SAFETY DIFFERENTLY
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Royal Manchester Children's Hospital

Patient Safety Incident Response Plan

2022-2025

Safety Differently

Effective date: June 2023
Estimated refresh date: June 2024

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Introduction

This patient safety incident response plan (PSIRP) sets out how Royal Manchester Children's Hospital (RMCH) 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.

There are a number of ways in which an incident can be responded to, however, for the purpose of this document, responses to patient safety incidents, will be focused on learning systems and improvement workstreams.

Patient safety incidents can be defined as an unintended or unexpected outcome for a patient, which is thought to have been contributed to by the health care system. Management of such patient safety incidents should not seek to apportion blame or determine causation but should focus on learning and improvement.

Not all patient safety incidents will be appropriately managed through the learning and improvement system and may require alternative methods of investigation, such as coronial reviews, professional standards and criminal routes. These types of reviews are not within the scope of this Patient Safety Incident Response plan.

Our Services

The Royal Manchester Children's Hospital (RMCH) is one of ten Hospitals that sits within the Manchester University Foundation Trust organisational structure.

RMCH is one of the largest and busiest Children' Hospital in Europe, delivering emergency, tertiary and specialist level care across a multi-site inpatient bed base.

RMCH also delivers several outreaching services, hosting the Northwest Transport Service (NWTS) and locality CAMHS services across North Manchester, Trafford and Central sites.

A number of networked services are hosted by RMCH. These networked services are delivered across a range of specialities, including Cancer services, Paediatric Surgery, Paediatric Critical Care, NORCESS, and Cleft, Lip and Palate.

RMCH services are offered across a number of key sites:

- Oxford Road Campus – tertiary services, paediatric critical care and CAMHS (inpatients).
- Wythenshawe – General Paediatrics (including HDU), Theatres, Day case and Outpatients.
- North Manchester – General Paediatrics (including HDU) and Outpatients.
- Trafford – dental surgery hub and Outpatients.
- CAMHS community services.

Defining our patient safety incident profile

There have been a range of initiatives and structures introduced at Trust level to support the development and implementation of the patient safety profiles across all Hospital sites. These initiatives include an increased focus on insight, oversight, involvement, improvement, and assurance, the utilisation of SPC charts as a means to identify variations and trends within data sets and the introduction of new ways of delivering proactive safety systems, utilising improvement methodology.

Within Royal Manchester Children's Hospital, patient safety incidents and Hospital level risks have been profiled by triangulating organisational data from recent patient safety incident reports, complaints, freedom to speak up reports, patient safety incident investigations, (PSIIs), mortality reviews, case note reviews, staff survey results, claims, staff suspensions and risk assessments.

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.

As shown below in table 1, the RMCH safety profile has identified ten incident categories which require an increased focus in relation to patient safety. These ten categories have been consistently under review during the last twelve months. Utilising 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 the 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, would require further investigation, under a special cause variation.

Of the ten areas identified, all are areas which have been previously highlighted across a number of RMCH forums and many already align to improvement work taking place across RMCH. This is a positive reflection of RMCH level of insight into its patient safety priorities and provides assurance that the Hospital is already working towards delivering focused and proactive learning.

Table 1: RMCH Safety Profile Priorities

Top Five Priority Categories Identified:

	Incident Type	Speciality
1	Medication error	RMCH-wide
2	Patient Care, Monitoring and Review	RMCH-wide
3	Access, Admission, Transfer, Discharge	RMCH-wide
4	Infrastructure – Staffing, Facilities, Utilities	RMCH-wide
5	Communication Failure	RMCH-wide

Further Learning Categories; Integrated Learning From Priority Categories

6	Medical Device Failure	RMCH-wide
7	Treatment / Procedure Delay / Failure	RMCH-wide
8	Clinical Assessment – Test Results/Reports	RMCH-wide
9	Documentation	RMCH-wide
10	Disruptive, Aggressive Behavior	RMCH-wide

Defining our patient safety improvement profile

Utilising the themes and trends identified within the RMCH Patient Safety profile, a number of safety improvement initiatives have been identified and commenced as outlined in Table 2, below.

