


# Patient Safety Incident Response Plan

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|                   | <b>NAME</b>                                   | <b>TITLE</b>                  | <b>SIGNATURE</b>   | <b>DATE</b> |
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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 along with Primary Care services including two GP practices. 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 to the Royal Wolverhampton NHS 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 NHS Trust.

Black Country Healthcare NHS Foundation Trust provides specialist mental health services to our patients 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.

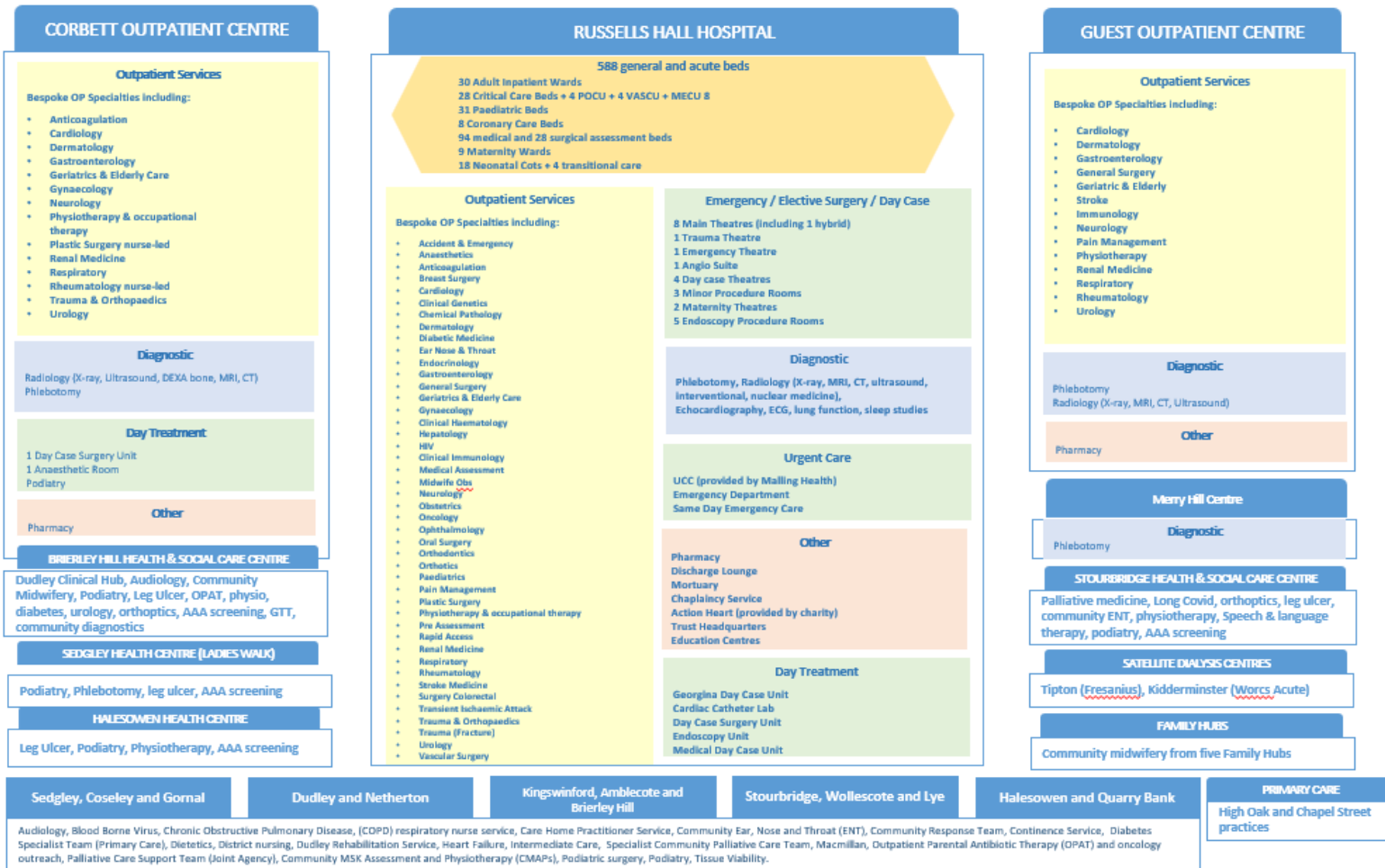
### **Divisional Structures**

Our services are organised into four operational divisions:

