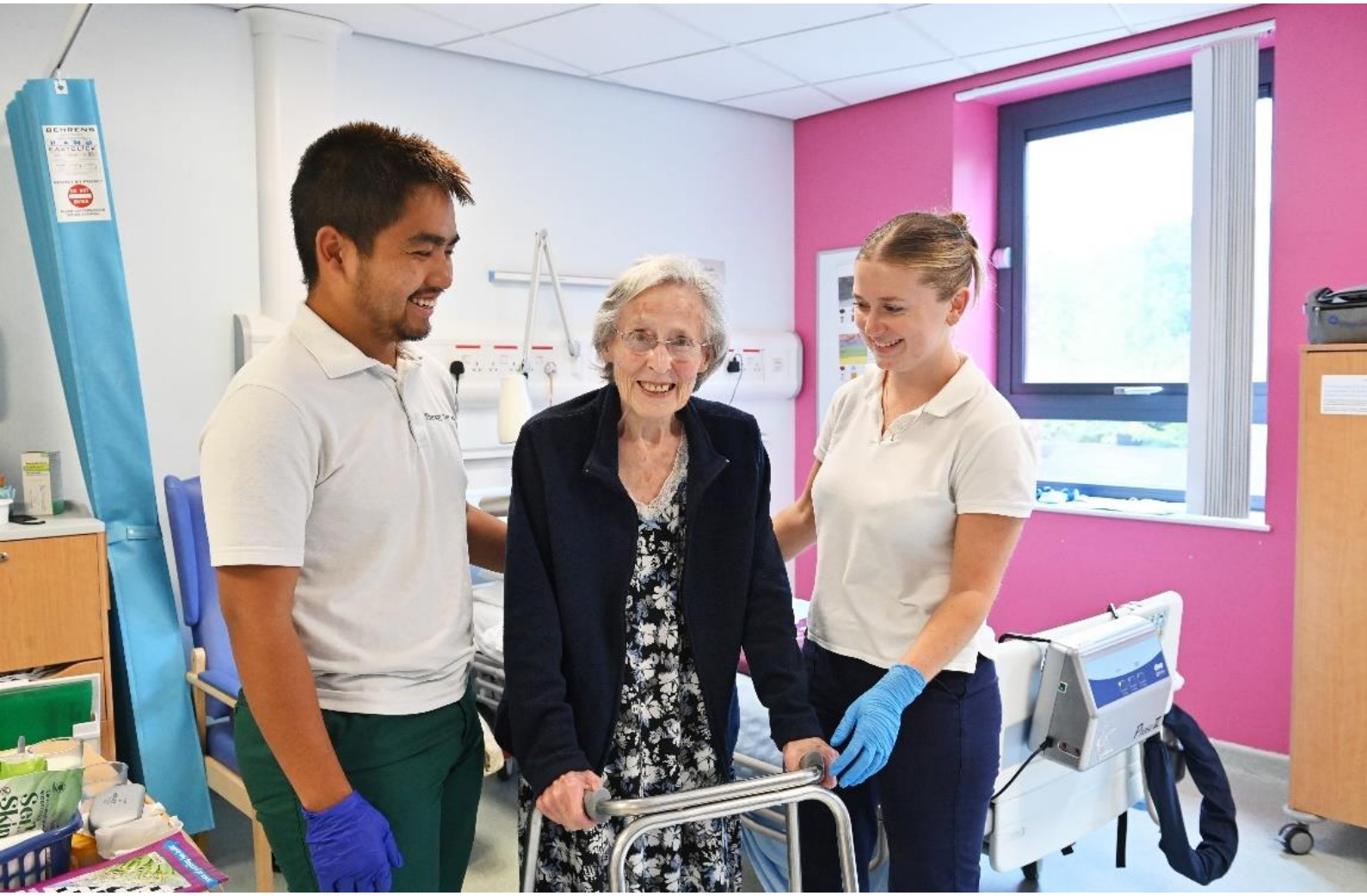
Mersey and West Lancashire Teaching Hospitals
NHS Trust



Patient Safety Incident Response Plan 2024-2026

Foreword

The Patient Safety Incident Response Framework (PSIRF) is a revised approach to how the NHS will respond and learn from Patient Safety Incidents. PSIRF is a process to investigate incidents and learn from them when they occur; a marked cultural shift in our approach to systems, protocols, and thinking. Working closely with families, patients, and staff, this framework will support us to make changes to ensure incidents that have occurred may be prevented from happening again.

