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WTWA

Patient Safety Incident Response Plan

2022-2025

Safety Differently

Our family of hospitals caring for you

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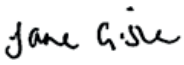
Reviewers	Jane Grimshaw	Director of Nursing, Wythenshawe, Trafford, Withington & Altrincham &		
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Introduction

This patient safety incident response plan (PSIRP) sets out how Wythenshawe, Trafford, Withington and Altrincham (WTWA) Hospitals which is part of Manchester University NHS Foundation Trust (MFT) intends to respond and 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.

Manchester University NHS Foundation Trust 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.

Due to the size and structure of MFT, it has been agreed that there will be a MFT Group level PSIRP which will outline the priorities of the Trust as a whole, and each Hospital/Managed Clinical Service (MCS) will hold its own localised PSIRP, that is aligned to localised patient safety priorities.

WTWA provides district hospital services to our local community as well as a number of tertiary services. WTWA also manages a number of single hospital services within MFT including, cardiac, trauma and orthopaedics, breast and urology.

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*

C. *incidentstransferring 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 patient safety incident response 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.

This 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 our changing patient safety profile.

There are many ways to respond to an incident. **This document 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 patients 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 this Plan include:

- Patient Safety Incident Investigations (PSIIs)
- Patient Safety Reviews (PSRs)

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.

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 resource (employee relations) teams for professional
- conduct/competence issues and if appropriate, for referral to professional regulators
- legal teams for clinical negligence claim
- medical examiners and if appropriate local coroners for issues related to the cause of a death
- the police for concerns about criminal activity

WTWA Strategic objectives

Act on feedback from patients, families, carers, and staff about the current problems with patient safety incident response and PSIIs in the NHS.

Develop a climate that supports a 'just culture' and an effective learning response to patient safety incidents.

Make more effective use of current resources by transferring the emphasis from the quantity of investigations to a higher quality, more proportionate response to patient safety incidents. The aim is to:

- make PSIIs more rigorous and, with this, identify causal factors and system-based improvements
- engage patients, families, carers, and staff in PSII and other responses to incidents, for better understanding of the issues and causal factors
- develop and implement improvements more effectively
- explore means of effective and sustainable spread of improvements which have proved demonstrably effective locally.

Addressing health inequalities

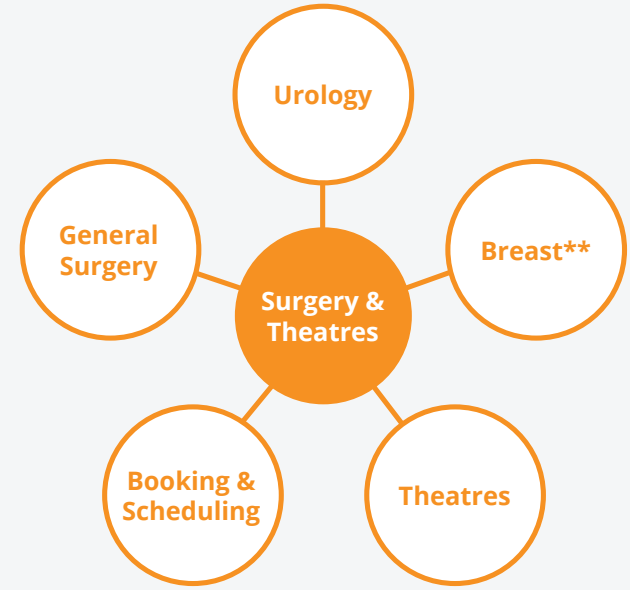
As a provider of a number of single hospital services across MFT, WTWA has a key role to play in tackling health inequalities in partnership with our local partner agencies and services. However, most of the fundamental factors driving inequalities in health are beyond the responsibility of the health 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.

