Gloucestershire Hospitals
NHS Foundation Trust

Patient Safety Incident Response Plan

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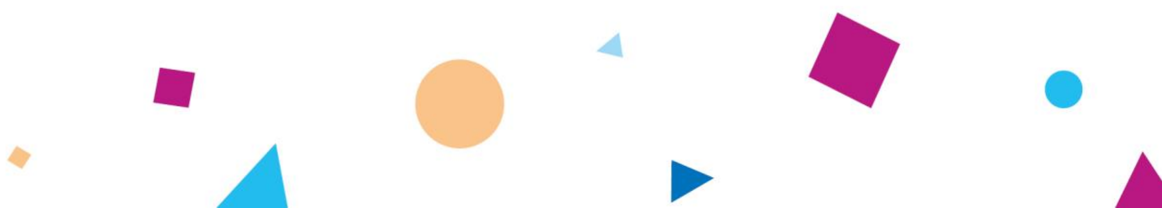


Introduction

This patient safety incident response plan (PSIRP) sets out how **Gloucestershire Hospitals NHS Foundation Trust** 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 Trust provides acute hospital services from two large district general hospitals, Cheltenham General Hospital (CGH) and Gloucestershire Royal Hospital (GRH). Maternity Services are also provided at Stroud Maternity Hospital. Outpatient clinics and some surgery services are provided by Trust staff from community hospitals throughout Gloucestershire. The Trust also provides services at the satellite oncology centre in Hereford County hospital.

Gloucestershire Hospitals NHS Foundation Trust is one of the largest hospital trusts in the country and provides high quality acute elective and specialist healthcare for a population of more than 650,000 people. Our hospitals are district general hospitals with a great tradition of providing high quality hospital services; some specialist departments are concentrated at either Cheltenham General or Gloucestershire Royal Hospitals, so that we can make the best use of the expertise and specialist equipment needed.

Our Trust employs around 8000 staff. Our success depends on the commitment and dedication of our colleagues. Many of our staff are world leaders in the fields of healthcare, teaching and research and we aim to recruit and retain the best staff possible. Our patients are cared for by more than 2,390 registered nurses and midwives, 905 Healthcare Assistants and 992 medical staff. 257 Healthcare Scientists and 527 Allied Health Professionals. In addition, our estates are looked after by 763 NHS Gloucestershire Managed Services staff,

Further details, including our organisational chart can be found on our website https://www.gloshospitals.nhs.uk/about-us/our-trust/who-we-are-and-what-we-do/

Defining our patient safety incident profile

Data Sources

Data sources were identified by the PSIRF working group based on those which would provide insight into our patient safety incident profile. Using these sources, data representing the preceding 12 months (June 2022 – May 2023) was reviewed, as the preceding years were impacted by the COVID-19 pandemic and were therefore potentially not representative of the ongoing safety profile of the organisation. It is intended that a small-scale data review will occur again 18 months after publication to cover the data period June 2022 - May 2024, to validate the selection of safety priorities with a larger data set and a full data review occurring, every four years. At this time the PSIRP will be updated as necessary, to ensure that it continually reflects the organisation as it changes.

The data sources used to identify our initial safety priorities include:

- Patient safety incidents,
- Risks and their controls,
- Claims
- Complaints
- Staff survey
- Inquests
- Freedom to Speak Up themes
- Patient Advisory & Liaison (PALs) themes
- Friends and Family Test (FFT) themes

Stakeholder Engagement

An initial list of potential safety priorities was identified by comparing the themes contained within these data sets and identifying areas of commonality. Whilst consideration was given to the frequently occurring outcomes, the focus was largely on the underlying issues and factors that appeared to contribute to different safety incidents and other forms of unwanted outcomes. This list was initially reviewed by the PSIRF working group, which consisted of members of the patient safety, risk and quality teams from across the Trust. This initial review identified a list of

potential safety priorities, which were then shared with staff Trust wide through a Quarterly Pulse Survey. Through this survey, staff members were able to comment on the proposed priorities by answering the following question:

> **As part of the development of our Patient Safety Incident Response Plan, a review of our data has highlighted the following themes from safety incidents, risks and patient feedback. Which of these do you believe should be included as Trust Safety Priorities for the coming year? (Choose up to 3)**
>
> - Staffing
> - Culture (i.e., Our organisational behaviours, values and normal practices)
> - How we introduce and use digital systems in our clinical and administration processes
> - Environment design and facilities
> - Falls
> - Pressure Ulcers
>
> What else would you include that is not listed above and why?

