NHS
The Christie
NHS Foundation Trust

Patient Safety Incident Response Plan

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Introduction to the Patient Safety Incident Response Framework

Purpose

This Patient Safety Incident Response Plan (PSIRP) sets out how The Christie NHS Foundation Trust intends to respond to patient safety incidents over a period of 12 to 18 months from April 2024. The plan is not a permanent rule that cannot be changed, and we acknowledge the challenge that this fundamental shift in approach brings with it. As an organisation we will remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred and the needs of the people affected.

The NHS Patient Safety Strategy (PSS) was published in July 2019 and describes the Patient Safety Incident Response Framework (PSIRF), a replacement for the NHS Serious Incident Framework 2015 (SIF). This document is the Patient Safety Incident Response Plan (PSIRP). It describes what we have done at The Christie NHS Foundation Trust to prepare to **"go live"** with PSIRF.

The Serious Incident Framework (2015) provided structure and guidance on how to identify, report and investigate an incident resulting in severe harm or death. PSIRF, on the other hand, is best considered as a learning and improvement framework with an emphasis on the system and culture. One of the underpinning principles of PSIRF is to undertake fewer **"investigations"** and deploy resource to improving systems and processes; this means taking the time to conduct systems-based investigations by people that have been trained to do them.

The Patient Safety Strategy challenges everyone to think differently about learning and what it means for our organisation. This Patient Safety Incident Response Plan (PSIRP) sets out how The Christie will respond to patient safety incidents reported by staff and patients, their families, and carers as part of work to continually improve Patient Safety Learning Responses (PSLRs) by:

- Refocusing Patient Safety Learning Responses towards a system analysis approach and the rigorous identification of factors and system issues.
- Focusing on addressing these causal factors and the use of improvement sciences to prevent or continuously and measurably reduce repeated 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.
- Acting proportionately to incidents and risks, ensuring a compassionate and engaged response is taken with affected parties whilst aiming to release resource from investigation processes to improvement programmes and work-streams.

Scope

This document covers responses conducted solely for the purpose of system learning and improvement. There is no remit within this plan or PSIRF to apportion blame or determine liability, preventability or cause of death in a response conducted for the purpose of learning and improvement.

Therefore, other processes and governance is outside of the scope of this document for example:

- Inquests
- HR issues
- Professional Conduct
- Complaints
- Claims
- PALS
- Freedom to Speak Up

The principal aims of each of the above responses differ from the aims of a patient safety response and are outside the scope of this plan.

This plan explains the scope for a systems-based approach to learning from Patient Safety Incidents (PSIs). We will identify incidents to review through nationally and locally defined patient safety priorities. An analysis of which is explained later within this plan.

Responses covered in this plan include:

- Patient Safety Learning Responses (PSLRs)
- Patient Safety Incident Investigations (PSIIs)

Our Safety Culture

As a Trust, The Christie have endeavoured to approach incident investigations with a focus on learning for improvement, seeking to adopt a restorative just culture within the organisation.

We recognise a culture of strong psychological safety underpins openness and transparency in incident reporting and promotes respectful investigations with meaningful system-based learning. The Christie encourages the reporting of incidents where any member of staff feels something has happened, or there is a risk, which has led to, or may lead to, harm to patients or staff.

Engagement and Involvement in Patient Safety Incidents

PSIRF recognises that learning and improvement following a patient safety incident can only be achieved if supportive systems and processes are in place. It supports the development of an effective patient safety incident response system that prioritises compassionate engagement and involvement of those affected by patient safety incidents (including patients, families, and staff).

We are committed to continuously improving the care and services we provide. We want to learn from any incident where care does not go as planned or expected by our patients, their families, or carers to prevent recurrence.

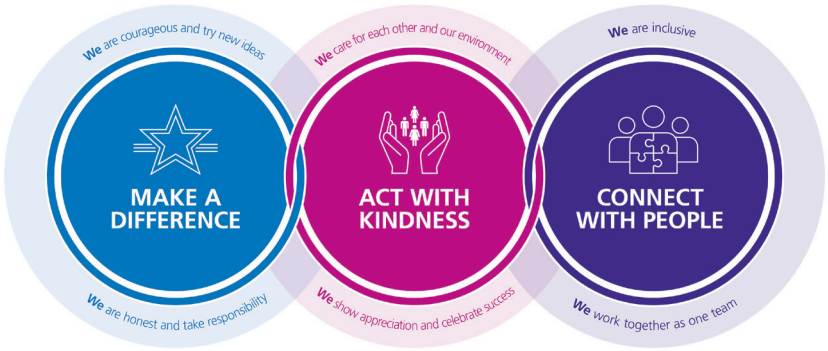
We recognise and acknowledge the significant impact patient safety incidents can have on patients, their families, and carers.