The NHS Patient Safety Strategy was published in July 2019 and describes the Patients Safety Incident Response Framework (PSIRF), a replacement for the NHS Serious Incident Framework. This document is the Patient Safety Incident Response Plan (PSIRP). It describes what we are doing at Mersey and West Lancashire Teaching Hospitals NHS now that we are one year on since the introduction of PSIRF.

PSIRF is best considered as a learning and improvement framework with the emphasis placed on the system and culture that support continuous improvement in patient safety through how we respond to patient safety incidents. PSIRF promotes a proportionate approach to responding to patient safety incidents, using the most appropriate investigation approach to maximize organisational learning.

Under the PSIRF framework, NHS organisations are requested to undertake annual reviews of the types of incidents to be investigated, based upon local risks, trends and priorities for highest impact. These then form the organisation's Local Priorities.

One of the underpinning principles of PSIRF is to do fewer "investigations" but to do them better. Better, means taking the time to conduct systems-based investigations by people that have been trained to do them. The NHS Patient Safety Strategy challenges us to think differently about learning and what it means for a healthcare organisation.

This Patient Safety Incident Response Plan (PSIRP) sets out how Mersey and West Lancashire Teaching Hospitals NHS Trust will respond to patient safety incidents reported by staff and patients, their families, and carers as part of work to continually improve patient safety incident investigations (PSIIs) by:

- Refocusing Patient safety incident investigation (PSII) towards a system analysis approach and the rigorous identification of interconnected causal factors and system issues
- Focusing on addressing these causal factors and the use of improvement science to prevent or continuously and measurably reduce repeat patient safety risks and incidents.
- Transferring 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.
- Including Quality Improvement Strategies for larger scale improvement plans to ensure lasting and effective change.

Aidan Fowler, National Director of Patient Safety, NHS England – "The introduction of this 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. "

A note from Mersey and West Lancashire Teaching Hospitals Acting Director of Nursing, Midwifery and Governance and Trust PSIRF Executive

