South Central Ambulance Service
NHS Foundation Trust

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Patient Safety Incident Response Plan

2024/25

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1.2	23 Sept 24	Amended / updated following SL changes in line with current team structure Added plan on a page for clarity of responses and reviews required Added colour for visual effect and clarity	Dawn Chase (Patient Safety Specialist)

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The Ambulance Services' PSIRF Network

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Health Services Safety Investigations Body

London Ambulance Service NHS Foundation Trust

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Solent NHS Trust

South East Coast Ambulance Service NHS Foundation Trust

Thames Valley Air Ambulance

University Hospital Southampton NHS Foundation Trust

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Foreword

"This framework is a move away from the current way the NHS responds to patient safety incidents, increasing focus on understanding how incidents happen – including the factors which contribute to them."

Aidan Fowler, National Director of Patient Safety, NHS England

The Patient Safety Incident Response Framework (PSIRF) is an enormous change for patient safety; fundamentally changing how the NHS responds to patient safety incidents and making safety culture a just culture. The new Framework enables a forward-looking proactive approach to prevent the reoccurrence of incidents. PSIRF is characterised by its four aims: compassionate engagement of all involved, a system-based approach, proportionate responses and supportive oversight.

Under PSIRF, the threshold for responding to patient safety incidents will change. Previously, the Serious Incident Framework (2015) categorised patient safety incidents according to the level of harm caused. Those incidents deemed 'Serious Incidents' required rigorously detailed investigative reports. This meant the response was often focussed on the production of the report itself, rather than identifying lessons or opportunities for improvement to prevent reoccurrence. Going forward, the threshold for a response will be based on the opportunity for learning and improvement.

It is essential that PSIRF, Just and Learning Culture (JLC) and Freedom to Speak Up (FTSU) work together to ensure safety culture is a just culture. Already we have demonstrated that initiatives to promote the reporting and recording of incidents (including near misses) are working. This has required significant effort to change culture by influencing behaviour, attitudes and perceptions. Getting culture right is essential to the success of PSIRF as it underpins all aspects of patient safety.

I am grateful to the many individuals and organisations who have supported our PSIRF Implementation Programme. In particular, I thank those early adopters and our fellow ambulance services who have so generously given us their time and so candidly shared their own lessons and experience.

PSIRF is just one part of the national Patient Safety Strategy (2019), which continues to be refined, revised, and improved. Our own priorities and patient safety risk profile will change too. PSIRF is designed to be flexible, so we will change and adjust as required. It is a very exciting and welcome change, which promises to put patients, not process or policy, at the forefront of patient safety.

Carol Rogers
Assistant Director of Patient Safety
January 2024

Part One: Introduction

This document, in conjunction with the Trust's PSIRF Policy, sets out how South Central Ambulance Service NHS Foundation Trust (SCAS) responds to patient safety incidents.

A patient safety incident (PSI) is defined by NHS England as "any unintended or unexpected event in healthcare (including omission) in which a patient was harmed or could have been harmed".

The aims of this Patient Safety Incident Response Plan (PSIRP) are to:

- Support continuous quality improvement
- Support more efficient use of resources required for responding to PSIs
- Support the change in focus from generating reports to identifying lessons and informing improvement to prevent reoccurrence

This is achieved by:

- Defining SCAS's patient safety risk profile
- Noting NHS England's national priorities for patient safety and specifying the methods (known as learning responses) SCAS will use to maximise learning and improvement.
- Defining SCAS's local priorities for patient safety and specifying the methods (known as learning responses) SCAS will use to maximise learning and improvement.

This document has drawn heavily on the experience of PSIRF early adopters and on the support of our fellow Ambulance Trusts. It has been developed by the Patient Safety Team, with input from across the organisation, and beyond. It should be noted that this document is not permanent; changes and amendments can be made at any time, subject to approval by the Trust's Quality and Safety Committee (QSC).

The PSIRP promotes the four characteristics of PSIRF by:

- Improving the experience of patients and families. This will be achieved by new engagement processes which actively place the patient, not policy or process, at the centre of patient safety.
- Using quality improvement methodologies to address causal and contributory factors to reduce likelihood of reoccurrence.
- Applying systems-based approaches to PSI responses. PSIRF is not about determining culpability or assigning blame but rather identifying lessons and opportunities for improvement.
- Reducing the number of investigations of individual PSIs in isolation. This will be done by empowering learning response leads to utilise a 'toolbox' approach of proportionate and considered responses.

Part Two: Our services

One of ten ambulance service trusts in England, SCAS provides emergency, urgent and non-emergency services. The Trust operates across six counties, serving a population of approximately 7.5 million. It comprises approximately 4,500 staff and a further 1,200 volunteers.

Emergency services

Emergency Operations Centres

SCAS has two Emergency Operations Centres (EOCs). Our contact centres receive over 1.2 million 999 calls each year made by the public, other healthcare providers and other emergency services. The EOCs are primarily tasked with receiving calls, deciding an appropriate response, and managing the deployment of emergency resources. They also provide specialist advisory services through the Clinical Support Desk, Urgent Care Desk, Maternity Desk, and Indirect Resource Desk. They can provide a control and communications facility to strategic commanders, and routinely liaise with other emergency services.

