SAFETY DIFFERENTLY
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Manchester University
NHS Foundation Trust

MREH & UDHM

# Patient Safety Incident Response Plan

2022-2025

## Safety Differently

Effective date: August 2023
Estimated refresh date: August 2024

| | Name | Title | Signature | Date |
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# Introduction

The patient safety incident response plan (PSIRP) July 2023 sets out how MREH and UDHM will seek to learn from patient safety incidents reported by staff and patients, their families, and carers as part of our work to continually improve the quality and safety of the care we provide.

Due to the size and structure of MFT, there is a Group level PSIRP which outlines the priorities of the organisation, supported by localised PSIRP's for each Hospital/MCS.

MREH and UDHM are part of Manchester University NHS Foundation Trust which is an NHS Acute Foundation Trust which operates 10 hospitals throughout Greater Manchester. It is the largest NHS trust in the United Kingdom. The Trust was formed on 1st October 2017 following the merger of Central Manchester University Hospitals NHS Foundation Trust (CMFT) and University Hospital of South Manchester NHS Foundation Trust (UHSM), and more recently the acquisition of North Manchester Hospital (NMGH).

MREH and UDHM provide ophthalmic and dental services to the local population of Manchester but are also tertiary centres providing specialist care and services across the UK.

This plan will help us measurably improve the efficacy of our local patient safety incident investigations (PSIIs) by:

- A *refocusing PSII towards a systems approach and the rigorous identification of interconnected causal factors and systems issues*
- B *focusing on addressing these causal factors and the use of improvement science to prevent or continuously and measurably reduce repeat patient safety risks and incidents*
- C *transferring the emphasis from the quantity to the quality of PSIIs such that it increases our stakeholders' (notably patients, families, carers and staff) confidence in the improvement of patient safety through learning from incidents*
- D *demonstrating the added value from the above approach..*

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.

# Scope

A PSIRP is a requirement of each provider or group/network of providers delivering NHS-funded care.

The PSIRP document should be read alongside the introductory Patient Safety Incident Response Framework (PSIRF) 2022, which sets out the requirement for this plan to be developed.

The aim of this approach is to continually improve. As such this document will be reviewed every 12 – 18 months to ensure that the site plan remains appropriate to the Hospitals changing patient safety profile.

There are many ways to respond to an incident. This PSIRP covers responses conducted solely for the purpose of system learning and improvement.

Patient safety incidents are any unintended or unexpected incident which could have, or did, lead to harm for one or more patient's receiving healthcare.

There is no remit to apportion blame or determine liability, preventability, or cause of death in a response conducted for the purpose of learning and improvement.

Responses covered in the plan include Patient Safety Incident Investigations, High Impact learning Assessments (HILA) and Patient Safety Reviews (PSRs).

Other systems are in place to manage specific issues or concerns. These include complaints management, legal claims, human resources investigations, professional standards investigations and rarely for MREH and UDHM coroners' inquests or criminal investigations. The principle aims of each of these responses differ from the aims of a patient safety response and are outside the scope of this plan. Where a response is required that is not conducted for patient safety, learning and improvement then the response will be appropriately referred to the relevant department.

# MREH & UDHM Strategic objectives

- Improve the safety of the care we provide to our patients and their families and improve our patients', their families', and carers' experience of it.
- Further develop systems of care to improve quality and efficiency.
- Respond quickly to incidents to ensure immediate safety actions are taken where needed.
- Improve the experience for patients, their families and carer's wherever a patient safety incident or the need for a PSII is identified.
- Involve patients and their carers in line with the Framework for Involving patients in Patient Safety (NHS June 2021)
- Improve the working environment for staff in relation to their experiences of patient safety incidents and investigations.
- Improve methods of communication to all staff in relation to reported incidents, investigations, and risk management.
- Work with regulators and external organisations to ensure care is timely, safe and exceeds expected standards.

# Addressing health inequalities

As a provider of healthcare across Greater Manchester MFT has a role to play in tackling health inequalities in partnership with our local partner agencies and services. However, most of the fundamental factors driving inequalities in health are beyond the responsibility of the health care system, for example education; economic and community development in our most deprived neighbourhoods; employment levels; pay and conditions; and availability of quality of housing. Through the implementation of PSIRP, MREH and UDHM will seek to utilise data and learning from investigations to identify actual and potential health inequalities and make recommendations to support tackling these.