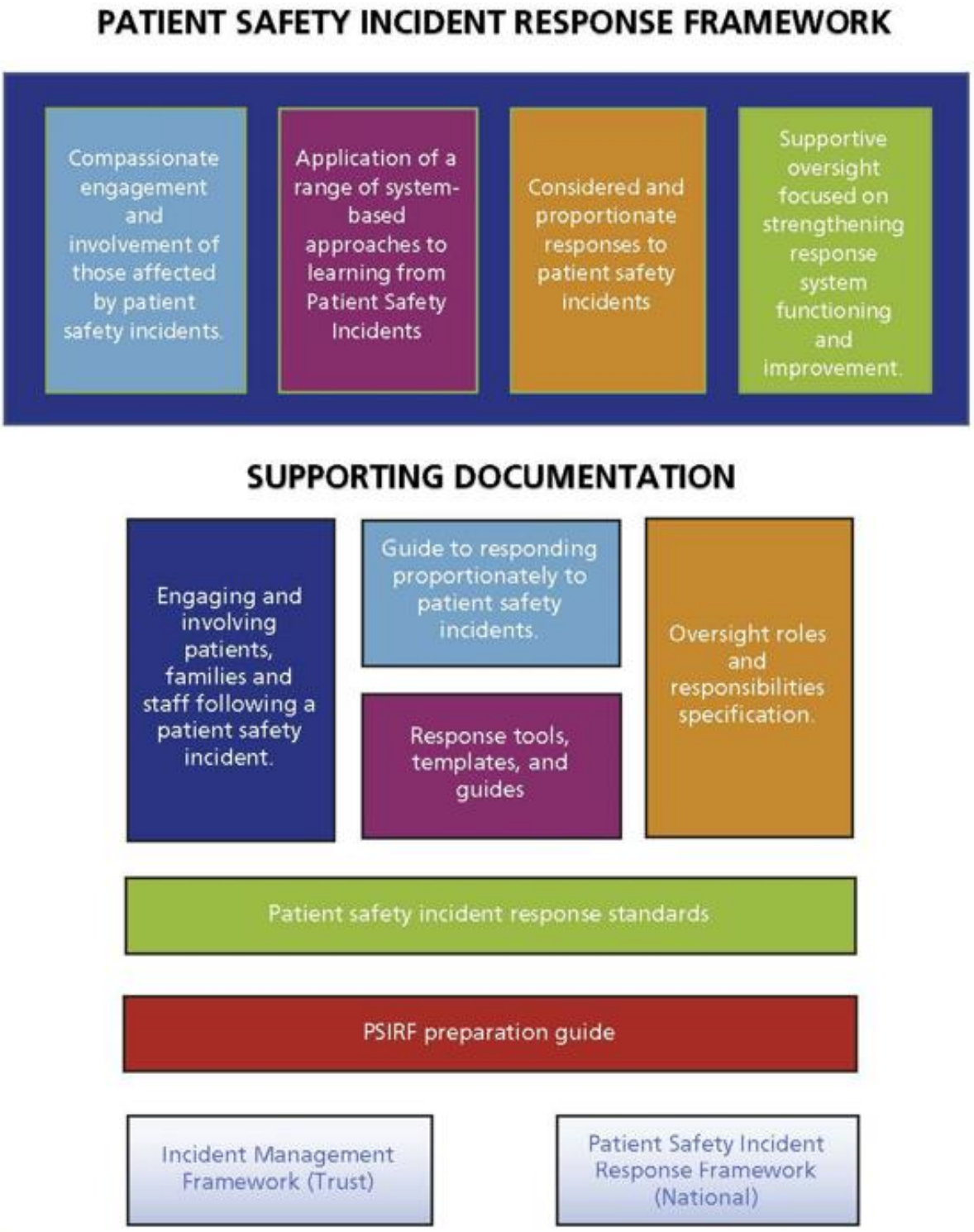
I am happy to present our revised Patient Safety Incident Response Plan for 2024-26. The Trust has developed its approach to working under the Patient Safety Incident Response Framework, working with colleagues across our newly formed divisions across Mersey and West Lancashire Teaching Hospitals NHS Trust.

As part of this plan's revision, we have consulted with our staff, patients, specialists, and have reviewed our safety data from the last 12 months to create our 'local priorities'. They continue to be our indicators as to when we will consider a Patient Safety Incident Investigation is required. We have continued to refine our methodology based on national guidance in supporting us in learning from a safety incident and making recommendations for action to reduce the risk of it from happening again. We also review what is working well at our Trust to help us promote and spread better practice.

I hope this plan provides you an insight into how we carry out investigations across our Trust as we continue to strive to deliver 5-star care across Mersey and West Lancashire Teaching Hospitals NHS Trust.

Lynne Barnes

Overview of the Patient Safety Incident Response Framework



Who we are?

Mersey and West Lancashire Teaching Hospitals NHS Trust provides healthcare in hospital and the community to people across St Helens, Knowsley, Halton, Liverpool Southport, Formby and West Lancashire.

