



Patient Safety Incident Response Plan



Patient safety incident response plan

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Foreword

PSIRF is a different and refreshing approach to how we respond to care related safety incidents. This is not a change which involves us doing the same thing but calling it something different but a cultural and system shift in how we respond to care related safety incidents and how we work to learn, improve and prevent an incident happening again. Our challenge is to transition from the long-standing serious incident framework and investigating incidents to produce a report because it might meet specific criteria in a framework, towards an emphasis on the outcomes of care related safety incident responses that support learning and improvement to prevent recurrence.

Where previously, we have had set timescales and external organisations to approve what we do – PSIRF gives us a set of principles that we will work to and although this could seem scary, we welcome the opportunity to take accountability for the management of our learning responses to patient safety incidents, with the aim of learning and improvement.

As we transition to this new approach, we must engage meaningfully with those in our care, families and carers to ensure that their voice is at the forefront of our investigations.

Our focus on developing and embedding a just and learning culture underpins how we will approach our incident responses. We have fostered a culture in which people feel they can report and highlight incidents knowing they will be supported.

As we move into adopting this new framework and process for responding to care related safety incidents, we accept that this will be an evolving process and 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.

We look forward to working with our commissioners, regulators and other stakeholders as we transition and respond to this NHS and nationally driven change. We will positively embrace this change and PSIRF offers us the opportunity to learn, improve and promote safe, effective, and compassionate care across all of our services, whilst also protecting the well-being of our colleagues.

Kevin Monteith
Director of Risk and Governance

Introduction

This patient safety incident response plan sets out how Active Care Group (ACG) intends to respond to care related safety incidents as we transition to the new way of working and implement the principles of the new framework. The plan will remain under review as we learn through the implementation process and through the findings of investigations as well as feedback from colleagues, patients / residents and their families or carers.

This plan will be implemented alongside the ACG PSIRF policy. The emphasis of the policy is on the process and culture to support continuous improvement in care related safety through our response to safety incidents.

One of the principles of PSIRF is to do fewer investigations but to do them better, this means taking the time to conduct system-based investigations by people that have been trained to do them. This plan and its associated policy set out our approach to thinking differently about learning and what it means for ACG.

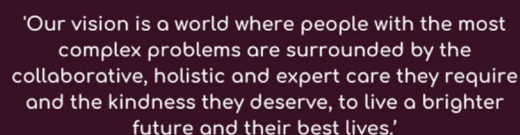
Carrying out investigations for the right reasons can and does identify learning that will help reduce the risk of harm. The transition from 'serious incidents' and Root Cause Analysis (RCA) methodology will take time to fully embed, this plan gives assurance that incidents resulting in serious harm will still be reviewed and a proportionate response will be agreed.

PSIRF recognises the need to ensure we have support structures for everyone involved in care related safety incidents. Part of which is the promotion of a culture of safety as led by all our colleagues and in line with the ACG behaviours.

This plan sets out the scope for a system-based approach to learning from care related safety incidents identified through our priorities, these priorities are aligned with our Quality Plan priorities.

