SAFETY DIFFERENTLY
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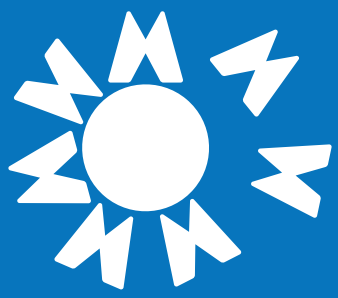
CSS

Patient Safety Incident Response Plan

2022-2025

Safety Differently



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Paper prepared by:	Donna Egan - Quality and Safety Lead, CSS
Date of paper:	29/11/22, updated April 2023, updated July 2023.
Subject:	CSS/MCS Patient Safety Incident Response Plan (PSIRP) 2022-2023
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support ✓ • Resolution • Approval ✓
Consideration of Risk against Key Priorities	Indicate which by ✓ • Clinical Outcomes ✓ • Safety ✓ • Patient Experience ✓ • Staff Engagement ✓ • Operational Efficiency Measures
Recommendations	To note the contents of this paper and approve the recommended safety priorities for 2023/24 ahead of formal sign off at the CSS Quality and Safety Committee Meeting in March 2023.

Clinical and Scientific Services Patient Safety Incident Framework Plan 2022-23

1 Overview

1.1 The National Patient Safety Incident Response Framework (PSIRF) published by NHS England/Improvement, focuses on developing the capability and capacity of healthcare organisations to respond to and learn from patient safety incidents, and patient safety in general, in a different way to approaches that have been used historically.

1.2 The National Patient Safety Framework, which was launched in September 2022, sets out the requirement for all healthcare organisations to develop their own Patient Safety Incident Response Plan (PSIRP) and develop localised plans for improving safety cultures across their organisation.

1.3 Due to the size and structure of Manchester Foundation Trust (MFT), it has been agreed that there will be a Group level PSIRP which will outline the priorities of the Trust as a whole, and each Hospital/Managed Clinical Service (MCS) will hold its own localised PSIRP, that is aligned to localised patient safety priorities.

2 CSS Patient Safety Priorities

2.1 MFT's Clinical Scientific Services (CSS) is a Managed Clinical Service with 6 Divisions, Anaesthesia, Critical Care and Perioperative Medicine, Allied Health Professionals (AHP), Imaging, Laboratory Medicine, Infection Prevention and Control/ Tissue Viability and Pharmacy, providing specialist services across all MFT Managed Clinical Services, Hospitals and Local Community Organisations in multiple specialities.

The following services are managed by CSS:

- Adult Anaesthesia for all specialities including the Pain Team (MRI, Wythenshawe, Trafford, UDHM, St Marys, NMGH) [1]
- Adult Critical Care Units and Outreach Teams (MRI, Wythenshawe, NMGH, Trafford)
- Resuscitation & Simulation Training Team
- Acute Care Team
- AHPs (all sites [2])
- Adult AHP Community Services (MLCO) [3]
- Adult Bereavement Services (all sites)
- Infection Control and Tissue Viability including all medical and nursing staff (all sites)
- Laboratory Medicine/Pathology (all sites)
- Medical Examiner Department
- Mortuary and body store (all sites)
- Medical Engineering and Maintenance (MEAM) all sites and community
- Pharmacy including Adult and Paediatric Services (all sites and community delivery service)
- Imaging (all sites) including Nuclear Medicine and Neurophysiology including Adult and Paediatric Services (all sites)

[1]Some support to paediatric anaesthesia at NMGH- under review
[2]Small specialist AHP teams at WYT and RMCH are out with CSS. ~ 1wte
[3]Some AHP services also site within the LCO

Each Division has identified Quality and Safety Leads as noted in Table 1:

Division	Quality and Safety Leads
Imaging	Andrea Brammer Ananth Ganapathy (Clinical Lead)
Pharmacy	Paul Griffiths - ORC Laura Costello -WTWA
DLM/Pathology	Andrew Sayce Fay Parkin Leena Joseph (Clinical lead)
Allied Health Professionals (AHP)	Samantha Breen Sarah Houghton Sue McCormick
Anaesthesia, Critical Care and Perioperative Medicine	Paul Lancaster (Anaesthesia Clinical Lead ORC) Nick Wisely (Anaesthesia Clinical Lead WTWA). Will Scott (Lead Nurse WTWA and NMGH Sherly Udeshi (Lead Nurse ORC) Richard Templeton (Clinical Lead CTCCU/CICU) Shoneen Abbas/ James Hanison (Clinical Lead ICU ORC) Tracy Duncan (Clinical Lead ICU NMGH)
IPC/TV	Michelle Worsley (Assistant Chief Nurse IPC) Rajesh Rajendran (Clinical Lead)

There are departmental leads identified to support the Divisional Quality and Safety Leads in all areas.

3 Focus and Vision

3.1 Our vision for Clinical and Scientific Services as set out in the CSS Quality and Safety Strategy 2023-2026 is to improve patient safety. This vision also mirrors that of the Trust to ensure continuous improvement in patient safety.

