NHS
North West
Ambulance Service
NHS Trust

PATIENT SAFETY INCIDENT RESPONSE GUIDE

Patients, families and carers

Introduction from the chief executive.

I would like to start by saying I am sorry that you find yourself here.

Everyone is different and there is no right or wrong way to feel. To try and make sure things like this don't happen in the future, we would like you to take part in a new programme designed to make sure we learn.

The Patient Safety Incident Response Framework is a significant shift in how NHS organisations respond to patient safety events; further details about the framework are explained in this guide.

I would encourage you to be involved as much as you would like to and feel able to. You can do this by asking questions and sharing information you have throughout the process.

NWAS has designed this guidance with the assistance of the Learn-Together Team. They are patients and family members who have experienced incidents, alongside a large group of people who have experienced investigations before. They have further resources available on their website: learn-together.org.uk. Their aim, along with our own is to make what happens next as easy and as meaningful for you as possible.

If you do not feel ready to be involved right now, that is fine. You can always get involved later, if and when you do feel ready.

Most importantly, you should do what feels right for you and those affected by what happened.

About this guide.

Why am I receiving this guide?

You, your family member, or the person you care for has been involved in a patient safety incident whilst receiving care from us. You are receiving this guide because we plan to carry out a learning response to improve safety.

Patient Safety Incident Response Framework (PSIRF)

The introduction of the Patient Safety Incident Response Framework (PSIRF) in Autumn 2023 was a significant shift in how NHS organisations respond to patient safety incidents (PSIs). The framework is a major step towards establishing a safety management system that embeds the key principles of patient safety culture, with a focus on understanding how incidents occur and how we can effectively make sense of, and learn from them, rather than apportioning blame to individuals.

North West Ambulance Service take all patient safety incidents seriously, and we have a patient safety incident response plan which is based on the requirements of the PSIRF framework. If you would like to see a copy of it, you can ask your learning response or engagement lead to provide you with a copy, or go through it with you.

You may hear different phrases used to describe a patient safety incident, for example:

- Patient Safety Event
- Adverse event
- Serious untoward incident
- Near miss
- Never event

What is a learning response?

The framework promotes a range of system-based approaches to learning from patient safety incidents. At North West Ambulance Service, we're committed to supporting our patients, their families and our staff utilising a national model known as the Systems Engineering Initiative Patient Safety (SEIPS) for learning and improvement.

PSIRF promotes a range of system-based approaches to learning from patient safety incidents; organisations are encouraged to use national tools and guidance available from NHS England. The national tools have been developed in collaboration with human factors experts and the Health Services Safety Investigations Body (HSSIB), who lead the way in modern healthcare safety investigation methodology.

Why be involved?

"First and foremost, be kind to yourself. It's the most emotional time to go through. Don't ever apologise for being emotional at a meeting. IF you don't understand something, ask and ask again. It's really important that you understand what is happening. Don't be afraid to ask for support."

Debra (daughter of Ellen), involved in a patient safety incident.

"It may feel as though there is a lot to take in at first, but please don't worry. As you are supported and guided through the different stages, there will be an opportunity to work together and answer your questions".

Penny (mother of Anna), involved in a patient safety incident.

"Patients and families really should get involved in investigations if they can and get the support they need. This is actually their experience. This is their life that's being investigated."

Joanne (mother of Jasmine), involved in a patient safety incident.

Contents.

If you would like this guide in an alternative format, please email talk.tous@nwas.nhs.uk.

Understanding you and your needs.

Meeting your main point of contact.

Your contact will aim to introduce themselves and have a discussion with you as soon as possible after the patient safety incident. Sometimes, our learning response may have already started by the time you meet your contact.

Your contact might introduce themselves and have a meeting with you to discuss you and your needs at the same time, or this might be two separate meetings.

You will be given time and space to share what you know about what happened. Patients and families who have experienced a patient safety incident say that being involved at this stage might be an important step on the road to recovery and making sense of what happened. If you choose to be involved, you will be guided and supported through it.

It's important to know who your contact is throughout this process. You can make a note of their details here:

My learning response/engagement lead:

Name: .....

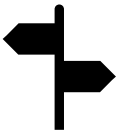
E-mail address: .....

Telephone: .....

Their working hours are: .....

Things to discuss:

- How would you describe what happened?
- How has this affected you and others around you?
- What support you need
- What questions do you have?
- What would you like to see happen next?



