Alder Hey Children's NHS
NHS Foundation Trust

Reference Number: FOIAH2324/447
From: Other

Date: 13 November 2023

Subject: The trust's Patient Safety Incident Response Plan

Q1 Under the Freedom of Information Act I would like to request the following information:

Link to or copy of your trust's Patient Safety Incident Response Plan (PSIRP)
Under the new Patient Safety Incident Management Framework (PSIRF), NHS England requires all trusts to develop and publish a Patient Safety Incident Response Plan, as outlined on page 6 of the framework. Some trusts have published this information already, while in some trusts it is still under development. So please can you advise whether your trust has developed this document yet, and if not, when it is likely to be published.

A1 See attachment - *Patient Safety Incident Response Plan V1.9 FINAL Updated 31 08 23 (002)*

Patient Safety Incident Response Plan

Effective date: October 2023

Estimated refresh date: October 2024

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Approved PSIRP V1.9 Final 31.08.23

Contents

Approved PSIRP V1.9 Final 31.08.23

1. Introduction

This patient safety incident response plan (PSIRP) sets out how Alder Hey Childrens NHS Foundation Trust (the Trust) intends to respond to patient safety incidents reported by our children and young people, their families and carers and our staff, as part of work to continually improve the quality and safety of the care we provide.

This plan is not a permanent rule that cannot be changed. The Trust will remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected.

Patient safety incidents are any unintended or unexpected incident which could have, or did, lead to harm for one or more child or young person in our care receiving healthcare.

There are many ways to respond to a patient safety incident. This PSIRP covers responses conducted solely for the purpose of system learning and improvement and that reduce risk and/or prevent or significantly reduce recurrence.

The plan will data driven, remain flexible and may change to consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected.

It will be underpinned by the existing Trust Managing Incidents and Serious Incidents Policy and the new Trust Patient Safety Incident Response Policy.

Responses covered in this Plan include:

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

Other types of responses exist to deal with specific issues or concerns, for example: 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 therefore outside the scope of this Plan.

Approved PSIRP V1.9 Final 21.08.23

2. Our Services

Alder Hey Children's NHS Foundation Trust is one of Europe's biggest and busiest children's hospitals, caring for over 330,000 children, young people and their families every year.

Located in Liverpool UK, we treat everything from common illnesses to highly complex and specialist conditions. We also have a number of community outreach sites enabling us to deliver care closer to children and young people's homes in local clinics locations from Cumbria to Shropshire, in Wales and the Isle of Man.

We know that a children's hospital is different and that our job is more than just treating an illness. To us, every child is an individual. As well as giving them the very best care, we set out to make them feel happy, safe, and confident as they play, learn, and grow. At Alder Hey, we are here to look after a child and their family and that includes mums, dads, brothers, and sisters.

Alder Hey is one of the two accredited major trauma centres for children in the Northwest and nationally commissioned as one of four epilepsy surgical centres, a service we provide in partnership with Manchester Children's Hospital.

As the regional cardiac surgical centre, we continue to lead in developing the cardiac network across the region to provide seamless care pathways for children with congenital heart problems. The Trust also is one of four commissioned paediatric national craniofacial units.

We have a number of well-established Children and Young Peoples' Forums which help us develop new ideas for how they can be at the centre of the Trust's plans and activities helping us keep children and young people's voices at the forefront, including continuing to play a key role in the recruitment of key Board level posts.

The Trust is supported by a number of charities and through the work that they do to support the hospital, we can ensure that Alder Hey's pioneering work continues to make a difference to the lives of children and young people. Our relationship with our charitable partners remains hugely important to us and never more so than during the Covid-19 pandemic and into the recovery period, during which time they worked tirelessly alongside us to support our patients, families and staff.

Alder Hey has a strong history of quality improvement and our Brilliant Basics approach supports team to make small changes that lead to big improvements and healthier futures for our children, young people and families. Brilliant Basics is our approach to improving quality, safety, effectiveness and experience. As we move into 2023/24 the focus will be on maturing and sustaining our approach to continuous improvement by:

- Supporting leaders at all levels to adopt the style and approach that will support improvement efforts.

