Stockport NHS Foundation Trust

Patient Safety Incident Response Plan

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	NAME	TITLE	SIGNATURE	DATE
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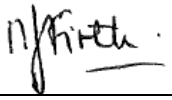
Reviewer	**Nicola Firth**	**Chief Nurse**		**27.07.2023**
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1. Introduction

"Patient safety focuses upon the avoidance of unintended or unexpected harm to people during the provision of health care. We aim to minimise harm from patient safety incidents, learn and drive improvements in safety and quality. Patients should be treated in a safe environment and protected from avoidable harm."

1.1. Purpose

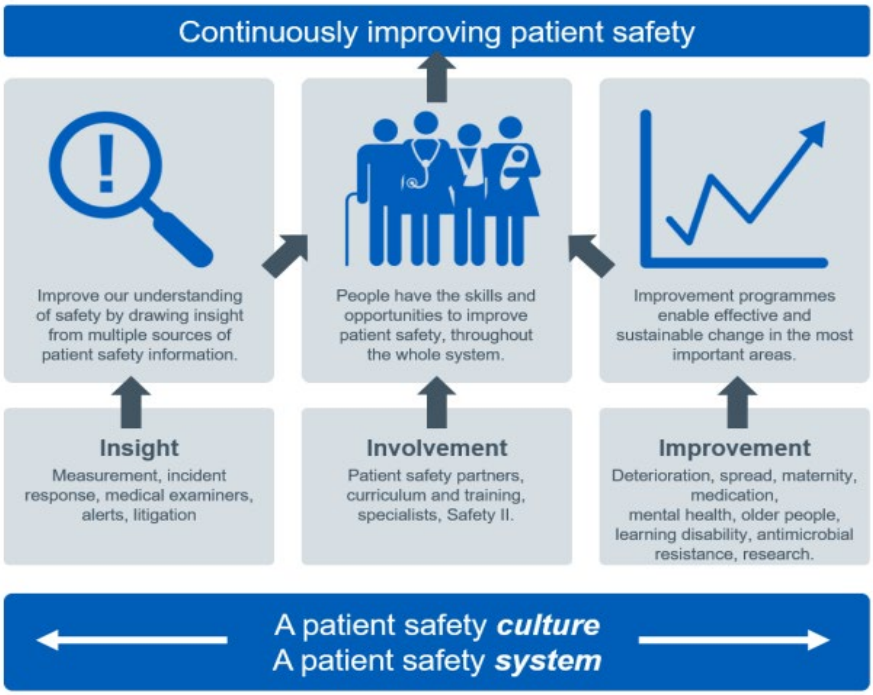
This Patient Safety Incident Response Plan (PSIRP) sets out how Stockport NHS Foundation Trust intends to respond to patient safety incidents over a period of 12 to 18 months from 1 October 2023 onwards. It explains how we will learn from patient safety incidents reported by staff, patients and their loved ones.

The Patient Safety Incident Response Plan is built upon the foundations of the NHS Patient Safety Strategy and the NHS Patient Safety Incident Response Framework. It has been created to support the continued development of a safe culture, safe systems and safe patient care. Central to the plan is the aim to learn and improve.

The NHS National Patient Safety Strategy first published in 2019 highlighted:

- The importance of understanding safety data to gain insight and understanding;
- The value of involvement of staff, patients and their loved ones to learn and improve;
- The impact that focused improvement can make to lead to sustainable change;
- That each organisation needs to develop and embed a culture of safety in order to continuously improve patient safety.

Figure 1: The NHS National Patient Safety Strategy



This plan is written with the principles of the NHS Patient Safety Strategy at its centre. By carrying out the actions agreed within this plan the Trust will be able to demonstrate how we seek to understand patient safety information, involve staff and patients to improve patient safety and how we will improve patient safety over the next 12 to 18 months.

In August 2022 the new NHS Patient Safety Incident Response Framework (PSIRF) was published. This will replace the NHS Serious Incident Framework (SIF) which provided principles and standards related to the identification, reporting and investigation of incidents based on harm categories. In Autumn 2023 Stockport NHS Foundation Trust will transition away from the SIF to utilise PSIRF as the framework for how it learns and improves from patient safety incidents.