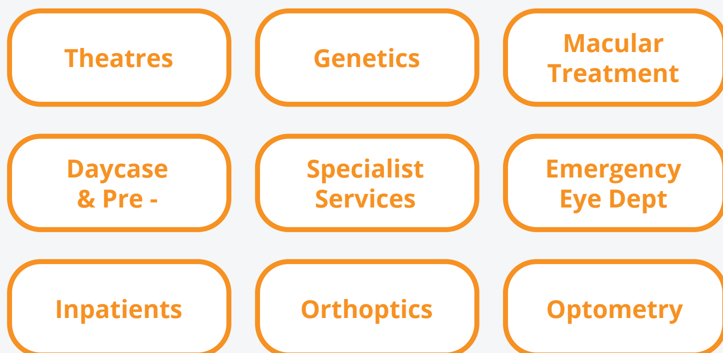
Our engagement with patients, families and carers following a patient safety investigation must also recognise diverse needs and ensure inclusivity for all. Any potential inclusivity or diversity issues must always be identified through the investigation process and engagement with patients and families, for example, during the duty of candour / being open process.

Both MREH and UDHM have identified a large proportion of health inequalities within their services including elderly patients, young patients who may not realise long term health implications of their conditions and those patients with learning disabilities and autism.

# Our Services - MREH

MREH provides ophthalmic services both on the Oxford Road Campus (ORC) and at satellite areas based at Altrincham General Hospital (AGH) , Withington Cataract Centre (WCC), Trafford Hospital and within specialist community sites at Wythenshawe shopping centre and Cheetham Hill shopping centre.