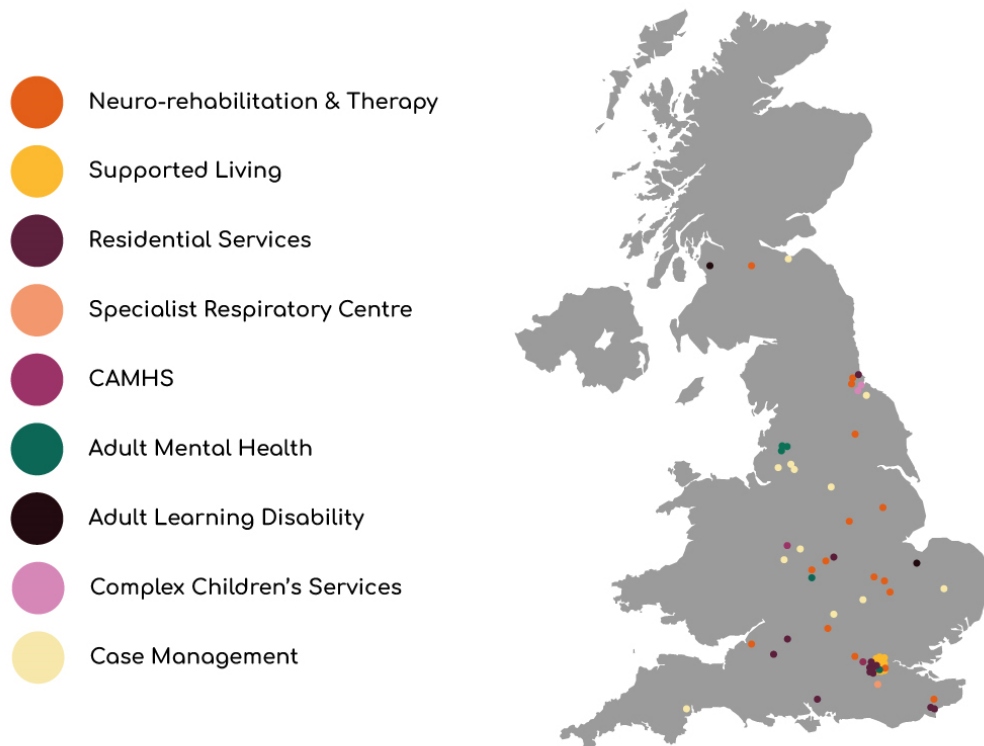
About Active Care Group

Active Care Group is the UK's leading national provider of complex care and rehabilitation services, harnessing innovation to raise standards and deliver better outcomes for children, young people and adults.



'Our vision is a world where people with the most complex problems are surrounded by the collaborative, holistic and expert care they require and the kindness they deserve, to live a brighter future and their best lives.'

Our services and locations



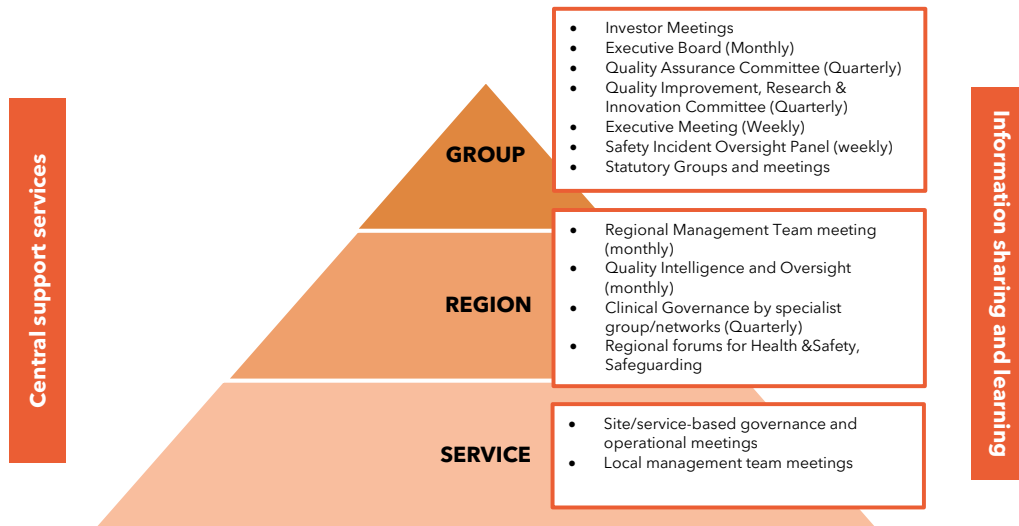
We reviewed our systems to understand the people who are involved in care related safety activities across ACG, as well as the system and mechanisms that support them. ACG is a pioneering provider of complex care, we place people at the heart of everything we do, improving people's lives by providing the best quality care tailored for individual needs. We provide progressive, personalised pathways of care that combine clinical expertise, personal support, and therapeutic and rehabilitation services enabling our service users to live the most rewarding lives possible whether in their own home or in one of our specialist care facilities.

Our residential services are organised into two geographical operating divisions (North, and South) with clinical governance organised into four specialised clinical networks:

- Social Care and Learning Disability
- Neuro-rehabilitation and Physical Health
- Mental Health Hospitals; and
- Children and Young People (CYP)

Our residential services are provided in a variety of settings including hospital based services, residential care homes and supported living services. In addition, we have a domiciliary care division and a case management division.

The ACG integrated governance framework will underpin the care related safety incident process, as set out in the diagram below. The weekly Safety Incident Oversight Panel (SIOP) will be responsible for the monitoring and allocation of Safety Incident Investigations (SII) and safety reviews.



Defining our patient safety incident profile

In 2021/22, the quality team undertook a programme of internal inspection, health and safety and peer review visits. Every service was reviewed using the relevant regulatory framework. These reviews identified local priorities for improvement that fed into individual site improvement plans (SIPs). Many examples of good and outstanding care were also identified during this process.