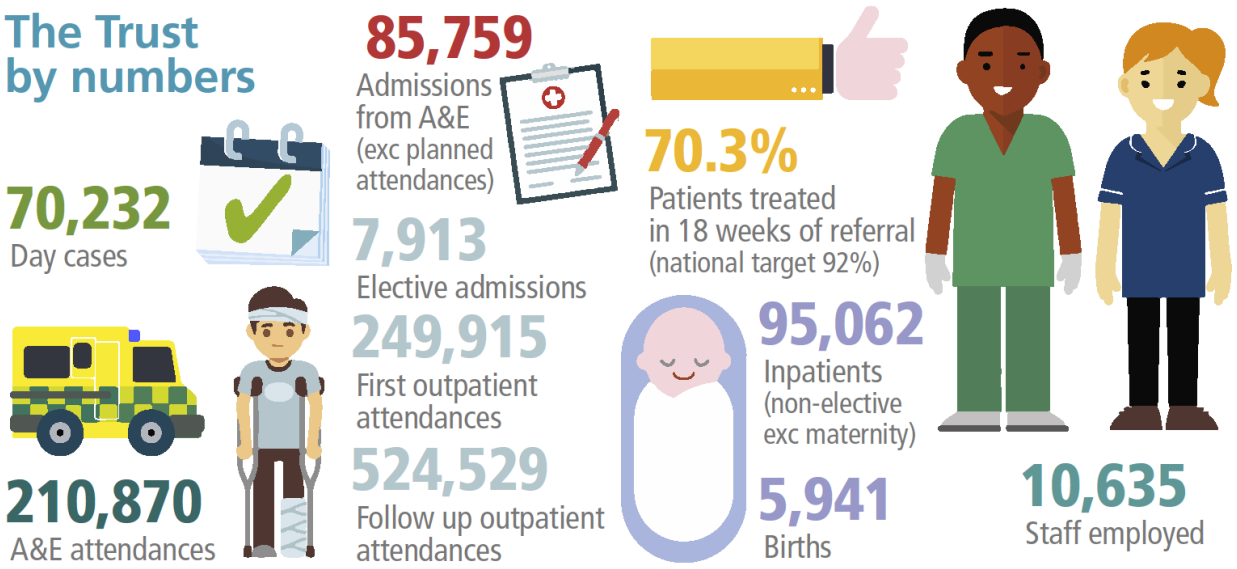
Acute care is provided at Southport and Formby District General Hospital, Ormskirk District General Hospital, Whiston Hospital, St Helens Hospital and Newton Hospital.

This includes adults' and children's accident and emergency services, intensive care and a range of medical and surgical specialities.

In addition, the Trust hosts the Mid-Mersey Neurological Rehabilitation Unit at St Helens Hospital. The Trust provides the Mid-Mersey Hyper-Acute Stroke Unit (HASU) and the Mersey Regional Burns and Plastic Surgery Unit, Northwest Regional Spinal Injuries Centre at Southport Hospital and provides specialist care for patients from across the North West of England, North Wales and the Isle of Man.

Women's and children's services, including maternity, are provided at both Whiston Hospital and Ormskirk Hospital.

The Trust also provides an Urgent Treatment Centre (UTC) at the Millennium Centre in St Helens, and Marshalls Cross Medical Centre (primary care services) and intermediate care and community services at Newton Hospital. In addition, the Trust delivers a range of community services, including adult community nursing (for St Helens), Contraception and Sexual Health Services (CaSH), frailty, falls, Healthy Heart, continence, chronic obstructive pulmonary disease (COPD) services and intravenous (IV) therapy, plus outpatient and diagnostic services from a range of other community premises.



This plan intends to be delivered with the existing Trust shared vision, which is:

''To provide 5-star patient care to all of our patients across Merseyside and West Lancashire.''

What PSIRF means?

PSIRF allows for further learning and opportunity to make improvements on the back of future incident investigations.

We now respond to Patient Safety incidents using a systems-based approach, removing a 'person focused' approach where the actions or inactions of people or 'human error', are stated as the cause of an incident.

Our Trust Board will have increased accountability and oversight of Patient Safety Incident Investigations.

Our investigators have undertaken specialist training and have the right skills and knowledge to conduct a Patient Safety Investigation with PSIRF methodology.

We will support Patients, families, and our staff through the process.

How PSIRF is different

The Patient Safety Incident Response Framework (PSIRF) 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. PSIRF supports the patient safety incident response standards by ensuring that there is appropriate governance arrangements in place to support local and national policy. It also advocates that there is in place competent people to undertake investigations proportionate to the type of incident that has been reported. PSIRF also advocates a high level of involvement with those people affected by the incident through compassionate engagement before, during and after the investigation.

