NHS
North West
Ambulance Service
NHS Trust

PATIENT SAFETY INCIDENT RESPONSE PLAN (PSIRP)

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Change record form

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Patient Safety Incident Response Plan (PSIRP)

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1. INTRODUCTION

This Patient Safety Incident Response Plan (PSIRP) sets out how North West Ambulance Service NHS Trust (NWAS) intends to respond to patient safety events over a 12 to 18 month period, however, 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.

The NHS Patient Safety Strategy was published in July 2019 and describes the Patient Safety Incident Response Framework (PSIRF), a replacement of the NHS Serious Incident Framework. The Serious Incident Framework provided structure and guidance on how to identify, report, and investigate an incident resulting in severe harm, or death. PSIRF is best considered as a learning and improvement framework with the emphasis placed on systems and culture that support continuous improvement in patient safety through how NWAS responds to patient safety incidents.

The NHS Patient Safety Strategy, 2019 describes PSIRF as 'a foundation for change' and as such, it challenges us to think and respond differently when a patient safety incident occurs. One of the underpinning principles of PSIRF is to carry out fewer 'investigations' but make them better. Better means taking the time to conduct systems-based learning responses by people that have been trained to do them. This PSIRP and associated organisational policies and guidelines will describe how it all works. The NHS Patient Safety Strategy challenges us to think differently about learning and what it means for healthcare organisations.

Carrying out learning responses for the right reasons can and does identify meaningful learning. The removal of the serious incident process does not mean 'do nothing', it means respond in the right way depending on the type of incidents and associated factors.

A risk to the successful implementation of PSIRF at NWAS is continuing to 'investigate' and review incidents as we have done previously and simply give the process a new label, however, the challenge is to embed new language, and an approach to learning responses that forms part of the wider response to patient safety incidents whilst allowing time to learn thematically from other patient safety insights.

PSIRF recognises the need to ensure we have support structures for those involved in patient safety incidents (patients, families, and our people), part of which is the fostering of a psychologically safe culture demonstrated by all our leaders and supported by trust-wide strategies, and associated reporting systems.

NWAS has developed our understanding and insights over two to three years, including discussions and engagement through our internal governance processes, and with external stakeholders. This plan provides the headlines and description of how PSIRF will be applied at NWAS.

Our PSIRP should be read in conjunction with the Trust's Patient Safety Incident Response Policy.

2. OUR SERVICES

2.1 Emergency Operations Centre (EOC)

Our EOCs receive and triage 999 calls from members of the public as well as well as other emergency services. EOC staff provide advice and dispatch an ambulance to the scene as appropriate. The Clinical Hub (CHUB) is based within the EOC and assesses patients via telephone and provides the most appropriate care based on

that assessment, known as hear and treat. This may be an ambulance (either emergency or urgent care), General Practitioner (GP) referral, referral to other services or self-care.

2.2 NHS 111

We deliver NHS 111 services for the North West region and are major contributors to the delivery of integrated urgent care. We signpost patients to the most appropriate care highlighted to them following triage and informed by the Directory of Services.

2.3 Paramedic Emergency Services (PES) or 999

These can be solo responders or double crewed ambulances providing emergency care to the population of the North West.

2.4 Patient Transport Service (PTS)

Our PTS provide essential transport to non-emergency patients, in Cumbria, Lancashire, Merseyside, and Greater Manchester, who are unable to make their own way to and from hospital, outpatient clinics, or other treatment centres.

2.5 Resilience

Our Hazardous Area Response Team (HART) and resilience teams are specially trained and equipped Paramedics who provide ambulance response to high-risk and complex emergency situations, including major incidents. They deliver our statutory responsibilities as a Category 1 responder under the Civil Contingencies Act (2004).

2.6 North West Air Ambulance (NWAA)

NWAA is an independent charitable organisation, whose strength lies in working collaboratively with strategic partners to deliver joined-up healthcare interventions, which achieve the best outcomes for the most unwell and critically injured patients. NWAA collaborates with NWAS, working together, we are able to deliver an integrated approach to pre-hospital care.

