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Patient Safety Incident Response Plan

... for a better Bolton

Patient Safety Incident Response Plan

Effective date: 01 January 2024

Estimated refresh date: 01 January 2025

Version Control

Version	Type of change	Date	Revisions
1	New document	November 2023	NA

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Glossary

Definitions for technical terms and acronyms used within this document

PSI or Patient Safety Incident	Patient safety incidents are unintended or unexpected events (including omissions) in healthcare that could have or did harm one or more patient
PSIRF	Patient Safety Incident Response Framework. The Framework supports the development and maintenance of an effective patient safety incident response system across the NHS
SEIPS	Systems Engineering Initiative for Patient Safety. A framework for understanding complex socio-technical systems. A systems based approach recognises that healthcare delivery requires many interactions between various components. It aims to understand how they all interact and influence outcomes. It focuses on wider system issues, not individuals.
LRT	Learning response tool. A toll or method used to learn from an incident that uses a systems based approach to learning
AACD	Adult Acute Care Division
ASSD	Anaesthetic and Surgical Services Division
ICSD	Integrated Care Services Division
FCD	Family Care Division
NHS Greater Manchester (NHS GM)	NHS Greater Manchester is the Integrated Care Board for Greater Manchester. A statutory NHS organisation which is responsible for developing a plan for meeting the health needs of the population, managing the NHS budget and arranging for the provision of health services in a geographical area.
AIS	Accessible Information Standard. This directs and defines a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication needs of people with a disability or sensory loss.
NICE	National Institute for Health and Care Excellence. Provides national guidance and advice to improve health and social care.
CQC	Care Quality Commission. The independent regulator of health and adult social care in England.
CNST	The Clinical Negligence Scheme for Trusts is a payment made to NHS Resolution who then handle all clinical negligence claims against member NHS bodies where the incident in question took place on or after 1 April 1995. There is a specific incentive scheme for maternity services that supports the delivery of

	safer maternity care through an incentive element to trust contributions to the CNST.
C.Diff / CDT	Clostridium Difficile or Clostridioides Difficile. A type of bacteria that can infect the bowel and cause diarrhoea. It commonly affects people who have been recently treated with antibiotics but can spread easily to others. CDT is a binary toxin frequently observed in Clostridium difficile strains associated with increased severity of C. difficile infection
NPSIPs	National Patient Safety Improvement Programmes. National priorities because of their potential to enable the most significant impact on patient safety.
PSII	Patient Safety Incident Investigation. An in-depth review of a single patient safety incident or cluster of events to understand what happened and how
LeDeR	LeDeR is a service improvement programme for people with a learning disability and autistic people. A LeDeR review looks at key episodes of health and social care a person received that may have been relevant to their overall health outcomes.
DHR	Domestic Homicide Review. A review into the circumstances around a death of your friend or family member following domestic abuse.
MHRA	Medicines and Healthcare products Regulatory Agency. MHRA regulates medicines, medical devices and blood components for transfusion in the UK.
ICO	Information Commissioner’s Office. The ICO is the UK's independent body set up to uphold information rights.
HTA	Human Tissue Authority. The independent regulator of organisations that remove, store and use human tissue for research, medical treatment, post-mortem examination, education and training, and display in public. The HTA also give approval for organ and bone marrow donations from living people.
SWARM Huddle	A type of learning response tool designed to start as soon as possible after a patient safety incident occurs to identify learning. 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
MDT Reviews	A type of learning response tool. An in-depth process of review, with input from different disciplines, to identify learning from multiple patient safety incidents, and to explore a safety theme, pathway, or process. To understand how care is delivered in the real world i.e. work as done.

After Action Reviews (AAR)	A type of learning response tool. A structured, facilitated discussion of an event, the outcome of which gives the individuals involved in the event understanding of why the outcome differed from the expected and the learning to assist improvement.

1. Introduction

1.1 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. The main aim being to support learning and improve patient safety. It is a key part of the NHS patient safety strategy. Published in 2019, the NHS Patient Safety Strategy: Safer Culture, Safer Systems, Safer Patients describes how the NHS will improve patient safety over the next five to ten years.

1.2 The Bolton Locality Plan, produced in 2016 by Bolton Clinical Commissioning Group, aspires to:

- Improve health outcomes, increase healthy life expectancy and reduce inequalities through targeted interventions. Including:
  − Reducing the number of people who have heart disease, a stroke, or diabetes
  − Reducing the number of people, especially older residents, who are injured due to falls.
- Support behavioural change with more people successfully managing their own health and wellbeing, supported by knowledgeable and skilled teams of integrated health and social care professionals.
- Reduce pressure on GPs, freeing up their time to support the management of people who have a higher level of clinical need.
- Reduce hospital-based care by improving access to local specialist health services, reducing ambulance call outs and emergency admissions to hospital (including from care homes).