### Oxford Road Campus




### Community Hospitals

### Paediatric Ophthalmology and Retinopathy of Prematurity

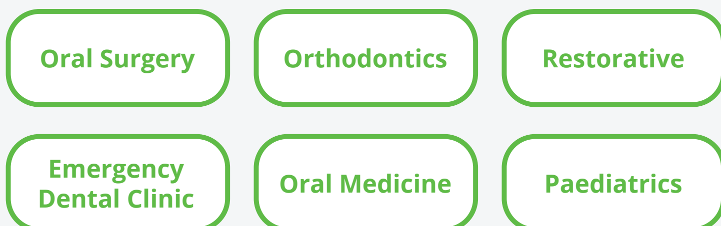
### Outreach

### Satellite Units & Virtual Clinics

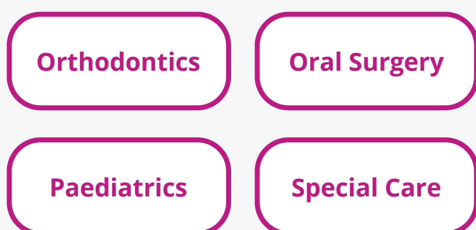
# Our Services - UDHM

UDHM provides dental services on the Oxford Road Site and at Trafford

**UDHM**




**Trafford**




**Peter Mount**

**MRI**

# Defining our patient safety incident profile

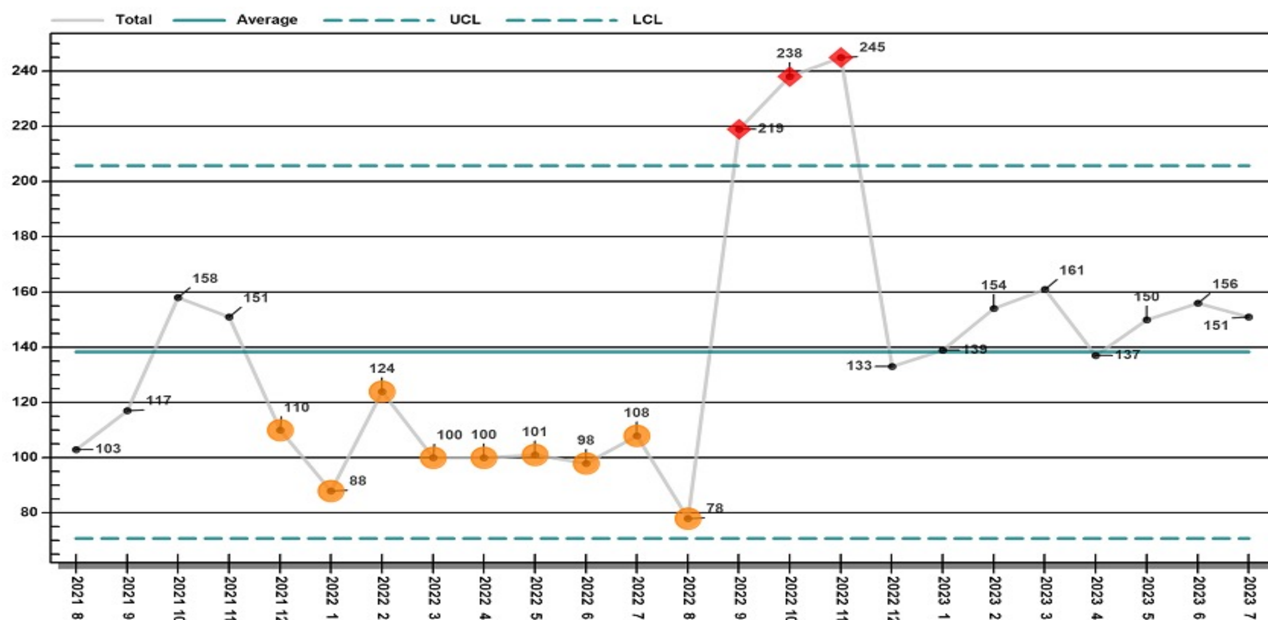
MREH and UDHM have and are focused on improving our approach to patient safety incidents, with many great examples of learning and involvement.

Essential to this has been the ongoing development of a patient safety culture in which people feel safe to talk. Having conversations with people relating to a patient safety incident can be difficult and MREH and UDHM will continue to explore how we can equip and support our colleagues to best hear the voice of those involved. This has included the use of High Impact Learning Assessments (HILA) as well as a move towards system-based reviews rather than root cause analysis.

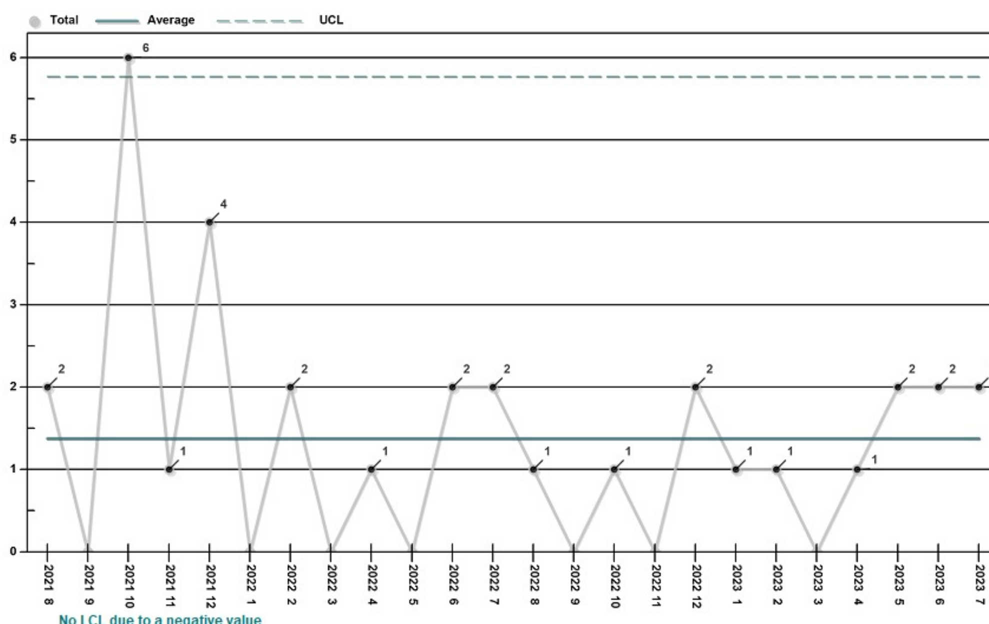
It is important to recognise that there are good reasons to carry out an investigation. Sharing findings, speaking with those involved, validating the decisions made in caring for patients and facilitating psychological closure for those involved are all core objectives of an investigation. The challenge for us is to develop an approach to investigations that facilitates thematic insights to inform ongoing improvement. Our approach must acknowledge the importance