- Supporting divisions to go further to align, enable and improve.

Approved PSIRP V1.9 Final 31.08.23

- Utilising the voice and ideas of children, young people and families that Alder Hey work with.

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3. Defining our patient safety incident profile

Patient safety incidents for Alder Hey have been profiled using available organisational data between January 2019 to December 2022 from:

- Patient safety incident reports
- Clinical and non-clinical incident data
- Top 10 incident cause groups
- Complaint's themes
- Legal claims
- Staff survey results
- Mortality and in patient death thematic reviews
- Trust wide quality improvement and harm reduction workstreams

Additional resources reviewed included: Freedom to Speak up reports, Annual Quality Accounts, Trust wide Quality Round and Quality Assurance Round insight reports and presentations, complaints and PALs reports, child deaths and mortality review reports, safeguarding data, patient safety quality improvement dashboards via our quality improvement programme Brilliant Basics, risk data, and direct consultation with children, young people and their families via open forums and through a range of children and young person's forums that we have in place.

ed PSIRP V1.9 Final 31.08.23

3.1 Data sources

A data review of the Trusts Risk and Incident Management System (Ulysses) was conducted for patient safety risks and incidents reported between January 2019 to 31st December 2022, to establish the number of reported patient safety incidences, reported harm levels and any subsequent patient safety investigations that took place as outlined below.

Chart 1

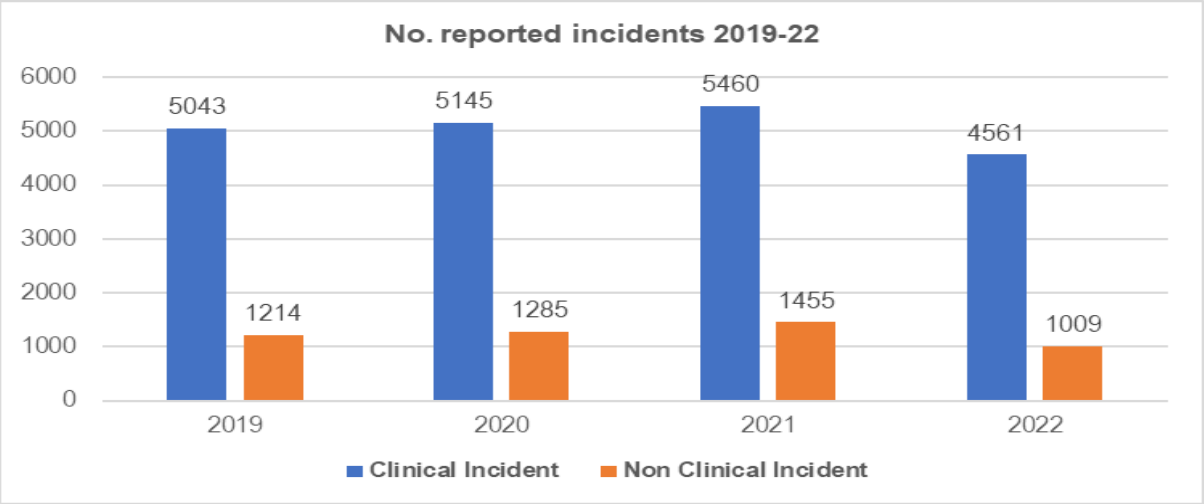
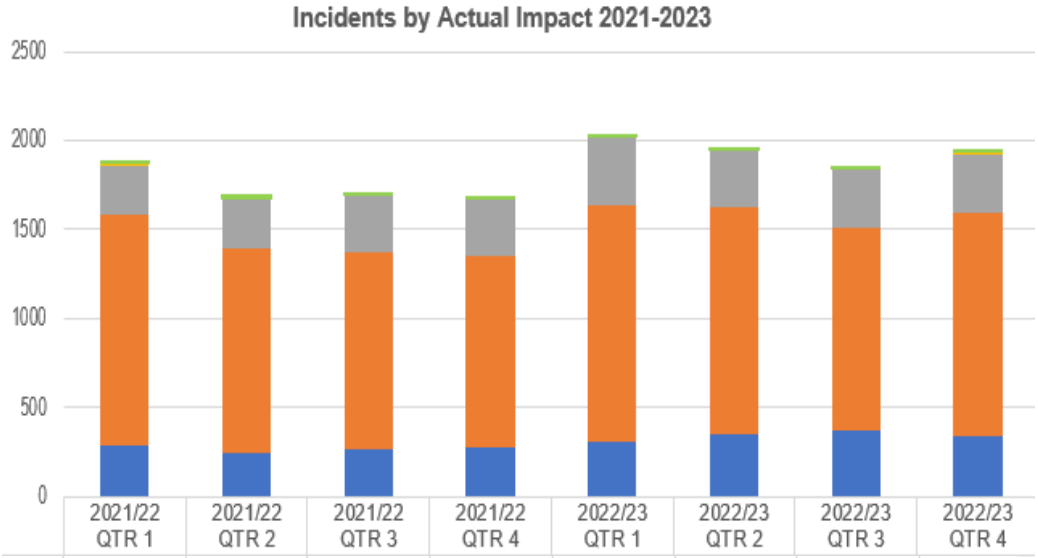