One of our key areas of focus for CSS is to ensure our integrated services support the MFT Group- Hospitals/MCS/Local Care Organisation (LCO) by improving quality and safety throughout our Managed Clinical Service.

Our ambition set out in the CSS Quality and Safety Strategy aligns with the Trust vision to be nationally and internationally recognised as a leading health care provider as well as to optimise the future health and wellbeing of our patients. We will support the Trust Patient Safety Plan 2023/24 by providing the assurance that we are delivering the vision and priorities set out.

This will be provided through the MCS meeting governance structure and our Patient Safety Plan 2023/24 which will include:

- The co-ordination of the effective implementation of the PSIRF
- The implementation of the Patient and Public Involvement in Patient Safety Framework and the National Standards for Patient Safety Investigations
- The achievement of the objectives set in the Group Quality and Safety Strategy
- An effective response to the findings of external reviews
- An effective response to the opportunities for improvement

The MCS monitor and manage performance through a range of key metrics:

- MCS quality and safety dashboard – to be developed
- CSS KPI and Performance Scorecard Reviews e.g., infection prevention KPI
- MCS accountability and oversight framework (AOF)
- IQP data underpinned by quality audit data and patient experience data, including complaints
- Accreditation – national and internal
- National Benchmarking against recommended peers (e.g., Shelford, ICNARC)
- Peer reviews
- Mortality reviews
- Workforce metrics e.g., Pulse Check and National Staff Survey
- National bodies feedback e.g., CQC report, MHRA, KPMG
- Harm Free Care e.g., falls, pressure ulcer and medication safety

3.2 We continue to develop opportunities to lead on research and drive service transformation to sustain continuous service improvement informed by our patients, stakeholders and workforce. CSS realises the benefits of the Single Hospital Service by promoting internal benchmarking and encouraging shared learning to ensure all our patients get the best quality of care experience. The MCS will contribute from all relevant professions to the cross cutting clinical standards groups, which will underpin this vision driving high standards across sites and services.

3.3 CSS demonstrate commitment to high standards through achieving accreditations from external bodies such as ACSA[4], CQC[5], MHRA[6] and QSI[7]. Each area has achieved the required accreditation standards, Critical Care was rated outstanding by the CQC in 2019.

Our values and behaviours and a safety culture will ensure quality and safety are everybody's business, to deliver the best patient outcomes and experience every time. Our work is underpinned by our commitment that 'Together Care Matters' and this is underpinned by our values and behaviours framework which sets out four values:

Everyone Matters | **Working Together** | **Dignity and Care** | **Open and Honest**

This framework creates a compassionate inclusive approach to achieving a culture that enables excellence and optimises the quality of care we deliver. Success is measured against the Accountability Oversight Framework (AOF) domains and used in conjunction with the CSS Quality and Safety Strategy 23-25 to ultimately ensure:

1. Our care is safe: we continuously, systematically, and consistently prioritise patient safety in everything we do.

2. Our care is effective: our patients are provided with the best possible clinical outcome based on their individual circumstances and vulnerabilities and ensuring we learn when care is not of the standard we would expect.

3. We are caring; respect, dignity, kindness and compassion and the protection of vulnerable service users are at the core of our service provision.

4. Our care is responsive: our services are quick and convenient to use and responsive to individual needs. We will ensure the patient / family voice is heard and they are involved is supporting patient safety utilising feedback from different sources including CSS Patient safety specialists.

5. We are well led: this strategy is underpinned by high quality leadership with clear focus on staff support and wellbeing.

6. We make our data count and measure for improvement and demonstrate a culture of continuous improvement and learning.

7. We are confident that our care is of high quality, and we understand, contextualise, and manage risk consistently and provide assurance.

[4]Anaesthesia Clinical Services Accreditation
[5]Care Quality Commission
[6]Medicines and Healthcare products Regulatory Agency
[7]Quality Standard for Imaging Accreditation

3.4 Clinical and Scientific Patient Safety Plan

The CSS Patient Safety Plan has been developed to support the Group Patient Safety Plan to move towards the National Patient Safety Framework and the priorities for 2023/24 are summarised by the following key action points:

1. Improving Patient Safety by improving the safety of the care we provide to our patients and improving the experience for patients, their families, and carers wherever a patient safety incident or the need for a PSII[8] is identified.

2. This will be achieved by focusing on aligning with the National and MFT Group workstreams to implement the Patient Safety Incident Response Framework based on 4 pillars which include the implementation of Safety 2 methodology, applying the learning from excellence, what went well, implementation of focused safety huddles and training in areas such as human factors which will feed into how and when risks are identified.

3. Improving Staff Engagement and Reporting Culture by improving the use of valuable healthcare resources and improving the working environment for staff in relation to their experiences of patient safety incidents and investigations.

4. This will be achieved by focusing on learning from best practice, celebrating excellence and supporting through the investigation process providing a real time response to incidents focussing on processes rather than individuals.

