|  |  |
| --- | --- |
|  | The Dudley Group NHS Foundation Trust RGB BLUE |

Patient Safety Incident Response Plan

Effective date: 15th November 2024

Estimated refresh date: 15th November 2025

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **NAME** | **TITLE** | **SIGNATURE** | **DATE** |
| **Author** | Amanda Last | Deputy Director of Governance |  | 26/08/2024 |
| **Reviewer** | Andy Proctor | Director of Governance | A black and white drawing of a black and white object  Description automatically generated with medium confidence | 26/08/3024 |
| **Authoriser** | Trust Board | N/A | Trust Board | 15/11/2024 |

Contents

[Introduction 3](#_Toc139870661)

[Our Services 3](#_Toc139870662)

Defining our patient safety incident profile 6

[Our patient safety incident response plan: national requirements 10](#_Toc139870664)

[Our patient safety incident response plan: local focus 11](#_Toc139870665)

# Introduction

The Dudley Group NHS Foundation Trust is committed to implementing change to improve patient safety whilst promoting a culture of openness and fairness. Our Patient Safety Incident Response Plan (PSIRP) sets out how we intend to respond proportionally to patient safety incidents. Our plan is not permanent. We will work hard to remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected. Our plan identifies how we will respond to national and local priorities; our responses are conducted solely for the purpose of systems-based learning and improvement. There is no remit within this plan to apportion blame, determine liability, preventability or cause of death. It is outside the scope of PSIRF to review matters to satisfy processes relating to complaints, HR matters, legal claims and inquests.

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 do not underestimate the impact this may have.

Subsequently, the wellbeing of our staff will be a key priority of our plan; we will treat staff fairly, provide meaningful support and act inclusively during the investigation process. Furthermore, our renewed focus on improvement work will support and enable staff to deliver the best care they can.

The Trust acknowledges the value our patients and their families have in the incident response and subsequent improvement work. Their different perspective and questions enable us to think differently about our approaches to improvement. We will work hard to ensure they are integral in our responses and that we provide support in a compassionate and meaningful manner.

# Our Services

The Dudley Group NHS Foundation Trust is the main provider of hospital and adult community services to the populations of Dudley, significant parts of the Sandwell borough and smaller communities in South Staffordshire and Wyre Forest. Working from three hospital sites, Russells Hall Hospital, Guest Outpatient Centre in Dudley and Corbett Outpatient Centre in Stourbridge, we provide the full range of secondary care services and some specialist services for the wider populations of the Black Country and West Midlands region. We provide specialist adult community based care in patients’ homes and in more than 40 centres in the Dudley community. A detailed overview of Trust services has been outlined in Figure 1.

We work together with system partner providers to ensure patients access the appropriate specialist pathway of care. The Trust provides the following specialist services where patients from neighbouring Trusts are referred into our pathways of care:

* Vascular surgery
* Paediatric Hypospadias surgery (plastics)
* Endometriosis
* Endoscopy for Zenkers diverticulum (referrals accepted nationally)

We refer our patients out the Royal Wolverhampton Trust for the following specialist care pathways:

* ENT for head & neck cancer surgery and oncology
* Cardiac surgery
* Interventional cardiology
* Thoracic surgery
* Neonatal intensive care
* Gynaecological oncology

Patients requiring joint revision surgery are referred the Royal Orthopaedic Hospital

Black Country Healthcare NHS Foundation Trust provides specialist mental health services to our inpatients under a Service Level Agreement.

An independently provided Urgent Treatment Centre operates from Russells Hall Hospital, co-located with the Emergency Department with arrangements for the appropriate transfer of patients between the two services.