Emergency medical resources

If a patient requires an emergency response, an emergency ambulance or specialist resource will be dispatched. Emergency ambulances are normally crewed by a registered paramedic and an emergency care assistant (ECA). Specialist paramedics or paramedic team leaders may be dispatched for complex incidents or critical patients. Emergency medical resources may ‘see and treat’ (treat and discharge patients at scene), refer to an alternative care pathway (such as GP or District Nurse) or convey to hospital.

Hazardous Area Response Team

Established in 2011, the Hazardous Area Response Team (HART) is a specialist group of paramedics specially trained and equipped to deliver pre-hospital emergency care to patients in hazardous environments.

HART works closely with partner agencies such as the Police, Fire and Rescue Service, Lowland Rescue Teams, and the Maritime & Coastguard Agency. HART may be deployed to patients in or near flooding, unstable buildings, or terrain inaccessible to vehicles. They may also attend patients requiring extrication from unusual or dangerous locations.

Specialist Operations Response Team

The Specialist Operations Response Team (SORT) is a 300-strong pool of paramedics and ECAs trained to respond to marauding terrorist attack (MTA) and chemical, biological, radiological,

or nuclear (CBRN) incidents. They can conduct mass decontamination of patients. It sits under the governance of the National Ambulance Response Unit (NARU).

HEMS and BASICS

Thames Valley Air Ambulance (TVAA) and Hampshire and Isle of Wight Air Ambulance (HIOWAA) operate within SCAS's area of responsibility. TVAA and HIOWAA are air ambulance charities providing helicopter emergency medical services (HEMS). HEMS enables rapid deployment of highly trained critical care practitioners to patients urgently requiring complex interventions or advanced pre-hospital care. They may also convey patients to hospital by helicopter.

The British Association for Immediate Care (BASICS) is a charitable company which provides pre-hospital immediate care through a network of affiliated volunteer schemes. Two schemes operate in SCAS's area of operations, BASICS Thames Valley and SCAS BASICS. Both schemes are formed of volunteer pre-hospital clinicians capable of providing enhanced pre-hospital care. This includes sedation, advanced analgesia, respiratory and ventilation support, cardiac and surgical procedures, and major trauma interventions. SCAS supports both BASICS schemes through the SCAS Charity.

Urgent services

SCAS operates the NHS 111 single point of access service. This is a dedicated phone number providing healthcare advice and information using a standard assessment process. Our 111 service is a 24/7/365 service which receives over 1.3 million calls annually.

Using NHS Pathways (a clinical assessment tool), the NHS 111 Health Advisor (Call Handler) will assess the needs of the caller and implement necessary action ranging from dispatching an ambulance to making a referral to the appropriate available service (such as a GP), or simply providing advice.

Our 111 service is supported by teams comprising specialist paramedics and senior nurses who help assess acute same day appointments on behalf of GP surgeries. There is also a falls and frailty service which works with occupational therapists to provide a holistic care package.

Non-Emergency Patient Transport Service

SCAS is contracted to provide a Non-Emergency Patient Transport Service (NEPTS) across Buckinghamshire, Berkshire, Hampshire, Oxfordshire, Sussex, and Surrey.
As an organisation we have over 40 years' experience and our teams are made up of ambulance care assistants, call takers, dispatchers, planners, and support staff.

The service is for eligible patients who are unable to use public or other transport due to their medical condition. We provide a vital service getting them safely and comfortably to hospital or other healthcare providers across the six counties – and sometimes further!

To support patients to access the service, our ‘Patient Zone’ allows members of the public to book transport, manage bookings, and check the journey status. We also provide a telephone and online booking service for Health Care Professionals.

We have PTS liaison officers in major hospitals, who are the public face of the NEPTS. They deal with bookings, queries and resolve problems or concerns. Most importantly, they ensure that all eligible patients are conveyed so that they get the treatment they need.

We provide a range of resources from wheelchair accessible vehicles to specialised ambulances to ensure our patients are conveyed safely, in comfort and with dignity.