The reports from these site visits, together with the data we collect routinely and the quality assurance framework (QAF), provide a rich source of information about quality and safety. In keeping with the key behaviour that we will ‘listen, learn and act’, we have studied and analysed this information to identify issues that are common themes across our services. This led to the development of our Quality Plan which sets out the priorities that should be the principal focus of our quality improvement effort over the next three years.

The Quality Plan was discussed with stakeholders from across the organisation including Registered Managers, Operational Leads, subject matter experts and Clinical Leads. We have also taken feedback from patients / residents and their families or carers through the internal inspection process and our Complaints, Compliments and Concerns processes.

As a result of this work, we have agreed **six safety incident priorities** which are set out below. These are aligned with our quality priorities and will form the foundation for how we will respond to care related safety incidents. Where deemed appropriate, Safety Incident Investigations (SII) and safety reviews will be agreed through the Safety Incident Oversight Panel.

These priorities will remain under review and will evolve as our improvement work develops and our Quality Plan and Strategy is embedded.

Our safety priorities

Self-harm behaviours resulting in serious injury particularly within our hospital settings.

Pressure injuries sustained in our care which should / could have been prevented.

Incidents of aggressive / assault behaviours by patients / residents to peers or colleagues.

Significant physical health deterioration that could have been avoided

Falls resulting in serious injury.

Medication errors

Defining our patient safety improvement profile

We have an established executive led safety incident oversight panel (SIOP) to oversee the operation and decision-making of the safety incident responses that are commissioned. This will include the final sign off process for all SIIs. Through this mechanism the Executive Board will be assured that it meets expected oversight standards but also understands the ongoing and dynamic incident and safety profile within the Group.

Our six care related safety priorities will be the focus for structured thematic review work in the next 18-24 months as well as any relevant national priorities.

Care related safety incidents that must be investigated under PSIRF are:

Care related safety incident that is a Never Event

Deaths more likely than not due to problems in care. This can be identified through an incident or the learning from deaths process

National priorities for investigations

The decision to carry out a care related safety incident investigation will be based on whether an incident is linked to ACG's priorities as set out in this plan, or if the care related safety incident is a new emergent area of risk (i.e. number of similar incidents indicating a new priority).

Over a number of years, ACG has developed its governance processes to ensure it gains insight from care related safety incidents and this feeds into quality improvement activity. We will also continue to draw on guidance and feedback from national and regional level NHS bodies, regulators, commissioners, partner providers and other key stakeholders to identify and define the quality improvement work we need to undertake.



The Quality Assurance and Quality Improvement Committees will provide assurance that quality improvement measures, including any safety improvement plans in use currently, or which require development and implementation in the future, continue to be of the highest standard. They will be responsible for the oversight of this quality improvement work including the robust use of quality improvement methodology.

Our specialist networks and operational regions/divisions are required to report to our Quality Assurance Committee in order to monitor and measure improvement activity across the organisation. This includes review of progress against our overarching quality priorities as defined by our quality strategy.

SIOP will also provide regular reports on the development of new safety improvement plans following reviews undertaken within PSIRF.

We plan to focus our efforts going forward on development of safety improvement plans across our most significant incident types we have identified locally. We will remain flexible and consider

improvement planning as required where a risk or new safety issue emerges from our own ongoing internal or external insights.

How we will respond to care related safety incidents

Deciding on the level and type of response will be a flexible approach, informed by our local and national priorities. Our objective is to facilitate an approach that involves decision making at a local, regional/divisional, and at a group level. This will include an agreed escalation process from service level to the executive led oversight panel.

Our approach is to support each region/division to establish their local processes. We envisage this being fully embedded in 2024.

As we transition into PSIRF, the Quality and Governance team will continue to work closely with the operational management teams to review and identify incidents that may require a care related safety incident investigation in line with the national and local priorities.