Getting involvement right with patients and families in how we respond to incidents is crucial, particularly to support improving the safety of the services we provide. Where staff are engaging in learning responses, guidance documents will be available to ensure they understand and are supported throughout the process.

Our Values

The Christie Trust Values

The Christie NHS Foundation Trust aims to demonstrate excellent and equitable clinical outcomes and patient safety, patient experience and clinical effectiveness for those patients living with and beyond cancer.



Our Value

Our Behaviours

We are courageous and try new ideas
We are honest and take responsibility

What this looks like: We demonstrate integrity by listening to others and taking ownership of our actions. We back each other to challenge the status-quo to keep improving.

Our Value

Our Behaviours

We care for each other and our environment
We show appreciation and celebrate success

What this looks like: We are caring and compassionate, taking care of our environment and those within it. We remember that every person is different, and every interaction is a real moment in their lives.

Our Value

Our Behaviours

We are inclusive
We work together as one team

What this looks like: We support each other, across disciplines and roles, to share insights, skills and resources, to deliver the highest standards of service delivery and patient care.

Aims and Objectives

The implementation of PSIRF will incorporate the four strategic aims of the PSIRF upon which this plan is based, the overarching aims and how these will be achieved through specific objectives (see Table 1), and our Trust visions embodied in our work.

Table 1

PSIRF, Strategic Objectives and Values and Behaviours

To demonstrate excellent and equitable clinical outcomes and patient safety, patient experience and clinical effectiveness for those patients living with and beyond cancer.

PSIRF Aims	Aim Description	Christie Values
Compassionate engagement and involvement of those affected by patient safety incidents.	When a patient safety incident investigation (PSII) or other learning response is undertaken, organisations should meaningfully involve those affected, where they wish to be involved.	**Connect with People** We are Inclusive, We work as one team.
Application of a range of system-based approaches to learning from patient safety incidents.	Organisations are encouraged to use the national system-based learning response tools and guides, or system-based equivalents, to explore the contributory factors to a patient safety incident or cluster of incidents, and to inform improvement.	**Make a Difference** We are Courageous and try new ideas.
Considered and proportionate responses to patient safety incidents.	Some patient safety incidents, such as Never Events and deaths thought more likely than not due to problems in care (that is, those meeting the Learning from Deaths criteria for investigation) all require a PSII to learn and improve. Some incident types will also require specific reporting and / or review processes to be followed.	**We are Honest and take Responsibility**
Supportive oversight focused on strengthening response system functioning and improvement.	All healthcare organisations providing and overseeing NHS-funded care must work collaboratively, with a mutual understanding of the aims of this framework, to provide an effective governance structure around the NHS response to patient safety incidents. Adopting a culture of psychological safety within governance and safety reporting.	**We act with Kindness** We show appreciation and celebrate successes.

The Christie Services

The Christie NHS Foundation Trust is the largest single cancer centre in Europe, treating over 60,000 patients per year. The trust provides Radiotherapy, systemic anti-cancer therapy (chemotherapy, immunotherapy, trial drugs), specialist surgery and a wide range of diagnostic and supportive services. Proton Beam therapy is also delivered, making the Christie the first NHS trust in the UK to offer this specialised treatment.

The Christie serves a population of 3.2 million across Greater Manchester and Cheshire, at our main Withington site and across satellite sites. As a national specialist in Cancer care, around a quarter of our patients are referred to us from other parts of the country.

The Christie at Home service provides chemotherapy and immunotherapy treatments to patients in their own homes.

Our sites:

- The Christie main site (Withington)
- The Christie at Macclesfield
- The Christie at Oldham
- The Christie at Salford
- Peripheral Outreach clinics (Bolton, Oldham, Wigan, Leighton, Stepping Hill)
- Bloods closer to Home (Winsford, Ashton-under Lyne, Worsley, Cheadle, Oldham, Bury, Bolton, Altrincham)

A trust wide review of our divisions and services was conducted to support our understanding of the scope of PSIRF. The services and their relevant divisions have been outlined in the below table.

