NHS
South Central
Ambulance Service
NHS Foundation Trust

Patient Safety Incident Response Plan PSIRP2 (2025-2027)

South Central Ambulance Service

CONTENTS

Part One

Introduction – 5

Part Two

Our services – 6

Emergency services – 6

Urgent services – 7

Non-emergency patient transport service – 8

SCAS charity – 8

SCAS Patient Safety Partners - 8

Part Three

Patient Safety Team / organisation of the Patient Safety Team - 9

Part Four

Management of Patient Safety Incidents – 10

Safety Review Panel – 10

Oversight and Scrutiny Group – 10

Service Level Oversight – 10

Coroners - 10

Part Five

Understanding our patient safety incident risk profile – 10

SCAS PSI profile process – 10

Stakeholder engagement – 11

Defining our patient safety improvement profile – 12

Part Six

Our patient safety incident response plan: national requirements – 13

Part Seven

Local priorities – 14

Emerging issues – 14

Learning from Deaths – 14

Agreed Local Priorities 2025-2026 – 14

PSIs not deemed Local Priorities but subject to monitoring and periodic review – 15

Part Eight

Training and education – 16

Requirements - 18

Appendix

Appendix One: Table showing learning responses used within SCAS – 20

Appendix Two: Table of acronyms and abbreviations – 21

Appendix 3: Glossary of terms – 24

Document Control	
Version	2.0
Approved by	Quality & Safety Committee Patient Safety & Experience Group PSIRF Implementation Programme Board
Approval date	October 2025
Executive Sponsor	Professor Helen Young *Chief Nurse*
Non-Executive Sponsor	Katie Kapernaros Non- Executive Director
Authors	Carol Rogers *PSIRF Training Lead* Dawn Chase Patient Safety Specialist
Issue Date	22 April 2024
Review Date	June 20275

Version history			
Version	**Date**	**Details of change**	**Change made by**
0.1	08 Sep 23	Initial document	Carol Rogers *Assistant Director of Patient Safety* and *Acting PSIRF Implementation Lead*
0.2	11 Oct 23	Extensively redrafted	Carol Rogers *Assistant Director of Patient Safety* and *Acting PSIRF Implementation Lead* Laura Shepard *Paramedic*
0.3	23 Oct 23	Extensively redrafted following review by Patient Safety Team	Carol Rogers *Assistant Director of Patient Safety* and *Acting PSIRF Implementation Lead* Laura Shepard *Paramedic* Henry Firth *Assistant Project Manager (Patient Safety)*
0.4	16 Nov 23	Amended following consultation with internal stakeholders	Carol Rogers *Assistant Director of Patient Safety* and *Acting PSIRF Implementation Lead* Laura Shepard *Paramedic* Henry Firth

			Assistant Project Manager (Patient Safety)
0.5	30 Nov 23	Amended following consultation with external stakeholders	Henry Firth *Assistant Project Manager (Patient Safety)*
0.6	23 Jan 24	Reformatted	Henry Firth *Assistant Project Manager (Patient Safety)* Penny Long *Executive Assistant to the Deputy Chief Nurse*
0.7	30 Jan 24	Foreword rewritten Revised following comments by PSIRF Implementation Programme Board	Henry Firth *Assistant Project Manager (Patient Safety)*
1.0	31 Jan 24	No changes made approved by Q&S Committee	Henry Firth *Assistant Project Manager (Patient Safety)*
2.0	Sept 25	PSIRP2 (2025-2027)	Carol Rogers PSIRF Training Lead
2.1	Feb 2026	Delays added as local priority	Dawn Chase Patient safety Specialist

Part One:

Introduction

This document, in conjunction with the Trust's Patient Safety Incident Response Framework (PSIRF) Policy, sets out how South Central Ambulance Service NHS Foundation Trust (SCAS) intends to respond to patient safety incidents/events over the next 18months. However, SCAS will maintain flexibility and consider circumstances as they arise related to patient safety incidents and the needs of those affected.

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 on an ongoing basis.
- 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 drew primarily on experience of PSIRF early adopters, and the support of our fellow Ambulance Trusts. In the year since transition however, we are now able to draw on our own experience, understanding and insights gained since transition in April 24.

PSIRP 2 has been developed, with input from across the organisation, the plan being informed by several data sources related to patient safety incidents/events reported and our PSIRF Plan of 24-25. 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.

