Patient Safety Incident Response Plan

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	NAME	TITLE	SIGNATURE	DATE
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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.

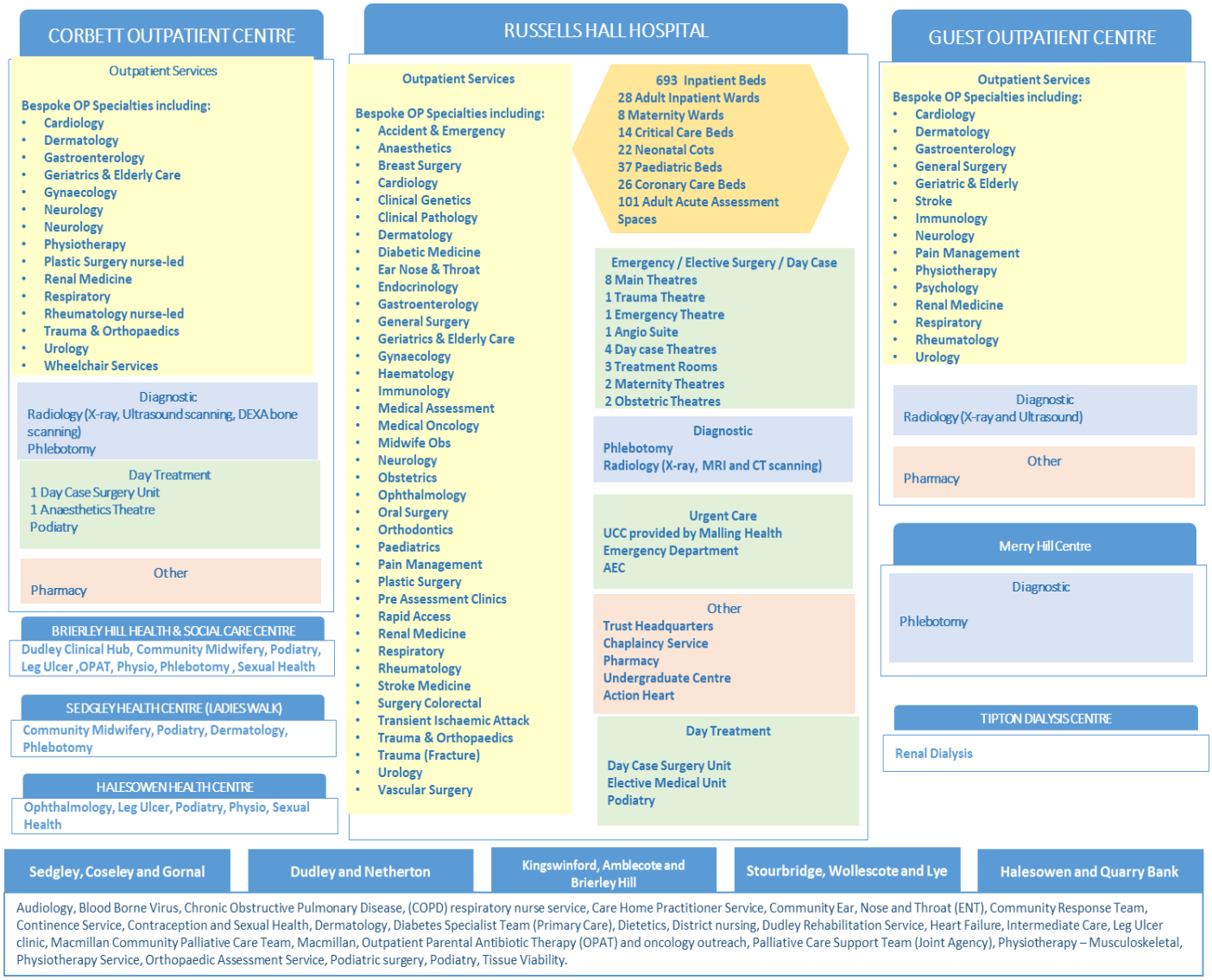
Divisional Structures

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 stillbirths 11 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	2020/2021	2021/2022	2022/2023
National priorities requiring patient safety investigation	Never Events	4	0	2
	Mortality Reviews – Level 1 reviews	1284	604	1320
	Structured Judgement Reviews (SJR)	324	123	112
	HSIB	5	6	7
	Deaths of persons with Learning Disabilities reviews (LeDeR)	19	11	13
	Safeguarding investigations	11	16	6
	Screening	8	9	8
Patient Safety Incidents conducted locally	Serious Incident	45	57	56
	Internal RCA (Yellow)	76	85	131
	Locally Managed incident (Green)	6023	8920	14353
Patient Safety Reviews	72 hour reports/Patient Safety Incident Review	N/A	23*	148
Patient Safety Reviews	PU SITs	99	108	185
**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 and Safety 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 Group Quality & 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/CNST Covering issues such as MDT working, communication with mother, CTG and USS interpretation/escalation, sepsis screening	Quality & Safety Group Quality & Safety 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 Group Quality and Safety Committee
Discharge	Quality Priority – 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 Group Deteriorating Patient Group and Dashboard Surgery, 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
Imaging Delay in receiving scans and checking results	Overarching Imaging departmental Improvement Plan Focus for future financial consideration into electronic system upgrade	Quality & Safety Group
Pathology Delay 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
Communication clinicians with patients/family	Work ongoing alongside the launch of Nursing Midwifery and AHP strategy. New national complaints standards aim to help improve communication with patients/ families Patient Experience Strategy #Call me project planned 2 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 Group Quality & 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 off Risk & 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 off Risk & 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 off Risk & 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 off Risk & 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 off Trust Safeguarding Board Risk & Assurance Group	Create organisational actions Oversight at Trust Safeguarding Board
Significant incidents in screening programmes	PSII	Director Sign off Risk & Assurance Group	Create organisational actions with oversight at appropriate specialist group level

Serious Hazards of Transfusion (SHOT)	PSII (comply with Blood and Safety quality Regulations and Good Practice Guidance)	Director Sign off Risk & 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