**Divisional Structures**

Our services are organised into three operational divisions:

* Medicine and Integrated Care
* Surgery, Womens and Children
* Community with Core Clinical Services

Each division works within our Governance Framework, triangulating quality governance data in their governance meetings, where improvement work can be tracked and risks escalated

**Figure 1: Trust Service Map**



Defining our patient safety incident profile

In accordance with the Patient Safety Incident Reporting Framework (PSIRF), we have utilised a multifactorial approach to formulate our patient safety incident /issue profile, namely:

* A series of thematic reviews across various workstreams
* An analysis of recent incident investigation activity
* A collation of existing quality improvement activity
* Engagement with our stakeholders

**Sources of Insight:**

Table 1 summarises the thematic reviews undertaken as part of our preparation work.

**Table 1: Thematic Reviews**

|  |  |  |  |
| --- | --- | --- | --- |
| **Source** | **Area** | **Sample** | **Review Timeframe** |
| **Incident Investigations**(Internal and Serious Incidents) | High level overarching review | 324 investigations | April 20 – Oct 22 |
| Falls | 117 investigations | Nov 19 – Oct 22 |
| Pressure Ulcers | 50 investigations | Nov 19 – Oct 22 |
| Maternity | 30 investigations | Nov 19 – Oct 22 |
| Delays in Diagnosis/Treatment | 16 investigations | Dec 21- Dec 22 |
| Clinical care | 46 investigations | Nov 19- Oct 22 |
|  |
| **Complaints** | Overarching review | 1814 complaints | Nov 20- Oct 22 |
| In-depth review | 106 complaints | Nov 20-Oct 22 |
| Focused sample review | 29 complaints | January 2023 |
|  |
| **Mortality Reviews** | Structured Judgement Review | 192 reviews | Jan 22-Dec 22 |
| Perinatal Mortality Reviews | 27 stillbirths11 neonatal deaths | Jan 21- Dec 22 |
| NHSR-led HSIB investigations  | 16 cases | Not specified |
|  |
| **Freedom To Speak Up Concerns** | All concerns raised | 175 concerns | April 21 – Dec 22 |
|  |
| **Legal Services** | Claims | 145 claims | Nov 19 – Oct 22 |
| Inquests | 47 inquests | Nov 19 – Oct 22 |

In order to further understand the Trust’s priority incidents, a data review of incident investigation activity has been undertaken. Table 2 illustrates the overarching incident activity data across a three year period.

**Table 2: Incident Activity**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Response Type** | **Category** | **2020/21** | **2021/22** | **2022/23** | **2023/24** | **Q1 24/25** |
| **National** priorities requiring patient safety investigation | Never Events | 4 | 0 | 2 | 1 | 0 |
| Mortality Reviews – Level 1 reviews | 1284 | 604 | 1320 | 1312 | 170 |
| Structured Judgement Reviews (SJR) | 324 | 123 | 112 | 193 | 39 |
| SJR reporting deaths more likely due to problems in care than not (great than 50%) |  |  |  | 1 | 0 |
| HSIB | 5 | 6 | 7 | 4 | 0 |
| Deaths of persons with Learning Disabilities reviews (LeDeR) | 19  | 11  | 13  | 17 | 3 |
| Safeguarding investigations | 11 | 16 | 6 | 30 | 7 |
| Screening | 8 | 9 | 8 |  |  |
| SHOT |  |  |  | TBC | 7 |
| Patient Safety Incidents conducted **locally** | Serious Incident | 45 | 57 | 56 | 34 | n/a |
| Internal RCA (Yellow) | 76 | 85 | 131 | 75 | n/a |
| Locally Managed incident (Green) | 6023 | 8920 | 14353 | 11339 | 2539 |
| Response under PSIRP (all planned and unplanned exclude SIT) | n/a | n/a | n/a | 39(12 AAR18 Swarm9 PSII) | 27(10 AAR12 Swarm5 PSII) |
| Patient Safety Reviews | 72 hour reports/Patient Safety Incident Review | n/a | 23\* | 148 | 150 | 28 |
| Patient Safety Reviews | PU SITs | 99 | 108 | 185 | 440 | 83 |
| *\*72 hr reports were not consistently utilised prior to May 2022* |  |  |

**Stakeholder Engagement:**

The findings of our analyses have been shared with our key stakeholders. Recognising that our patient safety issues may not always be reflected in standard intelligence sources, we actively worked with our stakeholders to ensure our issue/incident profile is reflective of ‘work as done’.

