Shropshire Community Health NHS Trust

Patient Safety Incident Response Plan

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Ratification date: 02/11/2023

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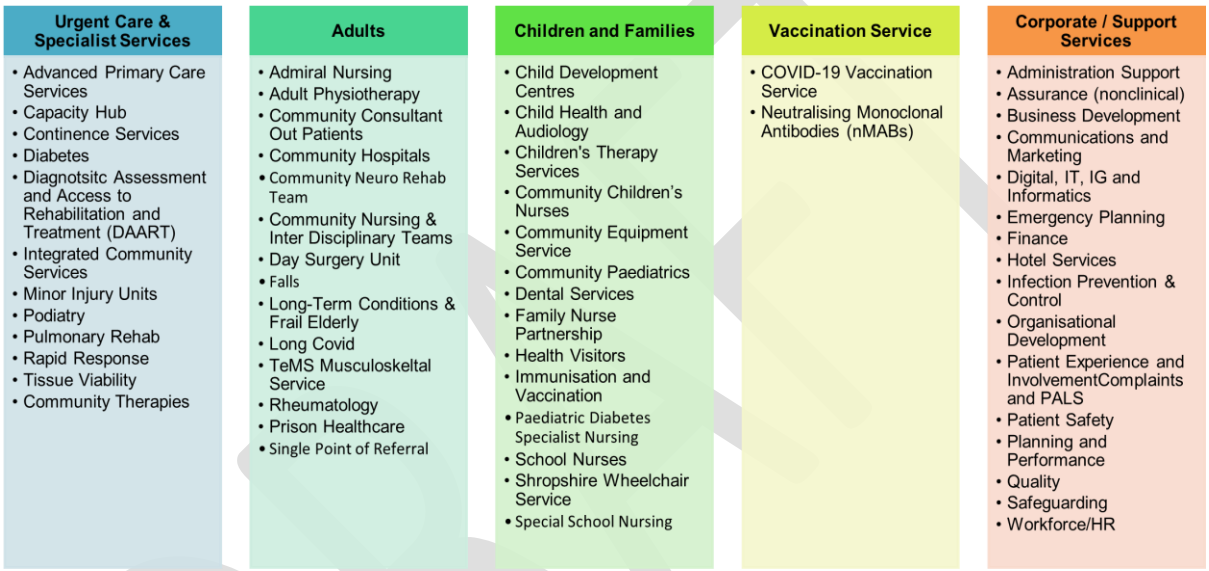
Introduction

This patient safety incident response plan sets out how Shropshire Community Health NHS Trust (SCHT) intends to respond to patient safety incidents over a period of 12 to 18 months. The plan is not a permanent rule that cannot be changed. We will remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected.

Our services



The SCHT Patient Safety Incident Response will cover the services outlined above.

Defining our patient safety incident profile

Stakeholder Engagement

A project group was established in January 2023, to implement the Patient Safety Incident Response Framework. To establish the group key stakeholders were identified as the following:

- Director of Governance (SRO, Executive lead, Co-chair)
- Head of Patient Safety & Patient Safety Specialist (Co-Chair)
- Associate Director of Operations
- Project Manager – Strategy
- Service Delivery Group Leads (*SDG managers should identify operational leads from their teams to attend the meetings*).
- Clinical Service Managers – (TeMS, OP, APCS)
- Service Leads (Tissue Viability, Diabetes, Respiratory, Virtual Wards & Rapid Response, Vaccination Service)
- Falls Prevention Team Leader
- AHP Lead (Adults AHP Professional Lead and Workforce Lead)
- Clinical Quality Leads (Adult nursing, Children & Families)
- Medical Leads - Medical Director and/or Associate Medical Directors
- Medicines Management - Chief Pharmacist / Medicines Safety Officer
- Head of Governance & Risk
- Complaints/PALS/FOI Manager
- Patient Safety Partners
- Patient Representatives
- Head of Safeguarding
- Quality Facilitator
- Associate Director of Workforce
- Head of Digital Services
- Communications Officer

Data Sources

The group used a variety of sources to identify the safety incident profile, reviewing information from the previous two to three years. This included:

- Datix incident profiles
- Key performance indicators
- Reported Serious Incidents or Never Events
- Patient experience data
- Clinical Audit
- Trust Risk Registers

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Defining our patient safety improvement profile

The Trust is developing strong governance processes across the Clinical divisions and the Governance Team and continues to review its' governance processes to ensure that they remain fit for purpose, ensure that patient safety is the focus and that there remains an ongoing process of effective learning, continuous improvement within a fair and just culture. The Trust will also continue to embrace national and regional guidance and support from NHS organisations, Regulators, and partner agencies.