> ***"The introduction of the NHS Patient Safety Incident Response Framework represents a significant shift in the way the NHS responds to patient safety incidents, increasing focus on understanding how incidents happen – including the factors which contribute to them."***
>
> Aiden Fowler, National Director of Patient Safety, NHS England

The Trust is clear that PSIRF is significantly different to the SIF and therefore our approach to learning and improving from patient safety incidents must also be different. It is an exciting opportunity for the Trust to take ownership of what and how it will investigate in relation to patient safety, in order to learn and improve.

PSIRF is a key part of the NHS Patient Safety Strategy and supports the development and maintenance of an effective patient safety incident response system that integrates four key aims:

- Compassionate engagement and involvement of those affected by patient safety incidents;
- Application of a range of system-based approaches to learning from patient safety incidents;
- Considered and proportionate responses to patient safety incidents;
- Supportive oversight focused on strengthening response system functioning and improvement.

Application of this plan will support the Trust to deliver a considered and proportionate response to patient safety incidents utilising a system-based approach to learning and improvement. The plan will be supported by updated Trust Incident Management Policies, including our approach to engagement and involvement of those affected by patient safety incidents.

1.2. Scope

This plan provides a description of how the Trust will apply PSIRF. The plan will focus upon:

- **Our understanding of our patient safety incident profile**
  What our data, both quantitative and qualitative tells us about patient safety at Stockport NHS Foundation Trust.
- **Our current patient safety improvement profile**
  As an organisation the Trust is committed to improving patient safety, we will describe all on-going improvement work across the organisation that impacts upon patient safety improvement.
- **Our Patient Safety Incident Response Plan**
  In light of what we have learnt about our incident profile and the already on-going improvement work the Board of Directors have signed off this Patient Safety Incident Response Plan (PSIRP) made up of two elements:
  - National requirements – here we describe the patient safety incidents that require a national response; what that response will be, and how we will learn from any incident response we undertake
  - Local focus – here we describe the patient safety incidents that have been agreed as locally priorities by the Trust Board; what our response to the incidents will be, and how we will learn from any incident response we undertake

This is the first Patient Safety Incident Response Plan developed by the Trust and it is intended that this plan be reviewed following a twelve month period, with a refreshed and updated PSIRP agreed by Board within eighteen months. The following timeframes will therefore apply:

PSIRP Update Timescales	
Launch of the PSIRP **(1 October 2023 –31 March 2024)**	1 October 2023
Full review of the PSIRP commences	1 October 2024
Updated PSIRP approved **(covering 1 April 2025 – 30 September 2026)**	1 April 2025

This patient safety incident response plan sets out how Stockport NHS Foundation Trust 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 occur and the needs of those affected.

1.3. Health Inequalities

When the National Patient Safety Strategy was updated in 2021 a greater emphasis was rightly placed upon reducing inequalities. Healthcare inequalities 'are not inevitable and can be significantly reduced. Avoidable health inequalities are unfair and putting them right is a matter of social justice' (The Marmot Review 2010). When healthcare inequalities increase the risk of harm to patients in healthcare or cause harm, they are then defined as patient safety inequalities.

Stockport NHS Foundation Trust will seek to better understand healthcare inequalities across the organisation and seek to improve by:

- Reviewing the collection of health inequalities data for incidents and complaints reported within its risk management system.
- Creating an action plan on how we will improve the collection of data so that we have better insight.
- We will engage with staff, patients and loved ones in line with the NHS England guide to 'Engaging and involving patients, families and staff following a patient safety incident'.
- Using the data collected to identify areas for improvement.

2. Our services

2.1. Our Trust

Stockport NHS Foundation Trust holds a unique position in the Stockport community as the provider of healthcare. We are an integrated provider of acute hospital and community services to the people of Stockport, as well as serving the populations of East Cheshire and the High Peak in North Derbyshire.

We offer a number of specialist services and play a key partnership role with Greater Manchester, Stockport and East Cheshire. With an annual budget of around £300 million and about 5,000 staff we provide healthcare for residents in Stockport, East Cheshire and North Derbyshire as well as patients we treat from other boroughs in Greater Manchester who choose our services.

2.2. Our services

Our main hospital is currently known as Stepping Hill, which provides emergency, surgical and medical services for people living in Stockport and surrounding areas. Our stroke services have been rated as the best in England and we also run one of the largest orthopaedic services in the region. We offer a range of core district general hospital services as well as some specialist services, such as orthopaedics, stroke, and urology that have a national reputation for excellence. We are also one of four designated specialist sites for acute and general surgery in Greater Manchester.