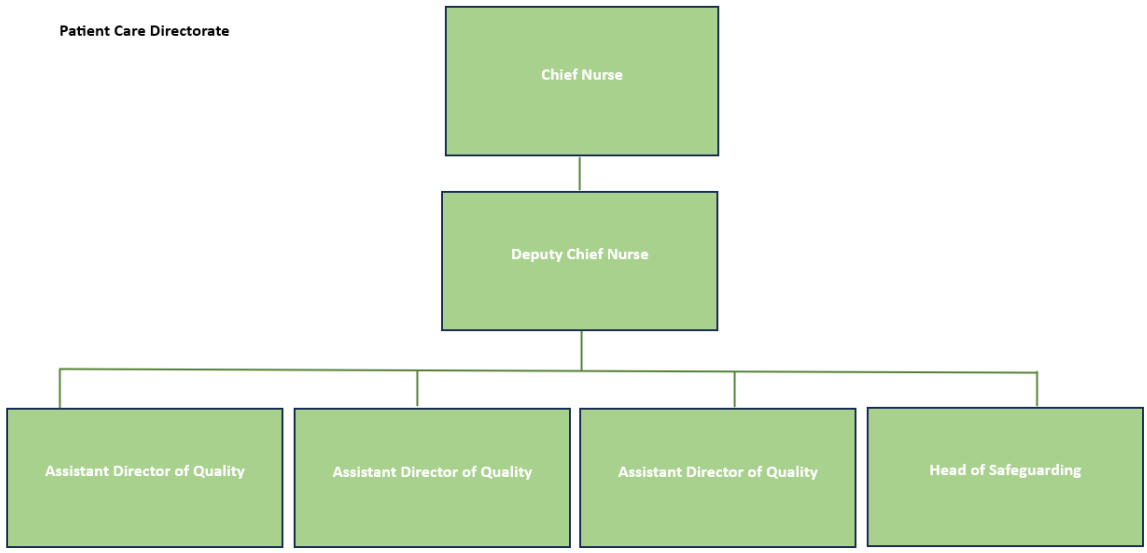
SCAS Charity

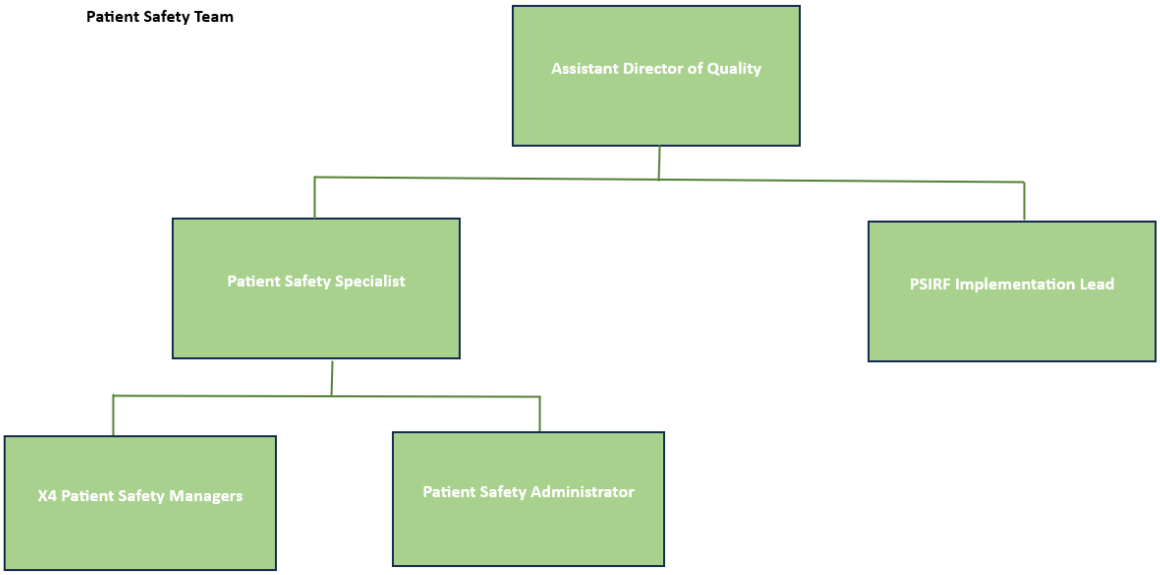
The South Central Ambulance Charity raises funds to support South Central Ambulance Service NHS Foundation Trust (SCAS). The money raised by the Charity is used to fund services, projects and equipment not supplied by government or NHS funding. Without the money we raise, people in our communities would have to wait longer for help which could affect their recovery.

SCAS Charity has over 1,200 volunteer responders. Our Community First Responders and our military, police and fire Co-Responders are trained to respond to life-threatening emergencies. They are deployed by the EOC, forming an integral part of our emergency medical response. SCAS Charity also supports volunteer patient transport drivers and welfare volunteers, as well as supporting SCAS BASICS.

Part Three: Patient Safety Team

Organisation of the Patient Safety Team





Part Four: Management of Patient Safety Incidents

This section provides a summary of the process which manages PSIs. Full detail is contained in the SCAS PSIRF Policy.

Safety Review Panel

The Safety Review Panel (SRP) meets weekly, is Co-Chaired by a member of the Medical Directorate, and an Assistant Director of Quality.

The purpose of SRP is to determine the learning response for those incidents where potential avoidable harm has occurred. The learning response will be selected based on the incident circumstances, opportunity for identifying lessons and opportunity for informing improvement.

Oversight & Review Group

Oversight & Review Group reviews and approves all completed investigations.

Coroners

If a PSI Investigation (PSII) involves a deceased patient, the coroner may request a complete factual report. The SCAS Head of Legal Services is supporting the development of the templates for the coroner. Coroners are being engaged to develop the new processes and templates required for transition to PSIRF.

Part Five: Understanding Our Patient Safety Incident Risk Profile

SCAS PSI profile process

Summary

To determine SCAS's local priorities, the PSIRF Implementation Lead collected and analysed three years of patient safety incident data (April 2020 – April 2023). This data included all categories of harm, as well as near misses.

Data sources

Included:

- Datix reports
- Learning from Deaths
- Freedom to Speak Up
- Complaints and patient experience reports
- Coroner requests
- Safeguarding annual report
- RIDDOR reports
- Fleet and Driving

- Analysis of trends in reports of Detailed Investigations (DI) and Serious Investigations (SI)

Excluded:

- Staff safety surveys were not included because the response rate was assessed as too low to provide an accurate or reliable data source.