Our Divisions and Associated Services:

Network Services

- Clinical Oncology
- Medical Oncology
- Referrals and bookings
- Haematology Services
- Teenage / Young Adult Oncology
- Metastatic Spinal Cord Compression
- Systemic anti-cancer treatment services
- Outpatient Services
- Proton Beam Therapy
- Radiotherapy
- Pharmacy services
- Satellite sites
- Medical Physics
- Clinical Engineering
- Diagnostic Radiology (Physics)
- Mechanical Workshop
- Medical Illustration
- Nuclear Medicine
- Radiopharmacy
- Radiotherapy Physics
- Ultrasound Medical Physics

Clinical Support and Specialist Surgery

- Inpatient wards
- Acute ambulatory care
- Critical Care / Acute Oncology Outreach
- Chaplaincy
- Complex Discharge
- Complementary Therapies
- Endocrinology
- Hospital at night team
- Health Records / Central Admin
- Integrated Procedures Unit / Procedure team
- Surgical admissions
- Radiology Services
- Interpreter service and Transport
- Nutrition and Dietetics
- Critical Care Unit
- Patient Flow / Bed Management
- Pre-op Assessment
- Rehabilitation
- Surgical Theatres
- Anaesthetic
- Supportive Care
- Psycho-Oncology

Research and Innovation

- Clinical Research Facility
- Clinical Trials Unit
- Biobank
- Disease specific research teams
- Research teams
- Central Research
- Patient recruitment

Corporate

- Patient experience, quality, and complaints
- Patient Safety
- Infection prevention and control
- Tissue Viability
- Sepsis
- Safeguarding
- Quality Improvement and Clinical Audit
- Freedom to speak up
- Health and Safety
- Performance
- Finance
- Workforce
- Human Resources

Corporate Development

- Occupational Health
- Communications
- Engagement
- Marketing

Digital Services

- Applications
- Analytics and Statistics
- Business Intelligence
- Clinical Data Capture
- Cyber Security
- Information Governance
- Infrastructure
- Software Development / Solutions / CWP
- Techbar support

Capital Estates and Facilities

- Capital / Facilities projects
- Soft Facilities
- Hard Facilities
- Site services

Christie Pathology Partnership

- Bereavement services
- Blood sciences
- Oncology genetics
- Pathology
- Histopathology
- Haematology
- Biochemistry
- Blood Transfusion Lab

School of Oncology

- Education
- Education Centre
- Clinical Skills Team
- Medical Library

Defining our Patient Safety Incident Profile

To successfully define our patient safety incident profile, it was imperative to first understand key risks and patient safety issues most pertinent to us from varied sources of available data. **Our approach to defining our incident profile is described below:**

Data Sources

A themed analysis of data within our Local Incident Reporting System (DATIX) was conducted. This highlighted the key themes within incidents and complaints that were received over the past 2 years. In addition to this we reviewed incidents that met the Serious Incident Framework and were investigated and reported to STEIS (external reporting system). The data breakdown is shown in the diagram below. We also supported this DATIX analysis with anecdotal evidence gathered from various engagement activity, including our Friday Focus group (bimonthly meeting to share learning). Advice was also sought from subject matter experts, e.g. clinical nurse specialists, pharmacy teams etc. to further support our Patient Safety Priorities.

DATIX
(Themed review of data over last 2 years)

16,000 incidents	313 Complaints	Serious incidents investigated under SI Framework
• Medication errors • Patient care / Monitoring • Appointments • Falls • Extravasation	• Care and treatment • Communication	• Management of Acute Kidney Injury • Management of Sepsis and deteriorating patient • Medication administration

Stakeholder Engagement

A variety of stakeholders were approached to give insight to areas of concern regarding risk to patient safety. Included in engagement were divisional governance leads, committee groups, complaints and claims team, and subject matter experts. Anecdotal insight was also sourced from 'frontline' staff via qualitative care audits and feedback in response to incidents. We will continue to engage our staff with the assistance of Patient Safety Champions within a variety of areas across the Trust. These members of staff will, with support from the Patient Safety Team, work to enhance our patient safety culture, embed core PSIRF principles and share trust wide learning.

From our data analysis and stakeholder engagement, the following patient safety priorities were identified and agreed. These priorities will be a focus for incident responses and safety improvement over the next 12-18 months from April 2024.