Patient safety incidents are unintended or unexpected events (including omissions) in healthcare that could have or did harm one or more patients. The PSIRF replaced the Serious Incident Framework (SIF) (2015) and makes no distinction between 'patient safety incidents' and 'Serious Incidents'.

As such it removed the 'Serious Incidents' classification and the threshold for it. Instead, the PSIRF promotes a proportionate approach to responding to patient safety incidents by ensuring resources allocated to learning are balanced with those needed to deliver improvement.

PSIRF is not a different way of describing what came before – it fundamentally shifts how the NHS responds to patient safety incidents for learning and improvement.

PSIRF :

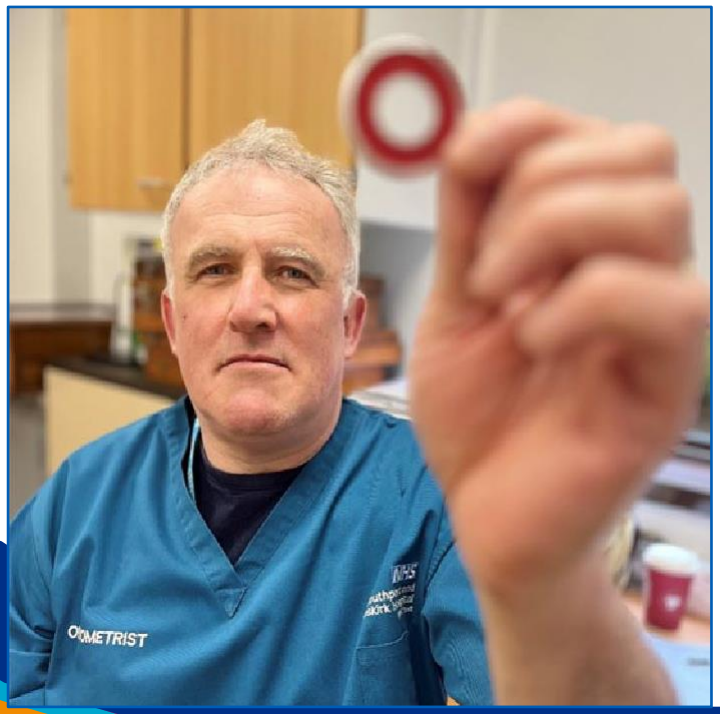
- Advocates a coordinated and data-driven approach to patient safety incident responses that prioritises compassionate engagement with those affected by the patient safety incidents.
- Embeds patient safety incident responses within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management. Organisations are required to develop a thorough understanding of their patient safety incident profile, ongoing safety actions (in response to recommendations from investigations) and established improvement programs. To do so, information is collected from a wide variety of sources, including wider stakeholder engagement.

How we prioritise our incidents and our investigation resource: Rationale

Mersey and West Lancashire Teaching Hospitals NHS Trust has a developed quality and safety assurance process to ensuring services are safe and effective.

In preparation for 2024/26 a further review has been undertaken to see if those priorities have changed, or if they need to continue for another year. The Trust also maintained the local priority of "areas of emerging risk" to ensure PSIIs will be commissioned if the Team consider this as an appropriate learning opportunity for the Trust and system partners in delivery of safe care to patients.

Our framework for investigation of patient safety incidents has been in place for 12 months and is supported by a team including specialists, investigators and subject matter experts as appropriate. Support is provided by clinical staff within specialties to ensure patient/family/carers are involved and kept informed of progress.



To improve our ability to deliver against PSII standards, the Trust :

- Assign a team of appropriately trained Patient Safety Incident investigators who have received system-based training on incident investigation methodologies.
- Assign an Executive Team/Board member to oversee delivery of PSII standards and support the sign off, of all PSIIs.
- Develop an incident investigation toolkit to support other Trust staff so they can review patient safety incidents where a PSII is not indicated but learning can still be identified.
- Ensure that the Trust has a Patient Safety Partner to be part of the PSIRF implementation and sub-committees as a patient voice and help shape investigations and learnings.
- Support and provide training to staff to develop and implement tools for Patient Safety Reviews (PSRs) to ensure they reflect current practice and analytical tools for a systems based approach to safety reviews.