Alongside the development of a safety oversight system within RMCH, which will allow for ongoing review and consideration of the RMCH risk and improvement profile, a proactive safety approach to the areas identified within the profile below, by undertaking focused work at both Hospital and local ward and department level.

Improvement profiles will be flexible and will be updated according to intelligence gained via the RMCH safety oversight system and learning gained from high impact learning reviews and PSII reviews.

Table 2: RMCH Improvement workstreams/ priorities.

Priority Category	Improvement Objective/ Commitment
Priority Category 1: Medication	We will implement the RMCH MCS Medicines Safety Strategy that is multi-disciplinary and is aligned to current safety monitoring structures.
	We will review the second checking of medicines process in place across RMCH to ensure it is effective and being used consistently across all areas.
	We will undertake a review of medicines storage across all areas of RMCH to ensure that medicine cupboards meet regulatory requirements and are fit for purpose.
	We will grow and develop the RMCH Medicines Safety Group, which will have appropriate representation from across all professions.
	We will review of the way in which medicine related incidents are investigated and ensure learning from what goes well, is incorporated into the learning culture of RMCH MCS.
Priority category 2: Patient Care, Monitoring, Review	RMCH will be a key stakeholder and pilot area for the launch of the national NPEWS tool.
	We will lead on Group wide Sepsis improvement workstreams, to ensure that Paediatric Sepsis pathways are effective across all Paediatric areas within the Trust (including NMGH and WTWA ED)
	We will develop a mandated centralised EWS/ Watcher's system.
	We will review the existing ESCALATE escalation pathway, to support appropriate and consistent escalation and response to parental and staff concerns.
	We will launch the Lead Consultant policy across RMCH.
	We will ensure robust oversight and monitoring of HIVE data, to ensure every patient has a provider care team and lead consultant allocated to them on admission to Hospital.
	We will develop of a robust monitoring system for NPEWS triggers and response via the RMCH Accountability Oversight Framework (AOF).
	We will launch our localised parental concerns process 'Speak to Sister, Chat to Charge Nurse' including the utilisation of the incident management process, as opposed to complaints process, for concerns raised by families about clinical incidents.
	We will optimise the data available from the parental concerns element of the NPEWS national tool.

Priority Category	Improvement Objective/ Commitment
Priority category 3: Access, Admission, Transfer, Discharge.	We will optimise the way in which HIVE supports patient access to services, including the promotion of proxy access to the MYMFT app.
	We will develop a safety oversight system across RMCH, to prevent patients becoming lost to follow up.
	We will ensure robust monitoring of the RMCH Transfer policy through clinical audit activity, to ensure that the policy is fit for purpose and that it promotes safety for all intra and inter Hospital transfers.
	We will review the RMCH Discharge policy to ensure it is fit for purpose and that it promotes safety.
	We will ensure that RMCH has robust transition plans in place across all of its relevant speciality teams, to ensure that all relevant patients are transitioned into adult services within a timely and effective manner.
	We will continue to implement innovative operational initiatives, such as the launch of virtual wards and a virtual discharge lounge, which will promote effective pathways for patients that are not only safe but reduce long waits and improve patient and families' experiences of RMCH services.
Priority category 4: Infrastructure – Staffing, Facilities, Utilities.	We will continue to develop our Hospital 24 rota's and undertake a comprehensive review of junior doctor rotas, workload, skill mix, and alternative roles being undertaken across RMCH for both in and out of hours.
Priority category 5: Communication Failure.	We will launch our parental concerns process, Speak to Sister, Chat to Charge Nurse across RMCH.
	We will utilise the incident reporting system to manage parental concerns, supporting Group wide work to establish a mechanism that allows families to report incidents/ concerns directly.
	We will further develop and enhance the RMCH Significant Event Team Support System (SETS), to ensure that all staff across RMCH are supported when there has been a significant patient safety event.
	We will review communication training and models in use across RMCH to enhance communication between teams.
	We will launch the Civility saves lives programme across RMCH.
	We will develop an RMCH patient and family's involvement and engagement strategy.
Priority category 6: Medical Device Failure.	We will demonstrate robust monitoring of medical device training compliance across RMCH.
	We will ensure all device related incidents are appropriately recorded via the yellow card system.
	We will ensure health and safety incidents are robustly reviewed and that learning is shared across RMCH.
Priority category 7: Treatment / Procedure Delay / Failure.	We will optimise the Theatre improvement programme, including a review of theatre utilisation.
	We will ensure our waiting list monitoring process is robust and that it ensures that patients are appropriately prioritised according to their clinical urgency.
	We will further develop and monitor our harm review process for long waiters.
Priority category 8: Clinical Assessment – Test Results/Reports.	We will review the processes for notification of critical results to ward medical and nursing staff to ensure thresholds are correct and that appropriate staff are being notified via suitable communication methods
	We will review HIVE results acknowledgement data by ward and specialty and develop actions and a trajectory for improved results acknowledgement performance