	Quarterly 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
	Quarterly Thematic Review	Strategic Pressure Ulcer Group	Tissue Viability Quality Improvement Plan Oversight: Quality and Safety Group
Delays in diagnosis and treatment resulting in significant harm/ potential harm	SWARM	Director sign off Risk & Assurance Group	Create local organisational actions and feed into a defined quality improvement group Oversight: Risk & Assurance Group
	6 monthly Thematic Review	Director sign off Risk & Assurance Group	Create local organisational actions and feed into a defined quality improvement group Oversight: Risk & Assurance Group
Delays to the treatment of a deteriorating patient resulting in significant harm/ potential harm	SWARM	Director sign off Risk & Assurance Group	Create local organisational actions and feed these into the Deteriorating Patient quality improvement group Oversight: Risk & Assurance Group
Delays in the treatment of sepsis resulting in moderate + harm/significant potential harm	PSII	Director sign off Risk & Assurance Group	Create local organisational actions and feed these into the Deteriorating Patient quality improvement group Oversight: Risk & Assurance Group
Infection Control Incidents: acquired infections. Issues with infection control procedures	HCAI Investigation Outbreak reviews	Director sign off Infection Prevention and Control Group	Actions fed into the IPC quality improvement programme Oversight: Quality & Safety Committee
Speciality Focus			
Maternity incidents (not subject to HSIB) resulting in significant harm/ potential harm	PSII	Director sign off Risk and Assurance Group	New learning to feed through to the appropriate Maternity quality improvement plan(s) Oversight: Quality & Safety Group and Committee
Imaging: Imaging related delays in scanning/ reporting (all levels of harm)	6 monthly Thematic Review	Director sign off Risk & Assurance Group	New learning to feed through to the Imaging service overarching improvement plan Oversight: Risk & Assurance Group
Paediatric/Neonatal: (including paediatric ED): all incidents resulting in significant or potential harm	PSII	Director sign off Risk & Assurance Group	New learning to feed through to the Service overarching improvement plan Oversight: Risk & Assurance Group

Diabetes/Insulin management: All incidents resulting in significant harm or potential harm	6 monthly Thematic Review	Director sign off Risk & 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 off Risk & Assurance Group	New learning to feed through to the Service overarching improvement plan Oversight: 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 understood Falls 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 understood Tissue 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 frameworks The 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.

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