Chart 2



	2021/22 QTR 1	2021/22 QTR 2	2021/22 QTR 3	2021/22 QTR 4	2022/23 QTR 1	2022/23 QTR 2	2022/23 QTR 3	2022/23 QTR 4
Total	1887	1691	1700	1682	2017	1951	1842	1934
Classification not assigned	14	17	9	6	1	2	2	1
Never Event	0	0	0	1	0	1	1	0
E - Severe, Permanent Harm	0	0	2	1	0	0	0	1
D - Moderate, Semi Permanent Harm	11	3	5	6	3	8	4	6
C - Minor, Non Permanent Harm	279	274	313	319	379	318	324	327
B - No Harm	1291	1154	1099	1069	1324	1269	1137	1259
A - Near Miss	292	243	272	281	310	353	374	340

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3.2 Stakeholder Engagement

The key stakeholders that have been consulted throughout the process to agree the identified priorities and Alder Hey's Patient Safety Incident Response Plan include:

- Our children, young people their families and carers
- Our staff
- Our commissioners
- Our Trust Board, Non-Executive Directors, and delegated committees

3.3 Stakeholder activity

Feedback and information provided by internal stakeholders, our children, young people, their families and carers and subject matter experts were considered in the development of our patient safety profile via a series of PSRIF events that included:

- Presentation of the patient safety data at:
  - Trust wide divisional and corporate levels meetings,
  - Speciality and sub speciality team meetings
  - Trusts Patient Safety Programme Board
  - Corporate Service Collaborative Meeting

    - Trust Safety Quality and Assurance Committee

    - Trust Board
- Attendance and discussion at a range of children and young person's forum events
- Open forums during Safety Month November 22
- PSIRF Big Conversation Event November 22

Qualitative and anecdotal feedback from our children, young people, their families and carers and our staff were also sought and collated via QR code to inform potential future categories for local patient safety incident investigation and system improvement.

The review also highlighted areas which required the collation of further intelligence to inform subsequent future plans.

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4. Defining our patient safety improvement profile

A range of staff, including our Trust Board, Non-executive Directors and Trust leads for each of the above data collection systems, were consulted and a prioritised list of patient safety areas for the year ahead agreed.

Our patient safety profile and subsequent plan was discussed, shared, and approved by our local PSIRF implementation team and presented to our established Patient Safety Board for agreement and ratification.

All patient safety improvement workstreams that currently report into our Patient Safety Board together with other patient safety initiatives ongoing across the Trust were also considered as noted below.