Identified Priority	Description	Source of Evidence / Data
Reduction of inpatient falls which lead to injury.	Whilst an inpatient resulting in long bone fracture.	Complaints, Incidents, falls committee.
Management of the deteriorating patient.	Delay / failure to recognise and treat deterioration resulting in escalation to level 2 or 3 care.	Incidents, anecdotal evidence, mortality reviews.
The identification and management of Acute Kidney Injury.	Failed recognition and response resulting in escalation to level 2 or 3 care.	Incidents, AKI Nurse Specialist, Anecdotal.
The identification and management of signs of Sepsis.	1 Hour ABX Breach / inappropriate management of signs of sepsis resulting in escalation to level 2 or 3 care.	Incidents, Sepsis Nurse Specialist, Anecdotal.
Tissue Viability Acquisition or Deterioration as an inpatient.	Local Priority	Incidents, Clinical Records Data, TVN lead, complaints.
Infection Prevention and Control HOHAI	Hospital onset, Hospital acquired C. difficile infections. Hospital onset, Hospital acquired MRSA blood stream infections.	Incidents, Clinical Records Data, IPC lead Nurse.
Extravasation of systemic anti-cancer treatment.	Local oncology specific priority.	Incident data
Disability	National priority	National Priority
Medicines Safety	Reducing medication administration errors.	Incidents, Anecdotal, serious incident investigations, complaints.
Patient's 'lost to follow up' post treatment resulting in moderate + harm.	Reduction in incidents regarding lack of follow up during patient treatment pathway.	Risk Register, Incidents, Complaints, Patient Feedback.
Safe transfusion administration.	Failure to follow transfusion policy-proportionate learning response applied.	Risk Register, Incidents, SI.
Never Event	As defined in the national **Never Event List 2018**.	Incidents
Death	**National** Where an incident has or is thought to have in the opinion of a medical professional resulted in the death of a service user.	MSG Process

Defining our Patient Safety Improvement Profile

The Christie Patient Safety Priorities were defined and mapped against our current patient safety related improvement work-streams. The table below outlines the existing work-streams within the organisation and those planned to meet the requirements of PSIRF and to progress our patient safety improvements.

Work-stream	Purpose
Existing work-streams	
Falls prevention group	Monitoring of falls per 1000 bed days. Themed reviews of monthly falls to support improvement plans.
Medicines and Transfusion Safety Group	Joint group for blood transfusion and medicines management. Assess themes from incidents to support improvement plans and actions.
SACT incidents group reviews extravasation incidents	Review of Extravasation incidents to provide shared learning and future improvements.
Infection Prevention and Control Committee	Committee to oversee standards of practice within Infection Prevention and Control. Thematic analysis of incidents, reviews, and outbreaks to enable future learning.
Lost to follow up / open referrals group	Monitoring of agreed actions to reduce risk of patients being lost to follow up. Reviewing incidents relating to 'lost to follow up' to support improvement plans.

Work-stream	Purpose
Planned work-streams	
Fundamentals of care • Falls (incorporate existing Falls Prevention Group) • Tissue Viability	Analysis of recurring themes from various patient safety sources incidents, complaints, learning responses. Development of system based actions to support sustainable improvement. Monitoring of ongoing system based actions.
Acute Oncology Group • Deteriorating patient • Acute Kidney Injury • Sepsis recognition and management	Analysis of recurring themes from various patient safety sources incidents, complaints, learning responses. Development of system based actions to support sustainable improvement. Monitoring of ongoing system based actions.
Medicines and Transfusion Safety Group (continued)	Joint group for blood transfusion and medicines management. Assess themes from incidents to support improvement plans and actions.
Infection Prevention and Control Committee (continued)	Committee to oversee standards of practice within Infection Prevention and Control. Thematic analysis of incidents, reviews, and outbreaks to enable future learning.
SACT incidents group reviews extravasation incidents (continued)	Review of Extravasation incidents to provide shared learning and future improvements.

Our Patient Safety Incident Response Plan: National Requirements

The national requirements are outline below with the required responses as per PSIRF guidance.

	Patient Safety Incident Type	Required Response	Anticipated Improvement Route
National Patient Safety Priorities			
Events Requiring a Specific Type of Response as set out in Policies or Regulations	**Incidents meeting Never Event criteria.**	PSII	Create local organisational actions and feed these into the quality improvement work-streams.
	Death thought more likely than not due to problems in care (incident meeting the learning from deaths criteria for patient safety incident investigations (PSIIs).		
	Death of a person with a learning disability / neurodiversity more likely than not due to problems in care.		
	Child deaths.	Refer for child death overview panel review.	
	Death of a person with a learning disability.	Locally-led PSII (or other response) may be required alongside the LeDeR – organisations should liaise with this.	National LeDeR team notification.
	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 Healthcare. Organisations must contribute towards domestic independent inquiries, joint targeted area inspections, child safeguarding practice reviews, domestic homicide reviews and any other safeguarding reviews (and inquiries) as required to do so by the local safeguarding partnership (for children) and local safeguarding adults boards.	

