SAFETY DIFFERENTLY
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NHS
Manchester University
NHS Foundation Trust

Manchester Royal Infirmary

Patient Safety Incident Response Plan

2022-2025

Safety Differently

Effective date: August 2023
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	Name	Title	Signature	Date
Author	Claire Powell	Associate Director, Assurance and Risk Management		
Reviewer	Dawn Pike	Director of Nursing		
	Leonard Ebah	Medical Director		
Authoriser	Vanessa Gardener	Chief Executive		

Forward

As the CEO of Manchester Royal Infirmary, I am delighted to be able to share our first published Safety Differently/Patient Safety Response Framework and Plan. As a hospital we are committed to delivering services for our patients and their families which meet their individual needs ensuring everything we do for our patients is grounded in best practice evidence and we are continually striving to learn and develop our services.

We have a well embedded Governance Framework supported by frameworks which provide oversight in terms of performance, improvement and research all underpinned by our Patient Involvement Plan. Safety of our services is the key driver of everything we do, and we are committed to creating and maintaining a culture of listening, learning and change to ensure that we Achieve Excellence for our patients, their families, and our staff.

Our plan outlines how we will continue to change the way we respond and review patient safety incidents ensuring that we continue to have a culture which is a compassionate and supportive response with our staff and demonstrate learning and improvements for our patients, families, and services.

Mrs Vanessa Gardener, Chief Executive

We are delighted to share our Safety Differently PSIRF framework and plan which will support our ongoing commitment to safety for our patients and staff within our services. Working collaboratively to learn from our incidents alongside our commitment to celebrate and take forward learning from our successes will enable us to always deliver safe effective responsive care to our patients and their families.

Mrs Dawn Pike, Director of Nursing

Dr Leonard Ebah, Medical Director

Introduction

The Patient Safety Incident Response Framework (PSIRF) (Figure 1)sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety and replaces the Serious Incident Framework (2015).

The Patient Safety Incident Response Framework (PSIRF) fundamentally shifts how the NHS responds to patient safety incidents for learning and improvement.
PSIRF is not an investigation framework that prescribes what to investigate, instead, PSIRF:

- Advocates a co-ordinated and data-driven approach to patient safety incident response that priorities compassionate engaement with those affected
- Embeds patient safety incident response within a wider system of improvement
- Prompts a significant cultural shift towards systematic patient safety management
- Allows for a propertionate and considered learning response to patient safety incidents.

Figure 1

The PSIRF advocates a co-ordinated and data-driven response to patient safety incidents. It embeds patient safety incident response within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management.

Within Manchester University NHS Foundation Trust, the approach has been aligned to our focus on Safety Differently which will be delivered through and overarching MFT approach and individual hospital/MCS Safety Differently/PSIRF delivery plans.

This document sets out how **Manchester Royal Infirmary (MRI)** will respond to patient safety incidents reported by staff and patients, their families, and carers as part of our continuous work to improve the quality and safety of the care we provide and strive to achieve excellence in everything that we do.

Our Services

The Manchester Royal Infirmary is located within the Manchester City Centre and is part of the Manchester University Hospitals NHS Foundation Trust.

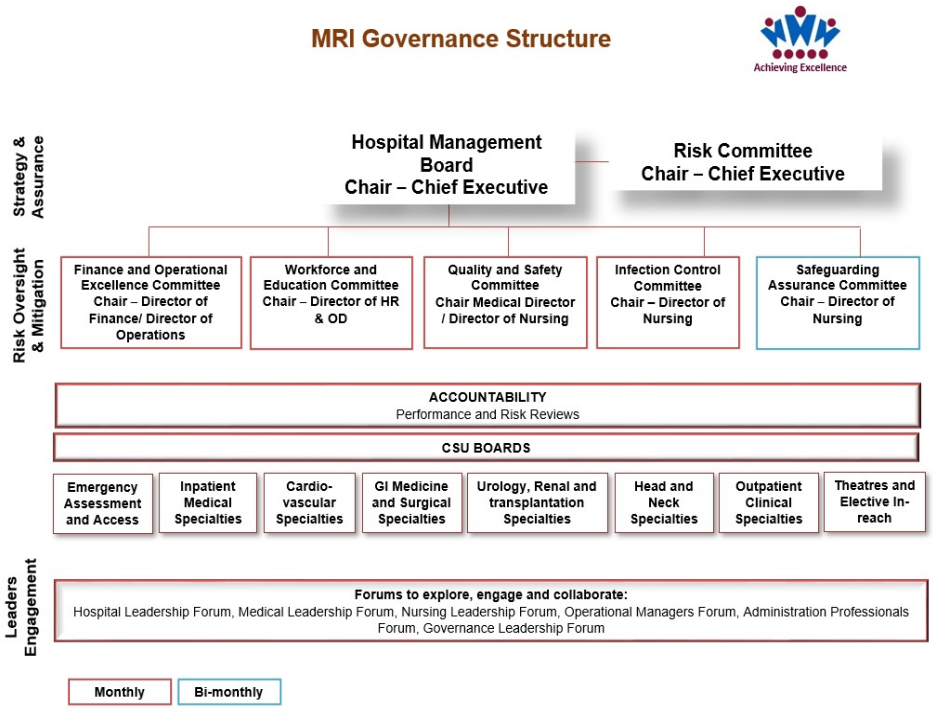
Manchester Royal Infirmary is located within the Manchester City Centre and is part of Manchester Foundation Trust, providing a range of local and tertiary services to Greater Manchester and the surrounding area.