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

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), ahead of transition to the PSIRF, we undertook an extensive exercise to formulate our patient safety incident /issue profile. These included:

- A series of thematic reviews across various workstreams (e.g. incidents, complaints, claims, mortality reviews etc)
- An extensive analysis of incident investigation activity
- A collation of existing quality improvement activity
- Engagement with our stakeholders

Following a two year period of working under the PSIRF, we have revisited our priority incident profile to ensure that this is an accurate reflection of activity. We have assessed our incident investigation activity, thematically reviewed our learning and reflected on the effectiveness of actions taken. Table 2 illustrates the overarching incident activity data across a five year period (pre and post PSIRF transition).

**Table 2: Incident Activity**

| Response Type   | Category   | 2021/22 | 2022/23 | 2023/24   | 2024/25  | 2025/26 (Q1, Q2, Q3)   |
|---|--|---------|---------|---|--|--|
| National priorities requiring patient safety investigation      | Never Events   | 0       | 2       | 1   | 0  | 2  |
|   | Mortality Reviews – Level 1 reviews  | 604     | 1320    | 1312  | 1690   | 1314   |
|   | Structured Judgement Reviews (SJR)   | 123     | 112     | 193   | 165  | 153  |
|   | SJR reporting deaths more likely due to problems in care than not (great than 50%) |         |         | 1   | 0  | 2  |
|   | HSIB   | 6       | 7       | 4   | 0  | 2  |
|   | Deaths of persons with Learning Disabilities reviews (LeDeR)                       | 11      | 13      | 17  | 15   | 18   |
|   | Safeguarding investigations  | 16      | 6       | 30  | 25<br>0 PSII   | 24<br>0 PSII   |
|   | Screening  | 9       | 8       | 0 PSII  | 0 PSII   | 0 PSII   |
|   | SHOT   |         |         | 21 SHOT reportable incidents<br>1 Swarm<br>1 PSII | 2 thematic reviews<br>29 SHOT reportable incidents<br>4 linked to PSII | 2 thematic reviews<br>25 SHOT reportable incidents<br>0 linked to PSII |
| Patient Safety Incidents conducted locally                      | Serious Incident   | 57      | 56      | 34  | N/A  | N/A  |
|   | Internal RCA   | 85      | 131     | 75  | N/A  | N/A  |
|   | Locally Managed incident   | 8920    | 14353   | 11339   | 20239  | 18088  |
|   | Response under PSIRP (all planned and unplanned exclude SIT)                       | n/a     | n/a     | 39<br>-12 AAR<br>-18 Swarm<br>-9 PSII             | 112<br>-38 AAR<br>-38 Swarm<br>-36 PSII                                | 87<br>-20 AAR<br>-41 Swarm<br>-26 PSII                                 |
| Patient Safety Reviews  | 72 hour reports/Patient Safety Incident Review                                     | 23*     | 148     | 150   | 124  | 103  |
| Patient Safety Reviews  | PU SITs  | 108     | 185     | 440   | 463  | 344  |
| Patient Safety Reviews  | SJR  | 2       | 27      | 34  | 55   | 51   |
| Learning from Excellence  | Good Care Events   | 579     | 888     | 1147  | 1133   | 969  |
| *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 fully reflected in standard intelligence sources, we actively worked with our stakeholders to ensure our issue/incident profile is reflective of 'work as done'. Our refreshed response plan was then shared and built upon at a range of Trust meetings including the Incident Decision and Learning Group, Quality and Safety Group, Risk and Assurance Group and Quality Committee. Trust wide communications both electronic and face to face has been undertaken to support this exercise and raise the awareness of PSIRF.