2.7 Community First Responders (CFRs)

We have one of the largest and longest-established CFR schemes in England, with some 567 active CFRs operating across all areas of the North West, providing an effective service in their local communities. CFRs are volunteers who live and work in local communities, trained and activated by our EOCs to attend certain calls, such as chest pain or cardiac arrest, where response time can make the difference between life and death. CFRs provide care and support to the patient until the arrival of an emergency ambulance. All CFRs are equipped appropriately to respond to the emergency they are sent to, they have access to the required levels of personal protective equipment (PPE) for their skill set and we continually review this to ensure it aligns with both organisational and national requirements.

2.8 Patient Transport Volunteer Car Drivers

Our Patient Transport Volunteer Car Drivers play an invaluable role in transporting patients to and from hospital appointments including renal dialysis, oncology, and routine appointments. The 190 operational volunteers operate across the North West and transport patients in their own vehicles whilst offering a friendly face and listening ear, putting patients who are often anxious or concerned about their appointment at ease.

3. DEFINING OUR PATIENT SAFETY PROFILE

NWAS has a commitment to learning from patient safety events and we have continuously developed our understanding and insights into patient safety matters over a number of years.

PSIRF sets no rules or thresholds to determine what needs to be learned from to inform improvement apart from the national requirements listed on page 10. To fully implement PSIRF, NWAS has completed a holistic review of patient safety data insights to understand areas of learning to inform improvement.

NWAS has engaged with key stakeholders, both internal and external and undertaken a review of data from various sources to arrive at a patient safety profile. This process has also involved identification and specification of the methods used to maximise learning and improvement. This has led to the development of the NWAS Local Priorities as listed on page 12.

Stakeholder Engagement
NWAS commenced planning for PSIRF following the release of the national documents from NHS England in August 2022. We have consulted extensively with several PSIRF early adopters to enable understanding of the practicalities of planning for and implementing PSIRF. The assistance received from early adopters has been invaluable.

PSIRF requires a different approach to the oversight of patent safety incidents. NWAS has engaged with the Ambulance Commissioning Team, historically part of NHS Blackpool CCG prior to the formation of Integrated Care Services (ICSs) as they are currently responsible for the oversight of our application of the Serious Incident Framework. NWAS has continued to engage with the Ambulance Commissioning Team and Lancashire and South Cumbria ICS to explore how PSIRF will affect the reporting and management for them.

Internally, various communication methods have been used to outline the significant differences between PSIRF and the Serious Incident Framework including engagement workshops held with key stakeholders, including those from the Trust's service lines. During these engagement workshops, the existing processes that are in place to manage and review patient safety events have been discussed to understand how these can be improved and identify new ways of working under PSIRF.

A resource analysis exercise was undertaken to understand the current resource and capacity for responding to patient safety incidents.

The data sources and how they were used to define our patient safety profile is detailed below. Once the data has been collated, it was shared with internal and external stakeholders supported by a number of engagement workshops to collectively review the data and finalise our Local Priorities.

Data Sources
To define our patient safety profile, data was taken from a variety of sources including assurance reports and data held within our Trust's Governance, Risk, and Compliance system, DatixWeb and Datix Cloud IQ (DCIQ). The Trust collated data over a three-year period and recognised the possibility of skew in the data arising from the COVID-19 pandemic.

We have also considered feedback and information provided by our stakeholders, and subject matter experts as part of the data collection process. Data and information (both qualitative and quantitative) have therefore been received from the following sources:

- Ambulance Clinical Quality Indicators (ACQIs).
- Claims/ litigation.
- Potentially contentious/ contentious inquests.
- Serious incidents & associated serious incident investigation reports.
- Learning from Deaths (LfD).
- Complaints; including Member of Parliament enquiries.
- Compliments.
- Freedom to Speak Up.
- Incidents; internally reported and externally reported.
- Safeguarding.
- Staff survey results.
- Risk registers.
- Care Quality Commission (CQC) reports.
- Human Resources/ employee relations case management.

Where it has been possible, we have considered elements of the data regarding health inequalities. As part of our engagement workshops, we have also considered new and emergent risks relating to future operational changes and changes in demand that historical data may not reveal.

The themes from the data sources were considered and discussed leading to the identification of our Local Priorities for a Patient Safety Incident Investigation (PSII) under PSIRF.

NWAS acknowledges whilst the defined list of Local Priorities has been agreed, this list is not fixed forever.

Our commitment is, that where a new risk emerges or learning, and improvement can be gained from a PSII into a particular incident or theme, this will be commissioned.

4. 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. NWAS 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.