Founded in 1752, the MRI has grown to become a major research and teaching hospital working with Manchester University's Medical School and a regional and national centre for services as diverse as kidney and pancreas transplants, haematology, vascular, major trauma, liver and pancreas surgery, rheumatology, and HIV care. Around 145,000 patients visit our Accident and Emergency Department each year.

The MRI has expanded from having just 12 beds in 1752 to 724 in 2003 and is currently undertaking a £40m refurbishment of our Emergency department and expansion of operating theatres.
Our many leading roles include providing Major Trauma Services, running the largest home kidney dialysis programme in the country, being the first to provide closed loop insulin pumps for patients with diabetes and in the first group of hospitals to provide the revolutionary CAR T cell therapy for blood cancers.

Patient care and service delivery within the MRI is delivered through eight Clinical Service Units. The services that sit within each CSU are described as below.

Emergency Access and Assessment	In Patient Medical Specialities	Cardiovascular Specialities	GI Medicine & Surgical Specialities	Urology, Renal & Transplantation Specialities	Head & Neck Specialities	Outpatient Clinical Services	Theatres & Elective In-Reach
Emergency Care Ambulatory Care Acute Medicine Orthopaedic Wards Fracture Clinic	Respiratory Medicine Complex in Pt. Palliative Care & Oncology Haematology	Vascular Surgery Hypertension Heart Care	Gastroenterology HPB Colorectal Surgery Endoscopy	Renal Urology Transplant Dialysis Units	ENT Maxillo-Facial H&N Cancer ENT Outpatients Audiology	Endocrinology Diabetes Metabilisim Rheumatology Immunology/Allergy Sexual Health/HIV Main Outpatients SMDU	Pre-op Assessment Day Case Theatres DSD



The hospital has a clear MRI Governance Framework which underpins the hospital delivery of our commitments through the Annual Planning Processes.

Scope

There are many ways to respond to an incident which occurs involving a patient, family member of a member of our staff. This document covers responses conducted solely for the purpose of systems-based learning and improvement. 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.

Other types of response exist to deal with specific issues or concerns. Examples of such responses include complaints management, claims handling, human resources investigations into employment concerns, professional standards investigations, 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.

This Plan explains the scope for a systems-based approach to learning from patient safety incidents. We will identify incidents to review through nationally and locally defined patient safety priorities. An analysis of which for the Manchester Royal Infirmary is explained later within this document. For this document patient safety incidents are defined as:

any unintended or unexpected incident which could have or did lead to harm for one or more patient's receiving care.

The plan is based on the Manchester Royal Infirmary core commitments and will remain flexible and responsive and consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected.

Our Commitments

We have clear commitments published for patients, staff, services and for the Hospital

To be effective in meeting their specific intended purposes, responses that are not conducted for patient safety learning and improvement are separate entities and will be appropriately referred as follows:

- Human Resources (employee relations) team for conduct competency issues and if appropriate referral to professional regulator.
- Legal Teams for the oversight and management of clinical negligence claims.
- Medical Examiners and if appropriate engagement with coroner's office where issues may be related to a death.
- Police for concerns related to potential/actual criminal activity.