1.3 Our aspirations are closely aligned with those of our commissioners and informed the development of our Trust Strategy. We will continue to work in partnership with them to achieve our shared ambitions. Our 2019-2024 Strategy describes our vision 'to be recognised as an excellent provider of health and care services, and a great place to work'. It has been created around 5 core ambitions:

1. Improving care, transforming lives
2. Working together for a better future
3. A skilled, healthy, thriving workforce
4. Financial and operational strength
5. Infrastucture, technology and innovation

1.4 Considering these factors, this Patient Safety Incident (PSI) Response Plan sets out how Bolton NHS Foundation Trust intends to respond to patient safety incidents over the next 12 months to improve patient safety and quality of care, in line with PSIRF principles. The plan is not a permanent rule that cannot be changed. We will

remain flexible and consider the specific circumstances in which patient safety incidents occurred and the needs of those affected.

2. Our services

2.1 Bolton NHS Foundation Trust provides a range of hospital and community health services in the Northwest Sector of Greater Manchester. We deliver services from the Royal Bolton Hospital site in Farnworth, in the Southwest of Bolton, close to the boundaries of Salford, Wigan, Blackburn and Bury as well as providing a wide range of community services from locations within Bolton.

2.2 The Royal Bolton hospital provides a full range of acute and a number of specialist services including urgent and emergency care, general and specialist medicine, general and specialist surgery and full consultant led obstetric and paediatric service for women, children, and babies. The Integrated Community Services Division consists of domiciliary, clinic and bed-based services across the Bolton footprint to GP registered population.

2.3 In total, we have 598 general and acute beds, 78 maternity beds and 35 critical care beds

2.4 The Trust has an estimated catchment population of 1,000,000 compared with a resident Bolton population of 285,000

2.5 In 2022/23 Bolton NHS Foundation Trust provided and/or sub-contracted 13 relevant health services (as defined by the CQC) across 41 specialties.

2.6 The services provided by the organisation have been mapped using profiling information from the Trust's intranet, divisional governance charts, the Trust's website and the most recent available CQC Inspection Report (October 2023)

2.7 Acute Adult Care Services Division (AACD)

2.7.1 The emergency department is a type 1 service. This means it is a consultant-led 24-hour service with full facilities for resuscitating patients. There are separate adult and paediatric emergency areas, a minors area, a same day emergency care unit (SDEC) which was re-launched (September 2022) and an urgent treatment centre.

2.7.2 Royal Bolton Hospital is the second busiest ambulance-receiving site in Greater Manchester.

2.7.3 The medical services consist of:

- 17 in-patient wards

- 54 respiratory beds with a ward based non-invasive ventilation service
- Coronary Care Unit
- 35 cardiology beds as well as
- Diabetes, gastroenterology, haematology, acute stroke, acute frailty, medical assessment, three care of the elderly and three escalation wards.

2.8 Anaesthetics and Surgical Services Division (ASSD)

2.8.1 ASSD delivers elective and non-elective specialist care across a wide range of clinical specialties.

2.8.2 We also offer both elective and non-elective surgery, as well as specialist clinical services delivered both at Royal Bolton Hospital and in the community.

2.8.3 In 2021/2022, we delivered more than 190,000 Outpatient appointments and performed 3,500 emergency surgeries in our theatres.

2.8.4 Our Critical Care department provides life sustaining treatment to patients with severe life-threatening illnesses and to patients after major surgical procedures.

2.8.5 The Critical Care Unit is a 19-bedded unit providing both high dependency and intensive care capacity.

2.8.6 We care for almost 1,400 patients a year, and are the third busiest critical care unit in Greater Manchester.

2.9 Diagnostic and Support Services Division (DSSD)

2.9.1 DSSD is a key support for Trust services and interacts with patients on many different inpatient and outpatient pathways.

2.9.2 The division operates a range of support services including Pharmacy, Laboratory Medicine, Radiology and Infection Prevention and Control.

2.10 Family Care Division (FCD)

2.10.1 The Family Care Division delivers a range of services including:

- Maternity
- Neonatal
- Sexual health
- Early pregnancy
- Gynaecology services
- Acute and community children's services including hospital and community based children's clinical services
- 0-19 Public Health Nursing

- Paediatric Allied Health Professionals and Paediatric Learning Disability.

2.10.2 More than 6,000 babies are delivered under our care and we carry out around 1,500 gynaecological procedures each year.

2.10.3 We also have a tertiary level Neonatal Intensive Care Unit and a level 2 Paediatric High Dependency service working in collaboration with Greater Manchester Acute paediatric services.

