SAFETY DIFFERENTLY
Our opportunities are endless

NHS
Manchester University
NHS Foundation Trust

North Manchester General Hospital

Patient Safety Incident Response Plan

2022-2025

Safety Differently

North Manchester General Hospital

Safety Priorities

- Medication safety
- Staffing
- Communication
- Pressure Ulcers
- Infection/sepsis management
- Management of the deteriorating patient
- Ensuring safe and effective follow up of care
- Safe and effective use of the Respect process
- Nutrition and Hydration
- Safeguarding
- End of Life/Palliative Care

Effective date: July 2023
Estimated refresh date: July 2024

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Introduction

North Manchester General Hospital (NMGH) which is part of Manchester Foundation Trust (MFT) are delighted to share our first published Patient Safety Incident Response Plan (PSIRP). The PSIRP sets out how NMGH intends to respond to patient safety incidents over the next 12 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 executive team are committed to ensuring that our PSIRP puts the patients and staff at the heart of the plans. Below is an update from NMGH executive team highlighting explaining why these key changes are so important.

The Patient Safety Incident Response Plan (PSIRP) changes the way the NHS respond and review patient safety incidents and focusses on improving our learning responses when patient safety incidents occur. At NMGH we are committed to ensuring we create a culture of passionate and supportive engagement to patients and staff, and we welcome those new changes. I am very proud to be sharing our plans with you.

Mr Ian Lurcock, Chief Executive

The PSIRP plans outlines the importance of collaborative working across learning events to ensure proportionate and quality learning outcomes, which is line with our strategic aim across NMGH. This is a welcomed shift in focus from doing many reviews to doing it well. Safety differently will empower all nurses, doctors, junior doctors, allied health professionals, patients and carers to feel supported.

Mrs Cheryl Casey, Director of Nursing

PSIRP advocates a compassionate response to patient safety incidents and creates a shared vision for working together to get it right. We are delighted to move into "Safety Differently" and fully support and endorse this exciting change.

Professor Matthew Makin, Medical Director

Our services

NMGH is located in Crumpsall which is 3.5 miles north of Manchester City Centre and is part of the wider family of MFT (since 2020). The hospital has a full accident and emergency department (A&E), which includes a separate paediatric A&E unit. We also offer a full range of general and acute surgical services and is the base for the region's specialist infection disease unit. We deliver approximately 26 different clinical services and serve Crumpsall, Moston, Blackley, Cheetham Hill, Collyhurst, Broughton, Prestwich and across the inner city. Our services support approximately 280,000 people from a wide range of backgrounds.

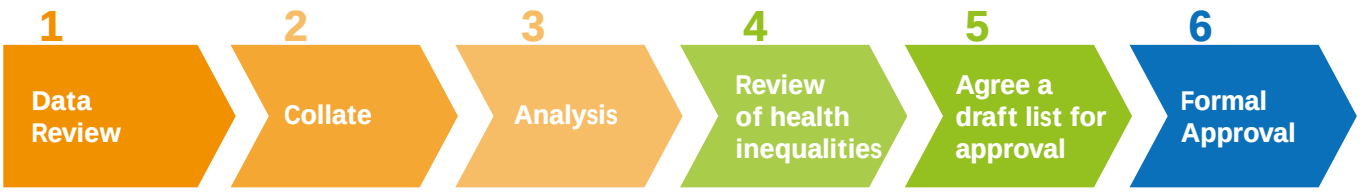
Our services range from A&E, children's services and the care of the elderly and we are very proud to be the specialist centre for infectious diseases (ID).
As part of MFT wider vision for single hospital services we have recently become the single hospital for ID. This is an exciting development which will support with making a different to the health outcomes, wellness, and quality of life for our diverse communities.

Further development is on the horizon as we plan a new hospital and wider health and care campus being built as part of 'once-in-a-generation' plans to transform both the hospital and the North Manchester area, creating new jobs, promoting healthy lifestyles, developing skills for the benefit of the local neighbourhood and beyond.

Defining our patient safety incident profile

Over several months in spring 2022, we started to review our patient safety profile and an in-depth review was undertaken of all our data, including incidents, complaints, inquests, SJRS and any additional intelligence. The review considered any inequalities within health care for the community we service. Following this review, the main patient safety risks were highlighted to the senior leadership team and discussed in various committees.

The process taken is defined below: (Figure 1)



1. Data Review

Our data review took place in spring of 2022 and underwent six stages. It is also worthwhile highlighting in 2021, North Manchester was part of Northern Care Alliance (NCA) and were working on different systems. Following disaggregation North became part of the "MFT family" and the data reviewed considered disaggregation and the complexity that came with the merge. We reviewed data from 1st April 2022 to 1st April 2023 for our thematic analysis. As part of that review, we determined that:

2. Collate

The data was collated and presented to the team at North Manchester.

3 Analysis

A thematical review was undertaken to understand the themes and a triangulation of all data was completed.

4. Review of inequalities

A review of patients within protected characteristics was undertaken against the community that we serve. Age, gender and ethnicity (if available) was also considered as part of the review.

5. Agree draft list for approval

A long list was determined for review and consideration within various committees, using staff feedback to ensure the focus was applied to the appropriate common themes.

6 Agreed list

The list was formally agreed and shared with staff.

Defining our patient safety improvement profile

Our profile was determined via a number of profiles including:

- Trust Wide Quality Improvement Projects (QIP)
- Safety improvement programmes already in place
- Operational Work
- National Projects
- Audits

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

Patient safety incident type	Required response	Anticipated improvement route
Never Events Criteria	PSII Systems Review	NMGH
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	NMGH
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	NMGH/GMMH
Child Death	Refer to child death process- High Impact Learning Assessment (HILA) and PSII if required	NMGH /Child Death Panel

Safeguarding • Domestic homicide • Looked after children • Babies • Abuse/violence	Reported to named safeguarding lead/ Refer to local authority.	Safeguarding leads NMGH/ Local safeguarding boards
Deaths in custody police custody, in prison, where health care is delivered by the NHS	NMGH will fully support and link in with any investigation that is needed which has been a referral via the Independent Office for Police Conduct (IOPC) or prison service.	IOPC
Maternity and neonatal incidents	Health and Safety Investigation Branch (HSIB)	HSIB
Learning from deaths – Structured Judgement Reviews (SJRS) which found death more than likely than not related to problems with the care	PSII	Learning from Deaths CMOG.

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

Patient safety incident type or issue	Planned response
Medication safety	HILA/ Thematical Review
Communication	HILA/Thematical Review
Staffing	HILA/ SWARM/ Thematical Review
Pressure Ulcers	Thematical review /After Action Review
Infection/sepsis management	PSII
Management of the deteriorating patient	PSII /MDT
Ensuring safe and effective follow up of care	SWARM
Safe and effective use of the Respect process	HILA/ Thematical Review
Nutrition and Hydration	PSII /MDT
Safeguarding	HILA/ SWARM/ Thematical Review
End of Life/Palliative Care incident	HILA/ SWARM/ Thematical Review