Our issue/incident list and response plan has been shared and built upon in the following ways:

1. Our monthly PSIRF implementation group meetings; the membership of which is multi-disciplinary and includes representees from all three operational divisions, our corporate directorates including clinical effectiveness, patient experience, patient safety, our Patient Safety Partners and Patient Safety Specialist.
2. Specific engagement sessions with Divisional Triumvirates
3. Sessions at Divisional and Directorate Governance meetings
4. Sessions with key groups of staff e.g., Infection Prevention Control Team, Senior Pharmacy Team, Falls Prevention and Tissue Viability Team.
5. Trust Management Group
6. Quality Committee

In addition to the engagement sessions outlined above, there has been a programme of Trustwide communications both electronic and face to face.

Our Patient Safety Partners have played a key role in defining our response priorities, the methodologies and how we ensure our patients and their relevant persons are supported, informed and are active partners in our responses.

## Defining our patient safety improvement profile

The findings of our thematic reviews have been collated with the analysis of our recent incident investigation activity and feedback from our engagement sessions. The themes identified have been aligned to ongoing and planned quality improvement activities; with the support of our Dudley Improvement Practice team these activities will be reviewed and built upon as we progress through the next 12 months. Our key patient safety improvement profile has been developed from this work and is detailed in table 3.

**Table 3: Patient Safety Improvement Profile**

|  |  |  |
| --- | --- | --- |
| **Area for Improvement** | **Improvement Activity** | **Oversight** |
| Falls Prevention & Management | Single improvement plan focusing on risk assessment completion, lying and standing blood pressure, falls prevention training, neurological observation, post fall assessment | Falls Prevention GroupQuality & Safety Group |
| Pressure Ulcer Prevention and Management | Single improvement plan focussing on assessments, equipment, escalation pathways, policy reviews and implementation and safeguarding | Strategic Pressure Ulcer Group Quality & Safety Group |
| Maternity Services | Service improvement plans linked to Ockenden/Saving Babies lives/CNSTCovering issues such as MDT working, communication with mother, CTG and USS interpretation/escalation, sepsis screening | Quality & Safety GroupQuality Committee. Trust Board |
| Diabetes Management | Diabetes and Insulin Safety Group oversight and improvement programme | Risk and Assurance Group  |
| Referral and Review Process | Service specific improvements:Urology – focused work on strengthening process with a 3 stage alert system to failsafe cancer patients.Gynaecology – over-arching improvement work for service including ensuring there’s a robust review/follow up of patients | Risk and Assurance GroupQuality Committee |
| Discharge  | Discharge Improvement Group in place | Quality and Safety Group |
| Care Handover/ Internal Transfer Process: | Transfer process policy review and improvement including an internal transfer document with the aim for this to be integrated on digital platform. Focused improvement work between ED and Paediatrics through daily huddles | Risk and Assurance Group |
| Care Ownership:Management of patients when experiencing multiple problems  | ‘Which Speciality Document’ in development Focused improvement underway in Surgery Division: Twice daily shift lead review of patient and their treatment plan launched in T&O – being trialled for wider role out. | Risk and Assurance Group |
| Adherence to escalation pathways   | Chest Pain Pathway Working GroupDeteriorating Patient Group and DashboardSurgery, Women’s and Children: Focused work on ward B3 planned in response to local intelligence with overarching oversight at GAME. | Deteriorating Patient Group Risk & Assurance Group |
| Timely medication | Medicines Management Group – improvement priority for time sensitive medication | Quality & Safety Committee  |
| ImagingDelay in receiving scans and checking results | Overarching Imaging departmental Improvement Plan Focus for future financial consideration into electronic system upgrade | Quality & Safety Group |
| PathologyDelay in checking results and receiving results | Focus for future financial consideration into electronic system upgrade Black Country Pathology Service improvement plan oversight  | Quality & Safety Group |
| Documentation/ Communication | Nursing Documents which account for 80% of clinical documentation are moving to the digital platform. This should be live end of this year. Working Group in place. Transfer process with respect to DNAR documentation/communication  | Risk & Assurance Group  |
| Communicationclinicianswith patients/family | Work ongoing alongside the launch of Nursing Midwifery and AHP strategy.New national complaints standards aim to help improve communication with patients/ familiesPatient Experience Strategy #Call me project planned2 stage consent process in surgery being rolled out to improve communication Links to work underway regarding Trust’s culture/behavioural framework and leadership framework | Risk & Assurance GroupQuality & Safety Committee |