Defining our Patient Safety Incident Profile

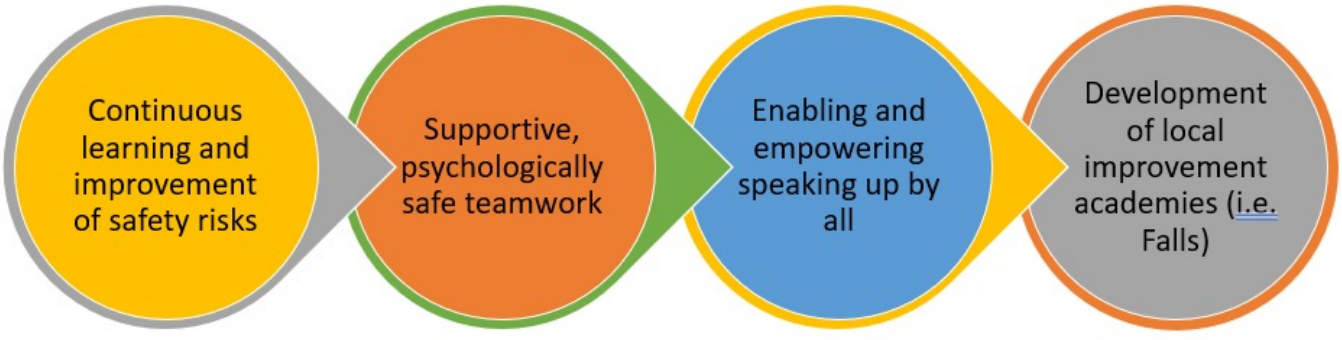
We used a thematic analysis approach to determine which areas of patient safety activity we focussed on to identify our patient safety priorities. Our analysis used additional sources of patient safety insights, beyond that of incidents which resulted in severe harm or death. Our used several sources of information, to enable us to identify the patient safety priorities described in this plan.

Sources of Insight

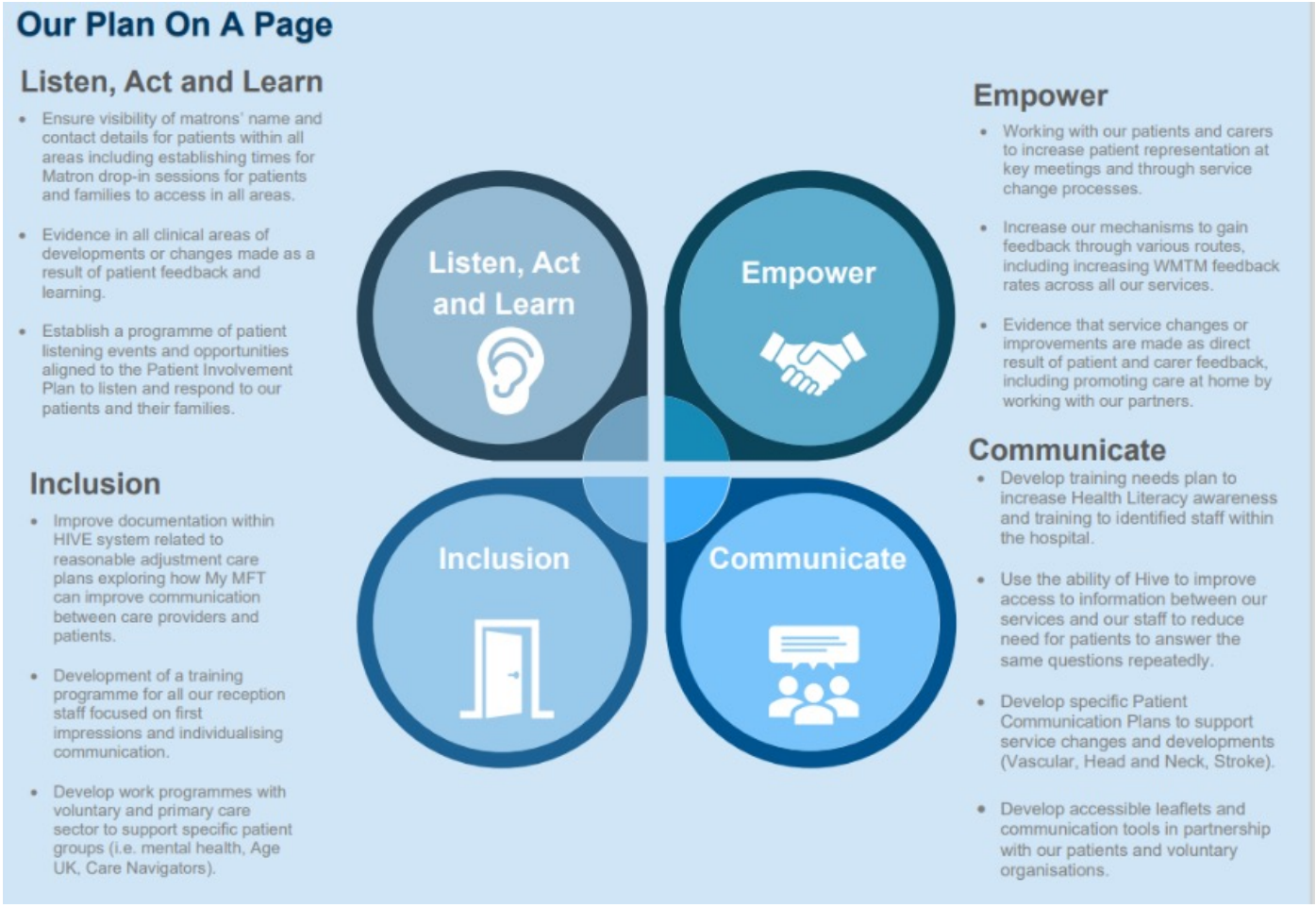
- Serious Incidents requiring investigation (SIRI'S), including falls and pressure incidents
- Patient Safety Incidents reported including all no, low and moderate harm incidents
- Hospital and Trust level risks related to patient safety
- Outcome of inquests
- Complaints and concerns received relating to clinical care and treatment.