We run a unit at the Meadows in Stockport which is a community Transfer to Access intermediate nursing care facility and Swanbourne Gardens which provides overnight breaks for children and young people with severe learning disabilities. We also run the Devonshire Centre for neuro-rehabilitation although this service will soon transfer to Salford NHS Foundation Trust.

We are proud of our community health services that run across 24 health centres and community clinics in Stockport. Our vision for neighbourhood services is to provide a joined up, high quality, sustainable, modern and accessible health and care system.

The new community models of care address the challenges of rising demand, supporting the growing number of people with complex and long-term conditions and the root causes of the financial challenges of Stockport.

We are an associate teaching hospital, helping to train a variety of health professionals for the future.

In our region, we are one of four specialist hospitals for emergency and high risk general surgery; one of three specialist stroke centres; and one of only two orthopaedic departments delivering c-spine surgery in Greater Manchester.

2.3. Mapping our services

Stockport NHS Foundation Trust provides a wide range of services both at Stepping Hill Hospital and within the community of Stockport. The services are mapped out below.

Hospital Services		Community Services	
• Acute care • Anti-coagulation • Audiology • Birth centre • Cardiology • Chaplaincy services • Children's continuing care • Colposcopy • Crisis Response Team • Diabetes and Endocrine • Ear, nose and throat • Echocardiogram and electroencephalogram • Emergency department • Endoscopy • Fertility • Gastroenterology • General surgery • Gynaecology • Haematology • Health mentors • Heart care unit • In-patient therapy • Intensive care and high dependency • Laboratory medicine • Maternity • Neonatal • Nephrology • Neuro-rehabilitation • Nutrition and dietetics service	• Older people services • Oncology • Ophthalmology • Orthodontics • Orthotics • Outpatient bookings • Outpatient hysteroscopy • Outpatient paediatrics • Outpatient speech and language therapy • Outpatient therapies including physio', hand, hydro', and dietetics • Paediatrics • Pain Clinic • Pharmacy • Pre-operative care and surgery pre-assessment • Radiology • Research and development • Respiratory medicine • Respiratory physiology • Rheumatology • Safeguarding • Stroke • Trauma and orthopaedics • Urology	• Active recovery • Adult continence service • Children's physiotherapy • Children's speech and language therapy • Children's community nursing team • Children's continence (PEBBLES) • Children's occupational therapy • Chronic fatigue syndrome (ME) • Chronic obstructive pulmonary disease (COPD) • Community advanced clinical practitioner and matron team • Community midwifery • Community neuro rehabilitation • Community orthotics • Diabetes • District nursing • Expert patients programme • Health visiting • Infant parent service • Nutrition and dietetics service	• Orthopaedics assessment service • Orthoptics and optometry • Palliative care • Parenting team • Physiotherapy • Podiatry • Pulmonary rehabilitation • Safeguarding • School nursing • Swanbourne gardens • Tissue Viability • Wheelchair/ specialist equipment

This Patient Safety Incident Response Plan is relevant to all services provided by the Trust.

3. Defining our patient safety incident profile

As part of the Patient Safety Incident Response Plan the Trust has completed a review of its patient safety incident profile. This means that we have reviewed our patient safety data – both quantitative and qualitative, and engaged with our stakeholders to better understand what our patient safety priorities should be.

3.1. Data sources

Patient safety data has been collected from the following sources to support understanding of patient safety at the Trust:

Data Source	Timescale
Patient safety incident reporting	01/04/2018 – 31/03/2023
Complaints received	01/04/2018 – 31/03/2023
Claims received – including the litigation scorecard	01/04/2020 – 31/03/2023
Inquest outcomes – including prevention of future death notifications	01/04/2020 – 31/03/2023
Mortality Review outcomes – including learning from death reviews	01/04/2020 – 31/03/2023
Getting it Right First Time (GIRFT) outcomes	01/04/2020 – 31/03/2023
Risk Register Review – review of patient safety risks within the Trust risk register	May 2023

Each data source has been interrogated to understand themes and trends to support the agreement of patient safety priorities for the Trust.