NWAS uses the Model for Improvement framework approach. This is led by the Quality, Innovation, and Improvement Directorate and gives our people the tools to ensure improvement is sustained.

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. NWAS will remain flexible and consider improvement planning as required where a risk or patient safety issue emerges from our own internal or external surveillance.

Recommendations from Patient Safety Incident Learning Responses, and PSIIs, must be translated into effective and sustained improvement action(s) with a focus on reducing risk. For this to occur, NWAS will apply knowledge of the science of patient safety and improvement to identify:

- What improvement(s) are needed.
- What change(s) are needed.
- How this will be implemented.
- How to determine if the change(s) have the desired impact.
- Are there any unintended consequences.

NWAS has several programmes and projects alongside patient safety improvement plans that are in progress. These relate to full programmes of work, as opposed to individual activities. They have been designed and prescribed to address known issues to patient safety.

An overview of these programmes, projects, and current quality improvement plans are tabled below.

Title	Area/ Speciality	Monitoring
Trust-wide		
NHS 111 Rota Review	NHS 111	Corporate Programme Board
Electronic Patient Record (EPR)	Digital & Innovation	Corporate Programme Board
Defibrillation Replacement	Paramedic Emergency Services	Corporate Programme Board
Emergency Services Mobile Communication Programme	Digital & Innovation	Corporate Programme Board
Estates Modernisation & SMART Sites	Trust-wide	Corporate Programme Board
Hospital Handover	Paramedic Emergency Services	
Medical Devices & Equipment	Trust-wide	Medical Devices Oversight Group
Local		
Cardio-Pulmonary Resuscitation (CPR) Times	NHS 111	NHS 111 Quality Business Group
Health Care Professional Line	Emergency Operations Centre	EOC Quality Business Group
Quality Assurance Visits (QAV) Redesign	Quality, Innovation & Improvement Directorate	
Building Quality Improvement Capacity	Quality, Innovation & Improvement Directorate	

5. OUR PATIENT SAFETY INCIDENT RESPONSE PLAN: NATIONAL REQUIREMENTS

Given that the Trust has finite resources for patient safety incident learning responses, NWAS intends to use those resources to maximise learning and improvement outcomes. PSIRF allows organisations to do this, rather

than repeatedly responding to patient safety incidents based on subjective thresholds and definitions of harm, from which new learning will be limited.

Some patient safety incidents, such as Never Events and deaths thought more likely than not due to problems in care will always require a Patient Safety Incident Investigation (PSII) to learn and improve. For other types of patient safety incidents which may affect a particular cohort of patients, a PSII will also be required. These have been determined nationally, NWAS fully endorses this approach as this will align with our aim to learn and improve within a just and restorative culture.

As well as PSIIs, some patient safety incident types require specific reporting and/or review processes to be followed. For clarity, all types of incidents that have been nationally defined as requiring a specific response will be reviewed according to the suggested methods and are detailed in the table below.

National guidance recommends 20 to 25 Patient Safety Incident Investigations per year. Attempting to do more than this will impede our ability to adopt a systems-based approach from thematic analysis and learning from excellence.

National Requirements		
Event	**Approach**	**Improvement**
Incidents meeting the Never Events Criteria 2018	PSII	Create local organisational recommendations & actions
Deaths thought more likely than not due to problems in care	PSII	Create local organisational recommendations & actions
Deaths of patients detained under the Mental Health Act (1983) or where the Mental Capacity Act (2005) applies	PSII	Create local organisational recommendations & actions
Mental health-related homicides	Refer to the NHS England Regional Independent Investigation Team for consideration for an independent PSII. Locally led PSII may be required	Respond to recommendations from external referred agency/ organisation as required. Feed actions into quality improvement work.
Maternity and neonatal incidents meeting the Healthcare Safety Investigations Branch (HSIB) criteria or Special Healthcare Authority (SpHA) criteria when in place	Refer to HSIB or SpHA for independent PSII. Referral Link	Respond to recommendations from external referred agency/ organisation as required. Feed actions into quality improvement work.
Child Deaths	Refer to Child Death Overview Panel (CDOP) review. Locally led PSII (or other response) may be required alongside the CDOP review.	Respond to recommendations from external referred agency/ organisation as required. Feed actions into quality improvement work.