Priority Category	Improvement Objective/ Commitment
Priority category 9: Documentation.	We will ensure that documentation on patients records, meets the required standards, through an annual clinical audit.
	We will ensure the safe and effective storage of section paperwork and Deprivation of Liberty orders, within the HIVE system, through biannual audit cycles.
	We will ensure that safeguarding practices via HIVE are safe and effective and ensure that there is a clear line of sight for staff of any patients and families under a safeguarding plan.
Priority category 10: Disruptive, Aggressive Behavior.	We will develop our staff knowledge and confidence in relation to legal frameworks and processes for children and young people in crisis.
	We will review our environmental risks associated with the care of complex patient groups within an acute setting.
	We will scope training opportunities for our staff relating to communication with patients, families, and each other.
	We will review and develop our 'Managing and Maintaining Relationships with Families' guidance, to ensure that our families and our staff are supported to work collaboratively from admission.
	We will continue to develop the newly established RMCH mental health delivery group.
Overarching/ All Priority Categories	We will strengthen our processes of and accessibility of all policies and guidelines across RMCH/MCS.
	We will develop a safety oversight system within RMCH that will ensure timely escalation and response to emerging risks and issues.
	We will develop a Hospital Quality and Safety Strategy/Plan, to ensure that the Hospital's vision and safety objectives are clearly captured and articulated to staff and families.
	We will ensure that our localised improving quality work-streams are aligned to the RMCH MCS audit strategy and held and/ or monitored centrally.
	We will develop an RMCH Quality and Safety communication strategy. To ensure effective shared learning is achieved and that there is engagement of all staff in Safety processes, from Board to ward.
	We will review the just culture system across RMCH, ensuring this is understood and applied consistently, to ensure that all staff are supported through all significant events.
	We will continuously review our staff education and training availability and format.

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

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 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 quality improvement strategy
Eg incident meeting Each Baby Counts criteria	Referred to Healthcare Safety Investigation Branch for independent patient safety incident investigation	Respond to recommendations as required and feed actions into the quality improvement strategy

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

Patient safety incident type or issue	Planned response	Anticipated improvement route
Never Events	PSII	Create local safety actions and feed these into both localised and Group wide oversight/ improvement workstreams.
Incidents where death has occurred, and potential contributory factors have been identified	PSII	Create local safety actions and feed these into both localised and Group wide oversight/ improvement workstreams.
Incidents where death has occurred, and potential contributory factors have been identified	CDRM/ Mortality Review	Learning shared via quality and patient safety structures.
Incidents raised by patients and families	HILA/PSII	Inform ongoing improvement efforts
Incidents within the patient safety profile	HILA/PSII/ alignment to improvement workstreams	SEIPS review/Inform ongoing improvement efforts