5. Patient safety incidents and hospital level risks for CSS/MCS have been profiled using organisational data from recent patient safety incident reports, complaints, freedom to speak up reports, patient safety incident investigations, (PSIIs), mortality reviews, case reviews, systems investigations, staff survey results, claims, staff suspensions and risk assessments.

6. The national PSIRP template requires CSS/MCS to use localised safety profiles to develop up to ten key priorities in relation to patient safety. The purpose of this exercise is to move from a reactive approach to patient safety, which risks themes and trends being missed, to a proactive approach that delivers focused learning in areas in which incident reporting is higher than expected levels to drive improvement.

[8]Patient Safety Incident Investigation
[9]When work went well

3.5 Patient Safety Priorities

During the period 01/04/2020-31/03/2022 just over 11,000 incidents were reported within CSS services. In total during this period there have been 18 serious incidents reported to the Strategic Executive Information System (StEIS)[10]. The Highest 6 reported incident categories were Clinical Assessment, Pressure Ulcers, Medication, Infrastructure (inc. Staffing), Access, Admission, Transfer and Discharge and Patient Care. Medication, Infrastructure (inc. Staffing), and Access, Admission, Transfer and Discharge all exhibited increases following the covid recovery with upper confidence special cause variations present in Feb / March 2022.

As shown below in table 3, the CSS/MCS safety profile has identified 8 incident categories which require an increased focus in relation to patient safety and application of improvement methodology. The 8 priority categories have been determined through a review of CSS/MCS incident numbers between 2021-2022, using statistical process control charts (SPC)[11]. SPC analysis allows for a greater understanding of themes by using the mean ratio of incident reporting within each category. The mean ratio is then used as a marker to determine if there is an increasing or reducing risk in these areas.

Due to variables in data which can be caused for a number of reasons, such as seasonal peaks in activity, an accepted upper and lower control level is applied, which if breached, have undergone further scrutiny to understand the reason behind the special cause variation (SCV). An example of this was around pressure ulcer SCV. This was investigated and found to be due to the acuity of the COVID positive patients within the critical care environment during the peak of COVID 19. Another example was an increase in SCV in Access, Admission, Transfer, Discharge incidents related to patient flow and capacity vs demand for CSS services. As a result of having this oversight, quality improvement projects are targeted to improve these pathways and risks to patient safety are identified early.

It should be noted, that of the 8 categories identified, all are areas which have been previously highlighted across several CSS/MCS forums, the previous PSIRP and many already align to improvement work taking place across CSS/MCS. This is a positive reflection of CSS/MCS level of insight into its patient safety priorities and provides assurance that the MCS is already working towards delivering focused and proactive learning. Risks and challenges have been articulated and targeted improvement workstreams are in place.

[10]NHS England system used to report and monitor serious incident investigations
[11]Statistical process analysis- a tool widely used in the NHS to understand whether change results in improvement.

Table 3 CSS Patient Safety Priorities 2022/23

	Incident type	Speciality
1	Access, Admission, Transfer, Discharge - including delayed scan, discharge planning intrahospital/ external transfer	ACCP, AHP, Imaging, Pharmacy
2	Checklists/ LOCSIP	ACCP, Imaging
3	Infection/ Sepsis - Acquisitions	ACCP, DLM, IPC, Pharmacy
4	Pressure Ulcers	ACCP, DLM, TVN
5	Medication Errors - Administration, Storage and Dispensing	Pharmacy, ACCP
6	Missed/ Delayed Diagnosis/ Treatment or Procedure Delay/ Delay in Recognising Complication – Including Imaging Delayed Diagnosis	Imaging, DLM, ACCP, AHP
7	Communication Failure	CSS-wide
8	Treatment/ Procedure Delay/ Failure - Including Nutrition and Hydration and Blood Transfusion.	Imaging/ DLM/ ACCP/ AHP

The recommended areas of focus as set out in table 3, will direct the CSS/MCS patient safety priorities from Spring 2022 into 2023 and will lead to several initiatives being implemented across a number of areas. These will include.

- The development of a CSS/MCS Safety Oversight System (SOS) – meetings commenced August 2022 with CSS Governance Team and divisional governance leads. Initially to discuss groupwide priorities highlighted through the Group SOS that impact on CSS services.

