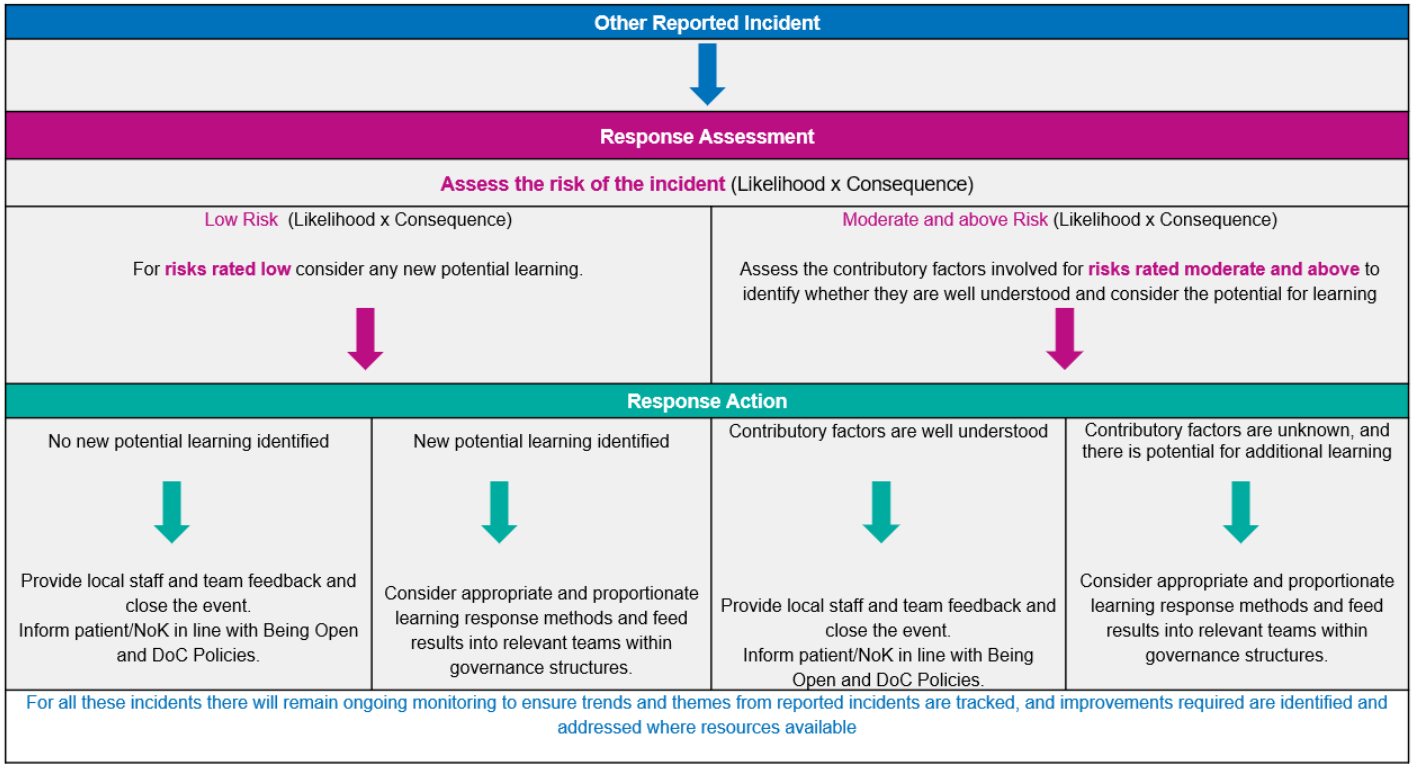
Consider appropriate and proportionate learning response method and feed results into relevant improvement group and teams within governance structures</td></tr>
<tr><td>Falls – Inpatient fall-reported Incidents</td></tr>
<tr><td>Pressure Ulcers acquired whilst under trust care</td></tr>
<tr><td>Surgical errors as a result of systemic failure to conduct safety checklist</td></tr>
<tr><td>Incidents reported about systemic failure to identify and act on sepsis or systemic failure to identify the deteriorating patient and act appropriately</td></tr>
<tr><td>Reported Incidents about follow up and action on the result by clinicians</td></tr>
<tr><td>Patient administration Incidents from systemic failure to refer and or act on referral from internal or external request (including tracking of pathway)</td><td colspan="2" rowspan="2">For all these Incidents there will remain on-going monitoring by the improvement groups and patient safety team to ensure trends and themes from reported Incidents are tracked and improvement plan having an impact.</td></tr>
<tr><td>Paediatric extravasation injury</td></tr>
</table>