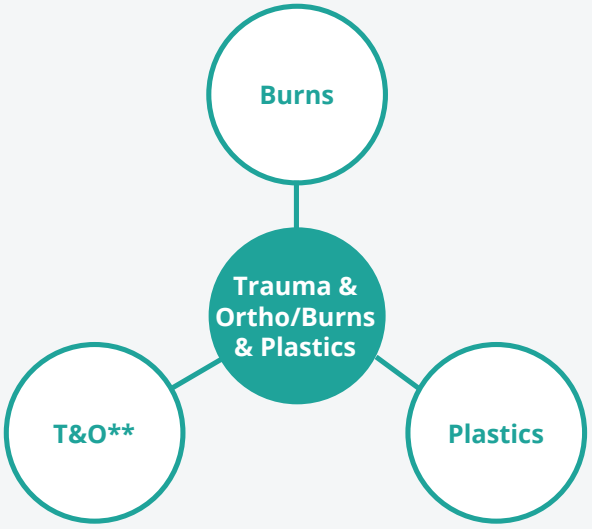
Through our implementation of PSIRP, we will seek to utilise data and learning from investigations to identify actual and potential health inequalities and make recommendations to support tackling these.

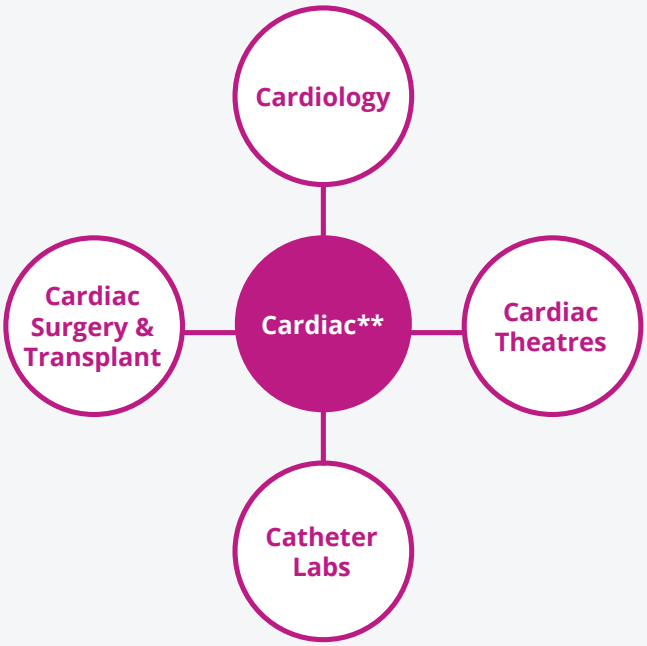
Our engagement with patients, families and carers following a patient safety investigation must also recognise diverse needs and ensure inclusivity for all. Any potential inclusivity or diversity issues must always be identified through the investigation process and engagement with patients and families,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