Our PSIRP promotes the four characteristics of PSIRF by:

- Improving the experience of patients and families. This is being achieved by our embedded engagement processes which actively places the patient, 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:

    - ❖ Patient Safety Incident Investigation (PSII)
    - ❖ After Action Review (AAR)
    - ❖ SWARM Huddles
    - ❖ Structured Judgment Reviews (SJR's) and Thematic analysis.

- PSIRF is not about determining culpability or assigning blame but rather identifying lessons and opportunities for improvement.

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. We receive 670,000 999 calls, and 1.5 million 111 calls every year

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 Major Incident commanders and routinely liaise with other emergency services. SCAS employ clinicians in the EOCs, who provide clinical advice to staff and patients. Approximately 16% of calls are 'Hear and Treat' – dealt with over the telephone without the need to send and ambulance resource.

Emergency medical resources

If a patient requires an emergency response, an emergency ambulance 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 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 select group of paramedics specially trained and equipped to deliver pre-hospital emergency care to patients injured or ill in hazardous environments.

HART works closely with partner agencies such as the Police, Fire and Rescue Service, Mountain 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 is governed by 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 organisation 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 across the SCAS geographical footprint. 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 1.5 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 Hampshire, and Milton Keynes. 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, 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.

SCAS Patient Safety Partners

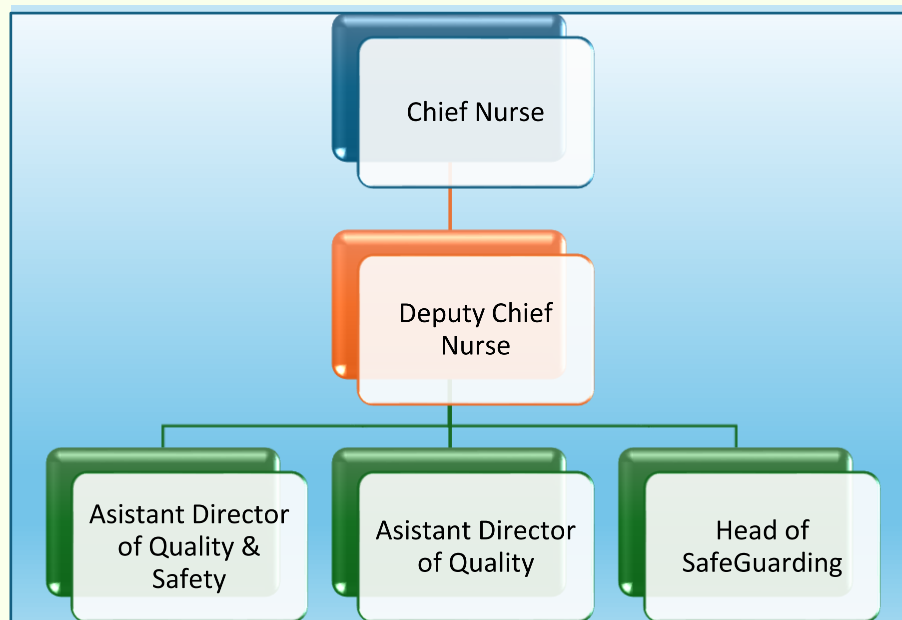
SCAS has recruited two patient safety partners (PSP's) to the Trust, these staff support us in a voluntary capacity.
Their roles within the first year in role will include:

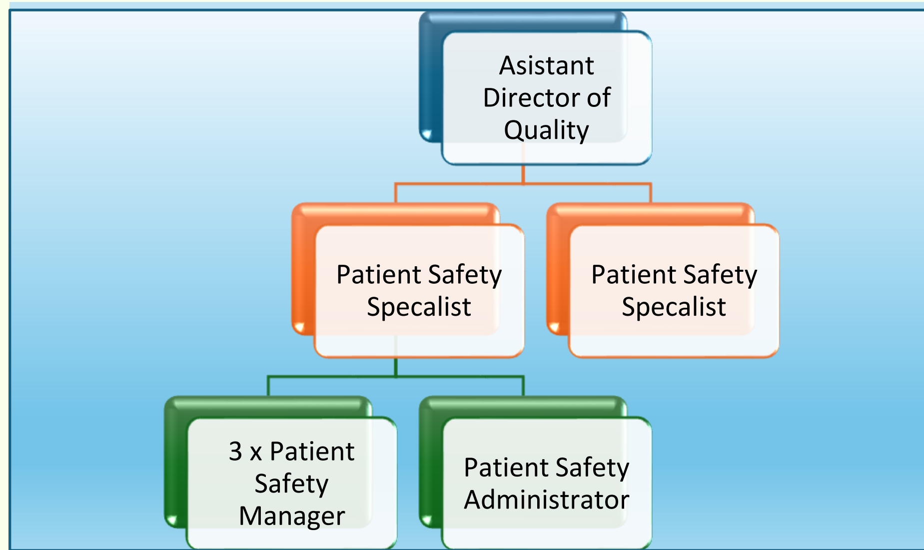
- Involvement in patient safety improvement projects
- Engagement with patients, families and carers to gather insights and improve safety practices.
- Participation in oversight groups for investigations to patient safety.