- Development of training on new methodology - ongoing workstream through presentation of methodology to Divisions and CSS Governance Team support to undertake investigations. Learning through doing/ in action approach has been taken by the CSS Governance Team due to the delay in the national offer. The AQUA[12] human factors training availability has been shared with teams and the e-learning for health programme to support PSIRF nationally is now on the learning hub for staff to access (level 1 and 2 only- awaiting levels 3-5). Current pressures due to rollout of HIVE electronic patient record (EPR) are impacting training but it is expected this will start to increase once this is embedded.
- Increased incident surveillance and use of SPC charts in those areas identified as a patient safety priority. Alignment of incidents, complaints, claim, and litigation themes being undertaken which continues to align with the priorities as set out in table 3. This is fed into the monthly CSS Quality and Safety Committee and quarterly Risk and Audit Committees to bring these themes together in a meaningful way to start improvement conversations and socialise teams to PSIRF methodology.
- A focus on integrated and shared learning. Safety II increased focus to support learning from what went well. Feedback of shared learning being undertaken through Quality and Safety committees locally, at MCS and Group level. Renewed focus on audit compliance and assurance requirements and linking in to PSIRP categories and early identification of risk.
- Focused learning reviews and improved cross site and MDT engagement in response to incidents which sit within the 8 categories identified for an increased safety focus. Increasing number of incidents and learning opportunities investigated using the High Impact Learning Assessment (HILA) approach since the implementation of the methodology in April 2021. Learning is identified much earlier in the process and actions put in place to mitigate which is shared. There is also increased focus on support for staff, just culture and safety culture. Being open and transparent with patients/ family including ensuring patient/ family involvement in development of terms of reference for investigations and good quality duty of candour discussions is also a focus.
- The use of quality improvement methodology to develop specific patient safety projects which are targeted in the 8 areas identified. Where themes have been identified from multiple incidents CSS have worked with Group and other sites /MCS but also within Divisions to extract quality learning and improvement.
- Enhanced monitoring and provision of assurance of the impact of interventions to ensure that they remain in place and are effective. Work is in place to continue in this area to provide tangible evidence of improvement and provide assurance for all investigations, not just higher impact or Never Events and we will regulate our Key Performance Indicators (KPI's) against CQC standards going forwards. There has been an increased focus on inquest assurance with reports being provided ahead of inquest that bring together the assurance related to associated incidents, complaints and identify risks and mitigation.

3.6 Challenges

There have been numerous challenges to the implementation of the PSIRP within CSS over the past 12 months. MFT commenced rollout of the Patient Safety Incident Response Framework in April 2021 and CSS developed a PSIRF plan.

In that time the number of investigations has increased rather than decreased as teams identify high impact learning related to incidents or outstanding practice. The impact of COVID, competing priorities on staff time such as the roll out of HIVE EPR and the delayed training offer has made it difficult for teams to sustain the number of investigations currently being undertaken and provide assurance on feedback and shared learning with the resources available.

[12]Advancing Quality Alliance

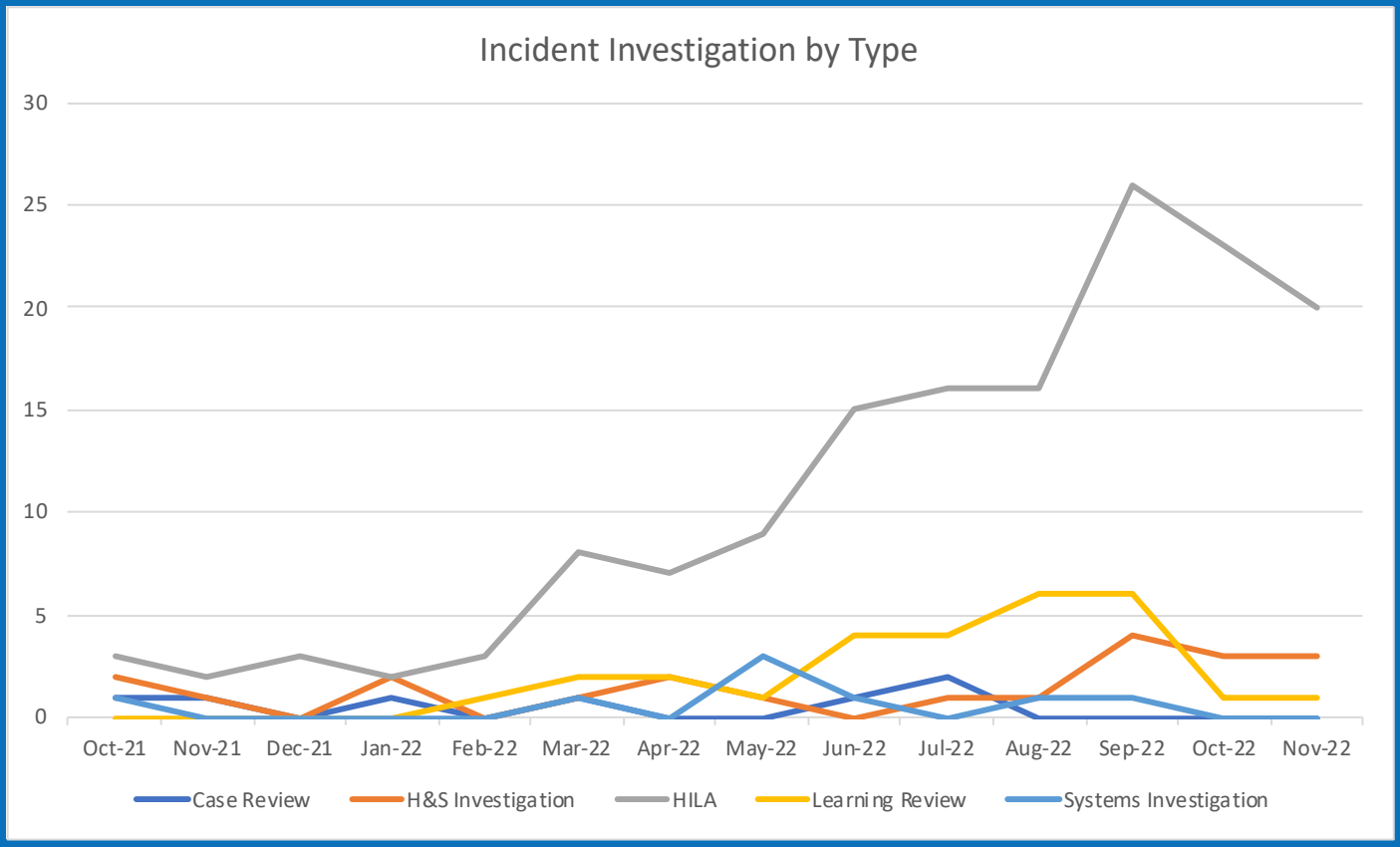
As we move towards increasing Safety II focus this in the short term will become increasingly difficult to maintain. Longer term as improvement projects are instigated the aim is that Safety I (harm) type investigations should become less frequent.