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. 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 and Position  | Oversight  |
|--|--|--|
| Falls Prevention & Management  | Trust-wide single improvement plan in place. Improvement activity making good progress with scheduled Trust-level oversight. Sustained decrease of falls incidents resulting in harm. After Action Reviews (AAR) process embedded.   | Falls Prevention Group<br>Quality & Safety Group                                 |
| Pressure Ulcer Prevention and Management                                   | Trust-wide single improvement plan in place. Improvement activity ongoing with good oversight Sustained decrease of Grade 3/4/ unstageable hospital acquired and community acquired pressure ulcers.   | Strategic Pressure Ulcer Group<br>Pressure Ulcer Group<br>Quality & Safety Group |
| Maternity Services   | Service single improvement plan in place. No significant change to incident numbers, harm profile or risk. Improvement activity continually strengthened with good engagement and oversight.   | Quality & Safety Group<br>Quality Committee<br>Trust Board                       |
| Diabetes Management  | Diabetes and Insulin Safety Group in place driving a co-ordinated programme of improvement which has demonstrated good progress. Improved position in terms of KPIs. Reduction in incidents of harm. Focus on improvement activity maintained with good reporting.   | Risk and Assurance Group   |
| Discharge  | Discharge Improvement Group in place. Regulation 28 issued during 2025 linked to unsafe discharge; improvement plan completed. Patient flow is one of the Trust's most significant issues and focus for improvement; to monitor unintended consequences of work, safe discharge requires monitoring. Unsafe discharge/ readmission incidents/ quality concerns remain a notable theme in reporting.  | Risk and Assurance Group   |
| Care Handover/ Internal Transfer Process:                                  | Issues with handover and internal referrals identified as an ongoing theme for improvement via the review of PSIRF response thematic review<br><br>Handover is an improvement objective on Quality and Safety Delivery Plan  | Quality and Safety Group   |
| Care Ownership: Management of patients when experiencing multiple problems | Issue continues to be raised through incident investigations Forms part of wider communication and internal referral themes (above)  | Risk and Assurance Group<br>Quality and Safety Group                             |
| Adherence to escalation pathways   | Chest Pain Pathway Working Group – limited formal assurances, however incidents with significant harm remain low. Deteriorating Patient Group and Dashboard – established improvement and oversight forum, Sepsis KPIs remain a challenge with ongoing improvement work Acutely unwell child improvement group – making good progress with improvement work, positive peer review outcomes in March 2026. However KPIs not consistently meeting trust target | Risk and Assurance Group<br>Quality and Safety Group                             |
| Timely medication  | Medicines Management Group – improvement priority for time sensitive medication Remains an area for improvement – features in Quality and Safety Delivery plan   | Risk and Assurance Group   |
| Imaging Delay in receiving scans and checking results                      | Overarching Imaging departmental single improvement plan Delays in imaging still remain an theme in incident reports and learning from investigations.   | Quality & Safety Group<br>Risk and Assurance Group                               |

|                                 |   |                              |
|---------------------------------|---|------------------------------|
|                                 | Thematic reviews scheduled on PSIRP have not taken place at agreed frequency – gaps in assurance.   |                              |
| Documentation/<br>Communication | Documentation concerns/incomplete documentation continues to be raised in incident investigations<br>Audits requirements are fed through to Clinical Effectiveness Group for scheduling | Clinical Effectiveness Group |
| VTE                             | Single Improvement Plan in place<br>Limited assurances on the effectiveness of the improvement work.<br>Incident themes continue  | Risk and Assurance Group     |
| Spinal Incidents                | Single Improvement Plan in place<br>Limited assurances on the effectiveness of the improvement work.<br>Incident themes continue.   | Risk and Assurance Group     |

## 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 6 Trust-led Patient Safety Incident Investigations (PSII/Swarm) and 3 externally led investigations (excluding LeDeR) during a 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).