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 (SRP)

Following the transition to PSIRF, the purpose of the SRP has evolved from its previous remit. The SRP now determines the appropriate learning response(s) for incidents where there is an opportunity for learning and improvement—typically in cases involving potential or actual avoidable harm, or those that meet the criteria for one of the agreed local priority categories.

Learning responses are selected based on the specific circumstances of the incident, the potential to identify meaningful lessons, and the opportunity to inform and drive improvement.

PSIRF Oversight & Review Group

Completed learning responses that have been subject to PSII, AAR, SJR or Thematic Review are approved at this group. PSIRF Oversight & Review Group (ORG). The Group is chaired by the Chief Nursing Officer & The Chief Medical Officer

Service Level Oversight

All learning responses other than Patient Safety Incident Investigations (PSII), After Action Reviews (AAR), and Structured Judgement Reviews (SJR) — including

incidents assessed as moderate harm or above — that do not require management by the Patient Safety Team under PSIRF will be managed, approved, and overseen at service level. The appropriate type of learning response will be agreed during the daily Critical Review Meetings, ensuring proportionality and alignment with PSIRF principles.

HM Coroners

In the case of deceased patients, HM Coroner may request a complete factual report. The SCAS Head of Legal Services supported the development of the templates for the coroner.

Part Five:

Understanding Our Patient Safety Incident Risk Profile

SCAS PSI profile process

Summary

To determine SCAS's local priorities initially, 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
- RIDDOR reports
- Fleet and Driving
- Care Quality Commission Reports (CQC)
- Risk Registers

Excluded:

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

In terms of determining the priorities for 2025/27 year a similar exercise has been repeated and all data reported between April 22nd, 2024- April 1st, 2025, has been subject to trend analysis. The aim being to confirm the current risk profile and identify any new risks and emerging risks which will form the basis of the plan for 25-26.

- Datix reports
- Learning from Deaths
- Freedom to Speak Up
- Complaints and patient experience reports, including external organisation's feedback to the Trust

- Coroner requests
- RIDDOR reports
- Analysis of trends in reports of Patient Safety Incident Investigations and other Learning Responses under the framework of PSIRF.

Stakeholder engagement (PSI profile and development of local priorities)

The following individuals were approached and asked to either provide relevant data or review and provide feedback on the proposed PSIR plan and local priorities:

- Head of Patient Experience
- Datix System Manager
- Chief Pharmacist and Trust Medication Safety Officer
- Freedom to Speak Up Guardian
- Senior Operations Managers
- Clinical Governance Leads
- Named Non-Executive Director for PSIRF
- Trust Risk Manager

Data collection (April 1st –June 1st 25)

All sources of data requested by the PSIRF Implementation Lead were provided.

Consultation of proposed local priorities (June 2025)

Following the analysis of the data, local priorities were proposed conducted. 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
- Pharmacy
- Legal
- Patient experience

The local priorities for 2025/27 were then reviewed and approved by the following committees:

- Patient Safety and Experience Group
- Quality and Safety Committee

DEFINING OUR PATIENT SAFETY IMPROVEMENT PROFILE

The Trust has been continually developing its governance arrangements and associated processes to ensure it gains insight from all patient safety events, and how this can result in local, or corporate quality improvement activity. SCAS has and will continue, to draw on guidance and feedback from national and regional level NHS bodies, regulators, Integrated Care Boards (ICBs), partner providers, and other key stakeholders to identify and assist with defining associated learning and improvement work we undertake.

We plan to focus our efforts moving forwards on the development of safety improvement plans across our most significant patient safety improvement types, either those within the national requirements, or those identified in our Local Priorities.