In addition to categories/ priorities outlined in the PSIRP (table 3) for CSS, any Safety I (actual harm /near miss) or Safety II (when things go well or are outstanding) incidents where learning is identified or mandated due to statutory requirements such as RIDDOR, SHOT, HTA, PHE or IRMER reporting requirements has meant that CSS has seen a marked increase in investigations, although teams have highlighted that the HILA approach is a better method from the perspective of time required and extracting learning to improve safety.

4 Situational analysis – CSS

4.1 Results of a review of activity and resources has been undertaken to look at the numbers of investigations undertaken since April 2021, to assist in estimating the resources required to undertake future investigation using the new methodology focusing on high impact learning rather than causation (root cause).

CSS Incident Profile - Numbers of Incidents Investigations and Type. The data below demonstrates that using the new methodology of also looking at Safety II, i.e., Near misses or no harm incidents, where lessons can be learnt, or good practice can be shared. It is noted that there has been an increase in investigations for 2022 from previous data used to estimate resource requirements.



Each type of investigation has a different resource requirement in terms of time, numbers of staff involved from both clinical teams and CSS Governance and which grade staff are required to complete the investigation. As demonstrated in Chart 4 this requirement is increasing.

Further work is required to understand training that is available and its implementation including mapping training requirements of staff involved in investigations. This includes use of statistical process control (SPC) methodology and data analysist support requirements.

As part of PSIRF implementation a review of resources utilised is required to be undertaken. The tables below (pages 10-13) give an overview of previous activity and estimated resources used for investigations previously undertaken as requested by Group.

Table 5. Patient safety incident investigation (PSII) activity: Mar 2018 to Mar 2022:

Table 5	2018-19	2019-20		2021-22	2022-23	Ave
Never Events	2	1		3	6	3↑
Serious Incident investigations (ie StEIS[13] reportable)	13	15		15	18	15.3↑
'Coroner-initiated' patient safety investigations	0	1		0	1	0.5↔
'Coroner-requested' signed statements following patient safety incidents	Not recorded	Not recorded		Not recorded	Not recorded	-
Patient/Family/Carer complaint-initiated patient safety investigations	Not recorded	1		0	1	0.5
Other PSIIs[14] (currently classed as ward, department or directorate-level root cause analyses)	4	6		13	32-3 or more harm	13.75↑
Incidents investigated locally but including/requiring a funded independent specialist on the investigation team	0	0		0	0	0
Independent PSIIs sourced and funded directly by the local provider	0	0		0		0
			2021-22	**Total**	**38**	**28***
Incidents referred (to HSIB[15]/Regional independent investigation teams (RIITs)/PHE[16], etc.) for independent PSII	0	0	0	0		0
Independent PSIIs commissioned nationally or regionally on behalf of the local provider	0	0	1	0		1
				Total		1

*Note year on year increase due to increasing CSS footprint.

[13]Strategic Executive Information System
[14]Patient Safety Incident investigations
[15]Health and Safety Investigation Branch
[16]Public Health England

Table 6. Estimate of current Serious Incident (SI) resources: 2021, This is a draft snapshot baseline measure which has been estimated using 2021 investigation types as more representative of future investigation methodology. This will require future work regarding actual requirements regarding time and cost:

Table 6 For SI investigations	Frequency	Grade(s)	Hours/ year	-£/year
Patient safety team hours dedicated to SI-level PSIIs (investigators at approx. 6 hours each investigation)	50	Various band 7 and above	300	-
Risk management team hours dedicated to SI-level PSIIs (governance teams – 3 hours initial review and subsequent reviews, QA 1 hour,)	50	7 8	300	-
Complaints team resources dedicated to SI-level PSIIs	0	0	0	0
Patient Advice and Liaison Service (PALS) team resources dedicated to SI-level PSIIs	0	0	0	0
Duty of Candour/'being open' resource (if not included above) dedicated to SI-level PSIIs	59	8	50	-
SI-related PSII panels (governance lead) approx. 2 per week	26 per quarter	8	17	-
SI-level PSII leads (at panel)	26 per quarter	8	17	-
SI-related PSII team members/assistants	26 per quarter	7	17	-
SI-related PSII subject matter experts (at panel)	13 per quarter	Various 8 - consultant	8.5	-
Staff involvement in SI-level PSIIs- (statements, information gathering etc. 1 hour)	50	Various	100	-
Resources offering support of staff involved in SIs and throughout any subsequent SI-level investigation (2 hours)	50	Various 7- consultant	100	-
Resources offering SI-level PSII investigator support throughout an investigation	50	Various 8- consultant	50	-
SI-related PSII reviewers	n/a included above			-
Board/executive team sign-off of SI-level investigations	50	MD/ DON	50	-
Solution/improvement identification, design and development costs (action planning) – resulting from SI-level investigations (if not included above)	Currently not monitored	n/a	n/a	n/a
Solution/improvement implementation costs – resulting from SI-related investigations	Currently not monitored	n/a	n/a	n/a
Solution/improvement monitoring/review – resulting from SI-level investigations (if not included above)	n/a	n/a	n/a	n/a
Staff RCA[17]/PSII training time (SI level) (Basic HF and investigation training 2 consultants and 2 Nurse or AHP per division- year 1) 5x5=25 staff	3 days training per individual for leads	Cons Nurse or AHP Governance leads	550	-
PSII trainer time/training fees (for SI-level courses)	unknown	unknown	unknown	-

[17]Root Cause analysis

Table 7. Estimate of current non-SI resources: 2021, This is a draft snapshot, baseline measure which has been estimated using 2021 investigation types as more representative of future investigation methodology. This will require future work regarding actual requirements regarding time and cost:

Table 7 For non-SI investigations	Frequency	Grade(s)	Hours/year	-£/year
Patient safety team hours dedicated to ward/department-level non-SI-related PSIIs (divisional teams-at least 1 hour per day)	Daily monitoring	Band 6-8 to Consultant	varies	-
Risk management team hours dedicated to non-SI PSIIs (CSS Governance Team 1.5 hours a day- band 7 1 hour a day band 8)	Daily monitoring	7 8		-
Complaints team resources dedicated to non-SI PSIIs	0	0	0	0
PALS team resources dedicated to non-SI PSIIs	0	0	0	0
Duty of Candour/'being open' resource (if not included above) dedicated to non-SI PSIIs- some DLM incidents require DOC regardless of harm	32+ regulatory	Various 8 - Consultant	60	
Non SI-level PSII panels	0	0	0	0
Non SI-level PSII leads (3 hours each)	32	Various 8 - consultant	96	-
Non-SI-level PSII team members/ assistants	unknown	unknown	unknown	-
Non-SI-level PSII subject matter experts	unknown	unknown	unknown	-
Staff involvement in non-SI PSIIs	32	Various 8 - consultant	64	-
Resources that support staff involved in non-SI level incidents and throughout any subsequent investigation	32	Various 8- consultant	64	-
Resources that support non-SI PSII investigator throughout an investigation	32	Various 8 - consultant	32	-
Non-SI PSII reviewers	Included above	Included above	Included above	Included above
Board/executive team sign-off of non-SI investigations (45 mins average)	32	Medical Director/ DON	32	-
Solution/improvement identification, design and development costs (action planning) – resulting from non-SI investigations (if not included above)	Not measured	N/A	N/A	N/A
Solution/improvement implementation costs – resulting from non-SI investigations	Not measured	N/A	N/A	N/A
Staff training time for non-SI PSIIs	As for SI investigations			
Non-SI-level PSII trainer time/training fees	unknown	unknown	unknown	Unknown

5 CSS Data on Themes and work being undertaken

Current themes identified across the Group include transfer, delays in radiology reporting, inter hospital management of patients (including major trauma pathway and inter-specialty management), care for patients with a learning disability, NG[18] tube patients: delay in feeding, PCI[19] pathway (external), Femoral lines, use of checklists and second checker. Active surveillance is underway regarding each of these areas.

For CSS there are several areas where special cause variation is demonstrated and should be the focus of investigations moving forwards. See Appendix 1, for detail of incident themes from SPC charts and Ulysses data for further information.

The number of incidents that fall within the category of access, admission, transfer and discharge demonstrates special cause variation and is an area being explored regarding the cause of this variation, identify themes and any improvement work to be undertaken and this should be a focus for CSS investigations. See Table 1 for Divisions where these are applicable.

Within CSS there have been 7 never events since April 2021 which have been investigated with high impact learning identified and are in relation to safety culture and use of checklists. HIVE now has checklists within the system, and this should support an improvement in compliance. Also highlighted through a systems investigation into inadvertent use of an air flowmeter rather than oxygen was the enduring assurance related to patient safety alerts. Work is ongoing with the Human Factors Academy to utilise a safety culture tool to drive improvement, and this is a focus for CSS investigations as part of the PSIRP.

There was a special cause variation for medication incidents and work is ongoing to identify themes that have been discussed at the Group Safety huddle and panels to target improvement work and provide assurance. HIVE implementation has also impacted on this.