## Our patient safety incident response plan: national requirements

Table 4 details our planned response to the national requirements of PSIRF. Based on previous reporting periods, we anticipate 8 Trust-led Patient Safety Incident Investigations (PSII) and 7 externally led investigations during the first 12 month period and we have planned our response resource accordingly. PSII are full systems-based investigations; a response team approach will be employed to their completion. The team will consist as a minimum of a patient safety lead (to lead and co-ordinate the response and report write), an engagement lead (to support the lead to ensure relevant staff and patient involvement in the response), a speciality lead (to provide the necessary care expertise) and a director lead (oversee, approve and champion improvement activity). A guidance document and a standard report template is available.

**Table 4 Nationally Defined Incident Responses**

|  |  |  |  |
| --- | --- | --- | --- |
| **Patient Safety Incident Type** | **Required Response**  | **Approval Forum** | **Anticipated Improvement Route** |
| National Never Events  | PSII | Director sign offRisk & Assurance Group | Create local organisational actions and feed into speciality/practice improvement plans (dependent on incident) |
| Deaths thought more likely than not due to problems in care (SJR indicates incident meets the learning from deaths criteria) | PSII | Director sign offRisk & Assurance Group | Create local organisational actions and feed these into the quality improvement strategy |
| Deaths of persons with Learning Disabilities | LeDeR | Externally led review | Recommendations to be reviewed ad led through Mortality Surveillance Group |
| Deaths of patients under a Mental Health Act | PSII | Director sign offRisk & Assurance Group | Create local organisational actions Oversight of Mortality Surveillance Group |
| Incident meeting Each Baby Counts criteria | Referred to Healthcare Safety Investigation Branch for independent investigation | Director sign offRisk & Assurance Group | Respond to recommendations as required and feed actions into the quality improvement plan |
| Serious safeguarding reviews | External review or internal independent PSII (case dependent) | Director Sign offTrust Safeguarding BoardRisk & Assurance Group | Create organisational actionsOversight at Trust Safeguarding Board |
| Significant incidents in screening programmes | PSII | Director Sign offRisk & Assurance Group | Create organisational actions with oversight at appropriate specialist group level |
| Serious Hazards of Transfusion (SHOT) | SEIPs Review (comply with Blood and Safety Quality Regulations and Good Practice Guidance) | Director Sign offRisk & Assurance Group | Create organisational actions with oversight at appropriate specialist Governance Group |

# Our patient safety incident response plan: local focus

Our local response plan has been formulated in line with the requirement of PSIRF. We have considered:

* incident types we understand well and have established aligned quality improvement plans for
* incidents we need to understand further in order to strengthen our improvement workstreams
* resource capacity to undertake an achievable effective plan
* feedback from our key stakeholders

Table 5 summarises our planned local responses. The table also shares the associated approval and improvement routes. Based on previous reporting periods, we anticipate our local PSIRP to generate 22 PSII over the 12 month period. We have also planned our response capacity to also undertake up to 10 further PSII. This will enable the investigation of significant incidents that may arise which do not feature on our plan but need full investigation.