Figure 1: Quarterly Pulse Survey Question

Using the feedback from the survey, supplemented by an additional review of emerging risks the safety priorities listed below were agreed.

Due to ongoing improvement work within the maternity department, this supplemental review included further consideration of any trends which highlighted the necessity for maternity specific safety priorities, which were not already encompassed by the identified Trust-wide safety priorities. This additional review concluded that whilst the majority of the Trust-wide safety priorities were equally relevant to maternity, an additional safety priority related to the recognition and escalation of deterioration within pregnancy, should be considered. This was subsequently added to the priorities listed below.

Staffing	Communication
Culture	Patient Falls
Digital Systems	Pressure Ulcers
Patient Flow and discharge	Deterioration during pregnancy and/or delivery

Table 1: GHNHSFT Local Safety Priorities 2024-2026

Defining our patient safety improvement profile

The improvement programmes and projects identified below have been agreed as part of the Trust strategic priorities for 2023/2024 and the Trust quality prioritise for 2023/2024.

The strategic priorities are developed through the Strategy & Transformation Group and agreed through the Trust Leadership Team, the programmes and projects agreed then make up the Strategy and Transformation portfolio for the year. The items below are only those which impact on the quality of care delivered by GHT and therefore do not constitute the entire transformation portfolio of the organisation.

These priorities will be reviewed annually, or more frequently if required, and updated accordingly.

The quality priorities have been developed following consultation with staff and stakeholders and are based on both national and local priority areas. A range of data and information has been used to identify these, such as:

- Analysis of themes arising from internal and external quality reports and indicators.
- Patient experience insights: National survey programme data, complaints data, PALs concerns, compliments, feedback from the Friends and Family Test (FFT), and local survey data, focus groups and experience stories to our Board.
- Patient safety data: safer staffing data, national reviews, incidents, claims, duty of candour, mortality reviews and Freedom to Speak up data.
- Effectiveness and outcomes: Getting It Right First Time (GIRFT) reports, clinical audits and outcomes data.
- Staff, key stakeholders and public engagement – throughout the year seeking the views of people at engagement events.
- Engaging directly with our Governors on our quality priorities (many of our Governors sit on steering groups and committees and so are able to influence and challenge quality of care).
- Reviewing key policy and national reports.

For 2024/2025, the quality priorities will be aligned to the safety priorities identified in our Patient Safety Incident Response Plan.

In addition to these improvement priorities the Trust has an active programme of improvement carried out by staff and supported by the Gloucestershire Safety and Improvement Academy (GSQIA). A list of these improvement activities is maintained and updated by the Clinical Effectiveness and Improvement Team. Further information about the Academy and Improvement projects can be found on our website: [Quality Improvements (gloshospitals.nhs.uk)]

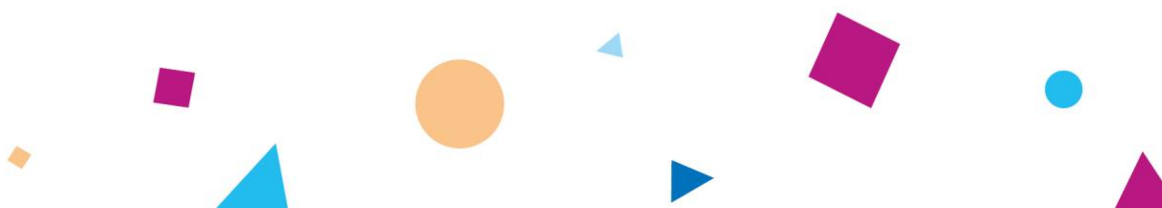
Origin	Improvement Programme	Improvement Projects
Service Improvement / Transformation	**Urgent & Emergency Care Transformation**	High Intensity Users Board Rounds Diagnostics Virtual Wards Discharge Lounge
	Colleague Experience and Culture Programme	Leadership & team working Delivering transformational change and improvement People policies, processes and practises Board to ward - integrated quality

Quality Priorities 2023/2024		
	To improve maternity safety/ experience	Delivering the 10 safety standards within the NHS Resolution Maternity Incentive Scheme (MIS).
	To improve emergency department (ED) care safety/ experience	Delivering the Commissioning for Quality and Innovation indicator (CQUIN 05) "Identification and response to frailty in emergency departments".
	To improve adult inpatient safety/ experience	Monitoring and then reducing/eliminating our use of escalation beds.
	To improve experience of discharge	"simple" discharges.
	To enhance and improve our safety culture	Implementing the National Patient Safety and Incident Response Framework (PSIRF)
	To improve our prevention of harm (pressure ulcers and falls)	Improve our risk assessment, prevention and management of harm in relation to pressure ulcers and falls. This will include the delivery of the CQUIN (CQUIN 12) assessment and documentation of pressure ulcer risk assessments.