In addition, the hospital, in line with the NHS Patient Safety Strategy 2019, established an Insight Cell, which was tasked with using sources of safety data, to inform in a proactive, responsive, and sensitive manner how safe care is in the hospital, sense early signals of safety issues and articulate whether safety is improving over time. Our patient safety 'insight' work aims to improve understanding of safety across the whole system by drawing intelligence from multiple sources of patient safety information, including incidents, complaints, risks, Coroners reports, friends and family testing and trend analysis.

The MRI Transformation Plan supports a programme of continuous improvement that encompasses several the PSIRP priorities and supports a positive compassionate 'Safety Culture through:



We have started work with our patients and their families to enable us to integrate their insight and views into the delivery of our patient safety priorities. Our Patient Involvement Plan is embedded in ensuring that the patient voice is visible in all that we do, especially our approach to and the delivery of safe and effective services. Our Patient Involvement Plan is summarised below and will be key to the delivery of our commitment to Achieving Excellence in Safety.



We have developed patient safety recommendations within our Safety Differently/PSIRF plan, based on the original thematic analysis and our on-going insight which will ensure that our approach is always flexible and dynamic.

Situational Analysis of Patient Safety Activity.

In the last three years, more than 30,087 Patient Safety Incidents have been reported within the Manchester Royal Infirmary, with 481 or 1.59% of these being investigated as Serious Incidents as per the Serious Incident Framework. A large proportion of work undertaken by our Clinical Service Units and Corporate Governance Team is related to what had become a time-consuming process. Safety Differently/ PSIRF gives us the opportunity to keep the learning from previous processes and develop this further to expand our insight and learning opportunities to support safe and effective delivery of care for our patients, alongside compassionate leadership for our staff.

The analysis of the Manchester Royal Infirmary review demonstrates the profile summarised in Table 1 below of patient safety PSRIF related activity broken down into specific themes:

Table 1 - MRI Situational Analysis of Patient Safety Activity

Patient safety Activities	Activity	Definition	Annual Average
National Priotities	Never Event	Patient safty incident which met the criteria for never events framework and reported to STEIS as a SIRI	5
	Incident resulting in death	Serious Incidents requiring investigation which met the standard investigation criteria and resulted in a patient death	17
		Incidents resulting in death which related to a patient with a diagnosed learning disability	
		Mortality reviews including Structured Judgement Reviews	87
Local Patient Safety Activities	Serious Incident Requiring Investigation (SIRI)	Serious Incident Requiring Investigation (SIRI) which met the standard investigation criteria	14 (4 are #NOF)
	Patient Safety Incident Reviews	Includes moderate harm incidents meeting requirements for Standard Duty of Candour, not meeting SIRI criteria	200
		Coroner imitated patient safety investigations	0
		Root Cause Analysis Reviews for level 3 and above incidents: Pressure Ulcers, Falls, Infection control, VTE, Blood transfusion	151
	Patient Safety Incident Validation	Patient safety incidents of low/no harm requireing validation at ward/ department level.	17130
Note: Data from 1st April 2022 - 31st March 2023			