4.1 Current Patient Safety Board Improvement workstreams:

- Sepsis
- Neonatal Safety
- Medication Safety
- Parity of Esteem
- Learning Disabilities
- Antimicrobial Resistance (AMR)

4.2 Other Trust Patient Safety Improvement Programmes:

- Safer Theatres at Alder Hey (STAT) Programme and Mini-STAT (Junior Doctor Induction)
- Meditech Unacknowledged Notices Workstream
- Hospital Optimisation: The Acutely Unwell Child, Get Me Well – Specialist Pathways, Get Me Well – Acute Medical Pathways
- ED at its Best
- Advancing Outpatients Care
- Infection Prevention Control - Isolation of Patients
- Prevention of Infections related to the Hospital Environment
- Safety Huddles in ED
- Urgent Treatment Centre (UTC)
- Zero Tolerance

All the above patient safety programmes are supported and delivered using our Brilliant Basics Quality Improvement (QI) methodology that is widely embedded across the Trust.

In addition, a review of the resource and activity associated with the current Serious Incident Framework for the period 2019 - 2022 was also undertaken to determine how many PSIIs can be supported during 2023/24.

Approved PSIRP V1.9 Final 31.08.23

This review was carried out alongside the NHS National Incident Response Standards for Patient Safety Investigation to ensure that all future PSIIs are compliant with these standards.

This review included oversight of the current level of resource required for PSRs, using different review techniques where a PSII is not indicated.

Category	2019	2020	2021	2022
Patient safety incident investigation into Never Events	4	1	1	2
Mortality Reviews	58	63	76	58
Incidents **referred** (to HSIB/Regional independent investigation teams (RIITs)/Public Health England (PHE)) for independent PSII	2	1	1	0
Deaths of persons with learning disabilities reviewed at HMRG and submitted to LeDeR	9	8	0	6
Child Safeguarding Critical Incident Reviews/rapid reviews	17	13	25	9
Local Child Safeguarding Practice Review (LSCPR)	9	5	14	3
Domestic Homicide Reviews (DHRs)	0	5	2	2
Safeguarding Adult Review (SARs)	0	4	2	0
Incidents in screening programmes	0	0	1	0
Coroner initiated patient safety incident investigations [ward]	NA	12	19	16
Coroner initiated patient safety incident investigations [ED]	NA	6	10	11
Patient/family/carer complaint-initiated patient safety incident investigations	21	23	22	30
Serious Incident investigations (Investigations under the current NHS Serious Incident Framework and reported to StEIS)	15	17	10	6
Level 2 incident investigations utilising a systems framework for review	28	16	17	18
Level 1 incident investigations utilising a systems framework for review	23	11	21	31
Patient Safety reviews/Rapid reviews/Thematic reviews	4	11	140	306

Approved PSIRP V1.9 Final 31.08.23

This review has been led by the Patient Safety Team with support and involvement from the Corporate and Divisional Governance leads, senior leadership Nursing and Allied Health

Professional Team, Heads of Nursing /Allied Health Professions and Matrons, Medicines Safety Pharmacists, Trust Mortality lead, Freedom to Speak up Guardian, Safeguarding

team, Human Resources team, Head of Quality Improvement and our children and young people.

Incident types, recurrence and severity were explored, together with careful consideration of safety improvement opportunities and knowledge, together with plans and quality improvement interventions already in place.

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5. Our Patient Safety Incident Response Plan: National Requirements

National patient safety priorities are set by the PSIRF and other national initiatives for the period 2023 to 2024. These priorities require a Patient Safety Incident Investigation (PSII) to be conducted by the Trust to identify and maximize opportunities for learning.

Patient Safety Incident Investigations (PSIIs) include a range of techniques (such as interviews and observations) to systematically identify the circumstances surrounding incidents.

While most PSIIs will be conducted locally by our organisation, some may be conducted independently and funded by our organisation or regionally/nationally.

In addition to a PSII some patient safety incident types will require specific statutory reporting and/or review process to be followed. All types of incidents that have been defined nationally as requiring specific responses are outline below and will be reviewed according to the national suggested methods.