2.10.4 There is a range of options for where people can choose to give birth including:

- at home with support from our midwifery team
- at Ingleside Birth and Community Centre, our midwife led unit in Salford
- at the Beehive Unit our midwife led unit at Royal Bolton Hospital
- at the Royal Bolton Hospital delivery suite, our doctor led unit at the hospital

2.11 Integrated Community Services Division (ICSD)

2.11.1 The ICSD places an emphasis on avoiding hospital attendances and admissions by responding to health and social care issues in our community. This includes providing intensive therapy and re-ablement packages to support our patients' independence.

2.11.2 We have more than 940 staff who help to deliver 40+ services, including district nursing, IV therapy, diabetes and homeless and vulnerable adults services

2.11.3 We also have staff working during the day at Wilfred Geere and 24 hours a day at Laburnum Lodge, intermediate care services run by Bolton Council.

2.11.4 The subsequent plan has been developed in collaboration with each of the divisions and relevant stakeholders (including patient representatives) to ensure it reflects the variety of services the organisation offers.

3. Defining our patient safety incident profile

3.1 Stakeholder Engagement

3.1.1 We have engaged with a range of stakeholders to create a list of PSI types that are jointly identified as areas of interest in terms of risk and potential learning and improvement. As part of the profile development process, we engaged with the following groups/stakeholders:

- Divisions via Divisional Governance meetings
- Family Care Division development session
- Monthly PSIRF Implementation Group meetings
- Bolton ICB (now NHS GM)

- Greater Manchester ICB (now NHS GM)
- Specialist nursing teams (Tissue viability, Enhanced care, Admiral nurse, learning disabilities)
- Staff experience manager
- Equality, diversity and inclusion programme manager
- BoSCA Lead
- Director of Operations/Chair of the regional health inequalities enabling group
- North West Ambulance Service
- Greater Manchester Mental Health NHS Trust
- Healthwatch
- Patient representatives
- Locality systems quality group
- Divisional stakeholder workshop to stratify key themes

3.2 Data Sources

3.2.1 Discussions with our stakeholders were underpinned by a review of both qualitative and quantitative data from a range of sources covering the last 1-3 years

- Patient safety incidents reported via Safeguard 2020-2023
- Falls data 2021/2022 and 2022/2023
- Complaints data 2020-2023
- Claims data 2020-2023
- CNST Scorecard
- Pressure ulcer data 2021/2022 and 2022/2023
- Divisional review report of top 10 cause groups for incidents 2020-2023
- Quality Improvement Strategy
- Audits and NICE compliance
- Quality Improvement – local initiatives
- Learning from Deaths quarterly reports Q1-3 2022/23
- Integrated Performance Monitoring Reports Q1-3 2022/23
- Serious Incident investigation reports and action plans 2022-2023
- Divisional organisation and governance charts
- NHS Staff Survey 2022 Benchmarking Report and Breakdown Report

3.2.2 Following the review of data, we were able to identify the top 15 most significant patient safety themes. By reviewing the current improvement work underway and engaging with stakeholders, we were able to narrow the list down to the top five patient safety themes.

3.2.3 To ensure this approach was consistent, measurable and comparable, Divisions were asked to rank the top 15 themes using the following matrix:

1. Are there any surprises?
2. Are there any themes you would add?
3. Using the matrix below give each theme a score from 1 to 5* (incl any themes you would add)
4. Rank the themes in order of priority/concern (1 being the highest priority)
5. Give each theme a total score

Level of harm**	Likelihood of harm**	Confidence in existing safety measures/ improvement work	Potential for new learning	Ranking	Total score

***Using the Trust matrix as per risk register*

3.2.4 As part of the consultation process, we engaged with patient representatives and Healthwatch to gain feedback from people who use our services. We asked for their views on the top five themes and what they felt should be included in our plan.

3.2.5 We held a separate workshop with the Families division to explore and understand the main safety themes specific to that division. As a result, we have developed a specific chapter within the plan for Families services. This is to ensure the plan reflects some of the specific nuances of these services.

3.2.6 There was a two-week stakeholder consultation period for the draft policy and plan in line with the Trust's procedural document development and management processes. We reviewed feedback and amended the draft documents accordingly. The final draft policy and plan were presented to Clinical Governance and Quality Committee and Quality Assurance Committee before finally being submitted to Trust Board for approval.

3.2.7 The plan aims to support the Trust to use resources effectively and enhance opportunities for learning and improvement. However, it is not a permanent set of rules and can be changed if appropriate. As well as the plan, we will remain flexible and consider the specific circumstances in which patient safety incidents occur and the needs of those affected. We have also developed a PSI Response Policy to support implementation of the plan.

A copy of the policy is available here.

4. Defining our patient safety improvement profile

4.1 In order to identify and agree our patient safety improvement profile it was important to understand what improvement and transformation work is planned or already underway across the Trust, locally and nationally.