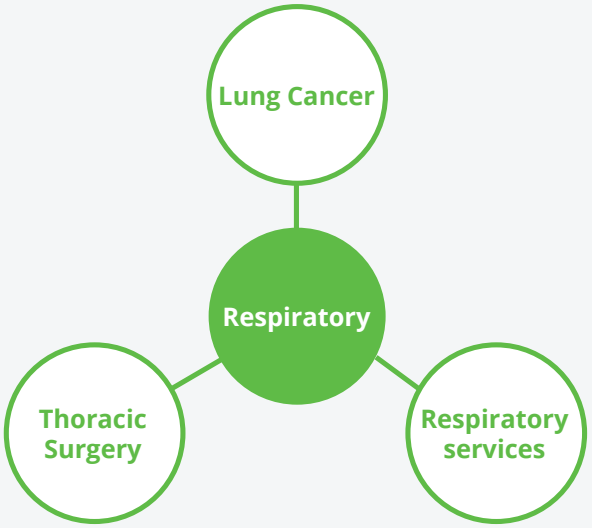
Our Services

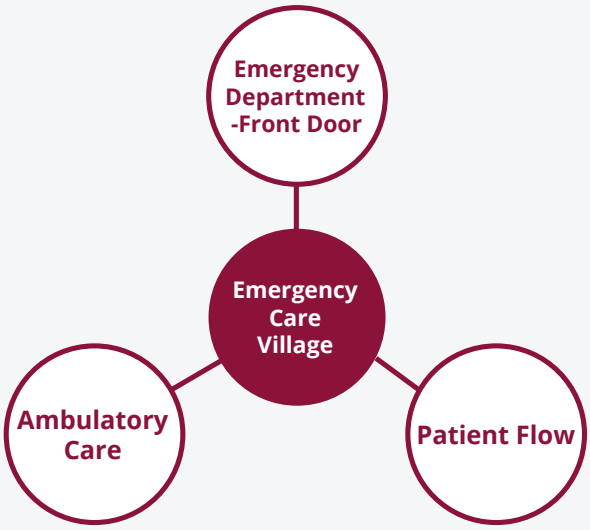
WTWA has six clinical divisions providing a wide range of services.

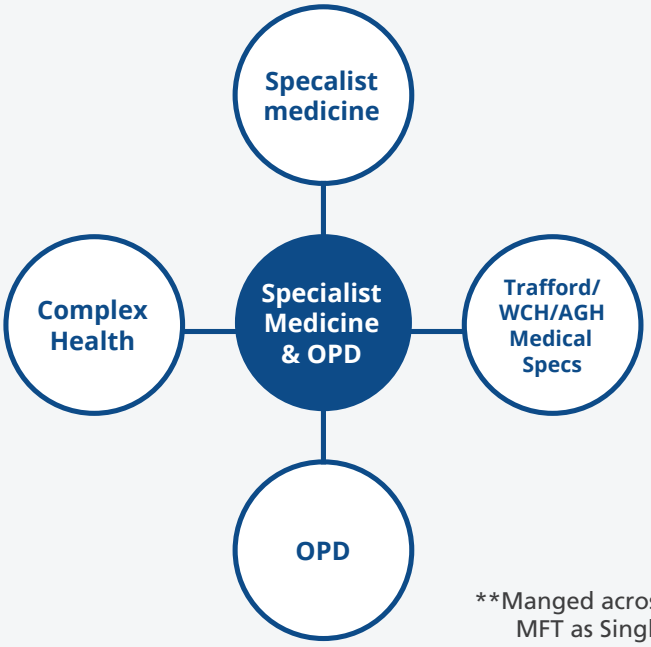












**Manged across MFT as Single Hospital Service

Through the Managed Clinical Service model, there a number of services hosted across WTWA managed as part of Managed Clinical Services (MCS):

Paediatric Services Managed by RMCH	**Obstetrics, Gynaecology & Neonates** Managed by Saint Mary's	**CTCCU, AICU, Radiology, AHP & Labs** Managed by Clinical & Scientific Services	**Eye & Dental Outpatient Services** Managed by Manchester Royal Eye Hospital & University Dental Hospital	**SHS: ENT/Max Fax, Renal Dialysis (@ AGH) Gastro / Endoscopy** Managed by Manchester Royal Infirmary

With the introduction of elective surgical hubs nationally to support access and timeliness of elective surgical procedures, the Trafford site is home to the Trafford Elective Hub (TEH), the focus is on those high volume, low complexity procedures in various specialities. Therefore, surgeons from across MFT will utilise the TEH to drive improvements in waiting time, with protected capacity for elective surgical pathways.

Defining our patient safety incident profile

Over the past 2 years, WTWA as part of MFT has focused on improving our approach to patient safety incidents, with many great examples of learning and involvement.