Swarm reviews are a more rapid approach to incident review. The reviews are led by a patient safety lead (to facilitate discussions, co-ordinate and report write) and a specialist lead, bringing together key staff to review work as done; swarms have a more streamlined reporting template.

Guidance documents and standard report templates are available for both.

**Table 4 Nationally Defined Incident Responses**

| Patient Safety Incident Type   | Required Response  | Approval Forum  | Anticipated Improvement Route  |
|--|--|---|--|
| National Never Events  | A proportionate response: PSII/Swarm case dependent (PSII no longer nationally mandated)   | Director sign off<br>Incident Response Approval Meeting | 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<br>Incident Response Approval Meeting | Create local action plans. Recommendations to be reviewed and considered by the Mortality Surveillance Group for incorporation into the group's wider quality improvement plan.      |
| Deaths of persons with Learning Disabilities   | LeDeR  | Externally led review                                   | Recommendations to be reviewed and considered by the Mortality Surveillance Group for incorporation into the group's wider quality improvement plan                                  |
| Deaths of patients under a Mental Health Act where concerns regarding care have been raised via the SJR process              | PSII   | Director sign off<br>Incident Response Approval Meeting | Create local action plan. Recommendations to be reviewed and considered by the Mortality Surveillance Group for incorporation into the group's wider quality improvement plan        |
| Incident meeting Each Baby Counts criteria   | Referred for external Maternity and Newborn Safety Investigations (MNSI)                   | Director sign off<br>Incident Response Approval Meeting | Respond to recommendations as required and feed actions into maternity single improvement plan.  |
| Serious safeguarding reviews   | External review or internal independent PSII (case dependent)                              | Director Sign off<br>Trust Safeguarding Board           | Create local action plan. Recommendations to be reviewed and considered by the Trust's Internal Safeguarding Group for incorporation into the group's wider quality improvement plan |
| Significant incidents in screening programmes  | PSII   | Director Sign off<br>Incident Response Approval Meeting | 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) | Local sign off<br>Oversight of Transfusion Group        | Create organisational actions with oversight at the Trust's Transfusion Group and Clinical Effectiveness 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 and focussed approach to proportionality in our response decision making, we anticipate our local PSIRP to generate approximately 10 PSII over the 12 month period and 30 swarms. We have also planned our response capacity to also undertake up to 10 further PSII and 10 swarms. This will enable the investigation of significant incidents that do not feature on our plan but need investigation.

Our local plan is also anticipated to generate the following numbers of responses:

- 8 Thematic reviews
- 23 Falls AAR
- 404 shortened investigation tools (pressure ulcer care)

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 focusing on the changes made to our initial PSIRP.