4.2 Quality Account Priorities 2022/2023

4.2.1 In our Quality Account for 2021/22 we set ourselves a series of key priorities for improvement for 2022/23, these were:

- Improving the response to escalation from clinical teams following a deterioration in a patients National Early Warning Score (continuation from 2021/22)
- Antibiotic prescribing standards
- Rheumatology
- Improving information for patients
- Accessible Information Standards (AIS)

4.2.2 Full details regarding our aims and progress against these priorities can be found in the Bolton NHS Foundation Trust Quality Account 2022-23 which can be found here: https://www.boltonft.nhs.uk/app/uploads/2023/07/Bolton-NHS-Foundation-Trust-Quality-Account-2022-23.pdf

4.3 Quality Account Priorities 2023/2024

4.3.1 Following consultation with our stakeholders, the following were highlighted as our quality account improvement priorities for 2023/24:

1. Pressure Ulcer Improvement

Aims:

- To reduce Hospital acquired category 2 pressure ulcers by 50% by 31/07/24
- To reduce Community acquired category 2 pressure ulcer by 30% by 31/07/24
- To eradicate category 3 and 4 pressure ulcers by 31/07/24

2. C.difficile infection reduction

Aim:

- Reduce Healthcare associated C.diff Toxin (CDT) positive cases by 33% by 30/06/24, with a sustained reduction to the Greater Manchester peer mean (50%) by 31/12/2024

3. Enabling and empowering our staff through the development of quality improvement skills

Aim:

- 25% increase in Bolton NHS Foundation Trust Staff who have an awareness of the fundamentals of Quality Improvement by 31/03/24 (through QI fundamental training, improvement collaborative involvement, BoSCA* QI involvement)

**BoSCA stands for Bolton System for Care Accreditation. It is an internal accreditation programme that supports all inpatient areas to provide safe, effective, consistent, compassionate care to our patients and their families.*

4.3.2 Trust-wide Quality Improvement work reflects these priorities.

4.4 Trust-wide Quality Improvement Work

Name of QI project/Area of focus	Status
Quality improvement skills capability building	In progress
Standardising nursing handover	In progress
Pressure ulcer collaborative	In progress
C.Diff collaborative	In progress
Sepsis	Scoping - Bringing together NEWS, Sepsis and deteriorating patients workstreams together
Improving the learning from deaths process	Scoping
End of life care – staff education, access to side rooms, information sharing with patient and relatives	In progress
Noise at night	In progress
Nursing documentation optimisation	In progress

4.4.1 Continuous improvement of clinical quality is further incentivised through the contracting mechanisms that include quality schedules, penalties and where applicable commissioning for quality and innovation (CQUIN) payments. (See Service Transformation section)

4.5 National Patient Safety Improvement Programmes (NPSIPs)/Priority Areas of Focus

4.5.1 The NHS Patient Safety Strategy 2019 identifies four national priorities because of their potential to enable the most significant impact on patient safety along with ongoing work in three key priority areas.

4.6 NPSIPs

- Preventing deterioration and sepsis
- Medicines safety
- Maternal and neonatal safety
- Mental Health Safety

4.7 Ongoing national priority areas of focus

- Antimicrobial Resistance and Healthcare Associated Infections
- Safety and learning disabilities
- Safety issues affecting older people

4.8 Divisional Quality Improvement Work

Name of QI project/Area of focus	Status
ICSD – Community Nursing and Treatment rooms: Purpose T risk assessment mandatory as part of all initial assessments. Increase team knowledge around pressure damage management and pressure ulcer related issues.	In progress
ICSD – Community nursing safety huddle alignment	Established
ICSD – Introduction of patient information card (Rheumatology)	Established
ICSD –Neuro epilepsy maternity pathway	In progress
DSSD – Accessible Information Standards in relation to text reminders and digital letters for outpatient and/or elective care	In progress
Pharmacy – Prescription tracking system	In progress
DSSD – Nurse-led PICC and midline insertion service	Well established
Pharmacy – Assembly of medications for discharge	In progress
AACD – Learning from falls	In progress
ASSD – Discharges (F4)	Scoping
ASSD - THR/TKR ambulatory care pathway	In progress
ASSD – Breast cancer end of treatment summaries	Well established
AACD – Standardising acuity measures in the emergency department	In progress
AACD – Enhanced Care Lounge	In progress
AACD – New Inpatient flow system	In progress
AACD – Productive ward	Established
AACD – Criteria led discharge	In progress
AACD – Ward welcome packs	In progress
AACD – Staff information cue cards	In progress
Speech and Language Therapy services - Improving patient experience and mouth care in long term nil by mouth patients using Biozoon	In progress
Speech and Language Therapy services - Improving functionality and experience in patients with muscle strength weakness –using EMST	In progress

The clinical audit reports for 29 national clinical audits and 216 local clinical audits were reviewed by the Trust in 2022/23. Full details of the actions being taken to improve the quality of healthcare provided can be found in the aforementioned Bolton NHS Foundation Trust Annual Quality Account 2022-2023.