It is understood that by defining the local priorities and the type of incident response required for learning, there needs to be consideration of the resources required to undertake these proportionate responses. The Trust is committed to ensuring there is a suitably trained workforce to deliver on the PSIRF requirements and will be looking to further develop the team in 2025.

How we have prioritised our incidents and our investigation resource (continued)

The Trust uses a thematic analysis approach to determine which areas of patient safety activity it should focus on, to establish the local priorities.

Our analysis uses several data sources and safety insights from key stakeholders.

The patient safety risk process was a collaborative process to enable us to define the top patient safety risks from incident reporting and then cross reference these from several other data sources including key stakeholders.

The key priorities were defined from this list based on number of Serious Incident investigations conducted and areas where the Trust had existing quality priorities or initiatives in place.

QI Initiatives

Following PSIIs undertaken in 2023-24 there have been a number of safety initiatives implemented which include-

- Review of the storage of Ophthalmic implants to prevent mis-selection
- Alerts added to Careflow for Gastroenterology patients with existing outpatient referrals to prompt follow up rather than re-referral.

Key stakeholders included:

- Staff from all levels and areas
- Senior Managers within the Trust
- Patient Safety Specialists
- Staff from all levels and areas
- Commissioners
- Patient Safety Partners
- Patient Safety teams.
- Healthwatch
- Cheshire and Mersey ICB

The sources of information to support the thematic review included:

- Patient safety incident reports
- Complaints
- Mortality reviews
- Claims and outcomes of inquests
- Trust Risk Register
- Staff survey on patient safety key priorities
- Feedback from Safety groups

National Priorities for PSIRF

Listed below are the national priorities which will either require a full Patient Safety Incident Investigation (PSII) or the use of an appropriate Patient Safety Tool.

		Event	Approach	Improvement
Patient Safety Incident Investigation	National Priorities	Incidents meeting each baby counts criteria	Referred to Healthcare Safety Investigation Branch (HSIB)	Respond to recommendations from external referred agency / organisation as required. Potentially local led PSII.
		Incidents meeting maternal death criteria		
		Child Death	Initiate child death review process	
		Death of person with learning disabilities	Reported and reviewed by Learning Disabilities Mortality Review (LeDeR) programme	
		Safeguarding incidents meeting criteria	Reported to named safeguarding Lead	
		Incidents in screening programmes	Reported to Public Health England (PHE)	
		Deaths of patients in custody, in prison or on probation	Reported to Prison and Probation Ombudsman (PPO)	
		Incidents meeting the Never Event criteria	Patient Safety Incident Investigation Team	Create local organisational recommendations and safety improvement plans. Patient safety investigation will be undertaken.
		Incidents resulting in death (incidents meeting the learning from deaths criteria for PSII)	Patient Safety Incident Investigation Team	
		Domestic Homicide	Support and contribute to system Domestic Homicide reviews (DHRS and Support Police Investigation	
		Deaths of patients detained under the Mental Health Act (1983) or where the Mental Capacity Act (2005) applies	Support and contribute to system reviews and Support Police Investigation	
		Mental health-related homicides		
	Trust Prioritie	Local organisation PSIRF priorities	Patient Safety Incident Investigation Team or Divisional Response utilising the PSIRF Toolkit	
Patient Safety	Local Level	No / Low Harm Patient Safety Incidents	Validation of facts at local level recorded on DATIX	Inform thematic analysis of ongoing patient safety risks at teams, specialty, directorate, division, and trust level. Relevant patient safety tool will be used to investigate incident.
		Moderate and Severe Harm incidents	Statutory duty of candour and appropriate PSR tool	

Our Trust priorities

Listed below are the Trust priorities which should be considered for a full PSII or other investigation approach to learn and improve, these will be coordinated by the PSIRF team. Whilst other types of priorities will be investigated by a separate resource or governing body or locally in the Trust by the specialist area the incident occurred in.