Approved PSIRP v1.9 Final 31.08.23

National Focus Priorities		
Patient safety incident type	**Required response**	**Anticipated improvement route**
All incidents meeting the Never Events criteria (2018) or its replacement	Patient Safety Incident Investigation	Create local organisational actions and feed these into the Patient Safety Board as part of the QI process for Trust wide/Divisional action
Any incident meeting the learning from deaths criteria i.e. death thought more likely than not due to problems in care	Patient Safety Incident Investigation	
All child deaths (including children with learning disabilities)	All child deaths are reviewed as part of the Trusts HRMG process and referred to the Trusts Mortality lead. If relevant, any child death will be referred to the child death overview panel (CDOP) via the Trusts safeguarding team for investigation. Refer	Safeguarding team to liaise with CDOP as locally led PSII may be required. Respond to recommendations from

	to the Child death review statutory and operational guidance.	external parties for learning purposes.
Neonatal incidents: Incidents which meet the 'Each Baby Counts'	Referred to Healthcare Safety Investigation Branch for independent patient safety incident investigation (https://www.hsib.org.uk/maternity/) All cases of severe brain injury (in line with the criteria used by the Each Baby Counts programme) must also be referred to NHS Resolution's Early Notification Scheme All perinatal deaths must be referred to MBRRACE.	Respond to recommendations as required from external referred agency and feed actions into the Patient safety Programme Board to be considered as part of QI process. All local MBRRACE recommendations to be presented and monitored via Clinical Outcomes and Effectiveness Group (CEOG)
All Safeguarding/ Rainbow Centre incidents	Incidents must be reported to the Trusts safeguarding team/Named safeguarding leads for review/multi-professional investigation and possible local authority referral.	Respond to recommendations as required from external referred agency and feed actions into the Trust Safeguarding and Statutory Services Assurance Group to be considered as part of QI process.
Incidents in screening programmes	Incidents must be reported by Director of Infection Prevention Control (DIPC) to Public Health England (PHE) in the first instance for advice on reporting and investigation (PHE's regional Screening Quality Assurance Service (SQAS) and commissioners of the service)	Respond to recommendations as required from external referred agency and feed actions into the Patient safety Programme Board to be considered as part of QI process.
Mental health-related homicides by persons in receipt of mental health services or within six months of their discharge	Incidents must be discussed with the relevant NHS England and NHS Improvement regional independent investigation team (RIIT)	Respond to recommendations as required from external referred agency /Divisional oversight and improvement.

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6. Our Patient Safety Incident Response Plan: Local Focus

Local patient safety priorities are set by the Trust in collaboration with all key relevant stakeholders (see sections 3 and 4) for the period 2023 to 2024. In addition to analysing our local patient safety profile, we have taken the following considerations into account when defining our local patient safety priorities.

Criteria	Considerations
Potential for harm	• People: physical, psychological, loss of trust (patients, family, caregivers) • Service delivery: impact on quality and delivery of healthcare services; impact on capacity • Public confidence: including political attention and media coverage
Likelihood of occurrence	• Persistence of the risk • Frequency • Potential to escalate

Approved PSIRP V1.9 Final 31.08.23

Our local patient safety priorities require a Patient Safety Review (PSR) and include several techniques to identify areas for improvement, immediate safety actions and to respond to any concerns raised by the affected child, young person, family, carer, or staff.

Note: There may be patient safety incidents not outlined in the priority list below for which a PSR is undertaken based on the request or views of those affected, including patients and their families.

There are several Trust wide patient safety quality improvement workstreams/programmes of work already being undertaken (section 4) and are therefore not included in the priority list below.

All PSRs are conducted locally by our organisation with different PSR techniques adopted depending on the intended aim and required outcome.

There are five broad categories of PSRs agreed with stakeholders to be utilised at Alder Hey Childrens NHS Foundation Trust

- Rapid Review
- Situation, Background Assessment, Recommendation (SBAR) review
- Thematic Review
- Multi-disciplinary team (MDT) review

- Safety Huddle incorporating a Hot/Cold debrief.