3.2. Stakeholder engagement

Alongside the review of patient safety data we have sought to collaborate with our stakeholders to agree the patient safety priorities within this plan.

Stakeholder engagement	
Trust staff and team members	Regular PSIRF sessions have taken place across the Trust. In July these focused upon agreement of the local priorities for patient safety
Patients, families and carers	The Trust has engaged with the local Healthwatch and Community Champions Network to seek input into the Patient Safety Incident Response Plan
NHS Greater Manchester Integrated Care Board (ICB)	The Trust has engaged with key team members at the ICB in the creation of this plan.
Council of Governors	The Trust has engaged with the Council of Governors to seek input into the Patient Safety Incident Response Plan

4. Defining our patient safety improvement profile

As part of the Patient Safety Incident Response Plan the Trust has completed a review of its patient safety improvement profile. This means that we have reviewed all improvement and service transformation work across the organisation to better understand the totality of activity currently planned or taking place which will improve patient safety.

4.2. The Quality Strategy 2021-2024

Stockport NHS Foundation Trust has a Trust Quality Strategy 2021-24 with an ambition to:

Start Well – Improve the first 1,000 days of life

Live Well – Reduce avoidable harm

Age Well – Reduce avoidable harm

Die well with dignity – Improve the last 1,000 days of life

Stockport Quality Strategy Schemes	
Pressure Ulcers	Aims: • 5% reduction on acute care 22/23 reported figures – no more than 87 acquired pressure ulcer incidents reported • 10% reduction on community care 22/23 reported figures - no more than 137 pressure ulcer incidents reported • No more than 5% of all pressure ulcers reported as a result of a lapse in care • No category 3-4 pressure ulcers due to a lapse in care Oversight: All pressure ulcers will be reviewed using the organisations pressure ulcer proforma and reviewed at harm free care group where lesson learning and actions will be identified. Any acquired pressure ulcers requiring further escalation will be reviewed at incident review group and Patient Safety Incident Response Group (PSIRG).
Falls	Aims: • 5% reduction in moderate harm or above caused by falls • 10% reduction in lapses in care Oversight: All falls will be reviewed using the organisations falls proforma, and reviewed at harm free care group where lesson learning and actions will be identified. Any falls requiring further escalation will be reviewed at incident review group and PSIRG
Infection Prevention	Aim: • No more than 40 cases of clostridium difficile in line with national trajectories • Zero MRSA bacteraemia Oversight:

	All healthcare acquired infections are reviewed, and lesson learning identified via the healthcare acquired infection panel where lesson learning and actions are agreed. There is also additional oversight via the Infection Prevention and Control Group. Any healthcare infections requiring further escalation will be reviewed at incident review group and PSIRG.
Ward Accreditation Scheme StARs	Aim: • To maintain 50% of wards as green accreditation • To have no more than 25% of wars as red accredited Oversight: The ward accreditation programme is a continuous programme of review, learning and improvement linked to the CQC domains of safe, effective, caring, responsive and well led. Progress is reported to Quality Committee.

4.1. Transformation Schemes

The Stockport NHS Foundation Trust Service Transformation Team provides a proactive resource for continuous improvement to the Trust. The current transformation schemes include:

Stockport Transformation Schemes	
Digital Health Development	Aim: To conduct and evaluate a pilot of a Stockport Local Clinical Assessment Service (LCAS) and implement a virtual ward for Stockport locality.
Endoscopy Improvement Project	Aim: To ensure that utilisation of endoscopy sessions are fully maximised.
Frailty Programme	Aim: To support a standardised approach to identifying people living with frailty and develop a clear operating model and pathways depending on levels of severity.
Surgery Out of Hours	Aim: To improve the provision of out of hours medical staffing in the surgical division and effective flow of patients from the emergency department to surgical admissions unit.
Children's, Young People and Families	Aim: To improve pathways that our patients under the age of 18 access, including supporting their transition to adult services.
Cancer Improving Outcomes	Aim: To implement best timed pathways, supporting faster diagnosis. To implement personalised stratified follow up pathways.
Outpatients	Aim: To improve patient experience of their outpatient journey, enhancing the efficiency of Trust outpatient services.