**Table 5: Locally defined incident responses**

| Patient Safety Incident  | Planned Response  | Approval Forum  | Anticipated Improvement Route  |
|--|---|---|--|
| Falls  | Falls After Action Review (significant harm)                | Falls Prevention Group                                      | Falls Prevention Single Improvement Plan<br>Oversight: Quality and Safety Group  |
|  | Annual Thematic Review                                      | Falls Prevention Group                                      | Falls Prevention Single Improvement Plan<br>Oversight: Quality and Safety Group  |
| Pressure Ulcers  | Shortened Investigation Tool (SIT) (Grade 3, 4 unstageable) | Pressure Ulcer Review Group                                 | Local level improvement plans  |
|  | Annual Thematic Review                                      | Strategic Pressure Ulcer Group                              | Tissue Viability Single Improvement Plan<br>Oversight: Quality and Safety Group  |
| Delays in diagnosis and treatment  | SWARM (significant harm)                                    | Director sign off<br>Incident Response Approval Meeting     | Create local organisational actions and feed into a defined quality improvement group<br>Oversight: Risk & Assurance Group                       |
|  | Annual Thematic Review                                      | Risk and Assurance Group                                    | Create local /organisational actions<br>Oversight: Risk & Assurance Group  |
| Delays in the treatment of sepsis resulting in moderate + harm/significant potential harm                          | PSII  | Director sign off<br>Incident Response Approval Meeting     | Create local organisational actions and feed these into the Deteriorating Patient quality improvement group<br>Oversight: Risk & Assurance Group |
| Infection Control Incidents: acquired infections. Issues with infection control procedures                         | Response in line with Midlands regional approach            | Director sign off<br>Infection Prevention and Control Group | Actions fed into the IPC quality improvement programme<br>Oversight: Quality Committee   |
| <b>Speciality Focus</b>  |   |   |  |
| <b>Maternity:</b><br>Incidents (not subject to MNSI) resulting in significant harm/potential harm                  | Proportionate Response (Swarm/PSII dependent on case)       | Director sign off<br>Incident Response Approval Meeting     | New learning to be added to Maternity single improvement plan(s)<br>Oversight: Quality & Safety Group and Quality Committee                      |
| <b>Imaging:</b><br>Imaging related delays in scanning/ reporting (all levels of harm)                              | 6 monthly Thematic Review                                   | Risk and Assurance Group                                    | New learning to be added to the Imaging single improvement plan<br>Oversight: Quality and Safety Group   |
| <b>Paediatric/Neonatal:</b><br>(including paediatric ED): all incidents resulting in significant or potential harm | Proportionate Response (Swarm/PSII dependent on case)       | Director sign off<br>Incident Response Approval Meeting     | New learning to be added to the service single improvement plan<br>Oversight: Quality and Safety Group   |
| <b>Gynaecology:</b> all incidents resulting in significant or potential harm                                       | SWARM   | Director sign off<br>Incident Response Approval Meeting     | New learning to be added to the single improvement plan<br>Oversight: Quality and Safety Group   |

|  |                              |   |  |
|--|------------------------------|---|--|
| <b>Serious Hazards of Transfusion (SHOT) -</b><br>All incidents resulting in significant harm or potential harm                | Thematic Review<br>Annually  | Risk and Assurance Group                                | New learning to be added to the Service single improvement plan oversight at the Trust's Transfusion Group and Clinical Effectiveness Group. |
| <b>VTE:</b><br>All incidents   | Thematic Review<br>6 monthly | Risk & Assurance Group                                  | New learning to be added to the Thrombosis Group single improvement plan<br>Oversight: Risk & Assurance Group                                |
| <b>Spinal Incidents</b><br>All incidents   | Thematic Review<br>Annually  | Risk and Assurance Group                                | New learning to be added to the single improvement plan  |
| <b>Chest Pain Pathway:</b><br>incident resulting in harm linked to concerns in compliance with or effectiveness of the pathway | Swarm                        | Director sign off<br>Incident Response Approval Meeting | Create local actions / create single improvement plan as deemed necessary<br>Oversight: Risk and Assurance Group                             |

**Table 6 – Local response rationale**

| Patient Safety Incident Type  | Rationale for planned response   |
|---|--|
| Falls resulting in significant harm   | <p>Extensive history of incident investigation. Improvement work required well understood</p> <p>Falls prevention lead in post with monthly improvement forum</p> <p><b>AAR</b> enables a more proportionate response to check for new risk factors, on the reoccurrence of key factors as well as ensure good immediate management</p> <p><b>Annual thematic review</b> will provide a deep dive approach to a wider sample of falls.</p> <p>*Reduced frequency of thematic reviews given the positive position in terms of the focus on improvement activity and reduction of incidents with significant harm and to enable more time for improvement activity to embed before reassessment.</p>   |
| Pressure Ulcers (Grade 3, 4, unstageable)                                       | <p>Extensive history of incident investigation. Improvement work required well understood</p> <p>Tissue Viability lead in post with weekly review meetings and monthly improvement forums</p> <p><b>SIT</b> 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</p> <p><b>Annual thematic reviews</b> will provide a deep dive approach to a wider sample of incidents</p> <p>*Reduced frequency of thematic reviews given the positive position in terms of reduction of incidents with significant harm and to enable more time for improvement activity to embed before reassessment.</p>  |
| Delays in diagnosis and treatment resulting in significant harm/ potential harm | <p>Some localised improvement work undertaken/ongoing however effectiveness of actions has not yet been evidenced in terms of incident reporting.</p> <p>Established Deteriorating Patient Group and Acutely Unwell Child Group have good oversight of key metrics and have a strong improvement focus in terms of sepsis and acute illness.</p> <p><b>SWARM</b> tool chosen to enable prompt conversational approach to review with staff across the patient pathway to enable rapid improvement work as needed.</p> <p>Deep dive <b>annual thematic review</b> scheduled to provide assurance on improvement activity and to ensure there are no missed risk factors across wider sample base.</p> <p>*Reduced frequency to annual given established oversight forums to enable improvement work to embed prior to wider assessment.</p> |