4.9 Service Transformation

Please see Appendix 1 for a full list of the service transformation and improvement work underway with an impact on patient safety

5. Our patient safety incident response plan: national requirements

5.1 Some events in healthcare require a nationally mandated response. The table below summarises the guidance on nationally mandated responses to certain categories of event and sets out whether that mandated response needs to be a PSII or another response type, including referring the event to another organisation to manage.

Patient safety incident type	Required response	Anticipated improvement route
Incidents meeting the Never Events criteria	PSII	Create local organisational actions and feed these into the quality improvement strategy
Death thought more likely than not due to problems in care (incident meeting the learning from deaths criteria for patient safety incident investigations (PSIIs))	PSII	Create local organisational actions and feed these into the quality improvement strategy
Mental health-related homicides	Referred to the NHS England Regional Independent	Dependent on RIIT decision. Respond to

	Investigation Team (RIIT) for consideration for an independent PSII Locally-led PSII may be required	recommendations as required and feed actions into the quality improvement strategy
Deaths of patients detained under the Mental Health Act (1983) or where the Mental Capacity Act (2005) applies, where there is reason to think that the death may be linked to problems in care (incidents meeting the learning from deaths criteria)	Locally-led PSII	Create local organisational actions and feed these into the quality improvement strategy
Child deaths	Refer for Child Death Overview Panel review Locally-led PSII (or other response) may be required alongside the panel review – organisations should liaise with the panel	Dependent on Panel review outcome. Respond to recommendations as required and feed actions into the quality improvement strategy
Deaths of persons with learning disabilities	Refer for Learning Disability Mortality Review (LeDeR) Locally-led PSII (or other response) may be required alongside the LeDeR – organisations should liaise with this	Dependent on LeDeR Review. Respond to recommendations as required and feed actions into the quality improvement strategy
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	Refer to local authority safeguarding lead The Trust must contribute towards domestic independent inquiries, joint targeted area	Dependent on Local Authority line of enquiry/action/review

- the incident relates to FGM, Prevent (radicalisation to terrorism), modern slavery and human trafficking or domestic abuse/violence	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	
Incidents in NHS screening programmes	Refer to local screening quality assurance service for consideration of locally-led learning response	Create local organisational actions and monitor for effectiveness/ safety improvement
Domestic homicide	A domestic homicide is identified by the police usually in partnership with the community safety partnership (CSP) with whom the overall responsibility lies for establishing a review of the case Where the CSP considers that the criteria for a domestic homicide review (DHR) are met, it uses local contacts and requests the establishment of a DHR panel The Domestic Violence, Crime and	Dependent on police and CSP review

	Victims Act 2004 sets out the statutory obligations and requirements of organisations and commissioners of health services in relation to DHRs	
Incidents meeting 'Each Baby Counts' and maternal deaths criteria: - Intrapartum stillbirth: the baby was thought to be alive at the start of labour but was born showing no signs of life. - Early neonatal death: the baby died, from any cause, within the first week of life (0 to 6 days). - Potentially severe brain injury diagnosed in the first seven days of life and the baby was diagnosed with grade III hypoxic–ischaemic encephalopathy; or was therapeutically cooled (active cooling only); or – had decreased central tone, was comatose and had seizures of any kind. - Maternal deaths: death while pregnant or within 42 days of the end of the pregnancy from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes (excludes suicides).	Referred to Maternity and Newborn Safety Investigations (MNSI) for independent patient safety incident investigation	Respond to recommendations as required and feed actions into the quality improvement strategy
Also to consider:		
Incidents reportable under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 2013 and Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R.	Refer to Health and Safety Executive. Locally-led learning response may be required/requested.	Create local organisational actions and monitor for effectiveness/

		safety improvement
Radiation Exposure Incidents – IR(ME)R	Incidents are reportable to CQC. Locally led learning response may be required/requested.	Create local organisational actions and monitor for effectiveness/ safety improvement
Medicines and Healthcare products Regulatory Agency (MHRA) reportable incidents All transfusion-transmitted infections (TTI) must be reported to MHRA. MHRA Yellow Card reporting Any adverse incident involving a medical device should be reported to the MHRA, including problems with the instructions for use, packaging or the use of the device itself, particularly if the incident has led, or might have led to death, life-threatening illness or injury.	Refer to MHRA. Locally led learning response may be required.	Respond to recommendations as required. Create local organisational actions and monitor for effectiveness/ safety improvement
Serious Hazards of Transfusion (SHOT) reportable incidents Serious adverse reactions and events related to blood components, including any novel components such as convalescent plasma and whole blood. Serious adverse reaction: an unintended response in a patient that is associated with the transfusion of blood or blood components that is fatal, life-threatening, disabling or incapacitating or which results in or prolongs hospitalisation or morbidity Serious adverse events: Any untoward occurrence associated with the collection, testing, processing, storage and	Refer to MHRA Where blood components are being used in clinical trials this must be recorded in the SHOT submission. Locally led response required.	Respond to recommendations as required. Create local organisational actions and monitor for effectiveness/ safety improvement

