SAFETY DIFFERENTLY
Our opportunities are endless

NHS
Manchester University
NHS Foundation Trust

Manchester Local Care Organisation
and Trafford Local Care Organisation

Patient Safety Incident Response Plan
2022-2025

Safety Differently

Manchester Local Care Organisation

Trafford Local Care Organisation

Effective date: September 2023
Estimated refresh date: September 2024

	Name	Title	Signature	Date
Author	Caroline Greenhalgh	Associate Director of Quality Governance		4th August 2023
Reviewer	Quality and Safety Committee (Quality Priorities)			19th July 2023
Authoriser	Sohail Munshi	Chief Medical Officer		8th August 2023

Contents

Introduction

This patient safety incident response plan sets out how Manchester and Trafford Local Care Organisations 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

Around 5,000 staff make up Manchester and Trafford's adult and children's NHS community teams and adult social care teams. They include district and community nurses, social workers, health visitors, therapists, care staff, support staff and many other health and care professionals. Our staff serve a population of over 820,000 people across Manchester and Trafford.

Our services support the very youngest, with services such as the Vulnerable Baby Prevent & Protect Service and Health Visiting Teams; to those nearing the end of their life with our Macmillan teams.

We have prevention teams and rehabilitation teams. We have also established innovative new ways of working to support the most complex cases, with our Active Case Management Service and Trafford Rapid Response Urgent Care Therapy Team.

Many of our services prevent people from being admitted to hospital and/or enable them to be safely discharged from hospital, including our Home Intravenous (IV) team, Hospital at Home pilot and Manchester Community Response Teams.

We take a neighbourhood approach to care as we understand that people require care as close to home as possible. We know that local areas have different requirements. This neighbourhood approach is based on dividing Manchester into twelve neighbourhoods and Trafford into four, each containing 30-50,000 people. This enables us to tailor care to local needs. We also provide a range of specialist services across the four wider localities (North, Central and South Manchester and Trafford) and city-wide to support people in the community.

Defining our patient safety incident profile

The plan has been developed in partnership with colleagues across Manchester and Trafford through engagement through existing structures and alignment with operating plans across Manchester and Trafford. A range of insight has been used to inform the patient safety profile.

Figure 1: Insight sources

Manchester and Trafford Local Care Organisations provide community health services including:

- District Nursing
- Health Visiting
- School Nursing
- Manchester Crisis Response
- Trafford Crisis Response
- Podiatry
- Musculo skeletal Services (MSK)
- Community Neurological Rehabilitation
- Community Stroke therapy
- Pulmonary Rehabilitation
- Nutrition and Dietetics
- Children's Community Nursing including complex and palliative care
- Children and Young People's Occupational Therapy
- Children and Young People's Physiotherapy
- Community Paediatrics
- Community Dental Services
- Intermediate Care
- Bladder and Bowel Services
- AAA (Abdominal Aneurysm) Screening
- Falls Service
- Palliative Care and End of Life Service
- Manchester Care Management
- Treatment Room
- Childrens Orthoptic Service
- Childrens Asthma Service
- Community Learning Disability Service
- Sickle Cell and Thalassemia Services
- Audiology
- Medicines Optimisation Service
- Speech and Language Service
- Tissue Viability
- Specialist Weight Management Services
- Combined ADHD Services
- Phlebotomy Service

This list is not exhaustive. For a complete list of services Manchester and Trafford Local Care Organisations provide please follow the link to the websites:

https://www.manchesterlco.org/

https://traffordlco.org/

LCO services carry out an average of 115,349 care contacts every month. The LCO has reported 6398 incidents (June 2021 – May 2023), of these less than 0.1% are moderate or serious harm incidents or incidents resulting in death. Falls and pressure damage make up 100% of the serious incidents reported. The LCO received 41 formal complaints in 2022 – 2023.

A long list of priorities was derived from the sources of insights outlined in figure one. These were further refined to understand where the biggest impact can be made for those priorities that are within the gift of the LCO. For example, discharge as a whole is not included as a LCO only priority as this requires a system response to improvement. The priorities agreed at Quality and Safety Committee in July 2023 are set out below:

1. *We will provide harm free care by ensuring safe and effective assessment of risk and management of pressure damage within our services.*
2. *We will provide harm free care by ensuring safe and effective assessment of risk and management of falls care within our services.*
3. *We will provide safe and effective management of medication for our patients by increasing the number of error free prescribing interactions*
4. *We will provide safe and effective management of medication for our patients by increasing the number of error free administration interactions.*
5. *We will ensure that medication is stored and destroyed safely*

Defining our patient safety improvement profile

Figure 2 shows the large scale change programmes the LCO is leading. Long term conditions, the resilient discharge programme and the children's transformation programme are system level programmes that the LCO are leading on behalf of the system.

The community health transformation programme is a LCO wide programme to review the current commissioned service to ensure equitable services are provided.

The pressure damage reduction programme has delivered improvements in the management of pressure damage to patients being cared for at home and within our bed based care. This programme will continue throughout this year alongside the wound care improvement programme. The medication management improvement programme consists of smaller discreet programmes of work to look at different elements of the medication management processes. The falls improvement programme forms part of a large MFT wide programme.