	To improve our care for patients whose condition deteriorates	improvement work in the area of including patients/carers and their families in identifying deterioration – through the "Worries and Concerns Programme"
	To improve mental health care for our patients coming to our acute hospital	Implementation of the Trust's Mental Health Strategy – Whole Person Care Strategy.
	To improve our care for patients with diabetes	Responding to the national diabetes audit findings (children and adults).
	To reduce health inequalities	Continue to deliver the Core20Plus5 health inequalities programme focused on tackling tobacco dependency for colleagues, inpatients and in maternity.
	Surgical experience	Delivering the Commissioning for Quality and Innovation Indicator (CQUIN 02) supporting patients to drink, eat and mobilise (DrEaMing) after surgery.
	Equality, diversity and inclusion – equality priorities	Improving our translation and interpretation services including the accessibility of our services.

	Commissioning for Quality and Innovation (CQUINs)	Delivering our 5 agreed CQUINs: CQUIN02: Supporting patients to drink, eat and mobilise (DrEaMing) after surgery (TARGET - 80% of patients within 24hrs) CQUIN04: Prompt switching of intravenous to oral antibiotic (TARGET 40% of fewer) CQUIN05: Identification and response to frailty in emergency departments (TARGET 30% receiving clinical frailty assessment) CQUIN07: Recording of and response to NEWS2 score for unplanned critical care (TARGET 30% having timely response Early Warning Score (EWS) 5-6 60-minute response and EWS 7+ response time 30 min) CQUIN12: Assessment and documentation of pressure ulcer risk assessments (Target: 70% to 85%).
	Caring for people at the end of their lives	Improvement of our compliance with national guidance on care at the end of life (One Chance to Get It Right, NICE guidelines and the Quality Standards for end-of-life care).

Table 2: GHNHSFT Local Safety Improvement Profile



Our patient safety incident response plan: national requirements

	Patient safety incident type or issue	Description	Planned response and anticipated improvement route
National Safety Priorities	Never Events	Incidents meeting the Never Events criteria	Review at Patient Safety Review Panel to confirm criteria met & immediate safety actions. PSII. Create local organisational actions and feed these into the quality improvement strategy
	Death thought more likely than not due to problems in care	Incident meeting the learning from deaths criteria	Review at Patient Safety Review Panel to confirm criteria met & immediate safety actions. Structured judgement review triggering PSII. Create local organisational actions and feed these into the quality improvement strategy.

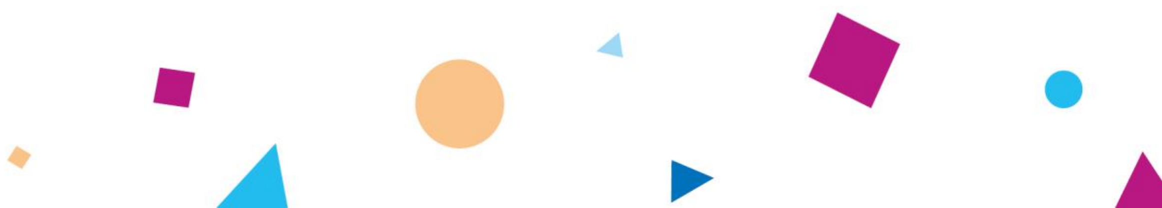
	Incident meeting Each Baby Counts criteria	Incident meeting Each Baby Counts criteria	Referred to Healthcare Safety Investigation Branch for independent patient safety incident investigation. Refer to NHS Resolution as required. Respond to recommendations as required and feed actions into the quality improvement strategy.
	Deaths of patients detained under the Mental Health Act (1983) or where the Mental Capacity Act (2005) applies, where there is reason to think that the death may be linked to problems in care	Incidents meeting the learning from deaths criteria	Review at Patient Safety Review Panel to confirm criteria met & immediate safety actions & consider Duty of Candour. PSII Create local organisational actions and feed these into the quality improvement strategy
	Mental health-related homicides	Mental health-related homicides	Review at Patient Safety Review Panel to confirm criteria met & immediate safety actions Referred to the NHS England Regional Independent Investigation Team (RIIT) for