If you haven't been offered a meeting, you can ask your main point of contact to arrange one. Don't worry if you don't cover everything, you can get back in touch with any questions at any time.

Agreeing how you work together.

Understanding whats involved.

It is unlikely that you have been involved in something like this before. It is important that you know what to expect from the process. If you have any questions, your main point of contact will do their best to help you.

NHS England defines a **patient safety incident** as an "unintended or unexpected incident which could have or did lead to harm for one or more patients receiving healthcare".

NHS trusts are required to let patients and their families know that a patient safety incident has occurred and provide support following. This process is called **Duty of Candour**.

For some patient safety incidents, it will be appropriate to conduct what's called a **patient safety incident investigation (PSII).**

The purpose is to identify organisational learning to improve systems, and not to blame people. When things go wrong it's usually caused by many things rather than one alone.

The time taken to complete investigations varies due to multiple factors, such as the complexity of the event and the number of people, **system partners** and services involved.

A trained member of staff will be appointed to lead an investigation. Where possible and appropriate they will be independent of the clinical area where the incident occurred.

The investigation will gather information from various sources, including you and your family, to help understand what happened. You will have your own views about what happened and it's important you share these.

Towards the end of the investigation, a report will be produced based on all evidence gathered. This will explain what is thought to have happened and why. It may also outline key learning points aiming to reduce the likelihood of it happening again, and what actions might be taken based on these points. You will be asked to check the report before a final version is produced.

As well as the patient safety investigation, you may be involved in different processes. For example, following a patient safety incident that has led to an unexpected death, you might be involved in an **inquest** by the **coroner**, or an independent body may carry out an investigation.

Your Preferences.

Understanding your preferences for working together are important, we will discuss with you how you wish to be involved. Our team will engage with you in a compassionate way. Please inform our team of any preferences for your involvement, this could include (but is not limited to):

- Provided with verbal updates as the investigation progresses.
- Share your experience.
- Ask questions that you would like to be looked into.
- Check a copy of the report.
- Receive a copy of the report.

Your main point of contact will be able to provide support and guidance throughout.

Getting and giving information.

The investigation is a bit like a jigsaw. There are different pieces of information relating to the incident. The team gathers different information and tries to understand different experiences of what happened, as well as pulling together common themes and finding points of disagreement.

You are a key part of this jigsaw; you have a unique and valuable perspective on what happened and may have information others do not have access to.

The information you share will be brought together with information from staff and other relevant sources.

Terms of Reference.

We will ensure you're involved in setting terms of reference. These cover aspects of care that we will look at, with agreed boundaries. You will help to agree and set these as you may have your own questions, you would like to be answered.

It's important to note, there may be occasions where we may not be able to answer all your questions. Your main point of contact will be able to support you with this and give an explanation if this occurs.

You may need time to think about questions, it's ok if you don't have any or don't want to be involved. Some people prefer to wait for their main point of contact to pass on information. But if you have any questions, you can get in touch with your main point of contact. They will be happy to answer any questions you have.

Your questions.

You may like to write down any questions you have on this page.

Gathering information.

As well as listening to your story, there are lots of types of information we will gather to answer the questions set out in the terms of reference.

- We may look at the Electronic Patient Record, to see what was written down and what clinical treatment was provided.
- We will talk to people involved in the incident to build a good idea of what happened.
- We may visit the area (or similar) to observe the environment and how people work.
- We may review and refer to policies and guidance.

Once information has been gathered, the information will be analysed. We use a model called System Engineering Initiative for Patient Safety, also known as SEIPS.

Patient safety incidents result from multiple interactions between system factors, SEIPS prompts us to look for interactions rather than the straightforward cause that affects relationships.

We may look for common themes and carry out risk analysis.

The report.

All the information gathered from different perspectives will be brought together to produce a report.

This outlines what was thought to have happened and why. It may also outline key learning points aiming to reduce the likelihood of it happening again, and what actions we might need to take.

We've adopted and use the national template for our report. It's designed to ensure a standard approach and the report is of good quality.

We will ask how you, your relative or the person you cared for would like to be referred to in the report. We can use your preferred choice or a generic term like "the patient".

The report continued...