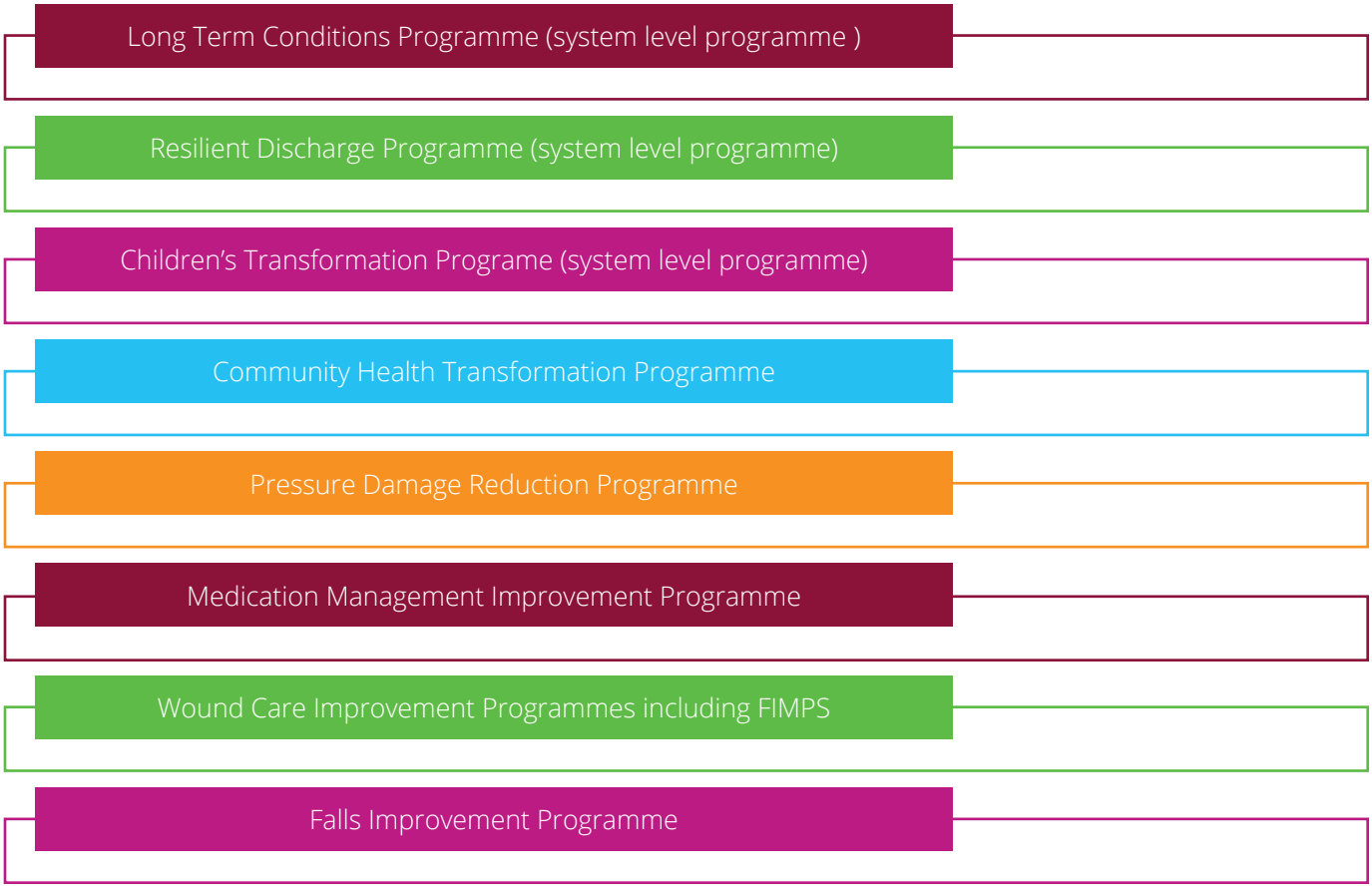

Figure 2

Our patient safety incident response plan: **national requirements**

Patient safety incident type	Required response	Anticipated improvement route
Never Events Criteria	PSII	Existing improvement work-streams that are specific to the never event through the Group and local structures
Death thought more likely than not due to problems in care (in-cident meeting the learning from deaths criteria for patient safety incident investigations (PSIIs))	Structured Judgement Review/PSII	Learning from Deaths Group. Align improvement actions to specific improvement work-streams
Deaths of person with learning disability	Referred to LeDeR	LeDeR committee
Safeguarding incidents	Refer to Local Authority Safeguarding Lead for appropriate response on a case by case basis	Safeguarding Partnership
Incidents in NHS screening programmes	Refer to local quality assurance service for consideration of appropriate learning response	Existing speciality improvement workstreams

Our patient safety incident response plan: **local focus**

Through our analysis of our patient safety insights, based on both the original thematic analysis and the updated incident review, we have determined the patient safety priorities we will focus on for the next year. These patient safety priorities form the foundation for how we will decide to conduct Patient Safety Incident Investigation (PSII) and patient safety reviews. The patient safety priorities were agreed at the Quality and Safety Committee in July 2023.

Patient safety incident type or issue	Planned response	Anticipated improvement route
Pressure damage	Thematic review/PSII	Pressure damage improvement workstream led by Head of Nursing (Adults) and Lead Nurse – IPC and Tissue Viability
Medication administration	Thematic review/PSII	Medicines Management Group
Medication prescribing	Thematic review/PSII	Medicines Management Group
Medication storage and destruction	Thematic review/PSII	Medicines Management Group
Falls	SWARM	Falls Improvement Group