distribution of blood or blood components that might lead to death or life threatening, disabling, or incapacitating conditions for patients or which results in, or prolongs, hospitalisation or morbidity.		
Human Tissue Authority (HTA) reportable incidents Establishments licensed in the Post Mortem sector must notify the HTA within five working days of a serious incident or near miss occurring or being discovered.	Refer to HTA Locally led response required	Create local organisational actions and monitor for effectiveness/ safety improvement
Independent Commissioners Office (ICO) reportable incidents GDPR breaches to be reported to ICO within 72 hours.	Refer to ICO Locally led response required	Create local organisational actions and monitor for effectiveness/ safety improvement

6. Our patient safety incident response plan: Local focus

6.1 Themes identified for local focus with the tools we aim to use in each situation. We know these tools support learning from past events but we will also combine this approach with tools that allow us to learn from what is happening in real time. This may include tools such as process mapping, observation and horizon scanning. Section 7 provides information about our toolkit.

6.2 Plan for all Divisions (as applicable)

Patient safety incident type or issue	Planned response	Anticipated improvement route
Cancer patient or Management of patient with pre-malignant condition lost to follow up	Patient Safety Incident Investigation – the first four that result in any level of harm and/or themed investigation of 6 near misses.	Create safety actions and feed these into divisional, Trust or local improvement plans as appropriate

	Divisionally, all other incidents managed in line with the PSI management process and escalated to PSII panel if indicated.	
Tests/Scan results/reports – Delay/failure to undertake or review	This is a complex issue with multiple known challenges that would benefit from a quality improvement focus	Put forward for quality improvement project 2024/25.
Discharge/Transfers of care (Patients 75 yrs +) – Failure to provide adequate information, referrals process to other services	Inform current quality improvement work and escalate to NHS GM for locality focus/response	Engagement with all relevant stakeholders to inform and develop ongoing improvement efforts
Violent/Aggressive behaviour involving patients with Dementia/LD/Cognitive impairment	SWARM Huddle or after action review with specialist nurse input and annual review of themes	Create safety actions and feed these into divisional, Trust or local improvement plans as appropriate
VTE – Failure to reassess within 24 hours and/or subsequent reassessment following changes to a patient's condition.	Patient Safety Incident Investigation – one per quarter / four per year Divisionally, all other incidents managed in line with the PSI management process and escalated to PSII panel if indicated.	Create safety actions and feed these into divisional, Trust or local improvement plans as appropriate
Medication administration – Missed administration of critical medication in the Emergency Department or Community with failure to escalate	Patient Safety Incident Investigation – one per quarter / four per year Divisionally, all other incidents managed in line with the PSI management process and escalated to PSII panel if indicated.	Create safety actions and feed these into divisional, Trust or local improvement plans as appropriate
Category 3 & 4 Pressure Ulcers	SWARM Huddles feeding into Trust wide/locality	Inform ongoing improvement efforts as

	Quality Improvement Collaborative	per 2023/24 Quality Account Priorities
Category 2 Pressure Ulcers	SWARM Huddles and quarterly thematic analysis feeding into Trust-wide/locality Quality Improvement Collaborative	Inform ongoing improvement efforts as per 2023/24 Quality Account Priorities
Falls with severe harm	SWARM Huddles and quarterly thematic analysis	Inform ongoing improvement efforts
Falls – repeat falls 3+ in a single inpatient period	SWARM Huddles and quarterly thematic analysis	Inform ongoing improvement efforts
TTOs – Patients sent home without medication	Monthly audits/Quarterly thematic review	Inform ongoing improvement efforts
Hospital Acquired C.Difficile	SWARM Huddles feeding into Trust wide/ locality Quality Improvement Collaborative	As per Quality Account priorities 2023/24
Recognition of deteriorating patient/delay in escalation	Divisional After Action Review feeding into Trust wide Quality Improvement work (currently at scoping stage) and wider NPSIPs	Build case for new improvement plan / Inform ongoing Quality Improvement work
Advanced care planning, recognition of dying patient, DNACPR	Learning from Deaths process feeding into Trust wide Quality Improvement work (currently at scoping stage)	Build case for new improvement plan / Inform ongoing Quality Improvement work

6.3 Plan for Families Division

6.3.1 The Families Division continues with all of the national maternity quality and safety initiatives designed to meet the national ambition to reduce the number of stillbirths and neonatal deaths:

- Saving Babies Lives Care Bundle
- Ockenden report 2022
- NHS resolution maternity incentive scheme
- Maternity and Neonatal Safety Collaborative
- Each Baby Counts
- Kirkup Report 2022
- Improving Equity and Equality in maternity and neonatal care.
- Tommy's app

In addition, the Division has identified the following key patient safety themes they will be focusing on in the next 12 months:

Patient safety incident type or issue	Planned response	Anticipated improvement route
Neonatal Unit – Unexpected Admission, identification and management of sepsis	After Action Review with escalation to PSII if further in-depth review/ learning identified.	Create safety actions and feed these into divisional, Trust or local improvement plans as appropriate
Neonatal unit closures due to staffing/skill mix and capacity issues	SWARM Huddle with actions feeding into CNST action plan	Create local safety actions and monitor via Divisional Governance, feeding into Trust quality monitoring and escalation processes as required.
Neonatal, Maternity & Gynaecology Communication- conflicting information from staff, mis-communication	SWARM Huddle to aid prompt identification of issues. Annual thematic review Each baby counts behavioural toolkit is being rolled out across maternity by the Saving Babies Lives midwife, includes escalation which often features in incidents	Create local safety actions and monitor via Divisional Governance to identify possible themes that may require more in-depth improvement work
Neonatal & Gynaecology Medication – prescribing/ administering	SWARM Huddles and bi-annual thematic review	Inform ongoing improvement efforts and feed into Trust safety improvement action as per Trust-wide plan above.

Neonatal & Gynaecology Failure to follow processes (guidelines/ policies)	After Action Reviews where incident results in harm along with quarterly thematic review to understand broader system issues.	Create local safety actions and monitor via Divisional Governance, feeding into Trust quality monitoring and escalation processes as required. Potential to put forward for quality improvement project 2024/25.
Neonatal, Gynaecology and Maternity Documentation – failure to document all clinical care	Quarterly audit to identify key issues and themes	Create local safety actions and monitor via Divisional Governance, feeding into local improvement projects if appropriate.
Gynaecology Tests/Scan results/reports – Delay/failure to review results	After action reviews with findings feeding into wider Trust improvement work	Create local safety actions and monitor via Divisional Governance. Identified issues and safety actions to inform broader Trust QI projects (in line with Trust-wide plan)
Gynaecology Discharge/ Transfers of care – Failure to complete timely discharge correspondence	SWARM Huddle or After Action Reviews with findings feeding into wider Trust improvement work	Create local safety actions and monitor via Divisional Governance. Identified issues and safety actions to inform broader Trust QI projects (in line with Trust-wide plan)
Gynaecology Aggressive/violent behaviour involving patients with mental health issues	Annual thematic review with input from specialist nursing staff/teams	Create local safety actions and monitor via Divisional Governance.
Gynaecology Delayed diagnosis/Missed diagnosis: Missed cancer, delayed	Incidents involving cancer patients lost to follow up managed as per Trust-wide plan. All other incidents managed by the Division through MDT or after action	Create safety actions and feed these into divisional, Trust or local improvement plans as appropriate

diagnosis of cancer, ectopic pregnancy	review with escalation to PSII panel if indicated as appropriate in line with escalation processes.	
Maternity Post- partum haemorrhage: Failure to identify/escalate and management of antenatal anaemia	Thematic review	Create local safety actions and monitor via Divisional Governance. Possibly escalate for PSII if indicated.
Acute paediatrics and integrated community paediatric service Medication prescribing and administration errors	Quarterly thematic review	Inform ongoing improvement efforts and feed into Trust safety improvement actions as appropriate
Acute paediatrics, Integrated community paediatric service & sexual health service Medical devices/ equipment – Availability, fit for purpose	SWARM Huddles	Create local safety actions and monitor via Divisional Governance, feeding into Trust quality monitoring and escalation processes as required. Expand the Divisional Medical Devices taskforce into a monthly meeting with extended Terms of Reference that review incidents and share learning.
Integrated community paediatric service and Allied Health Professionals Service Referrals process	Quarterly thematic reviews feeding into Divisional/ Trust /North West forums	Inform Divisional/Trust and Regional safety improvement plans. Create referral forms and examples where required e.g. Tertiary hospitals to

		community care. Discuss at network meetings.
Acute Paediatrics & 0-19/25yrs services Lack of suitably trained staff	Quarterly audit and undertake review of evidence based models for paediatric acute care.	Create local safety actions and monitor via Divisional Governance, feeding into Trust quality monitoring and escalation processes as required.
All paediatric community services Did not attend/ was not brought	SWARM Huddles	Create local safety actions and monitor via Divisional Governance. Put forward for quality improvement project.