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

Patient safety incident type	Required response	Anticipated improvement route
Never Events Criteria	PSII Systems Review	MRI
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 Systems Review MDT	MRI
Deaths of person with learning disability	Structured Judgement review – Refer to Learning Disability (LeDer) Review Programme	LeDer programme
Deaths of a patient detained under the Mental Health Act and care delivery problems have been identified	MDT PS11 Systems review	MRI/ GMMH
Child Death	Refer to child death process- High Impact Learning Assessment (HILA) and PSII if required	MRI/RMCH
Safeguarding Domestic homicide Abuse/violence	Refer to local authority.	MRI Safeguarding leads Group Safeguarding panel

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

Through this review, we have identified the following local events we must investigate through a PSII in addition to the national 'must dos':

Through our analysis of our patient safety insights, based on both thematic analysis and the incident review, we have determined six patient safety priorities we will focus on for the next two years. 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 approved at the Quality and Safety Committee on 8th August 2023 and form part of the MRI Quality and Safety Work Plan. Delivery of these priorities will be monitors through the MRI Governance Processes as a key process within the MRI Quality and Safety Committee meeting structure.

	MRI Patient Safety Priorities MRI Priority	Required response	Rationale	Anticipated improvement route
1	Falls	SWARM HILA	Falls were the highest patient safety incident identified at the MRI Work has commenced on an improvement program based on learning opportunities identified	Falls Academy
2	Nutrition and Hydration	HILA	Nutrition and Hydration is a risk identified on the MRI Risk register and is a theme through SIRI panel and incident reporting	Nutrition and Hydration Academy MRI Fundamentals of care
3	Infection Prevention	HILA AAR PS11 Systems Review	Infection Prevention is identified as a risk on the MRI Risk register. Identified as a priority via reported incidents and complaints	Infection Prevention Academy MRI Fundamentals of care
4	Procedural Safety	PS11 Systems Review Walk Through	The introduction of the HIVE (electronic patient record) system in September 2022, introduced a number of changes in the way procedural safety is carried out and recorded As the system becomes business as usual it has been identified as a priority to audit	Audit outcome and learning
5	Patient Journey	PS11 Systems Review AAR	Patient journey is identified on the MRI Risk register for Urgent and Planned care Improvement program commenced	Transformation program
6	Medicines Safety	HILA PS11 Systems review Walk Through	Medicines safety is a risk identified on the MRI risk register. Incidents and complaints indicate that medication and medicines errors are a patient safety concern	Medications Safety Academy MRI Fundamentals of care

Appendix 1

PSIRF Terms and abbreviations

PSIRF - Patient Safety Incident Response Framework
National investigation framework to which all Trusts must implement by Autumn 2023.
promotes a range of systems-based approaches for learning from patient safety incidents rather than traditional methods that look to identify a single cause

PSIRP - Patient Safety Incident Response Plan
The plan which sets out the key patient safety priorities for each organisation based on insights gathered from a range of sources

DOC - Duty of Candour
health and care professionals must: tell the person (or, where appropriate, their advocate, carer or family) when something has gone wrong. apologise to the person (or, where appropriate, their advocate, carer or family) offer an appropriate remedy or support to put matters right (if possible)

HILA - High Impact Learning Assessment
Completed following a high scoring patient safety incident to identify areas of learning leading to improvement

PSII- Patient Safety incident investigation
An in depth review of a single patient safety incident to understand what happened and how

SWARM
swarm-based huddles are used to rapidly identify learning from patient safety incidents. Immediately after an incident, staff. 'swarm' to the site to quickly analyse what happened and how it happened and decide. what needs to be done to reduce risk.

AAR - After Action Review
A structured facilitated discussion of an event, the outcome of which gives individuals involved in the event understanding of why the outcome differed from what was expected and the learning to assist

MDT - Multidisciplinary team
Review led by team made up of professionals from multiple disciplines to aid a rounded discussion

WALK THROUGH
Tool used to look at the steps in the process which may have led to an incident or event to identify where there may be a gap/omission/ or weakness in process