Stakeholder engagement (PSI profile and development of local priorities)

Stakeholder analysis (June 2023)

The following persons were assessed as either required for data collection or likely to be required for review or approval of PSIR Plan local priorities:

- Head of Patient Experience
- Datix Super User
- Complaints Manager
- Chief Pharmacist and Trust Medication Safety Officer
- Freedom to Speak Up Guardian
- Senior Operations Managers
- Executive Leads
- Named Non-Executive Director for PSIRF
- Just and Learning Culture Lead
- PSIRF Implementation Programme Board
- Medical Devices Lead
- Trust Risk Manager
- HIOW ICB representatives

Initial engagement (June to August 2023)

The PSIRF Implementation Lead, supported by the Patient Safety Specialist (PSS) and Project Manager, met with all key stakeholders assessed as either required for data collection or likely to be required for review or approval of PSIR Plan local priorities. This was often combined with initial engagement as part of the PSIRF communications and staff engagement workstream.

Data collection (July to August 2023)

All sources of data requested by the PSIRF Implementation Lead were provided. Due to conflicting priorities and capacity across SCAS, certain departments were unable to provide the data in as full or timely manner as hoped. An example is that of medicines management, which is limited to Datix entries only. It should be noted that, taken as a whole, more than sufficient data was collected. The data collection was well-supported by senior leaders across the organisation.

Consultation of proposed local priorities (September to November 2023)

Following the analysis of the data, ten local priorities were initially proposed. Initial review was conducted by the Patient Safety team. This was followed by informal 'sense checks' with selected senior leaders.

The proposed local priorities were then formally reviewed by the following:

- Assistant Directors of the Patient Care Directorate
- Clinical Governance Leads
- Medical Leads
- Operational Support Services leads (fleet and clinical equipment)
- Pharmacy

The proposed local priorities were then reviewed by the following committees:

- Patient Safety and Experience Committee
- Quality and Safety Committee

Approval of local priorities (December 2023)

Approval was delegated to the PSIRF Programme Board, composed of senior leaders across all key stakeholder groups (including HIOW ICB).

External engagement

HIOW ICB was kept informed of progress throughout the process as part of the PSIRF Implementation Programme governance and reporting. HIOW ICB was consulted to review and advise proposed local priorities.

Hampshire and Isle of Wight Air Ambulance (HIOWAA) and Thames Valley Air Ambulance (TVAA) were also consulted to review and advise proposed local priorities. Strengthened relationships have set foundations for future collaboration and mutually supporting patient safety improvement plans under PSIRF.

The Ambulance Services' PSIRF Network was used to great effect to share good practice and provide mutual support and assistance throughout the risk profiling and priority development process.

There was no public or patient consultation. Public and patient consultation is planned to take place prior to transition. This will be led by the two Patient Safety Partners (PSPs) currently being introduced.

Part Six: National Priorities

Nationally defined incidents requiring local PSII

Patient safety incident type	Required response	Anticipated improvement route
Incidents that meet the criteria set in the Never Events list 2021	PSII	Develop organisational actions which feed into the wider Safety Improvement Plan.
*Incidents that meet the 'Learning from Deaths' criteria; that is, deaths clinically assessed as more likely than not due to problems in care.	PSII (unless learning has been fully understood with no new learning)	Develop organisational actions which feed into the wider Safety Improvement Plan.

Nationally defined priorities for referral to other bodies or teams for review and/ or PSII

Patient safety incident type	Requirement
Maternity and neonatal incidents: 'Each Baby Counts', Maternal Deaths	Health Services Safety Investigations Body (HSIB)
Maternity and neonatal incidents: all cases of severe brain injury	NHS Resolution's Early Notification Scheme
Maternity and neonatal incidents: all cases of severe brain injury all perinatal and maternal deaths	Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE)
Mental health related homicides by persons in receipt of mental health services or within 6 months of their discharge	NHSE Regional independent investigation team (RIIT)
Child deaths	Child death panel
Deaths of persons with learning disabilities	Learning from lives and deaths – people with learning disabilities and autistic people (LeDeR).
Safeguarding incidents	Local authority
Deaths of patients in custody, in prison or on probation where healthcare is/was NHS funded and delivered through an NHS contract:	Prison and Probation Ombudsman and Care Quality Commission (CQC)

Part Seven: Local Priorities

Local Priorities: PSIs predetermined to be responded to by a PSII

Those patient safety incidents requiring PSII have been identified by analysis of SCAS's risk profile and Trust-wide consultation, as described above.

PSIs not considered Local Priorities will be responded to by an appropriate and proportionate learning response, as determined by SRP. This may include a PSII. A full list of learning responses can be found in Appendix Two.

Emerging issues

An emerging issue is a type of patient safety event which has unusually increased in frequency, the reasons for which are not otherwise understood.

Such trends which are assessed as having both:

1. The potential to pose serious risk for patients, families, carers, staff or other organisations
2. The potential for new learning and improvement is so great (within or across a healthcare service/pathway) that it warrants the use of extra resources

Emerging issues will warrant a comprehensive PSII as a learning response.

Learning from Deaths

Where a Learning from Death (LfD) review does not indicate a PSII should be completed, the Trust will prepare a factual report upon request from the Coroner. The report should focus on the chronology, analysis, and link to our Patient Safety Improvement Programme. Learning should be identified using the proportionate response, prescribed by the IRG.