Special cause variation has also been noted for:

- Transfer/ discharge within Critical Care and is driven by patient flow and capacity vs demand issues. Patient flow is impacting on the ability for Critical Care to discharge patients within a timely manner and is leading to an increase in mixed sex breeches. Monthly KPI meetings are now established on the ORC, Wythenshawe and NMGH sites with work ongoing on the NMGH site to engage the hospital site teams and improve the reporting and escalation process on that site, in addition an updated escalation policy is in development.
- Treatment delay in Laboratory Medicine and Imaging further impacted since implementation of HIVE. Turnaround times (TATs) delayed due to capacity vs demand. A risk is now on the risk register regarding staffing MFT/001253 and MFT/006222, actions are in place to mitigate and escalated to GROC.
- There is a backlog of reporting radiology images, which is multifactorial. There is a nationally recognised lack of radiologists which results in a backlog of reporting, which is normally mitigated with a mixture of extra contractual lists and outsourcing to external reporting companies. The backlog appears to have significantly increased in examinations from September to October 2022.

[18]Nasogastric
[19]Percutaneous coronary intervention

The reason for the disparity is due to:

- Staffing – Multiple radiologist vacancies across the Trust and nationally.
- Technical IT problems resulting in the inability to outsource examinations. 'Cube' – funding has been approved – no date for installation.
- North Manchester Disaggregation – on 8th September 2022, MFT acquired a reporting backlog from Northern Care Alliance and no additional staff allocated with the acquisition of NMGH service.
- Demand vs capacity – increasing annual demand for radiology services in line with the national picture.
- HIVE deployment and rollout.
- Risk has been assessed at 16 and currently with SLT for review.

CSS SPC chart and complaint themes review, highlights the above areas that will require local focus for investigation, in addition to Group and National priorities as well as statutory requirements to investigate incidents in areas such as HTA[20], SHOT[21], IRMER[22], RIDDOR[23] and PHE[24].

7 Plan to roll out PSIRF

7.1 The CSS plan for the implementation of PSIRF started to roll out in April 2021 with engagement of the Divisional teams as well as the Executive Team. Each Division is still required to develop its own implementation plan and identified lead(s). To achieve readiness to be compliant with the PSIRF in CSS by September 2023 the principle of 4 pillars will be applied:

- Stakeholder mapping
- Discovery- identifying areas of focus regarding risk
- Training
- Implementation

In readiness for full implementation of PSIRF CSS will:

1. Identify areas for investigation including Safety I and Safety II investigation as outlined in Table 3. This has been underway since April 2021. Work is still required to move from investigation to improvement work around all themes which has been hampered by training issues, regulatory requirement for investigation and safety I incidents and capacity due to HIVE EPR rollout.

2. Implementation of Safety II methodology and increased scrutiny of excellence reports (new format to be confirmed) - applying the learning from what went well. Increased scrutiny of excellence within CSS since February 2022 but sharing of learning from group at CSS Quality and Safety Committee since April 2021. CSS Safety Oversight Huddle commenced in August 2022 and plan to share output from CSS specific Excellence Reporting to be implemented. Currently sharing good and outstanding practice which is raised at Group Huddle that is applicable within CSS to share learning.

[20]Human Tissue Authority
[21]Serious Hazards of Transfusion
[22]Ionising Radiation Medical Exposure Regulations 2017
[23]Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013
[24]Public Health England

3 Training – including Human Factors, simulation, patient safety specialists and making data count. See point 4.6 bespoke CSS sessions undertaken and Group Presentations at CSS Quality and Safety Committee. Patient Safety Specialists identified across each Division and CSS attendance at Group meetings to facilitate change. Training has been hampered by the delay in the national training provision being rolled out which has impacted on ability to roll out all aspects of the plan as detailed in point 8 below. Also provision of good quality patient, family feedback and duty of candour, ensuring staff have the skills and confidence to ensure investigations are inclusive and focus on what is required.

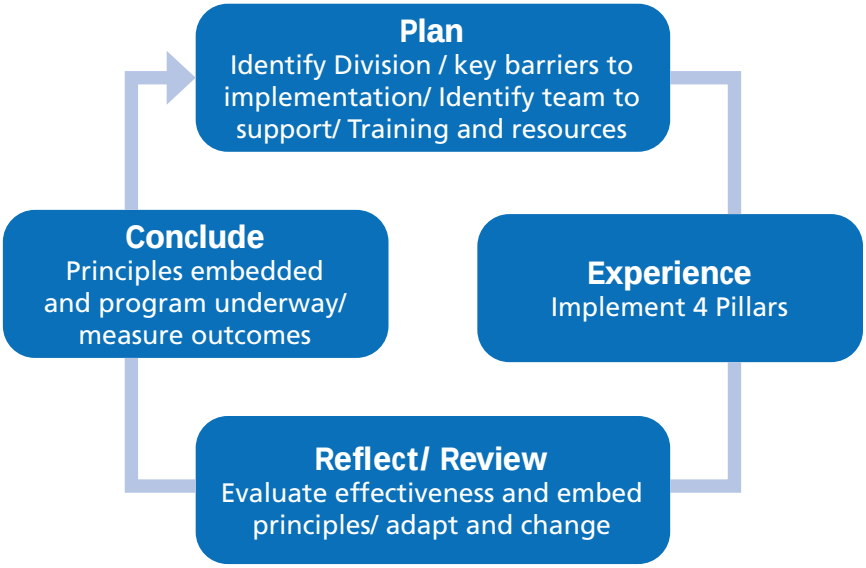
4 Implementation of Safety Huddles weekly, CSS wide initially using the safety oversight dashboard as a template and exploring the use of this template at divisional level. Due to capacity and COVID 19 pandemic and HIVE rollout this has been delayed but commenced in August 2022. Work is underway to identify specific key areas within the CSS Safety Oversight System (SOS) to mirror the Group work undertaken in this area and how to collate data whilst awaiting the Group electronic solution and data analyst support.