Our Patient Safety Incident Response Plan: Local Focus

The guidance in this table outlines the advised learning responses based on criteria within each patient safety profile. The type of response will also depend on:

- The views of those affected, including patients and their families.
- Capacity available to undertake a learning response.
- What is known about the factors that lead to the incident(s).
- Whether improvement work is underway to address the identified contributory factors.
- Whether there is evidence that improvement work is having the intended effect / benefit.
- If an organisation and its ICB are satisfied risks are being appropriately managed.

	Patient Safety Incident Type	Required Response	Anticipated Improvement Route
	Local Patient Safety Priorities		
Consideration of Learning Response by Divisional PSIG	**Deteriorating Patient**	After Action Review under Divisional PSIG.	Create local and organisational actions and feed these into the **Patient Safety Priority Improvement Group (PSPIG) Acute Oncology.**
	Failure to recognise and act on signs and symptoms of deterioration.		
	Failure to recognise and act on signs and symptoms of deterioration causing a delay or unexpected admission to critical care.	PSII	
	Tissue Viability	Rapid review for DPSIG consideration. Decision by Divisional PSIG if After Action Review then required.	Create local and organisational actions and feed these into the **Patient Safety Priority Improvement Group (PSPIG) Fundamentals of Care.**
	Deterioration or during admission development of Grade 1 or 2 pressure ulcer.		
	Medicines Safety	After Action Review / Multidisciplinary Team Review / Thematic analysis under Divisional PSIG.	Create local and organisational actions and feed these into the **Patient Safety Priority Improvement Group (PSPIG) Medicines and Transfusion Safety.**
	Administration errors.		
	Medication errors resulting in moderate + harm to patient.	PSII	
	AKI	Multidisciplinary Team Review under Divisional PSIG. PSII if prompted by Divisional PSIG.	Create local and organisational actions and feed these into the **Patient Safety Priority Improvement Group (PSPIG) Acute Oncology.**
	Failed recognition and / or treatment of Acute Kidney Injury resulting in deterioration.	Multidisciplinary Team Review under Divisional PSIG. PSII if prompted by Divisional PSIG.	Create local and organisational actions and feed these into the **Patient Safety Priority Improvement Group (PSPIG) Acute Oncology.**

	Patient Safety Incident Type	Required Response	Anticipated Improvement Route
Consideration of Learning Response by Divisional PSIG	**Sepsis** Failed recognition and / or treatment of sepsis resulting in deterioration.	Multidisciplinary Team Review under Divisional PSIG. PSII if prompted by Divisional PSIG.	Create local and organisational actions and feed these into the **Patient Safety Priority Improvement Group (PSPIG) Acute Oncology.**
	Infection Prevention and Control COHA / HOHA, Clostridium Difficile (toxin positive). MRSA BSI.	PIR	NIPR
	Transfusion Failure to follow correct transfusion policy (including near miss).	After Action Review / Rapid Review.	Create local and organisational actions and feed these into the **Patient Safety Priority Improvement Group (PSPIG) Medicines and Transfusion Safety.**
	Falls Fall whilst inpatient resulting in long bone fracture. Falls resulting in major harm to individual.	**After Action Review** To determine if fall preventable. **Unpreventable fall** Learning through Falls Prevention Group. **Preventable** PSII.	Learning and actions to support **Patient Safety Improvement Group (PSPIG) Fundamentals of Care.**
	Extravasation Extravasation resulting in severe harm to individual.	SWARM for immediate reflection and shared learning. After Action review if requested by Divisional PSIG. PSII if requested by Divisional PSIG.	Create local and organisational actions and feed these into the **Patient Safety Priority Improvement Group (PSPIG) Extravasation.**
	Lost to follow up / open referrals Lost to follow up / open referral that has resulted in a significant delay to an individual.	After Action review if requested by Divisional PSIG. PSII if requested by Divisional PSIG.	Create local and organisational actions and feed these into the **Patient Safety Priority Improvement Group (PSPIG) Lost to follow up / open referrals.**
Local Divisional management	**Other incidents which have resulted in moderate to severe harm or a near miss where there is potential for wider learning.**	Duty of Candour. **Divisional PSIG assessment:** MDT Review / AAR / PSII.	Relevant improvement work-stream. Shared learning at Quality and Safety Group.
	Other incidents / prevalent themes which have resulted in minor or no harm but there is potential for wider learning.	Themed review by area. Rapid review.	Local action plans and improvements. Shared learning at Quality and Safety Group.