Part Six:

Our patient safety incident response plan: National requirements

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.

Learning from Deaths

Where an incident meets the learning from deaths national priority definition and a learning response under PSIRF is required, the Assistant Medical Director or designated approved person will complete a Structured Judgment Review (SJR). The Trust will then prepare a factual report for HM Coroner.

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	Maternity and Newborn Safety Investigations (MNSI)
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 overview panel (CDOP)

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)
Domestic Homicide	respond to recommendations from external referred agency/ organisation as required. Feed actions into quality improvement work.

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' risk profile and Trust-wide consultation, as described above.

The response to PSIs not considered Local Priorities will be 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 One.

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 learning response. The SRP will determine the type of learning response.

Agreed Local Priorities 2025-2026:

Category	Patient Safety Incident	Required response	Learning from excellence
Patient care and treatment	Non conveyance to hospital in cases of declared chest pain where acute coronary syndrome cannot be excluded.	Statutory DOC (Where indicated) Learning response required where chest pain has been declared in line with policy which has potentially contributed to avoidable harm. Learning response to be agreed at SRP	Trust-wide patient safety improvement plan. *Clinical Services Policy and Procedure (CSPP) 7: Care Policy Pathway and Procedures*
	Inappropriate discharge on first attendance	Statutory DOC (Where indicated) Learning response where patients who were previously discharged at scene *either* recontact within 24 hours **and/ or** suffer harm within 72 hours.	Trust-wide patient safety improvement plan. *Clinical Services Policy and Procedure (CSPP) 7: Care Policy Pathway and Procedures*
	Failure to convey patients STEMI, Fast Positive, Major Trauma, Abdominal Aortic Aneurysm to appropriate facilities and within national target time frames:	Statutory DOC (Where indicated) Learning response to be agreed at SRP	Trust-wide patient safety improvement plan.
Medicine management	Incorrect administration of life saving medication e.g.	Statutory DOC (Where indicated)	Trust-wide patient safety improvement plan.

	adrenaline for anaphylaxis, diazepam.	Learning response where there has been a failure to administer a medication in line with BNF and JRCALC guidance.	
Mental Health Care	Failure to follow appropriate care pathway (MHA / MCA)	Statutory DOC (Where indicated) Learning response to be agreed at SRP	Trust-wide patient safety improvement plan.
Delays	Delays that have contributed to harm	Statutory DOC (Where indicated) Learning response to be agreed at SRP	Trust-wide patient safety improvement plan.
Emerging issue	Sudden rise in occurrences without an identified cause.	Emerging issues will warrant a comprehensive learning response. The SRP will determine the type of learning response	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.

Part Eight:

Training and Education

Summary

A core cohort of staff are compliant with the standards set out in the patient safety syllabus, to support embedding process. Clinical, Operational and corporate staff who were identified as being required to undertake learning responses or have oversight of them under PSIRF have either completed or are in the process of completing the core modules, delivered by an HSSIB. Training compliance in year will be monitored by the Patient Safety Specialist and reported through the Patient Safety Executive Group, until such time as the PSEG has assurance that we have sufficient numbers of staff trained and then it will become part of business as usual.
Core Modules • Patient safety syllabus level 1: Essentials for patient safety • Patient safety syllabus 2: Access to practice are mandatory training requirements for all staff.

The Trust have one nominated Patient Safety Specialist who has completed patient safety specialist training being delivered nationally.

Core modules

- Patient safety syllabus level 1: Essentials for patient safety
- Patient safety syllabus 2: Access to practice
- Involving those affected by patient safety incidents in the learning process
- System approach to learning from patient safety incidents
- Oversight of learning from patient safety incidents

Requirements

Topic	Minimum Duration	Content	Learning Response Leads	Engagement Leads	PSIRF Oversight Roles
Systems approach to learning from patient safety incidents	2 days / 12 hours	• Introduction to complex systems, systems thinking, and human factors • Learning response methods: interviewing, 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 incidents 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	✓	✓	✓

Topic	Minimum Duration	Content	Learning Response Leads	Engagement Leads	PSIRF Oversight Roles
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, not just individual performance • Avoiding inappropriate blame • Creating a just culture focused on learning	✓	✓	✓
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	• Stay up to date via conferences, webinars, etc. • Contribute to a minimum of two learning responses	✓	✓	

Appendix One: Table showing learning responses used within SCAS

Learning response	Method	Objective
Structured judgement review (SJR)	Clinical document review	This approach will be used when clinical judgement is required as part of a learning response.
Patient safety incident investigation PSII	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.
Thematic Review	Investigation multiple PSII Reports	A method of analysing quantities of data to identify common themes, topics, ideas and patterns that come up repeatedly.