|   |  |
|---|--|
| 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 - <b>PSII</b>   |
| Infection Control Incidents: acquired infections. Issues with infection control procedures                      | <b>HCAI Investigation. Outbreak reviews</b> will continue in line with current practice  |
| <b>Maternity</b> incidents (not subject to MNSI) resulting in significant harm/ potential harm                  | Proportionate response ( <b>PSII or swarm dependent upon case</b> )- maintain investigative approach given 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.<br><br>*Removed the need to always use PSII approach as this is not always deemed appropriate and can be excessive in terms of resource especially when care period is short. |
| <b>Imaging:</b> Imaging related delays in scanning/ reporting (all levels of harm)                              | Incident trends regarding delays remain.<br><br><b>6 monthly thematic review</b> approach will enable larger sampling approach, close monitoring of concerns and changes in the risk without spending excessive time formally investigating incidents.<br><br>*To continue as 6 monthly due to limited improvement demonstrated and delays/gaps in the undertaking of the scheduled thematic reviews.  |
| <b>Paediatric/Neonatal:</b> (including paediatric ED): all incidents resulting in significant or potential harm | Acutely Unwell Child Group well established to drive improvements in care and review relevant incidents. Remains a focus for the Trust, KPIs noted to be a challenge.<br><br>*Use of <b>Swarm and PSII</b> - removed the need to always use PSII approach as this is not always deemed appropriate especially in shorter episodes of care or where issues are well understood.   |
| <b>Diabetes/Insulin management:</b> All incidents resulting in significant harm or potential harm               | The Trust has an established Diabetes and Insulin management group which has made excellent progress with the quality improvement workplan. The service has seen an improved position in terms of KPIs with a reduction in incidents of harm.<br><br>Thematic review in the 23/24, 24/25 plan stood down but close monitoring of incidents to take place via Insulin Management Group. Continued oversight of improvement work at Risk and Assurance Group.  |
| <b>Gynaecology:</b> all incidents resulting in significant or potential harm                                    | The service continues to see higher proportions of harm associated with incidents with limited assurance regarding improvement work<br><br><b>SWARM</b> reviews to continue which will enable prompt reviews of new significant incidents but time will be focussed on the priority improvement work rather than extensive full re investigation.  |
| <b>VTE: all hospital acquired VTE</b>   | No significant improvements demonstrated. There is some insight in the areas for improvement but there is a need for system wide improvement and given the numbers of incidents 6 monthly thematic review is deemed the most appropriate response  |
| <b>SHOT</b>   | In addition to the nationally required seips reviews, an annual thematic review is scheduled to be undertaken by the patient safety team to allow for a wider collation of recurrent issues and an assessment of the effectiveness of improvement activity across the period.  |
| <b>Spinal Incidents</b>   | Incidents with harm continue to be reported (low in number but issues raised indicate ineffective learning)<br><br>*Formalised need for annual thematic reviews to provide a wide sample approach to review the effectiveness of improvement work plan.  |
| <b>Chest Pain Pathway incidents</b>   | Limited formal assurance on effectiveness of pathway therefore incidents of harm or near miss to be formally reviewed utilising a Swarm.   |