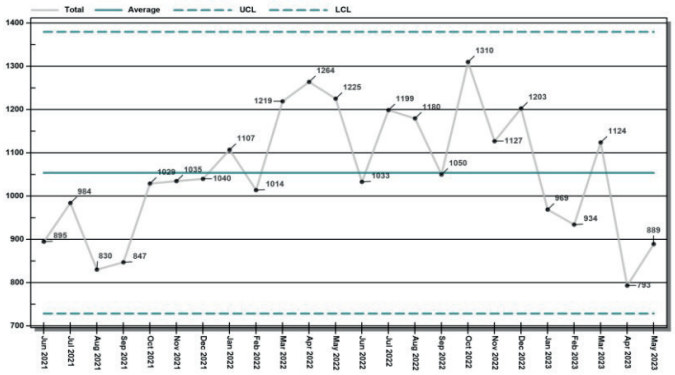
Essential to this has been fostering a patient safety culture in which people feel safe to talk. Having conversations with people relating to a patient safety incident can be difficult and we will continue to explore how we can equip and support our colleagues to best hear the voice of those involved. 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 of organisational culture and what it feels like to be involved in a patient safety incident.

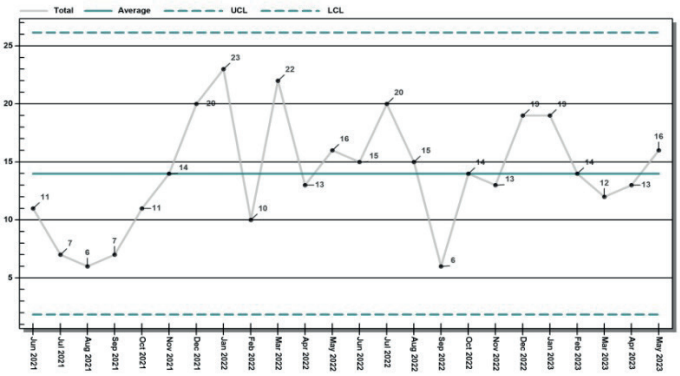
Patient safety incidents and Hospital level risks for WTWA have been profiled using organisational data including:

- Incident Reports: Two years of data has been reviewed and review of any special cause variation considered and triangulated with other data sources.
- The WTWA Risk Register was reviewed, with a focus on risks related to patient safety and this was triangulated with incidents and complaint themes

- Complaints and compliment's themes were reviewed.
- Friends and Family Test (FFT), What Matters To Me (WMTM) and Quality Care Round (QCR) data reviewed and triangulated with other data sources.
- Coroners' findings including prevention of future death notifications.
- National & Clinical Audit outcomes and recommendations were reviewed, and the themes triangulated with other data



WTWA All incidents June 2021- May 2023



WTWA Notifiable incidents June 2021- May 2023

Defining our patient safety improvement profile

WTWA has a comprehensive programme of patient safety improvement, as well as an active Quality Improvement programme. The clinical governance framework enables a robust assurance process, providing assurance that improvements are being made, embedded and sustained.

WTWA works collaboratively with our colleagues from across MFT and the Local Care Organisation (LCO), as well as external stakeholders to improve safety.

The Quality improvement priorities for WTWA

- The Deteriorating Patient
- Safer Surgery and Interventional Procedures
- Dementia
- Falls prevention
- Tissue Viability
- Infection Prevention and Control
- Medication Safety
- Mental Health & Safeguarding
- Access, Admission and Discharge
- End of Life
- Nutrition and Hydration

These key priorities are discussed, and assurance given of progress through the following groups and committees:

- Quality & Patient Safety Committee
- WTWA Safeguarding Committee
- WTWA Infection Prevention and Control
- WTWA Falls Operational Group
- Falls collaborative
- WTWA Medicines Management Committee
- Trust Medicines Safety Committee
- Theatre Safety Committee
- Meeting
- Nutrition steering Committee WTWA
- WTWA Patient Experience Delivery Group
- WTWA Clinical Effectiveness Committee

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
Never Events	PSII	Create local organisational actions and feed these into the WTWA and MFT quality improvement strategies
Learning from Deaths: 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 WTWA and MFT quality improvement strategies
Deaths of Persons with learning disabilities	PSII	Create local organisational actions and feed these into the WTWA and MFT quality improvement strategies
Safeguarding Incidents	PSII	Create local organisational actions and feed these into the WTWA and MFT quality improvement strategies
Incidents in NHS Screening Programmes	PSII	Create local organisational actions and feed these into the WTWA and MFT quality improvement strategies

Table 1

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

The WTWA safety profile has identified ten incident categories which require an increased focus in relation to patient safety. Table 2, details the locally identified areas of focus and improvement.