	NWAS to liaise with the CDOP.	
Death of persons with Learning Disabilities, or Autism	Refer for Learning Disability Mortality Review (LeDeR). Locally led PSII (or other response) may be required alongside the LeDeR. NWAS to liaise with this review. Referral Link	Respond to recommendations from external referred agency/ organisation as required. Feed actions into quality improvement work.
Safeguarding incidents in which: ▪ Babies, children, or young people are on a child protection plan; looked after plan, or a victim of wilful neglect or domestic abuse/ violence. ▪ Adults (over 18 years old) are in receipt of care and support neds from the local authority. ▪ The incident related to FGM, Prevent (radicalisation to terrorism), modern slavery and human trafficking, or domestic abuse/ violence.	Refer to Local Authority Safeguarding Lead via the NWAS named Safeguarding Lead. NWAS named Safeguarding Lead will contribute towards domestic independent inquires, joint targeted area inspections, child safeguarding practice reviews, domestic homicide reviews and any other safeguarding reviews (and inquiries) as required to do so by the local safeguarding partnership (for children) and local safeguarding adult boards.	Respond to recommendations from external referred agency/ organisation as required. Feed actions into quality improvement work.
Incidents in NHS screening programmes	Refer to Local Screening Quality Assurance Service for consideration of locally led learning response.	Respond to recommendations from external referred agency/ organisation as required. Feed actions into quality improvement work.
Deaths in custody	Any death in prison or police custody will be referred (by the relevant organisation) to the Prison and Probation Ombudsman (PPO) or the Independent Office for Police Conduct (IOPC) to carry out the relevant investigations. NWAS will fully support these investigations where required to do so.	Respond to recommendations from external referred agency/ organisation as required. Feed actions into quality improvement work.

Domestic Homicide	Identified by the police usually in partnership with the Community Safety Partnership (CSP) with whom the overall responsibility lies for establishing a review of the case. Where the CSP considers that the criteria for a domestic homicide review (DHR) are met, it uses local contacts and requests the establishment of a DHR panel. NWAS will contribute as required by the DHR panel.	Respond to recommendations from external referred agency/ organisation as required. Feed actions into quality improvement work.

6. OUR PATIENT SAFETY INCIDENT RESPONSE PLAN: LOCAL PRIORITIES

PSIRF allows organisations to explore patient safety incidents relevant to their context and the population served. Through analysis of our patient safety insights, based on the review of multiple data sources, and engagement workshops held, NWAS has determined that the Trust will focus on three Local Priorities for focus.

This number of Local Priorities have been selected due to the breadth and complexity of the services NWAS provides. National guidance recommends that 3-6 learning responses per priority are conducted per year. Attempting to do more than this will impede our ability to adopt a systems-based learning approach from thematic analysis and learning from excellence.

Local Priorities requiring a PSII.
The Local Priorities identified for a Patient Safety Incident Investigation (PSII) have been agreed by the Trust's Executive Leadership Committee (ELC), Quality and Performance Committee, and the Board of Directors for the next 12 to 18 months.

Local Priorities		
Event	**Approach**	**Improvement**
Prevention of deterioration to critically unwell patients with contributing harm	PSII	Create local organisational recommendations & actions that feed Safety Improvement Plan
Errors in 999 and 111 call handling which led to a delay with contributing harm	PSII	Create local organisational recommendations & actions that feed Safety Improvement Plan
Face to face or telephone assessment which is managed down an incorrect pathway contributing to harm	PSII	Create local organisational recommendations & actions that feed Safety Improvement Plan

Locally defined patient safety events requiring a PSII.
Any unexpected safety event that carries a level of risk and/or learning for patients/ families/ carers, healthcare staff or organisations that is so great (within or across the healthcare system), where the contributory factors are not widely understood and therefore warrants the use of extra resources to mount a comprehensive PSII response.

Locally pre-defined patient safety events requiring a learning response.
For any patient safety incident not meeting the PSII response, or any other incident, we will use appropriate and proportionate approaches as outlined within the PSIRF. For lesser harm incidents, NWAS propose to manage these at a local level with ongoing thematic analysis, with findings being reported via the PSIRF governance arrangements. This may lead to new or supplement existing improvement work.

NWAS will use the following Patient Safety Learning Responses:

- Patient Safety Incident Investigations (PSIIs)
- After Action Review (AAR)
- SWARM Huddle
- MDT Review
- Thematic Review

For patient safety incidents resulting in moderate or severe harm, NWAS will enact the Statutory Duty of Candour.