Agreed Local Priorities:

Category	Patient Safety Incident	Planned learning response	Learning from excellence
Delays	Delays	PSII only where the incident is likely to indicate a new theme (when bench marked against delays Thematic Analysis).	• ICB-led collaborative work with other providers. • Internal action plan to support system-wide improvement.
Patient care and treatment	Failure to convey to hospital	PSII where chest pain has been declared in line with policy which has potentially contributed to avoidable harm.	Trust-wide patient safety improvement plan. *Clinical Services Policy and Procedure (CSPP) 7: Care Policy Pathway and Procedures*
	Failed discharge	PSII where patients who were previously discharged at scene *either* suffer harm within 72 hours *or* recontact within 24 hours.	Trust-wide patient safety improvement plan. *Clinical Services Policy and Procedure (CSPP) 7: Care Policy Pathway and Procedures*
	Thrombolysis: failure to convey stroke patients to appropriate hospital within national timeframe.	PSII where timeframe has been breached for FAST+ patients.	Trust-wide patient safety improvement plan.
Equipment failure	Zoll device failures	PSII where PSI occurs involving *either* delay initiating early defibrillation *or* device failed to shock a shockable rhythm.	Trust-wide patient safety improvement plan. Asset Management System Project.
Medicine management	Incorrect administration of adrenaline to patients having an anaphylactic reaction.	PSII where there has been a failure to administer adrenaline in line with BNF and JRCALC guidance.	Trust-wide patient safety improvement plan.
	Medicines modules	PSII where medicines modules are not stocked or correctly tagged.	Track and trace system. Estates improvement (medicine storage)
	Unavailability of controlled drugs	Learning response to be determined by SRP.	Trust-wide patient safety improvement plan.
Emerging issues	Failure to classify obstetric emergency as Category 1 response.	PSII where potentially avoidable moderate or serious harm has occurred in cases involving patients up to 37 weeks' gestation (cases 37 weeks and above are escalated to HSIB).	Trust-wide patient safety improvement plan.
	Abdominal aortic aneurism (AAA)	PSII where there has been a failure to recognise potential AAA and thereby failed to transfer to right facility.	Trust-wide patient safety improvement plan.
	Mental health Care issues	Learning response to be determined by SRP.	Trust-wide patient safety improvement plan.

PSIs not deemed Local Priorities but subject to monitoring and periodic review:

Other PSIs exist which are not deemed priorities but nonetheless warrant monitoring by the Patient Safety Team and will be subject to periodic review. These are PSIs which, although having a high risk of serious harm, a learning response is unlikely to identify new learning. Alternatively, the improvement activity already being undertaken is assessed as sufficient and would not be helped by additional learning responses.

ICT failure

Given the extensive improvement work currently being undertaken both by SCAS and within the wider NHS, ICT failures are not considered a local priority for learning responses.

Part Eight: Training and Education

Summary

Satisfying the training and education requirements has required energetic and enthusiastic leadership across the organisation. This is an ongoing workstream within the PSIRF Implementation Programme to ensure that staff can apply appropriate and proportionate learning responses depending upon the severity of the incident.

Staff requiring training have been individually directly engaged by the PSIRF Implementation Lead. With support of senior leaders, this has ensured that SCAS will have met the staff training requirements to transition.

Post-transition, additional training will be required to ensure depth and account for staff turnover. It is planned that a further 24 staff should undertake Systems Engineering Initiative for Patient Safety (SEIPS) training. SEIPS is a framework for understanding outcomes in complex socio-technical systems. A business case to secure funding for this will be included as part of the budgeting for Financial Year 2024/2025.

Requirements

Topic	Minimum Duration	Content	Learning Response Lead	Engagement Leads	Those in PSIRF Oversight Roles
System approach to learning from patient safety incidents	2 days/12 hours	• Introduction to complex systems, systems thinking and human factors • Learning response methods: including interviewing and asking questions, capturing work as done, data synthesis, report writing debriefs and after action reviews • Safety action development, measurement, and monitoring	✓		✓
Oversight of learning from patient safety incidents	1 day/6 hours	• NHS PSIRF and associated documents • Effective oversight and supporting processes • Maintaining an open, transparent and improvement focused culture • PSII commissioning and planning			✓
Involving those affected by patient safety incident in the learning process	1 day/6 hours	• Duty of Candour • Just Culture • Being Open and apologising • Effective communication • Effective involvement • Sharing findings • Signposting and support		✓	✓
Patient safety syllabus level 1: Essentials for patient safety	eLearning	• Listening to patients and raising concerns • The systems approach to safety: improving the way we work, rather than the performance of individual members of staff • Avoiding inappropriate blame when things don't go well • Creating a just culture that priorities safety and is open to learning about risk and safety	✓	✓	✓
Patient safety syllabus level 2: Access to practice	eLearning	• Introduction to systems thinking and risk expertise • Human factors • Safety culture	✓	✓	✓
Continuing professional development (CPD)	At least annually	• To stay up to date with best practice (e.g. through conferences, webinars, etc) • Contribute to a minimum of two learning responses	✓	✓	✓

All staff

Essentials of Patient Safety:

All staff are required to complete both Level 1 and Level 2 Essentials of Patient Safety courses. Although this training is not PSIRF-specific, the knowledge and understanding of patient safety it provides promotes improved safety culture and practices aligned to PSIRF.

As of September 2024, more than 95% of staff had completed Level 1 and more than 91% had completed Level 2.

Learning Response Leads

Patient Safety Team

All Patient Safety team staff have completed the Health Services Safety Investigations Body (HSIB) Safety Level 2 training.