Appendix Two: 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.*
FAST+	Face, Arms, Speech, and Time: *A test to help recognise the most common signs of a stroke. FAST+ (positive) denotes that patients have one or more signs. FAST- (negative) denotes patient displays no signs*.
FTSU	Freedom To Speak Up: *A clear and straightforward 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*.
HSSIB	Health Services Safety Investigations Body: *An expert advisory group offering support and guidance to NHS organisations' investigations also conducting 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*.
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*.
MDT	Multi-disciplinary team: *A diverse group of professionals working together*.
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*.
PSEG	Patient Safety and Experience Group.
PSI	Patient Safety Incident: *Any unintended or unexpected incidents which could have or did lead to harm to one or more patients' 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*.
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*.
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	Safety Review Panel: *A panel to support, review and oversee all moderate/serious incidents reported within Datix. Cases are identified which meet the threshold a learning response under PSIRF*.

Appendix Three: 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

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 effectively and sustainably address 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.

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

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.

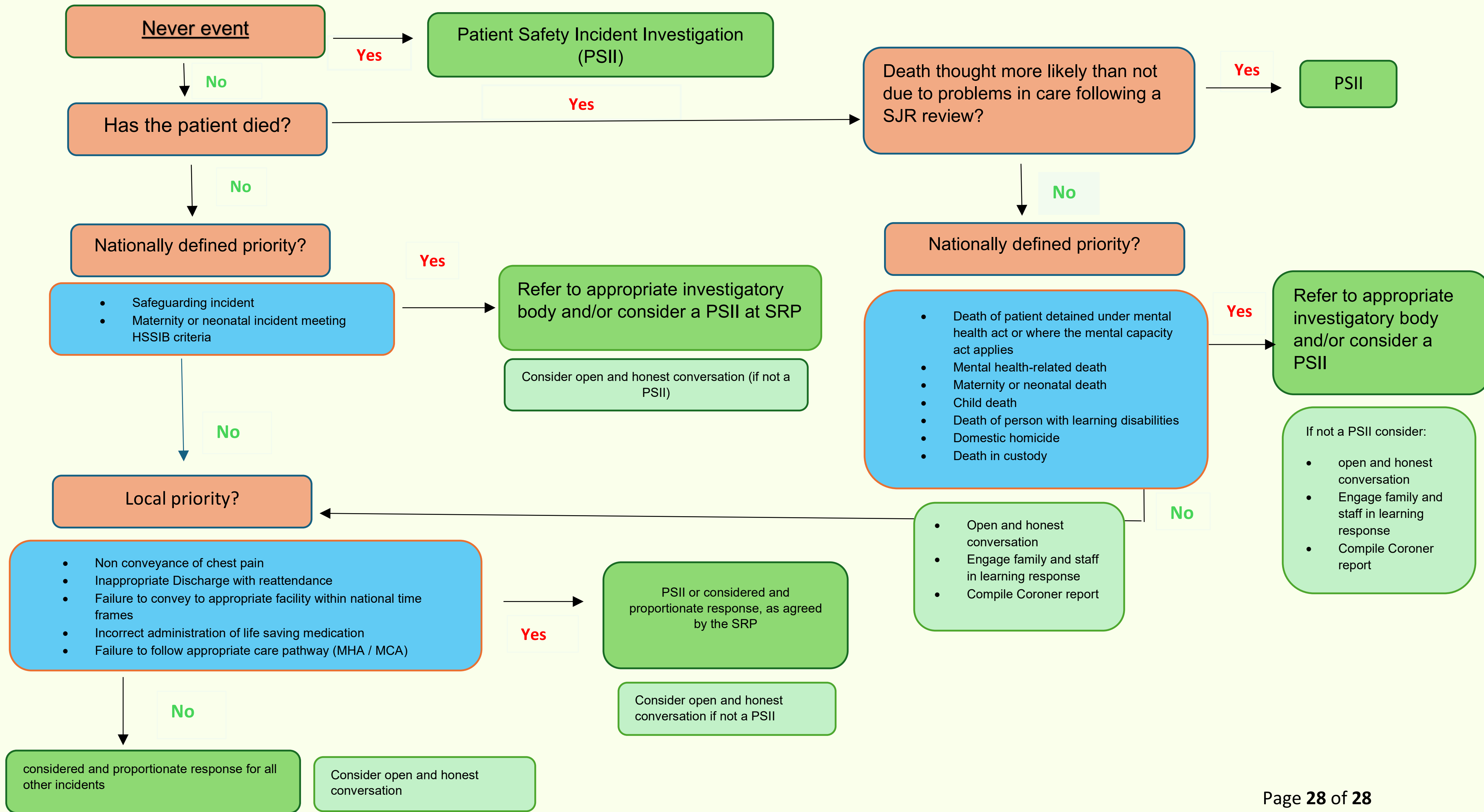
Systems-based approach: Recognising multiple elements interacting within decision-making.