		Event	Approach	Outcome / Improvement
Health and care safety incident investigation	National Priorities	Death of a person with learning disabilities	Refer for Learning Disabilities Mortality Review (LeDeR) Liaise with ICB (LeDeR Local Area Co-ordinator) as locally led SII may be required.	
		Safeguarding incidents in which: <ul style="list-style-type: none"> 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 Refer to local authority safeguarding lead the local safeguarding partnership (for children) trafficking or domestic abuse/violence. 	Reported to Head of Safeguarding Refer to local authority safeguarding lead. Healthcare provider 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	Respond to recommendations made
		Deaths of patients detained under the Mental Health Act (1983) or where the Mental Capacity Act (2005) applies, where there is	SII	Create local recommendations and actions

		reason to think that the death may be linked to problems in care (incidents meeting the learning from deaths criteria)		
		Child deaths	Refer for Child Death Overview Panel review. Locally-led SII (or other response) may be required alongside the panel review – organisations should liaise with the panel.	Create local recommendations and actions
		Incidents meeting the Never Event criteria	SII	Create local recommendations and actions
		Incidents resulting in death thought more likely than not due to problems in care (incident meeting the learning from deaths criteria for patient safety incident investigations (SIIs))	SII	Create local recommendations and actions
	ACG Priorities	<ul style="list-style-type: none"> • Self-harm • Pressure injuries • Challenging Behaviour • Physical health • Patient falls • Medication errors 	Care related safety incident responses/investigation as agreed by SIOP	Create local recommendations and actions feeding into governance framework
Safety incident review	Local level	<p>Incident resulting in moderate or severe harm</p> <p>No/Low harm and near miss incidents</p>	<p>Response in line with the Duty of candour requirements</p> <p>Validation of facts</p>	<p>Inform thematic analysis of ongoing care related safety risks</p>

As part of our implementation of PSIRF we will move away from Root Cause Analysis style investigations and instead transition to Systems Engineering Initiative for Patient Safety (SEIPS).

The focus of a system-based approach is examining the components of a system (e.g., person(s), tasks, tools and technology, the environment, the wider organisation) and understanding their interdependencies (i.e. how they influence each other) and how those interdependencies may contribute to patient safety. A system-based approach therefore recognises that it is insufficient to look only at one component, such as only the people involved.

SEIPS training will be provided to nominated persons within ACG, this cohort of colleagues will lead on care related safety incident investigations with support from co-investigators selected for their subject matter expertise.

We will also be utilising other methods for post incident learning, these include:

- Incident Debrief
- Safety huddles
- After Action Reviews
- Team Incident Reviews
- Clinical cabinets

Involvement of patients/residents, families and carers following incidents

We recognise the significant impact incidents can have on those directly involved as well as families and carers. Getting involvement right with patients/residents and their families in how we respond to incidents is crucial, particularly to support improving the services we provide. As part of our suite of policies linked to PSIRF, we are developing procedures and guidance to support colleagues in how to engage and discuss incidents with their patients/residents and family members.

Part of this implementation plan will be to undertake a specific piece of work to gather feedback from patients / residents and their families or carers who have been part of an investigation into a safety incident. We will look to gather their views in order to learn more on how we can improve our training and support for colleagues in how to discuss incidents with them and ensure their voices are heard.

“When an incident has happened, communicating with, and involving families in the investigation process is essential. An adverse event can be a deeply wounding experience, causing distress and trauma for those involved. As an organisation we must be able to listen to the experiences of those who have been through this and understand what has happened and the impact this had had on them and their loved one. This helps us learn and can be a real catalyst for change. Ultimately, most families just want for their experience not to be repeated. We must never lose sight of that”.

Natasha Sloman, Chief Quality Officer

Involvement and support for colleagues

The support we provide to our colleagues following an incident is also being improved as part of the PSIRF implementation.

We are committed to a ‘Just and Learning Culture’ to ensure it is a safe and fair place, where everyone’s voice is encouraged, valued and listened to, helping us to continually learn, inspire change and improve.

When a colleague reports an incident or is providing their insights into someone in their care for an investigation, we will actively encourage a safe space to discuss the events, explore the system in which they work and listen openly without judgement.

Colleague support

ACG Employee Assist Programme (EAP)

Occupational Health Service

A network of trained Mental Health First Aiders.

Our new policy, procedures and guidance will support this in practice. We recognise that many colleagues will be involved with a care related safety incident at some point in their careers and this can be a traumatic experience. We have a number of support systems in place for our colleagues.

Our policy framework and toolkit of response options sets out other ways colleagues can respond to incidents and support each other in the process. This will detail both how to respond to incidents thematically, but also how to respond to individual incidents. We have outlined several ways we can respond to individual incidents, including:

- Debrief:
 - An unstructured, moderated discussion.
- Safety huddle proactive:
 - A planned team gathering to regroup, seek advice, talk about the day.
- Safety huddle reactive:
 - Triggered by an event to assess what can be learned.
- After action review:
 - A structured facilitated debrief



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we will be
kind & honest



we will
listen, learn & act



we will be
fair & inclusive

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