Patient safety incidents and Hospital level risks for MREH and UDHM have been profiled using organisational data including:

- Incident reports
- Complaints, PALS and compliments
- Excellent reports and "shout outs"
- Legal claims
- Audit where there is a patient safety focus. NB UDHM do not participate in National Clinical audits and MREH supply data for complication and visual outcomes of cataract surgery to the national Ophthalmic Database
- Review of the MREH and UDHM risk registers to ensure that the risk registers include patient safety risks that reflect the reported incidents, audit action plans and themes from complaints.
- Quality Care Round (QCR), What Matters To Me (WMTM) and Friends and Family Test (FFT) data is reviewed as a part of the Quality meeting




All incidents for MREH and UDHM




Notifiable incidents for MREH and UDHM

# Defining our patient safety improvement profile

Our incident profile between August 2021 and July 2023 our risk profile and our patient experience metrics has enabled MREH and UDHM to identify a list of priorities with the aim to improve the safety of our patients and their families across our hospital sites and in the community.

MREH Table 1

| | Incident type | Specialty |
|---|---|---|
| 1 | Capacity across all specialties | ALL |
| 2 | Access, admission, transfer and discharge | ALL |
| 3 | Clinical assessment, diagnosis and tests | ALL |
| 4 | Patient treatment/procedure /surgery | ALL |
| 5 | Patient care monitoring and review | ALL |
| 6 | Medication | ALL |
| 7 | Falls, slips and trips | ALL |
| 8 | Infection/ sepsis management | ALL |
| 9 | Communication and consent | ALL |
| 10 | Medical devices | ALL |

UDHM Table 1

| | Incident type | Specialty |
|---|---|---|
| 1 | Capacity within services | ALL |
| 2 | Communication and consent | ALL |
| 3 | Access, admission, transfer and discharge | ALL |
| 4 | Medical device and equipment | ALL |
| 5 | Patient treatment/procedure and surgery | ALL |
| 6 | Infrastructure – staffing, facilities, utilities | ALL |
| 7 | Patient care, monitoring, review | ALL |
| 8 | Health and safety/general accident | ALL |
| 9 | Documentation and information governance | ALL |
| 10 | Falls. Slips and trips. | ALL |

The key priorities for MREH and UDHM are:

- Maximise capacity both surgical and outpatients to ensure patients are treated and reviewed in the recommended time frames.
- Develop new ways of working which operate safely and within MFT and national guidelines in order to increase capacity.
- Focus relentlessly on improving access, safety, clinical activity and outcomes.
- Improve continuously the experience of patients, carers and families.
- Implement the People Plan to support staff and developing their skills to ensure that safe and effective care is provided.
- Improve communication with all staff across MREH and UDHM in relation to incident and investigation feedback and risk management.

The key priorities are discussed through the following Committees:

- Quality and Safety Committee (MREH & UHDM)
- Safety Committee (MREH & UDHM)
- Hospital Management Board (MREH & UDHM)
- Joint Quality Board
- Joint Safeguarding Committee
- Joint Infection Control meeting
- MREH Pharmacy Sub Committee
- MFT Medicines Safety Committee
- Risk Management Committee (MREH & UDHM)

# Our patient safety incident response plan: national requirements

Patient Safety incidents that 'must' be investigated under PSIRF are detailed below in table 1.

| Patient safety incident type | Required response | Anticipated improvement route |
| --- | --- | --- |
| Eg incidents meeting the Never Events criteria | PSII | Create local organisational actions and feed these into the MREH & UDHM quality improvement strategy |
| Eg death thought more likely than not due to problems in care (incident meeting the learning from deaths criteria for patient safety incident investigations (PSIIs)) | PSII | Create local organisational actions and feed these into the MREH and UDHM quality improvement strategy |
| Safeguarding Incidents | PSII | Respond to recommendations as required and feed actions into the MREH & UDHM quality improvement strategy |