The implementation of the points above will support the following aims:

- Learning from best practice and sharing information.
- Providing a real time or rapid response to learning when things go wrong.
- Seeing a real difference - improvement in data, patient and staff experience, knowledgeable workforce, increased sharing of good practice.
- Increased oversight of safety issues that will be fed into local meetings and to staff on the frontline to ensure there is a real impact.
- Improving our safety culture - using culture tools and audit to demonstrate improvements.

The plan will also involve monitoring of data monthly for any outlying information that requires further investigation.

Chart 10. The Implementation Cycle



8 The Detail of the Plan

8.1 Implementation of Safety I and Safety II methodology

The CSS Governance Team have been working with divisional teams on completion of HILA and different types of investigations utilising the human factors methodology. This has moved the focus away from causation/ Root Cause Analysis to sharing of high impact learning, this is to support progressing the changing approach to patient safety.

To prepare staff for the implementation, presentations were undertaken by the Senior Group Quality and Safety Team at the CSS Quality and Safety Committee, to introduce the PSIRF and related methodology. Local sessions via teams have been undertaken to further enhance this work by the CSS Governance Team. The challenge is to now support divisional teams to communicate this message widely so that staff have the knowledge and psychological safety to report incidents and participate in investigations and know how to access support if they are involved in an incident.

8.2 Resources and Training requirement

The PSIRP for CSS has been shared at CSS Quality and Safety Committee and with CSS Patient Safety Experts to socialise staff to the methodology ahead of the launch in September 2022. This included information on the Trust plan for future investigations including Safety II work, training and resource requirements such as:

- SPC data analysis - resources will be required to implement this across all services within CSS, to make it relevant and make the real-time data count. CSS wide data will need to be scrutinised, and a dashboard developed with data analyst input (See Group Safety Oversight System- SOS) this should then move to local divisional data/ divisional dashboards to allow real time identification of statistical variation, identifying emerging negative trends and impact of improvements.
- Human Factors Methodology – to undertake human factors scoping exercise of Human Factors Academy (HFA) Members and Patient Safety Specialists in the first instance and identify training requirements. Resource requirements to provide training will require review.
- Patient Safety Specialists and Governance Leads require training in the principles of investigation using new methodology - HILA[25]/Case review/ Systems review etc., not only for patient harm but where things went well, this is an additional resource requirement.
- Training of teams in tools developed by the HFA - such as safe culture tool, simulation, project 2V[26] and debrief.
- Divisions should develop individualised training packages specific to their requirements.
- Applying the learning from what went well.
- Implement a plan to investigate and share good practice across the MCS and Trust where applicable, utilising SPC and other tools to measure for improvements and merge with current Quality Improvement methodology.

[25]High Impact Learning Assessment
[26]Second Victim

8.3 Implementation of Safety Huddles

Development of huddles, weekly CSS huddles set up (see Group SOS) plan to review regarding frequency and requirement for divisional huddles to share the information from Group Safety Huddle with teams and provide Group with oversight of any emerging issues, outstanding practice or risks within the MCS.

9 Conclusions and Recommendations

In conclusion, for CSS to comply with the Group and National requirements to fully implement PSIRF and improve patient safety, there is an increased requirement for monitoring, data analysis, oversight, sharing of high impact learning, training in the various methodologies that will be utilised and with that the resources to implement the plan. This will lead to benefits in timely identification of high impact learning to improve services across the MCS which can be shared across the Trust to promote shared learning. The introduction of PSIRF will promote benefits for patients and staff.

For patients and families, this process will enhance their experience and standards of care delivered and lead to a reduction of adverse incidents due to staff acquiring increased knowledge and skills. This will be achieved from sharing good practice rather than focusing only on when things go wrong. There will be a greater understanding of the factors that impact or influence the work they undertake every day and the potential impact, both positive and negative. This approach will help to engage and support staff and patients in the investigation process, in a less punitive or negative way and promote improved multidisciplinary team working across the Trust and facilitate patient or family involvement in the process.

The contents of this paper should be noted for approval regarding the recommended safety priorities for CSS in 2023/24.