Several system-based learning response methods are available to respond to a patient safety incident or cluster of incidents. These will be applied where contributory factors are not well understood, and further local improvement work is required to enable the greatest potential for new learning and improvement.

	Patient safety incident type	Speciality	Planned/Suggested Response(s)	Anticipated improvement route
1	Slips, Trips and Falls	All	HILA SWARM Thematic Review	WTWA Falls Operational Group / Falls collaborative Quality & Patient Safety Committee
2	Medication Safety	All	HILA MDT SWARM PSII Observation Walkthrough	WTWA Medicines Management Committee / Trust Medicines Safety Committee
3	Access, Admission, Transfer, Discharge • Including impact of SHS transition	All	HILA MDT SWARM PSII Observation Walkthrough	Locally identified workstreams or QIP appropriate to theme and improvement identified / Quality & Patient Safety Committee / Safeguarding Committee
4	Disruptive, aggressive behavior • Impact of mental health patient delays	All	HILA SWARM MDT	WTWA Safeguarding Committee WTWA Risk Committee Quality & Patient Safety Committee
5	Patient Treatment / Procedure /Surgery • Delay / Failure - Treatment / Procedure	All	HILA MDT PSII SWARM Walkthrough	Theatre Safety Committee Meeting
6	Patient Care, Monitoring, Review: • Delay/Failure in assessing patient • Delay/Failure to monitor • Ensuring safe and effective follow up of care	All	HILA MDT PSII SWARM	Locally identified workstreams or QIP appropriate to theme and improvement identified / Quality & Patient Safety Committee

7	Pressure ulcers	All	Thematic Review	Locally identified workstreams or QIP appropriate to theme and improvement identified / WTWA Safeguarding Committee
8	Infection / Sepsis Management	All	Outbreak review Thematic Review	WTWA Infection Prevention & Control Committee meeting
9	Consent	All	HILA MDT	Theatre Safety Committee Meeting
10	Nutrition and Hydration	All	HILA Thematic Review MDT SWARM	Locally identified workstreams or QIP appropriate to theme and improvement identified

Table 2

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 senior clinicians, undertaking reviews in their allotted management time. The WTWA Risk & Governance Team do not have any line management responsibilities with regards investigators and thus limited influence over how investigators prioritise their time for investigations. Investigation reports have WTWA executive level 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.

Learning response leads, those leading engagement and involvement and those in PSIRF oversight roles require specific knowledge and experience. Learning responses are not led by staff who were involved in the patient safety incident itself or by those who directly manage those staff and it is recommended that learning responses are led by staff at Band 8a and above.

Therefore, job planning and time is required to enable identified staff to complete the required PSIIs. Table 3 below outlines the proactive response planning and overview of estimated resource allocation for patient safety incidents that fall outside national priorities.

Response Type	Category	Total number of responses	Hours
PSII	Locally defined PSIIs	15	**Minimum 60 hours per investigation for:** • 1 lead investigator • 1 support investigator **Up to 30 hours per investigation for:** • subject matter expertise • family liaison **Plus Up to 30 hours per investigation for:** • investigation oversight and support • administration support • interview and statement time of staff involved in the incident • SLT approval and sign off
	Unanticipated Incidents identified as requiring PSII	5	As above
PSRs	All types including learning from work went well (safety II)	1000	Approximately 20 hours per response review

Table 3