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

Appendix Four: Plan on a page

Patient Safety Event Occurs

		EVENT	APPROACH	IMPROVEMENT
Patient Safety Incident Investigation	National Priority	Maternity and neonatal incidents: 'Each Baby Counts', Maternal Deaths	Referred to MSNI	Develop organisational actions which feed into the wider Safety Improvement Plan.
		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)	
		Child deaths	Child death overview panel (CDOP)	
		Safeguarding incidents	Reported to the Trust named safeguarding lead & Local authority	
		Deaths of persons with learning disabilities	Learning from lives and deaths – people with learning disabilities and autistic people (LeDeR).	
		Death of patients in custody/prison/probation	Prison and Probation Ombudsman and Care Quality Commission (CQC)	
		Mental health related homicides	NHSE Regional independent investigation team (RIIT)	
		Domestic Homicide	respond to recommendations from external referred agency/ organisation as required. Feed actions into quality improvement work.	
		Incidents that meet the criteria set in the Never Events list 2021	Patient Safety Incident Investigation (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.	Patient Safety Incident Investigation (PSII) (unless learning has been fully understood with no new learning)	
Patient Safety Incident Review	Local Level Trust Priority	**Patient Safety Priorities:** **1. Patient Treatment and Care** - Non conveyance of chest pain - Failed discharge on scene - Failure to convey patients (STEMI, Fast Positive, Major Trauma, Abdominal Aortic Aneurysm) to appropriate hospital within national timeframe **2. Medicine management** - Incorrect administration of life saving medication e.g. adrenaline for anaphylaxis, diazepam. **3. Mental Health Care** - Failure to follow appropriate care pathway (MHA / MCA) **4. Delay** - Delays that have led to patient harm	• PSII where determined • After Action Review (AAR) • Structured Judgement Review (SJR) • SWARM huddle • Local management of incident	Create local organisational recommendations and actions feeding into improvement priorities
	Other	**Emerging themes issues**	• PSIRF Learning response to be decided at SRP	Create local organisational recommendations and actions feeding into improvement priorities
		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	



SCAS Patient Safety Incident Response Plan (PSIRP 2)
Never event
Yes
Patient Safety Incident Investigation (PSII)
No
Has the patient died?
Yes
Death thought more likely than not due to problems in care following a SJR review?
Yes
PSII
No
Nationally defined priority?
Yes
Safeguarding incident
Maternity or neonatal incident meeting HSSIB criteria
Refer to appropriate investigatory body and/or consider a PSII at SRP
Consider open and honest conversation (if not a PSII)
No
Nationally defined priority?
Yes
Death of patient detained under mental health act or where the mental capacity act applies
Mental health-related death
Maternity or neonatal death
Child death
Death of person with learning disabilities
Domestic homicide
Death in custody
Refer to appropriate investigatory body and/or consider a PSII
If not a PSII consider:
open and honest conversation
Engage family and staff in learning response
Compile Coroner report
No
Open and honest conversation
Engage family and staff in learning response
Compile Coroner report
No
Local priority?
Non conveyance of chest pain
Inappropriate Discharge with reattendance
Failure to convey to appropriate facility within national time frames
Incorrect administration of life saving medication
Failure to follow appropriate care pathway (MHA / MCA)
Yes
PSII or considered and proportionate response, as agreed by the SRP
Consider open and honest conversation if not a PSII
No
considered and proportionate response for all other incidents
Consider open and honest conversation