Local Focus Priorities		
Patient safety incident type or issue	**Planned response**	**Anticipated improvement route**
Any medication incident regarding TPN and omission/delay of criterial medications	PSII/Thematic review	Via Medication Safety Group that feeds into Patient Safety Programme Board as current QI workstream
Access, Admission, Transfer and Discharge: Incidents regarding issues with movement of patients particularly delays to outpatient follow-up	PSII where agreed /Thematic review/SBAR	Via Trusts Safer Waiting List Management Group/Divisional oversight/Commissioning Quality Contract Meeting
Acutely unwell child - Any emerging themes identified from via the Hospital Optimisation working group	PSII where agreed/ Thematic review/Rapid review	Via Hospital Optimisation working group that feeds into Patient Safety Programme Board as current QI workstream
Incidents resulting in moderate or severe harm to child/young person	Statutory Duty of Candour Rapid review/SBAR PSII if indicated.	All Moderate/severe harm rapid reviews presented to the Patient Safety Incident Response Investigation (PSIRI) Panel for discussion/ decision on requirement for PSII /improvement route (if applicable)
Clinical management/diagnosis including delays to follow up/imaging incidents	Rapid review/Thematic review/safety huddle	Local cross divisional review
Invasive procedure incident (including injury) following surgery	Safety huddle /PSII where agreed	Via STAT programme /Theatre /Surgical divisional governance meetings
Health Care Acquired Infections (HCAIs)	SBAR/safety huddle	Via Infection Prevention Control Committee
Medication, prescribing, and administration including any 10-fold medication errors or incident involving controlled drugs	SBAR/safety huddle /Thematic review if required	Via weekly Medication safety officer review meeting/Divisional and ward meetings
No/Low harm patient safety incident	Safety huddle	Via divisional daily huddles

Approved PSIRP V1.9 Final 31.08.23

Medical device/Equipment failure	Safety Huddle/SBAR if indicated	Medical dives group that feeds into Patient Safety Programme Board
IT System/Documentation	MDT review/safety huddle	Via Digital oversight Committee/Divisional governance meetings
ED/Trauma related incidents	SBAR/safety huddle /Thematic review if required/Debrief	Via Trauma huddle/cross divisional governance meetings
Haemovigilance (MHRA/SHOT reportable incidents)	It is a regulatory and legal requirement to report all serious adverse events (SAE) and serious adverse reactions to the MHRA/SHOT http://www.shotuk.org/reporting. 'Appropriate level of investigation of contributing factors using a systems approach and application of human factors principles'	Appropriate corrective and/or preventative actions identified and taken in response to investigation. Transfusion committee oversight and improvement
Ionising radiation CQC notifiable incidents (IR(ME)R)	All significant accidental or unintended exposure incidents (SAUE) are notifiable to regulator within 2 weeks of event. PSII or PSR to be decided locally and report available to regulator within 12 weeks	Respond to regulators recommendations following internal investigation. Divisional oversight and improvement

Approved PSIRP V1.9 Final 31.08.23

7. Conclusion

This patient safety incident response plan (PSIRP) supports the requirements of the NHS England Patient Safety Incident Response Framework (PSIRF) and sets out how Alder Hey Childrens NHS Foundation Trust (the Trust) intends to respond to patient safety incidents reported by our children and young people, their families and carers and our staff, as part of work to continually improve the quality and safety of the care we provide.

The Trust acknowledges that PSIRF is a new approach to patient safety incidents advocating a co-ordinated and data-driven response to patient safety incidents, prompting a significant cultural shift towards systematic patient safety management.

As we move into adopting this new way of managing our patient safety incidents and learning reviews, we accept that we may not get it right at the beginning, but we will continue to monitor the impact and effectiveness of our PSIRF implementation, responding and adapting as needed if our approach is not achieving what we expect it to.

In this we have been supported by our children and young people, their families and carers, our staff, our commissioners and other stakeholders to allow us to embark on this nationally driven change.

Most importantly, PSIRF offers us the opportunity to learn and improve to promote the safe, effective, and compassionate care of our children and young people, their families and carers whilst also protecting the well-being of our staff. We welcome PSIRF's implementation and are ready for the challenges ahead.

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