The Trust Quality and Safety Committee will retain oversight of quality improvement measures and safety improvement plans. Its' subcommittee, the Patient Safety Committee will ensure that the clinical divisions provide robust assurance to learning and safety improvement plans, ensuring that the process of embedded learning from PSIRF continues.

The Trust has a Clinical and Quality Strategy that describes our approach to improvement including:

- Identifying our starting position
- Identify and monitor improvement measures
- Aligning to our strategic objectives

The recommendations from our Patient Safety Investigations and Patient Safety thematic reviews will flow through these processes linking them in directly to the Trusts Quality Improvement work.

Our patient safety incident response plan: national requirements

There are several national priorities outlined by NHS England and those outlined below are considered applicable to this Trust.

National priorities require an external escalation, where the Trust may need to contribute to an investigation. A locally led Patient Safety Incident Investigation (PSII) may be required dependent upon the circumstances surrounding the patient safety event.

Patient safety incident type	**Required response**	**Anticipated improvement route**
National Priorities		
Incidents meeting the national Never Events criteria 2018-Never-Events-List-updated-February-2021.pdf (england.nhs.uk)	Patient Safety Incident Investigation	Organisational Safety Improvement Plan

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A patient death thought more likely than not due to problems in care, as indicated by NHS England Learning from Deaths guidance. ngb-national-guidance-learning-from-deaths.pdf (england.nhs.uk)	Patient Safety Incident Investigation	Organisational Safety Improvement Plan
Incident in Screening Programmes	Patient Safety Incident Investigation / After Action Review / Thematic Review (if applicable)	Organisational Safety Improvement Plan
Child Death should be reviewed to the Child Death Review Panel	Review by Child Death Review Panel Patient Safety Incident Investigation / After Action Review (if applicable)	Organisational Safety Improvement Plan
Death of persons with Learning Disabilities, need to be referred to the Learning Disability Mortality Review (LeDeR) programme.	Referral to Learning Disability Mortality Review Programme Patient Safety Incident Investigation / After Action Review (if applicable)	Organisational Safety Improvement Plan
Safeguarding, under the following categories must be referred to local authority safeguarding lead. ○ babies, children, or young people are on a child protection plan; looked after plan or a victim of wilful neglect or domestic abuse/violence. ○ adults (over 18 years old) are in receipt of care and support needs from their local authority. ○ If the incident relates to FGM, Prevent	Referral to Local Authority Safeguarding Lead Patient Safety Incident Investigation / After Action Review (if applicable)	Organisational Safety Improvement Plan

(radicalisation to terrorism), modern slavery and human trafficking or domestic abuse/violence.		
Information Governance	Report to ICO if SI criteria met Investigation using PSIRF methodology / After Action Review	Organisational Safety Improvement Plan

Our patient safety incident response plan: local focus

Patient safety incident type or issue	**Planned response***	**Anticipated improvement route**
Transfer of Care Pathways	Datix investigation and MDT (multidisciplinary team) and multi-organisational review, reporting findings to the Patient Safety Working Group.	Co-production of safety improvement actions managed on a local/organisational safety improvement plan to feed into any wider system improvement plans.
Pressure Ulcers	Case by case review of all Cat 3 and 4 pressure ulcers by Safety Panel and proportionate response determined. Six monthly thematic review (incorporating SEIPS Model into the investigation of Datix)	Use the theme identified to focus the required quality improvement, monitored through the organisational safety improvement plan
Falls	Case by case review of all falls resulting in significant harm and/or meeting RIDDOR by Safety Panel and proportionate response determined. Six monthly thematic review (incorporating SEIPS Model into the investigation of Datix)	Use the theme identified to focus the required quality improvement, monitored through the organisational safety improvement plan

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Medication Events	Case by case review of all medication events by Medicines Safety Group and escalation to Safety Panel of any incidents resulting in significant harm and proportionate response determined. Quarterly thematic review (incorporating SEIPS Model into the investigation of Datix)	Use the theme identified to focus the required quality improvement, monitored through the organisational safety improvement plan
Assessment of incidents outside of the identified priorities	Proportionate response dependent upon the circumstances surrounding the patient safety event	Co-production of safety improvement actions managed on a local/organisational safety improvement plan.

*The Systems Engineering Initiative for Patient Safety (SEIPS) model will be used as a framework to guide all learning responses.

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