Respiratory Outpatients	Aim: To improve efficiency of Respiratory outpatient service in light of high demand and limited services.
Pain Management	Aim: To develop the urgent community response to support admission avoidance, focusing on transforming the current advanced clinical practitioner model. To ensure a 'patient-led' patient journey through pain management services.
Elective Booking Admin' Review	Aim: To deliver a fully centralised elective booking and scheduling structure for surgical specialities across the Trust.
Theatres Efficiency and Productivity	Aim: To ensure theatre usage is maximised by reviewing the patient journey from pre-op' to post-op' care.
Ophthalmology and ENT Theatre Productivity Project	Aim: To optimise theatre utilisation for ophthalmology and oral surgery – working alongside the main theatres efficiency and productivity scheme.
Antenatal Pathway Review	Aim: To ensure safety of service users of the antenatal services and timely review for women on scan pathways.
District Nurse Redesign	Aim: To review and redesign the District Nurse team and processes to make efficiencies, contributing to improved patient care and staff engagement.
Advanced Practice Future Model	Aim: To develop the urgent community service (UCRS) to support admission avoidance.
Medicolegal Pathway Redesign	Aim: To improve processes to ensure the organisation meets compliance with the UK General Data Protection Regulations (GDPR) Subject Access Request timescales.
Rapid Diagnostic Centre	Aim: To develop a Rapid Diagnostic Pathway for patients with non-site specific cancer symptoms, supporting patient experience and performance against the faster diagnosis standards.

5. Our patient safety incident response plan: national requirements

5.1. Incidents requiring a response as set out by national requirements

The Trust is required to respond to certain patient safety incidents according to national requirements. This section of the Patient Safety Incident Response Plan sets out what these national requirements are and how our learning will inform improvement at the Trust.

Incident type	Required response	Anticipated improvement route
Deaths clinically assessed as thought more than likely than not due to problems in care (incidents meeting the learning from deaths criteria for PSII)	Locally-led Patient Safety Incident Investigation (PSII)	Create local organisational actions and where appropriate feed these into the quality strategy or transformation schemes
Death of a patient where the Mental Capacity Act 2005 applies where there is reason to think that the death may be linked to problems in care (incidents meetings the learning from deaths criteria)	Locally-led PSII	Create local organisational actions and where appropriate feed these into the quality strategy or transformation schemes and Trust Integrated Safeguarding as necessary
Incidents meeting the Never Event criteria 2018 or its replacement	Locally-led PSII	Create local organisational actions and where appropriate feed these into the quality strategy or transformation schemes
Maternity and neonatal incidents meeting Healthcare Safety Investigation Branch (HSIB/ HSSIB) criteria	Referral to HSIB for independent PSII	Respond to recommendations as required and feed actions into the Maternity Sustainability Plan
Child Deaths	Refer to Child Death Overview Panel for review Additional PSII may be required alongside panel review – to be agreed on individual basis	Create local organisational actions to be overseen by the Trust Integrated Safeguarding Group. Where appropriate feed these into the quality strategy or transformation schemes

Deaths of persons with learning disabilities	Refer for Learning Disability Mortality Review (LeDeR) Additional PSII may be required alongside panel review – to be agreed on individual basis.	Create local organisational actions to be overseen by the Trust Integrated Safeguarding Group and Mortality Review Group. Where appropriate feed these into the quality strategy or transformation schemes.
Safeguarding incidents in which: • babies, children or young people are on a child protection plan; looked after plan or a victim of wilful neglect or domestic abuse/ violence • adults (over 18 years old) are in receipt of care and support needs from their local authority • the incident relates to FGM, Prevent (radicalisation to terrorism), modern slavery, and human trafficking or domestic abuse/ violence	Refer to local authority safeguarding lead The Trust will contribute to any safeguarding review and inquiry as required to do so by the local safeguarding partnership (for children) and local safeguarding adult's board.	Create local organisational actions to be overseen by the Trust Integrated Safeguarding Group. Where appropriate feed these into the quality strategy or transformation schemes
Incidents in NHS screening programmes	Refer to local screening quality assurance service (SQAS) for consideration of locally led learning response required.	Respond to input from SQAS and where required create local organisational actions for improvement. Where appropriate feed these into the quality strategy or transformation schemes
Deaths in custody where health provision is delivered by the NHS	The Trust will fully support the Prison and Probation Ombudsman (PPO) or Independent Office for Police Conduct (IOPC) with any investigation they undertake.	Respond to recommendations as required and create local organisational actions where relevant
Reportable infections meeting the national definition (hospital-onset healthcare associated, community-onset healthcare associated)	Submission to national IPC reporting system within 48 hours	Create local organisational actions where appropriate, to be overseen at Infection Prevention and Control Group with reporting to Patient Safety Group