INCIDENT TYPE	DESCRIPTION	ACTION
Escalation/care of the deteriorating patient	Incidents where the identification of a deteriorating patient has been delay leading to significant impact on patient outcome	**Patient Safety Incident Investigation**
Delayed /Misdiagnosis	Missed or delayed diagnosis that has impacted on patient outcomes, with potential for significant learning. These may include but are not exclusive to: • Patient Pathway issues • Outpatient waiting lists	**Patient Safety Incident Investigation**
Medication	Medication incident that has significantly impacted on patient outcomes. These may include but are not exclusive to: • Incidents requiring therapeutic drug monitoring • Insulin • Opioids • Anticoagulation	**Patient Safety Incident Investigation**
Pressure ulcers	Hospital Acquired Category 3 pressure ulcers and above, with potential for significant learning. These incidents will be subject to aggregated review which will inform the associated Trust Improvement Plan.	**Tissue Viability Learning Review**
Slips, trips, and falls	Inpatient fall leading to fracture of hip bone, with potential for significant learning. These incidents will be subject to aggregated review which will inform the Trust Improvement Plan.	**Falls Learning Review**
Infection Prevention Incidents	Hospital acquired infections meeting local/national criteria for investigation. These incidents will be subject to aggregated review which will inform the Trust Improvement Plan.	**Infection Prevention Learning Review**
Areas of emerging risk	Based on trend or analysis from the patient safety group, PSII will be conducted on specific areas of risk that have been identified	**Patient Safety Incident Investigation**

How we will respond to a patient safety incident under PSIRF

Aside from the national requirements that have been set out, PSIRF sets no further threshold to determine what method of response is required for any patient safety incident.

We have created our local priorities as a Trust with collective data and input from committees, patient safety groups, staff and patients.

When incidents arise, this does not mean that we will routinely investigate all incidents through PSIRF. This could lead to us recreating the old process of the Serious Incident Framework (SIF). Therefore, we have explored other toolkits and methods suggested for reviewing incidents outside of PSIRF and will use these tools in principle for Patient Safety Reviews (PSR).

We may undertake:

- Swarm reviews or team huddles (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.)
- Learning Reviews
- After action or MDT reviews
- Audits
- Structured Judgement Reviews (SJR's)
- Thematic Analysis
- Horizon Scanning

Staff that undertake these reviews will be trained and supported to conduct the method of review and set processes/frameworks will be in place to oversee this.

We will have 'ward to board' governance mechanisms in place and subsequent reporting structures to ensure that patient safety incidents and improvement is overseen effectively, and we learn from incidents and ensure the learning is placed back into the organisation.

Involvement of patients, service users, families, carers, and staff during incident investigations

We recognise and acknowledge the impact that patient safety investigations may have on our patients, service users, families, carers, and staff.

The Patient Safety Incident Response Framework has been put in place to ensure that those affected by an incident are engaged with in a meaningful way, shown compassion and ensure they are involved and for those affected to have the ability to understand or ask any questions in relation to an incident.

To ensure that this happens, our organisation will identify Family Liaison and Engagement Leads who will be trained and supported in giving advice and information during the investigation and supporting those affected.

This will aid our learning and improvements, but it will also allow us to support those affected and ensure that they are kept up to date with the investigation and can contribute towards it.

As a Trust we have worked hard to ensure we move away from a culture of blaming individuals in response to incidents to establishing a well embedded Just Culture. The Trust is committed to ensuring that Patient Safety Incident Investigations are conducted for learning and improvement purposes only.

For staff that are involved in incidents we will ensure that support is at hand when needed. We offer in house training on Human Factors which supports staff around psychological safety at work and offer other forms of patient safety training to ensure we embed a good Patient Safety Culture.

We value our staff and offer additional support from our excellent Health and Wellbeing services and Freedom to speak up services, should they have concerns.

Duty of Candour

Our Trust will ensure we are open, honest, and transparent about a patient safety incident investigation.

This means explaining when something has gone wrong and apologising for it, ensuring there are steps in place to put it right and keeping a secure record of the events. All our staff are accountable to ensure we comply with this, and this is part of their clinical registration.