Other relevant courses completed by the team include:

- NHS elect quality improvement coaching
- Effective chairing of meetings and constructive challenges
- Ensuring quality and safety at board and committees
- A systems approach to learning from patient safety incidents
- Bespoke board development: effective report writing
- Investigating incidents: a systems-based approach
- Investigative interviewing

Clinical governance leads:

All Clinical Governance Leads have completed HSIB Safety Level 2.

PSIRF Oversight Roles

Oversight training

Relevant members of the Executive Management Committee and selected senior leaders responsible for PSIRF oversight have been invited to attend PSIRF oversight training. This was delivered by HSIB on 1 and 8 November 2023.

Assistant Director of Quality

The Assistant Director of Quality has completed HSIB Safety Level 2.

Assistant Medical Director

The Assistant Medical Director has completed the HSIB Safety Level 2.

Patient Safety Specialist

- HSIB Safety Level 2.
- Patient Safety Syllabus levels 3 & 4

- Effective chairing of meetings and constructive challenges
- Ensuring quality and safety at board and committees
- A systems approach to learning from patient safety incidents
- Bespoke board development: effective report writing
- Investigating incidents: a systems-based approach
- Investigative interviewing

Consultant Pre-Hospital Care Practitioner

The Consultant Pre-Hospital Care Practitioner has completed the HSIB Safety Level 2.

SCAS Executive Management Committee and Trust Board

SCAS Board

The Assistant Director of Patient Safety and the PSIRF Project Manager delivered a presentation to the Trust Board to introduce PSIRF. This presentation explained how PSIRF is different to SIF, why this matters and what this means for SCAS.

Executive Management Committee

This was followed by a presentation, delivered by the Assistant Director of Patient Safety and the PSIRF Project Manager, to the Executive Management Committee. This presentation went into more detail on the changes, focussed on new policies, and changed responsibilities. It also detailed the PSIRF Implementation Programme.

Strategic Decision Makers

Senior leaders from across the Trust (including Non-Executive Directors) were invited to attend the strategic decision-makers course. This was provided by HSIB and took place on 14 September 2023.

Appendix One: Plan on a page

			EVENT →	APPROACH →	IMPROVEMENT
Patient Safety Event Occurs	**Patient Safety Investigation**	**National Priority**	Maternity and neonatal incidents - Meeting MSNI criteria	Referred to MSNI	Respond to recommendations as from external referred agency/organisation as required.
			Domestic Homicide	Identified by police in partnership with Community safety partnership	
			Child Death	Refer for Child Death Overview Panel review	
			Death of person with learning disabilities	Reported and reviewed by Learning Disabilities Mortality Review (LeDeR)	
			Safeguarding incident meeting criteria	Reported to the Trust named safeguarding lead	
			Incidents in screening programmes	Reported to Public Health England (PHE)	
			Death of patients in custody/prison/probation	Reported to the Prison and Probation Ombudsman (POP)	
			Mental Health related homicides	Referred to NHS England regional independent investigation team	
			Incidents meeting the Never Event criteria	Patient Safety Incident Investigation (PSII)	Create local organisational recommendations and system improvement plan and actions.
			Death of patients under the MHA/MCA		
	Patient Safety Review	**Local Level Trust Priority**	**Patient Safety Priorities:** **1. Delays** **2. Patient Treatment and Care** - Failure to convey to hospital - Failed discharge - Failure to convey stroke patient to appropriate hospital within national timeframe **3. Equipment failure** (Zoll device failures) **4. Medicine management** - Incorrect administration of adrenaline to patients having an anaphylactic reaction - **Medicines modules** - Unavailability of controlled drugs **5. Emerging issues** - Failure to classify obstetric emergency as Category 1 response - Abdominal aortic aneurysm (AAA) - Mental health Care issues	• PSII where determined • After Action Review (AAR) • Multidisciplinary review (MDT) • Critical Medicines - AAR Thematic review • SWARM huddle • Debrief • Local management of incident	Create local organisational recommendations and actions feeding into improvement priorities
		Other	Incident resulting in moderate or severe harm to patient	Statutory duty of candour and response technique - Case note review or AAR for example.	Informed by AAR or thematic analysis of ongoing patient safety risks
			No/Low Harm Patient Safety Incident	Validation of facts at local level – thematic analysis	

Appendix Two: Table showing learning responses

Learning response	Method	Objective
Immediate safety actions	Incident recovery	Actions implemented with immediate effect following an incident. Actions are designed to mitigate or eliminate risk of harm to patients, staff, equipment, or the environment.
"Being open" conversations	Open discussion	Facilitate a discussion with the affected patient, family, or carer about the incident to discuss what happened and identify their concerns and expectations.
Electronic Patient Care Record (EpCR) review	Clinical document review	To determine whether there were any problems with the care provided to a patient by a particular service. To routinely identify the prevalence of issues or when bereaved families/carers or staff raise concerns regarding care.
Structured judgement review (SJR)	Clinical document review	This approach will be used when clinical judgement is required as part of a learning response.
Debrief	Debrief	Verbal discussion of the incident by all who were present or involved. Uses a set list of questions to guide and prompt discussion.
Incident timeline	Incident review	To provide a detailed documentary account of an incident (what happened) in the style of a 'chronology'.
Schwartz rounds	Reflective practice	Group reflective practice forums giving staff from all disciplines an opportunity to reflect on the emotional and social effects of an incident (or group of incidents).
Patient safety incident investigation	Investigation	To explore decisions or actions as they relate to the situation, undertaken when an incident or near-miss indicates significant patient safety risks and potential for new learning.
Swarm huddle	Site analysis	To quickly analyse what happened and how it happened to decide what needs to be done to reduce risk of reoccurrence immediately after an incident.
After action review	Incident review	To identify and document best practices, gaps and lessons. A qualitative, structured review of the actions taken in response to an event.
Multi-Disciplinary Team Review	Discussion	To plan next steps of individual care during a discussion with healthcare professionals across relevant areas of care.
Tabular timelines	Incident review	To describe the order in which events occurred.
Clinical notes review	Clinical documentation review	To review quality of clinical notes.