Incidents meeting the criteria for reporting to Medicines Healthcare products Regulatory Agency (MHRA) and Serious Hazards of Transfusion (SHOT) and local Quality Management Systems	Report to MHRA/ SHOT Investigation of all required incidents documented within the SHOT definitions 2023. All transfusion incidents will be managed in accordance with Blood Safety and Quality Regulations (BSQR) and Good Practice Guidance (GPG).	Create local organisational actions where appropriate, to be overseen at Transfusion Group with reporting to Patient Safety Group

6. Our patient safety incident response plan: local focus

6.1. Incidents identified as a priority for Stockport NHS Foundation Trust

The Trust has reviewed the data sources available to it and engaged with key stakeholders to identify local priorities for patient safety. This section of the Patient Safety Incident Response Plan sets out what these local priorities are and how our learning will inform improvement at the Trust.

It is acknowledged that the local priorities are a focused list of incident types where the Trust has decided to invest its resources to learn and improve. The priorities were reached based upon a review of patient safety data alongside consultation and engagement with stakeholders. It is important to note that all other patient safety incidents reported will continue to be reviewed and responded to within our risk management system. Where necessary teams will utilise appropriate incident response tools to enable learning and improvement across all patient safety areas.

Although the local priorities below have been agreed and will be the focus of resource until the plan is reviewed, it is recognised that the Trust may gain new insight or reason throughout the time of the plan that requires additional responses to be agreed and take place.

Incident type	Planned local response	Anticipated improvement route
Nutrition and hydration incidents where: • there are identified lapses in care related to the weighing of patients, calculation of malnutrition universal screening tool (MUST) and dietician referral that led to weight loss of more than 5% of body weight and that is significant for that individual • there are delays in tube feeding or providing medication via tube, to a patient for more than 2 days due to lapses in care.	PSII/ thematic analysis	All PSIIs will be approved at Patient Safety Incident Review Group (PSIRG) and action plan related to improvement will be led by the Nutrition and Hydration Steering Group which is reported to Patient Safety Group and Quality Committee.
Acquired pressure ulcer incidents where: • a grade 3 or 4 pressure ulcer is acquired where lapses in care are identified as having contributed to skin deterioration.	PSII	All PSIIs will be approved at PSIRG and action plan related to improvement will be monitored as part of the Quality Strategy and action plan to achieve reductions in acquired pressure ulcers. This is reported to Patient Safety Group and Quality Committee. Safeguarding processes will also apply

		where appropriate with assurance received at the Trust Integrated Safeguarding Group.
Delayed diagnosis of cancer in a patient where: • initial review of the incident identifies that the delay is due to an omission, and where the patient outcome and treatment options are materially impacted by the delay in diagnosis	PSII	All PSIIs will be approved at PSIRG and action plan related to improvement will be monitored at the Cancer Quality Improvement Group. This is reported to Patient Safety Group and Quality Committee.
Deterioration of patients on the waiting list where: • the patient has a significant event or irrecoverable deterioration and following review by the clinician this is confirmed as a result of the extended waiting time.	After Action Review (AAR)/ Thematic analysis	AARs will be approved at PSIRG and any action plan related to improvement will be monitored. The quarterly patient safety report submitted to Patient Safety Group and Quality Committee will include a section to review themes and trends of AARs and ongoing improvement activity.
Maternity and neo-natal related incidents, outside of the scope of Healthcare Safety Investigation Branch (HSIB/ HSSIB) criteria where: • following review the Trust consider considerable learning and improvement will be identified	Local response to be agreed on individual incident basis. Where a theme is identified then a thematic analysis may be suitable.	All responses will be approved at PSIRG and any action plan related to improvement will be monitored via the sustainable maternity improvement plan that is presented to Patient Safety Group and Quality Committee.

Further detail regarding local priorities and how learning will inform improvement will be set out in the ‘Safety action development and monitoring improvement’ and Safety Improvement Plans sections of the Trust’s Patient safety incident response policy.