Based on previous incident activity our local plan is also anticipated to generate the following numbers of responses:

- 14 Thematic reviews

- 18 SWARM reviews

- 44 Falls AAR

The Patient Safety Team will support each of the planned responses; the input /role will vary dependent upon the response type (excludes SITS which are resourced locally).

Table 6 provides additional detail on rationale for our local response plan.

**Table 5: Locally defined incident responses**

|  |  |  |  |
| --- | --- | --- | --- |
| **Patient Safety Incident**  | **Planned Response**  | **Approval Forum** | **Anticipated Improvement Route** |
| Falls resulting in significant harm | Falls After Action Review | Falls Prevention Group | Falls Prevention Quality Improvement Plan Oversight: Quality and Safety Group |
| 6 monthly Thematic Reviews | Falls Prevention Group | Falls Prevention Quality Improvement Plan Oversight: Quality and Safety Group |
| Pressure Ulcers (Grade 3, 4, unstageable) | Shortened Investigation Tool (SIT) | Pressure Ulcer Review Group | Local level improvement plans |
| 6 monthly Thematic Review | Strategic Pressure Ulcer Group | Tissue Viability Quality Improvement PlanOversight: Quality and Safety Group |
| Delays in diagnosis and treatment resulting in significant harm | SWARM | Director sign offRisk & Assurance Group | Create local organisational actions and feed into a defined quality improvement group Oversight: Risk & Assurance Group |
| 6 monthly Thematic Review (to cover no/low harm) | Director sign offRisk & Assurance Group | Create local organisational actions and feed into a defined quality improvement groupOversight: Risk & Assurance Group |
| Delays to the treatment of a deteriorating patient resulting in significant harm/ potential harm | SWARM | Director sign offRisk & Assurance Group | Create local organisational actions and feed these into the Deteriorating Patient quality improvement groupOversight: Risk & Assurance Group |
| Delays in the treatment of sepsis resulting in moderate + harm/significant potential harm | PSII | Director sign offRisk & Assurance Group | Create local organisational actions and feed these into the Deteriorating Patient quality improvement groupOversight: Risk & Assurance Group |
| Infection Control Incidents: acquired infections. Issues with infection control procedures | Response in line with Midlands regional approach | Director sign offInfection Prevention and Control Group | Actions fed into the IPC quality improvement programmeOversight: Quality Committee |
| **Speciality Focus** |
| **Maternity** incidents (not subject to HSIB) resulting in significant harm/ potential harm | PSII | Director sign offRisk and Assurance Group | New learning to feed through to the appropriate Maternity quality improvement plan(s)Oversight: Quality & Safety Group and Quality Committee |
| **Imaging:**Imaging related delays in scanning/ reporting (all levels of harm) | 6 monthly Thematic Review | Director sign offRisk & Assurance Group | New learning to feed through to the Imaging service overarching improvement planOversight: Risk & Assurance Group |
| **Paediatric/Neonatal:** (including paediatric ED): all incidents resulting in significant or potential harm | PSII | Director sign offRisk & Assurance Group | New learning to feed through to the Service overarching improvement planOversight: Risk & Assurance Group |
| **Diabetes/Insulin management**: All incidents resulting in significant harm or potential harm | 6 monthly Thematic Review | Director sign offRisk & Assurance Group | New learning to feed through to the overarching improvement plan and Insulin Safety and Diabetes Care working group Oversight: Risk & Assurance Group |
| **Gynaecology**: all incidents resulting in significant or potential harm | SWARM | Director sign offRisk & Assurance Group | New learning to feed through to the Service overarching improvement planOversight: Risk & Assurance Group |
|  |  |  |  |
| **VTE:** | Thematic Review6 monthly | Director sign offRisk & Assurance Group | New learning to feed through to the Thrombosis Group improvement planOversight: Risk & Assurance Group |