We will ensure that we maintain the Statutory Duty of Candour for any incident that meets the national threshold, to do this we must:

- Tell the person/people involved (including the family, where appropriate) that an incident has taken place.
- Apologise and say that we are sorry.
- Provide a true account of what has happened, explaining and being clear about what we know at that point.
- Explain and be clear about what we are going to do to understand the events (for example if we conduct a PSII or PSR).
- Follow up by providing this information and the apology, in writing.
- Keeping secure written records of any meetings, or communications given.

Duty of Candour will also allow us to take insight and learning from incidents and we can provide this information back to those affected.

Roles and responsibilities

Our staff will have key roles to play in this new framework and we have listed some of the key roles that will help support this change to patient safety investigations.

Executive Directors and Non-Executive Directors

All Executive Directors have responsibility for ensuring incidents are investigated in a timely manner and responded to in accordance with this plan and appropriately signed off.

Patient Safety Specialists

The Trusts PSS team supports the Executive and Non-Executive Directors in carrying out their responsibilities for the management of PSII investigations within the trust and the presentation of learning and assurance back to system partners.

Patient Safety Partner

The PSP will support the Patient Safety Specialists and be actively involved in the design of safer healthcare at all levels in the organisation, this will be a voluntary role and represent 'the patient'.

Trust Lead for PSIRF

The Trust Lead for PSIRF will provide assurance on Patient Safety incident management processes and overseeing the functionality of the Trust's Patient Safety Incident panels. PSIRF Lead will work closely with system partners to ensure that PSII's are shared with the board and learning is distributed across the wide ICS and is shared in collaboration with other Trusts.

Patient Safety Incident Investigation Leads

The Patient Safety Incident Investigation Lead is responsible for undertaking a full investigation into patient safety incidents that meet the criteria within the plan, that they are conducted in accordance with the plan and for working closely with the family liaison officer to ensure patient/family/carers are given an opportunity to provide relevant information that will support the investigation, that they are kept informed of the process and outcome of the investigation.

Family Liaison and Engagement Lead

Family Liaison and Engagement Leads are responsible for ensuring appropriate support is offered to the patient/family/carers. They will confirm any questions of concern the family/patient/carer would like to include as part of the key lines of enquiry of an investigation. They will act as the link person for the patient/carer/family and ensure they are given the opportunity to provide relevant information that may inform the outcome of the investigation and linking in with the Patient Safety Incident Investigation Lead.

Divisional/Directorate Managers, Clinical Leads, Lead Matrons/Matrons/Senior Nurses and Service Managers

Ensure that appropriate experts are available to support the Patient Safety Incident Investigation Leads to carry out investigations within the relevant division and departments. They ensure that all investigations are completed in a timely manner by releasing all staff involved within an incident to attend any investigation discussions. They will also conduct Patient Safety Reviews using the appropriate toolkits.

Patient Safety Leads

The Patient Safety Teams support the Trust's governance teams in ensuring that the review, manage, investigate, and monitor learning from incidents. They work closely with the Patient Safety Incident Reporting and Investigation Teams in supporting the timely and appropriate reporting, recording, investigating and coordination of all incidents. The Patient Safety Leads are responsible for ensuring that risks and trends from incidents are escalated through the risk management process. Any learning is included within the Patient Safety and reported to the Governance Meetings so learning can be cascaded through the Quality and Safety processes within the and wider throughout the Trust.

Patient Safety & Governance Team

The Patient Safety and Governance Team are responsible for reviewing all incidents reported on the incident management system, obtaining additional information and amending incident details as necessary. They will manage and co-ordinate the triage of all incidents assigning the correct level of investigation in conjunction with the Divisional Patient Safety Leads. The Team is required to report incidents to relevant external stakeholders in accordance with their reporting requirements.

All Staff

All staff are required to provide information either/both verbal or written reports for any investigation for an unexpected event or incident in a culture of being open and honest, supporting colleagues with a view to learning lessons in a just culture. Line managers have a responsibility to ensure staff are released from duty to attend debriefings, round table discussions, interviews regarding any incident.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