			consideration for an independent PSII
	Maternity and neonatal incidents	Maternity & Newborn Safety Investigation (MNSI) criteria	Review at Patient Safety Review Panel to confirm criteria met & immediate safety actions & consider Duty of Candour. Refer to MNSI for independent PSII
	Child deaths	Death of a child	Review at Patient Safety Review Panel to confirm criteria met & immediate safety actions & consider Duty of Candour Refer for Child Death Overview Panel Locally-led PSII (or other response) may be required alongside the panel review – organisations should liaise with the panel
	Deaths of persons with learning disabilities	Death of a person with learning disabilities	Review at Patient Safety Review Panel to confirm criteria met & immediate safety actions & consider Duty of Candour

			Refer for Learning Disability Mortality Review (LeDeR). Locally-led PSII (or other response) may be required alongside the LeDeR
	Safeguarding incidents	Where: 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 the incident relates to FGM, Prevent (radicalisation to terrorism), modern slavery and human trafficking or domestic abuse/violence	Refer to safeguarding lead & to local authority lead, as required.
	Incidents in NHS screening programmes		Refer to local screening quality assurance service for consideration of locally-led learning response

			See: Guidance for managing incidents in NHS screening programmes

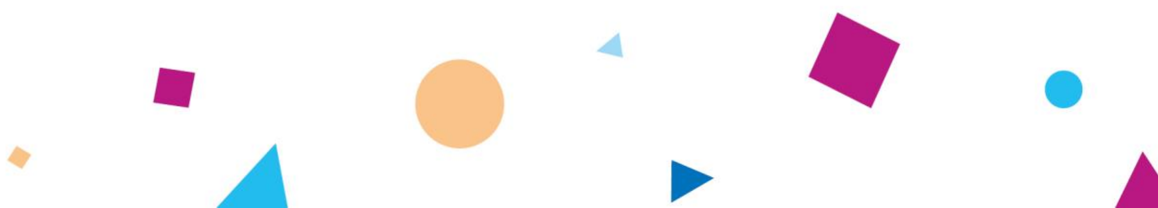
Table 3: National Safety Priorities and Improvement Approach



Our patient safety incident response plan: local focus

	Patient safety incident type or issue	Description	Planned response and anticipated improvement route
Local safety priorities	**Staffing**	Risks and incidents where inadequate numbers of staff or skill mix have been identified.	Trends identified and incidents reviewed and used to inform the workforce sustainability workstream of the people and organisational development strategy.
	Culture	Risks or incidents where team / department or organisational culture is impacting on behaviours, standards or safe delivery of services/ care.	Trends identified and incidents reviewed and used to inform the staff experience workstream of the people and organisational development strategy.
	Digital Systems	Risks and incidents related to the introduction and use of digital clinical systems.	Trends identified and incidents reviewed by the clinical systems safety group. Emerging risks/ issues identified for Quality Summits and inform ongoing improvement efforts

	Patient Flow and discharge	Risks and incidents related to impeded patient flow from assessment to discharge, including delays to discharge, excluding clinical complications.	Trends identified and incidents reviewed and used to inform the discharge improvement programme and the urgent and emergency care workstream. Emerging risks/ issues identified for Quality Summits and inform ongoing improvement efforts
	Communication	Risks and incidents that relate to communication between staff and patients and their families	Trend analysis used to inform quality improvement efforts
	Patient Falls	Patient fall	Incidents reviewed and trends identified Moderate/ severe harms and deaths plus those with other learning opportunities reviewed at falls learning hub. Learning, trends and annual audit used to inform improvement programme.



			Annual quality summit.
	Pressure Ulcers	Hospital acquired pressure ulcers	Incidents reviewed and trends identified. Moderate/ severe harms and deaths plus those with other learning opportunities reviewed at pressure ulcer learning hub. Learning & trends used to inform improvement programme. Annual quality summit.
	Delay to recognition and/or escalation of deterioration during pregnancy and/or delivery	Risks and incidents where delays in recognition and/or escalation of deterioration during pregnancy and/or delivery have or could have affected the safe care and outcome for mother or baby.	Trends identified and incidents reviewed by the maternity governance team; Individual incidents that meet national (mandated) criteria for PSII to be referred to MNSI and Patient Safety Review Panel. Emerging risks/ issues that do not meet criteria for referral to MNSI or Patient Safety Review Panel to be identified for Quality Summits and

			inform ongoing improvement efforts.

Table 4: GHNHSFT Local Safety Priorities and Improvement Approach