6.4 Responding to Other Reported Incidents

The following incidents (Incidents) include any Incident that is not a national/regulatory response requirement or one of our identified Trust Priority Incidents. Many of these Incidents will still be patient safety areas we are aware of with known contributory factors. These should just remain as Incidents to monitor at this stage because there is a limited resource available to act and improve all patient safety areas. Some Incidents may occur that have a high area of future risk to patients, staff and the organisation. These may require a proportionate response to understand the contributory factors prior to consideration on department or trust action. Safety concerns will be escalated through the appropriate governance structures and subject matter experts outlined in the Incident Management policy. The following table outlines the expected learning response for these Incidents.



6.5 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 (such as Trust priority Incidents). 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.

6.6 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

[1] https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-2.-Engaging-and-involving...-v1-FINAL.pdf

and provide some information,assurance and explaination on what approach was or wasn't taken and why. Full details will be within the Trust Incident Management policy.

6.7 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.

6.8 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.

7 Continuous Improvement and Assurance of Effectiveness

7.1 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 18 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. Any significant improvement requirement will be recorded onto the Quality Improvement Tracker for assessment and decision making for managing based on resource. The process below outlines the governance for continuous improvement and assessment of priorities:

Step 1

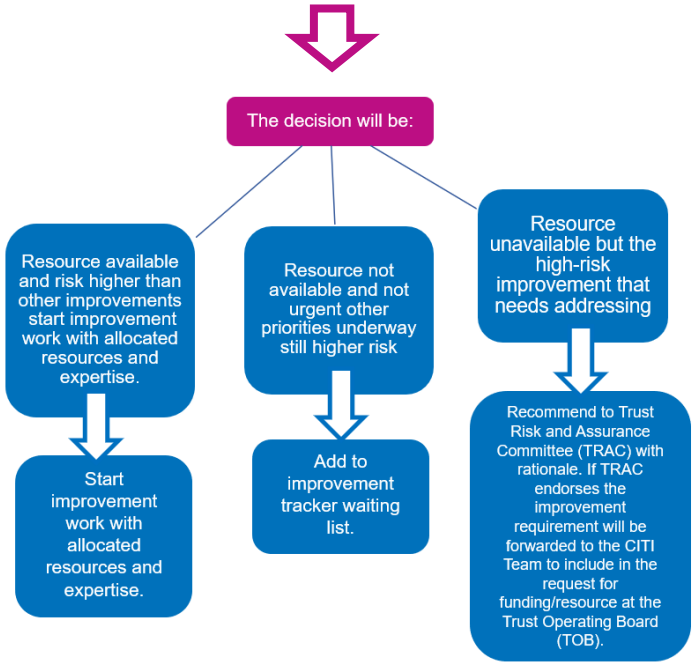
- New improvement identified/required through incident investigation, risk assessment etc

Step 2

- Recorded on improvement tracker (this includes basic risk assessment and resource required for the improvement)

Step 3

- Step 3 - The Improvement Tracker is reviewed and monitored by Trust Quality Improvement and Audit Committee (TQIaC) to assess resources available for improvement and **determine the priority** of improvements etc.



7.2 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.

Outputs from the findings and actions for the Patient Safety Investigations (PSII) conducted by the Patient Safety Specialists (investigators) will be discussed and agreed with the investigation owner(s) and if improvement work required included on the Trust Improvement Tracker.

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)

8 Risks of Implementing the Patient Safety Incident Response Plan

The Patient Safety Incident Response Framework (PSIRF) and our Patient Safety Incident Response Plan (PSIRP) will transform how we respond to incidents in the future. There are however key risks to achieving this 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 goverance 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.

9 Document History

Document History		
Date	**Comments**	**Approved by**
April 2023	Original version	PSC

10 Document Details

Document Detail	
Version	1
Effective from	December 2023
Date last reviewed	November 2023
Date of next review	November 2024