Appendix Three: Table of acronyms and abbreviations

Acronym	Definition
AAR	After Action Review: *A method of evaluation that is used when the outcomes of an activity or event have been particularly successful or unsuccessful.*
AAA	Abdominal Aortic Aneurism: *A weakening/dilation of the aorta passing through the abdomen.*
BASICS	British Association for Immediate Care: *A volunteer team of enhanced care pre-hospital clinicians able to provide advanced pain relief, sedation, cardiac and surgical interventions.*
BVM	Bag Valve Mask: *A handheld tool used to deliver positive pressure ventilations to a patient with insufficient respiratory effort. Consists of a self-inflating bag, a one-way valve and an oxygen reservoir.*
CBRN	Chemical, Biological, Radiological and Nuclear
CSPP	Clinical Services Policy and Procedure: *A SCAS document outlining local policies and procedures.*
CQC	Care Quality Commission: *The independent regulator of health and social care in England.*
ECA	Emergency Care Assistant: *A non-clinical member of staff trained to conduct emergency care. ECAs crew both emergency ambulances and non-emergency patient transport ambulances. On emergency ambulances, ECAs normally work in support of a registered paramedic.*
DI	Detailed Investigation: *A detailed report or plan to review thoroughly the care and treatment received by a patient.*
FAST+	Face, Arms, Speech and Time: *A test to help recognise the most common signs of a stroke. FAST+ (positive) denotes patients have one of more signs. FAST- (negative) denotes patient displays no signs*.
FTSU	Freedom To Speak Up: *A clear and simple process encouraging all staff to adopt a positive culture where everyone feels safe to speak up to stop potential harm.*
HART	Hazardous Area Response Team.
HAZMAT	Hazardous Materials.
HFACS	Human Factors Analysis and Classification System: *A user-friendly, cost-effective and evidence-based approach to incident investigation, based on the goal of understanding organisational systems*.

HSE	Health and Safety Executive: *A UK Government agency responsible for the encouragement regulation and enforcement of workplace health, safety and welfare*.
HSIB	Health Services Safety Investigations Body: *An expert advisory group offering support and guidance to NHS organisations investigations also carrying out their own as necessary.*
ICB	Integrated Care Board: *A statutory organisation that brings NHS and care organisations together locally to improve population health and establish shared strategic priorities within the NHS*.
IRP	Incident Response Panel: *An executive-led meeting where incidents escalated from SRP are reviewed. IRP identifies the level of potential harm and declares all incidents which meet the threshold for investigation as Serious Incidents (in accordance with the SI Framework).*
JLC	Just and Learning Culture: *A concept promoting a process where staff feel supported and empowered to learn.*
LeDeR	Learning Disabilities Mortality Review: *A programme to review deaths to identify potential learning improving services for people living with learning disabilities and autistic people*.
MBRRACE-UK	Mothers and Babies Reducing Risk through Audit and Confidential Enquires
MHRA	Medicines and Healthcare Products Regulatory Agency: *An executive agency regulating medicines, medical devices and blood components for transfusion within the United Kingdom*.
MDT	Multi-disciplinary team: *A diverse group of professionals working together*.
MSO	Medication Safety Officer: *The senior responsible person within SCAS for matters related to medicines safety*.
NARU	National Ambulance Resilience Unit: *A central support system for all UK ambulance services dealing with difficult situations*.
NEPTS	Non-emergency Patient Transport Service: *A transport service to allow eligible patients a way to hospital appointments*.
NHSE	National Health Service England: *A service to provide everyone in the United Kingdom with healthcare based on need and free at point-of-use*.
PSDG	Patient Safety Delivery Group: *The SCAS committee responsible for monitoring and reporting on initiatives, projects and programmes to improve patient safety*. Specific responsibility for those *initiatives, projects and programmes which enable SCAS to meet the CQC Exit Criteria.*
PSEC	Patient Safety Experience Committee: *The SCAS committee responsible for developing a strategic approach for critical system-wide patient safety issues*.