 **Table 6 – Local response rationale**

|  |  |
| --- | --- |
| **Patient Safety Incident Type** | **Rationale for planned response** |
| Falls resulting in significant harm | Extensive history of incident investigation. Improvement work required well understoodFalls prevention lead in post with monthly improvement forum**AAR** will enable a ‘lighter’ more proportionate response to check for new risk factors, on the reoccurrence of key factors as well as ensure good immediate management**Quarterly thematic reviews** with provide a deep dive approach to a wider sample of falls |
| Pressure Ulcers (Grade 3, 4, unstageable) | Extensive history of incident investigation. Improvement work required well understoodTissue Viability lead in post with weekly review meetings and monthly improvement forums**SIT** is a bespoke lighter response tool, which enable the collection of key factors which may contribute to incidents as well as ensure good immediate management**Quarterly thematic reviews** with provide a deep dive approach to a wider sample of incidents |
| Delays in diagnosis and treatment resulting in significant harm/ potential harm | An emerging theme over the previous 12 month period. Some localised improvement work undertaken/ongoing however in the context of post covid recover/wait times needs close monitoring of occurrence and effectiveness of improvement work.**SWARM** tool chosen to enable prompt conversational approach to review with staff across the patient pathway to enable rapid improvement work as needed.Deep dive **thematic reviews** scheduled to provide assurance on improvement effectivity and to ensure there are no missed risk factors across wider sample base |
| Delays to the treatment of a deteriorating patient resulting in significant harm/ potential harm | Established improvement forum and evidenced improvements overtime. Improvement programme ongoing with a monthly deteriorating Patient Group with good oversight via reporting structure SWARM tool chosen to enable prompt conversational approach to review care with staff across the patient pathway to enable rapid improvement work as needed |
| Delays in the treatment of sepsis resulting in moderate + harm/significant potential harm | Significant improvements in Sepsis care however based on historical incidents significant lapses in care will be subject to full investigation - **PSII** |
| Infection Control Incidents: acquired infections. Issues with infection control procedures | **HCAI Investigation. Outbreak reviews** will continue in line with current practice |
| **Maternity** incidents (not subject to HSIB) resulting in significant harm/ potential harm | Full investigation (**PSII**) due to the national scrutiny on maternity care and the need to understand significant issues in care further in order to build upon the high standards of care (CQC rated Good) and continue on improvement journey |
| **Imaging:** Imaging related delays in scanning/ reporting (all levels of harm) | Theme in workstreams regarding delays associated with Imaging. Recognised risk that our IT systems require up-grading and further development in order to introduce robust failsafe measures. Therefore a **thematic review** approach will enable close monitoring of concerns and changes in the risk without spending unnecessary excessive time formally investigating incidents  |
| **Paediatric/Neonatal:** (including paediatric ED): all incidents resulting in significant or potential harm | Local priority area for full investigation (**PSII**) due to the need to fully understand impacting factors to build upon improvement workstream. There has been a number of serious incidents in the previous 12 month period and the service is faced with challenges regarding staffing. There has also been two CQC inspections during 2023. |
| **Diabetes/Insulin management**: All incidents resulting in significant harm or potential harm | The Trust has a newly established Diabetes and Insulin management group which have a good understanding of the priority improvements required and have oversight of the progress made. There is oversight through established reporting frameworksThe group utilise **thematic review** approaches and this will be build upon as part of the PSIRP |
| **Gynaecology**: all incidents resulting in significant or potential harm | The service has seen an upward trend in serious incident report over the previous 12 month period. In response there is a good understanding of the improvement work required and the service are working through the improvements with the appropriate oversight in place.**SWARM** reviews will enable prompt reviews of new significant incidents but time will be focussed on the priority improvement work rather than extensive full re investigation. |
| **VTE: all hospital acquired VTE**  | There has been a lot of focus on the completion of the first VTE assessment which has seen significant improvement however concerns have been raised in terms of the quality of assessments and compliance with the second VTE assessmentThere is some insight in the areas for improvement but there is a need for system wide improvement and given the numbers of incidents thematic review is deemed the most appropriate response |

\**Guidance documents and report templates for each tool are available*