7. Learning Response Toolkit

7.1 A learning response toolkit based on NHS England recommended tools and guidance is available for staff to use when undertaking a learning response. The toolkit is available on the Trust intranet. We will continuously review and develop the toolkit based on best practice guidance.

8. References

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Saving Babies' Lives: A care bundle for reducing stillbirths, NHS England, 2016: saving-babies-lives-car-bundl.pdf (england.nhs.uk)

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Reading the signals Maternity and neonatal services in East Kent – the Report of the Independent Investigation, Kirkup, 2022: Reading the signals - Maternity and neonatal services in East Kent – the Report of the Independent Investigation (publishing.service.gov.uk)

The Tommy's App, Tommy's National Centre for Maternity Improvement, 2023: Tommy's National Centre for Maternity Improvement | RCOG

Improving equity and equality in maternity and neonatal care, NHS England: NHS England » Improving equity and equality in maternity and neonatal care

Appendix 1: Transformation and Improvement Work

Title	Description	Status
Cost Improvement Plan	A co-ordinated Trust led approach to delivering the organisation's financial plan that integrates with the financial plans of Bolton's Integrated Care Board and Greater Manchester.	Well established and ongoing
Productivity Improvement Plan	A co-ordinated Trust led approach to delivering the organisation's productivity plan that integrates with the stra tegy of Bolton's Integrated Care Board and Greater Manchester.	In progress. On-track
Workforce Transformation Programme	- Mapping our workforce - Locality wide so hospital, community, primary care, ICP, care homes and social services - MECC Pilot - Collaboration opportunity with voluntary sector - Management of People and Culture Group which will inform and define transformational priorities across the locality	In progress. On-track
Outpatients Transformation Programme	A Trust wide delivery programme informed by a number of key national drivers. The programme will drive a Trust wide approach to implementing key OP deliverables and monitor developed KPIs to ensure achievement of the outcomes & benefits	Well established
Urgent care Programme	Locality wide programme comprising several workstreams to improve performance, productivity, efficiency, patient experience and staff experience	Established
Theatre (Admitted) Improvement Programme	Programme including multiple workstreams to improve elective recovery, operational planning targets, productivity and efficiency, patient experience and staff experience	Well established
Maternity Transformation Programme	3-year plan with 4 key themes: Theme 1: Listening to and working with women and families with compassion Theme 2: Growing, retaining and supporting our workforce Theme 3: Developing & sustaining a culture of safety, learning and support Theme 4: Standards and structures that underpin safer, more personalised and more equitable care	Well established

Children and young people transformation programme	Programme including multiple workstreams to improve SEND and JTAI assessments, equitable outcomes, productivity and efficiency, patient experience and staff experience	Scoping
Community Diagnostic Centre	Aims to improve elective recovery, operational planning targets, productivity and efficiency, patient experience, staff experience	Well established
Health Inequalities Programme	Supports Health Inequalities Enabling Group and Oversight of the Programme Plan. Programme has 4 parts; - Education and Awareness - Development of Health Inequalities Impact Assessment - Know our patients and staff - Inclusion of HI on key trust documents (such as business case template and benefits realisation tracker)	Established
Making Every Contact Count	Leadership and oversight of MECC programme working collaboratively with system partners to improve patient experience, improve patient outcomes, reduce health inequalities, improve population health	Established
Think before you tick project	Clinically led project to reduce the number of tests ordered unnecessarily in order to improve patient experience, improve productivity and efficiency, improve performance.	Well established with plans to expand to primary care
Mortality and recording of co-morbidities	Oversight across the mortality work of which focus is around improving clinical recording which then allows accurate depth of coding (in particular comorbidities), training and education, coding review, clinical review, EPR optimisation, and Know Your Patient.	Well established
GIRFT	Oversight of annual national programme	Well established
CQUIN Schemes	- Appropriate antibiotic prescribing for UTI in adults aged 16+ - Recording of NEWS2 score, escalation time and response time for unplanned critical care admissions - Compliance with timed diagnostic pathways for cancer services - Treatment of community acquired pneumonia in line with BTS care bundle - Anaemia screening and treatment for all patients undergoing major elective surgery	Established

	- Timely communication of changes to medicines to community pharmacists via the discharge medicines services - Supporting patients to drink, eat and mobilise after surgery - Cirrhosis and fibrosis tests for alcohol dependent patients - Malnutrition screening in the community - Assessment, diagnosis, and treatment of lower leg wounds - Assessment and documentation of pressure ulcer risk - Achieving high quality Shared Decision Making (SDM) conversations in specific specialised pathways to support recovery	
ORCHA	Implementation of ORCHA (digital care apps) working with specialities to keep patients well at home.	Ongoing – review of contract
LIMs	Project management of LIMs upgrade (Lab system)	2-year programme commenced April 2022.

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