PSI	Patient Safety Incident: *Any unintended or unexpected incidents which could have or did lead to harm for one or more patient's receiving healthcare*.
PSII	Patient Safety Incident Investigation (PSII): *A formal investigation tool which aims to provide a clear explanation of how an organisation's systems and processes contributed to a patient safety incident*.
PSIRF	Patient Safety Incident Response Framework: *A cultural and system shift in our thinking and response to patient safety incidents and how we work to prevent an incident happening again*.
PSIRP	Patient Safety Incident Response Plan: *The document which sets out how SCAS responds to PSIs considered National and Local Priorities and related improvement work*.
RIDDOR	Reporting of Injuries, Diseases and Dangerous Occurrences Regulations: *Laws requiring employers and those responsible for work premises to report and keep records of work-related incidents*.
RIIT	Regional Independent Investigations Team: *A team responsible for managing and overseeing the independent investigation function on behalf of an organisation*.
RRV	Rapid Response Vehicle: *A car used by urgent or emergency healthcare professionals to reach patients as soon as possible to deliver care*.
SCAS	South Central Ambulance Service NHS Foundation Trust: *The Ambulance service for the counties of Berkshire, Buckinghamshire, Oxfordshire and Hampshire.*
SEIPS	System Engineering Imitative for Patient Safety: *A framework for understanding outcomes within complex socio-technical systems*.
SOP	Standard Operating Procedures: *A set of instructions compiled by an organisation to help workers carry out routine operations*.
SORT	Special Operation and Response Team: *A specialist team governed by The National Ambulance Response Unit (NARU) mainly dealing with Major Incidents, Terrorist Attacks and Hazardous Materials (HAZMAT) or Chemical Biological Radiological or Nuclear (CBRN) incidents and the decontamination of those patients*.
SRP	Serious Response Panel: *A panel to support, review and oversight all moderate/serious incidents reported within Datix. Cases are identified which meet the threshold for reporting as SI or require further discussion, consensus to confirm are formally escalated from this meeting to the Incident Review Panel (IRP)*.
WTE	Working Time Equivalent: *An employer's scheduled hours divided by the employers' hours for a full-time working week*.

Appendix Four: Glossary of terms

After action review (AAR): A method of evaluation that is used when outcomes of an activity or event have been particularly successful or unsuccessful. It aims to capture learning from these to identify the opportunities to improve and increase to occasions where success occurs.

Category One (Cat 1): An immediate response to a life-threatening injury or illness aiming to provide an average response time of 7 minutes.

Causal Factors: A major unplanned, unintended contributor to an incident that if eliminated would have either prevented the occurrence or reduced its severity or frequency.

Clinical Notes Review: A review of the care received by an individual, performed due to interest in the welfare of this patient or relative.

Coroner Request: A coroner will gather information to investigate whether a death was due to natural causes.

Datix Reports: Datix is a risk management information system used by SCAS designed to collect and manage data on adverse events, complaints, claims and risks to identify learning and implement improvements.

Duty of Candour: Being open and honest with patients and families when treatment or care goes wrong.

Hot Debrief: An interactive and structured team dialogue that takes place either immediately or shortly after a clinical case.

Human Error: A human error is an action or decision which was not intended that has negative consequences or fails to achieve the desired outcome.

Improvement Methodology: A systematic approach to evaluate current learning processes and adapting them to improve productivity, streamline workflows and bringing about a measurable improvement.

Inequalities data: Facts and statistics collected relating to health inequalities which are unfair and avoidable differences in health across the population, and between different groups within society.

Just Culture Approach: The treatment of staff involved in a patient safety incident in a consistent, constructive and fair way.

Learning from deaths: Recording relevant incidents of mortality, deaths reviewed, and lessons learnt to encourage future learning and the improvement of care.

Multi-disciplinary team review (MDT): A weekly or monthly meeting of a group of professionals who come together to make decisions regarding a patient's condition.

Neonatal death: A baby born at any time during the pregnancy who lives, even briefly, but dies within four weeks of being born.

Never Events: A nationally recognised category of incidents that could cause harm to people that should never happen and can be prevented.

Patient Safety Incident Response Framework (PSIRF): The national framework applicable to all NHS commissioned outside of primary care. Building on evidence gathered and wider industry best-practice, the PSIRF is designed to enable a risk-based approach to responding to patient safety incidents, prioritising support for those affected, effectively analysing incidents, and sustainably reducing future risk.

Patient Safety Incident Response Plan (PSIRP): Our local plan sets out how we will carry out the PSIRF locally including our list of local priorities. These have been developed through a coproduction approach with the divisions and specialist risk leads supported by analysis of local data.

Patient Safety Incident Investigation (PSII): Patient Safety Incident Investigation to be termed Patient Safety Learning Response Review (or PSLR).

PSIIs are conducted to identify underlying system factors that contributed to an incident. These findings are then used to identify effective, sustainable improvements by combining learning across multiple patient safety incident investigations and other responses into a similar incident type. Recommendations and improvement plans are then designed to address effectively and sustainably those system factors and help deliver safer care for our patients.

Principles of proportionality: The least intrusive response appropriate to the risk presented.

RIDDOR reports: A law that requires employers and other people in charge of work premises to report and keep records of work-related incidents.

Schwartz rounds: Schwartz rounds provide a structured forum where all staff, clinical and nonclinical, come together regularly discuss the emotional and social aspects of working in healthcare.

Stakeholder: People or groups who have an interest in what an organisation does, and who are affected by its decisions and actions.

Statistical Process Control (SPC): A tool used in the NHS to understand whether change results in improvement. It provides an easy way for people to track the impact of improvement projects.

Swarm Huddle: Swarm-based huddles are used to identify learning from patient safety incidents. 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.

Systems-based approach: Recognising multiple elements interacting within decision-making.

Tabular Timelines: To map a sequence of events, a table is formed providing an opportunity to record information.

Thematic analysis: A method of analysing quantities of data to identify common themes, topics, ideas, and patterns that come up repeatedly.