Patient Safety Incident Response Plan

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1. Introduction

This patient safety incident response plan sets out how Acacium Group intends to respond to patient safety incidents over a period of 12 to 18 months. The plan is not a permanent rule that cannot be changed. We will remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected. Patient safety investigations are carried out to identify circumstances and systemic causes and casual factors that contribute to a patient safety incident.

We will integrate the 4 aims of the Patient Safety Investigation Framework:

- compassionate engagement and involvement of those affected by patient safety incidents.
- application of a range of system-based approaches to learning from patient safety incidents.
- considered and proportionate responses to patient safety incidents and safety issues.
- supportive oversight focused on strengthening response system functioning and improvement.

Our commitment is to ensure that we will provide a systematic, compassionate and timely response.

2. Our Services

Acacium Group is a leading global healthcare delivery system with over 35 years' experience. Acacium Group has a purpose focused on improving people's lives through expert healthcare, social care and life sciences. Acacium Group's vision is to become the leading global healthcare solutions partner, differentiated in the way we combine our scale and insight in deploying temporary workforce, with technology, process management and clinical oversight to deliver the right outcomes for clients, patients and service users alike.

3. Defining our patient safety incident profile

Acacium Group has implemented the Patient Safety Incident Response Framework (PSIRF) which sets out the NHSE approach to developing and maintaining effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety. This replaces the Serious Incident Framework.

The PSIRF advocates a co-ordinated and data-driven response to patient safety incidents. It embeds patient safety incident response within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management.

This policy supports development and maintenance of an effective patient safety incident response system that integrates the four key aims of the PSIRF:

- compassionate engagement and involvement of those affected by patient safety incidents
- application of a range of system-based approaches to learning from patient safety incidents
- considered and proportionate responses to patient safety incidents and safety issues
- supportive oversight focused on strengthening response system functioning and improvement.

Responses to PSIRF follow a systems-based approach. This recognises that patient safety is a complex response. Responses do not take a 'person-focused' approach where the actions or inactions of people, or 'human error', are stated as the cause of an incident.

There is no remit to apportion blame or determine liability, preventability or cause of death in a response conducted for the purpose of learning and improvement. Other processes, such as claims handling, human resources investigations into employment concerns, professional standards investigations,

coronial inquests and criminal investigations, exist for that purpose. The principle aims of each of these responses differ from those of a patient safety response and are outside the scope of PSIRF.

Information from a patient safety response process can be shared with those leading other types of responses, but other processes should not influence the remit of a patient safety incident response.

4. Engaging and involving patients, families and staff following a patient safety incident

The 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). This involves working with those affected by patient safety incidents to understand and answer any questions they have in relation to the incident and signpost them to support as require.

5. Patient safety incident response planning

PSIRF supports organisations to respond to incidents and safety issues in a way that maximises learning and improvement, rather than basing responses on arbitrary and subjective definitions of harm. Beyond nationally set requirements, organisations can explore patient safety incidents relevant to their context and the populations they serve rather than only those that meet a certain defined threshold.

Our plan sets out how Acacium Group intends to respond to patient safety incidents. The plan is not a permanent set of rules that cannot be changed. We will remain flexible and consider the specific circumstances in which each patient safety incident occurred and the needs of those affected. We will work alongside our Commissioners, CQC and Local Authorities to identify incidents that will trigger a patient safety incident investigation (PSII). Examples of these include, unexpected death, serious safeguarding incidents and multi-organisational incidents.

Each business will also set out what incidents will trigger a PSII and this will be held locally and reviewed on a yearly basis in line with their incident data.

6. Reviewing our patient safety incident response policy and plan

Our patient safety incident response plan is a 'living document' that will be appropriately amended and updated as we use it to respond to patient safety incidents. We will review the plan every year to ensure our focus remains up to date; with ongoing improvement work to our patient safety incident profile.

We will do this by

- Focussing on the quality-of-service delivery by the adherence to local and national quality standards
- Protecting the rights, dignity and confidentiality of our patients, service users, customers and staff
- Providing person centric care and treatment that is relevant to individual needs
- Engaging with our service users/patients and customers to deliver a positive experience.
- Provide the best possible outcomes through the delivery of clinical excellence.
- Protect the health and safety of our service users/patients, customers and employees.
- Deliver the service with respect and empathy.

- Complying with relevant regulatory and governing bodies.
- Continually monitor by means of feedback and audit.
- Preventing incidents through proactive risk management.

To achieve this Acacium Group will ensure that:

- Our leadership team have an unwavering commitment to improving quality
- That we have a culture of improvement, encouraged by leaders at all levels
- We will systematically give people the skills to deliver improvement
- We put patients, service users, customers and staff at the centre of improvement

Our key priorities:

- Putting patient experience more clearly at the heart of what we do
- Improving client, patient, and service user experience
- Securing outstanding reputation with the regulators
- Developing robust clinical pathways as our business evolves

Our quality improvement approach has six core elements that underpin the strategy. This is how we deliver on our priorities. They are:

- Understanding what is happening in our organisation
- Giving people the skills to enable improvement
- Working collaboratively within the organisation
- Embedding an empowered culture of quality
- Clear priorities and plans for improvement
- The right leadership

When defining new contracts as part of this all stakeholders are involved in agreeing KPI's that must be met and these are measured in contract review meetings.

Each business has a Quality and Safety Meeting that is chaired by either the Group Chief Nurse, or in their absence the Group Deputy Chief Nurse. The output of these meetings is then feedback to the Global Clinical Director and then to the Board during the Governance Review.

Within each business the Clinical Lead/Chief Nurse has a separate clinical improvement plan based on their incident and complaint data. This is also discussed at the Quality and Safety Meetings and is a standing agenda item.

7. Defining our patient safety improvement profile

Patient Safety Incident	Where monitored	Anticipated improvement route
Individual Businesses report their incident and complaint date	Quality and Safety Meetings	Improvements or assurances would be reported and provided during these meetings
Monitoring of quarterly trends and themes	Quality and Safety Meetings	Assurance around themes and trends would be given through the Quality and Safety Meetings and then within the Governance Report to the Global Clinical Director and Board

PSIRF knowledge for staff	PSIRF training is available both face to face and via the E-Learning Platform	
Local Templates for PSIRF Improvement Plans	Each business will have their own plan	This will be monitored through the Quality and Safety Meetings
Monthly Complaints and Incidents meetings held	Monthly meeting with the complaints and incident team to ensure any issues/themes are picked up in between Quality and Safety Meetings	

Patient safety incident type or issue	Planned response	Anticipated improvement route
Pressure Damage reported within Community Business	Quality Assurance report	Reported through the Business Review Meetings and the Quarterly Quality Review Meetings
Admission to Hospital	Quality Assurance Report	Reported through the Business Review Meetings and the Quarterly Quality Review Meetings