# Our patient safety incident response plan: local focus MREH

| Patient safety incident type | Required response | Anticipated improvement route |
|---|---|---|
| Capacity across all specialties | HILA, Swarm, PSII, MDT | Quality and Safety Committee<br>Risk Committee |
| Access, admission, transfer, and discharge | HILA, Swarm, MDT<br>PSII Observation Walkthrough | Locally identified work streams, Quality and Safety Committee |
| Clinical assessment, diagnosis, and tests | HILA MDT PSII Walkthrough | Locally identified work streams, Quality and Safety Committee, Risk Committee |
| Patient treatment/procedure/surgery | HILA MDT PSII<br>Swarm<br>Walkthrough | Theatre Improvement Board<br>Safety Committee |
| Patient care monitoring and review | HILA MDT PSII<br>Swarm<br>Walkthrough<br>Observation | Quality and Safety Committee<br>Safety Committee |
| Medication | HILA Swarm MDT, PSII Walkthrough Observation | Pharmacy Sub Committee – MREH<br>MFT Medicines safety Committee |
| Falls, slips and trips | HILA PSII | Quality and Safety Committee<br>Joint Quality Committee |
| Infection/sepsis management | HILA PSII | Joint infection Control Committee MFT<br>Infection control committee |
| Communication and consent | HILA<br>MDT | Theatre Improvement Board |
| Medical devices | HILA Observation Walkthrough PSII | Safety Committee<br>MFT Medical Device Management group |

# Our patient safety incident response plan: local focus UDHM

| Patient safety incident type | Required response | Anticipated improvement route |
|---|---|---|
| Capacity within services | HILA, Swarm, PSII, MDT | Quality and Safety Committee<br>Risk Committee |
| Communication and consent | HILA<br>MDT | Quality and safety Committee |
| Access, admission, transfer and discharge | HILA, Swarm, MDT<br>PSII Observation<br>Walkthrough | Locally identified work streams, Quality and Safety Committee |
| Medical device and equipment | HILA Observation<br>Walkthrough PSII | Safety Committee<br>MFT Medical Device Management group |
| Patient treatment/procedure and surgery | HILA MDT PSII<br>Swarm<br>Walkthrough | Safety Committee |
| Infrastructure – staffing, facilities, utilities | MDT Walkthrough<br>HILA | Quality and Safety Committee Local workstreams |
| Patient care, monitoring, review | HILA MDT PSII<br>Swarm<br>Walkthrough<br>Observation | Quality and Safety Committee<br>Safety Committee |
| Health and safety/general accident | HILA MDT PSII<br>Swarm<br>Walkthrough<br>Observation | Local health and safety Committee<br>MFT Health, Safety and well-being Committee |
| Documentation and information governance | HILA Swarm MDT | Safety Committee Risk Committee |
| Falls, slips and trips | HILA PSII | Quality and Safety Committee<br>Joint Quality Committee |

Where a PSII is required (as defined in this Plan for both local and national priorities), the investigation / review will start as soon as possible after the patient safety incident is identified. PSII will usually be completed within one to three months of their start date, but not exceeding six months. Any PSII anticipated to require an extended timeframe should be agreed with the patient/family/carer.

# Incidents that meet the Statutory Duty of Candour thresholds

There is no legal duty to investigate a patient safety incident. Once an incident that meets the Statutory Duty of Candour threshold has been identified, the legal duty, as described in Regulation 20 says we must:

1. Tell the person/people involved (including family where appropriate) that the safety incident has taken place.
2. Apologise. For example, "we are very sorry that this happened".
3. Provide a true account of what happened, explaining whatever you know at that point.
4. Explain what else you are going to do to understand the events. For example, review the facts and develop a brief timeline of events.
5. Follow up by providing this information, and the apology, in writing, and providing an update. For example, talking them through the timeline.
6. Keep a secure written record of all meetings and communications.

# Resource analysis

The current incident management structure relies heavily on the Clinical Effectiveness team with limited support from senior clinicians and departmental managers undertaking reviews in their allotted management time. The MREH & UDHM Clinical Effectiveness team do not have any line management responsibilities with regards investigators apart from the team itself and thus limited influence over how investigators prioritise their time for investigations. Investigation reports have MREH and UDHM senior leadership team sign off.

In order to effectively deliver the requirements of the patient safety incident investigation standards and the PSIRF, consideration of the required resources and training is required.

It is recommended that learning responses are led by staff at band 8A and above who have had no involvement in the incident itself or by those who directly manage those staff involved.

Therefore, MREH and UDHM need to complete a resource analysis looking at job planning and training needs of those identified staff to complete PSIIs in the required time frame