The report will include:

- An executive summary – *This is a short description of the incident, findings and areas for improvement (at a glance).*
- Background and context – *This is a short description of the background to our response.*
- Description of the incident.
- Our approach – *This will explain how the incident was reported and decisions made on how to review and provide a response, terms of reference and how information is gathered.*
- Findings – *This will explain how the incident happened, it may include diagrams or tables to explain.*
- Safety action summary table – *This will list areas for improvement alongside specific safety actions.*
- Appendices – *This section will include additional information to understand the report, if applicable.*

Before the report is finalised, you will be sent a draft copy. Brace yourself for receiving the report, families have explained it can be difficult to read. It is factual with feelings removed. It's ok not to read it all in one go, its ok to show emotion.

Please be kind to yourself and give yourself time to digest the information and if necessary, make a list of anything and everything you wish to raise and question.

Discussing the findings.

Your main point of contact will work with you and explain the report, if necessary; meeting any additional support needs you may have. For example, translating the report into an alternative language, using larger font or using different coloured paper.

The report may be shared with others in the trust such as governance, patient safety or legal teams.

One thing that patients and their families say, is that the report can be difficult to read. Here are some important things to consider, which may make it easier.

- The purpose of the investigation is to **identify learning to improve systems, and not to blame people**. When things go wrong it is usually caused by many things, rather than just one thing.

- Everyone is different and there is no right or wrong way to feel. But **you might want to read the report together with others who have been affected by the patient safety incident, such as your family.** You might also want to meet with your main point of contact again after taking some time to read through it. Your contact will try to direct you to support that is specific to you and your needs if necessary.

- **You do not have to read it all at once.** You might find it useful to read it a section at a time. You can always come back to other sections when you feel ready.

- Any information you provided has been brought together with information from other relevant sources, such as healthcare staff and clinical notes. **All information is equally valuable. However, there may be points of disagreement. These should be clearly highlighted in the report.** You should speak to your main contact about these points of disagreement in more detail if you are unsure and highlight any additional points of disagreement that aren't made clear.

- **The report is written for different audiences which includes you**, but also includes others such as healthcare staff and senior management. Because of this, reports are often written in non-technical language and use a factual tone. which might appear insensitive. This is not the intention. This is to make the report accessible to all. **However, if there is anything you do not fully understand (e.g., any medical terms) please speak to your main point of contact.** They will provide you with a detailed explanation.

- **Within the report, information may be anonymised.** For example, it may use terms like 'the patient', or 'the nurse', rather than giving their names. This may appear insensitive but that is not the intention. This may be due to various reasons such as General Data Protection Regulation (GDPR).

Next steps.

Receiving the final report.

After making any necessary changes, your main point of contact will provide you with a copy of the final report. You might want to meet with them to discuss what has changed as a result of feedback as well as your thoughts and reflections.

As the formal process comes to an end, hopefully, you will be able to move forward feeling reassured by the outcome. Your valuable involvement will help to reduce the risk of the same thing happening again.

Once the investigation is complete, this marks the end of the formal process. For us, we must start to implement the safety actions included in the report. There may be certain things we cannot attend to immediately (e.g., increasing the number of staff or changing a particular working environment).

Our safety actions are monitored by **Integrated Care Boards (ICB)**, also known as **commissioners**. We will be expected to address these actions within specific timescales and require support and guidance to do this from commissioners and **system partners**.

You may want to share your story for use in future training or quality improvement work. If this is something you would like to be part of, please let your main point of contact know.

Patient and family survey.

You may want to tell us about your experience for us to work towards continuous improvement. Your nominated engagement lead will ask you to complete a survey, they will go through this with you and provide necessary support if required.

Information you provide will be used solely for the purposes of improving our services. If you would prefer not to be included in the survey, please inform your engagement lead to ensure you are opted out.

Your support needs.

Being involved in a healthcare patient safety incident can be distressing and you may find the process difficult. You can talk to your main point of contact about how you are feeling and they may signpost you other services:

Citizens Advice can give high-quality, independent advice about any problems or questions you might have. They can provide you with the knowledge and confidence to find a way forward. They have a network of national and local independent charities that can provide free and confidential advice. You can find out more at https://www.citizensadvice.org.uk/. You can also call an advisor on 0800 144 8848.

Mind is a registered charity that provides support and advice to anyone who is suffering with their mental health. If you have been affected emotionally following the incident you experienced or if you are finding the investigation process difficult, you can contact Mind. You can find general support resources and information about local services at https://www.mind.org.uk/. You can also email them on info@mind.org.uk or call their helpline on 0300 123 3393.

Samaritans is a registered charity providing support to anyone in emotional distress or anyone who is struggling to cope. If you have been emotionally affected by an incident you were involved in, you can contact the Samaritans for free and there will always be someone there to listen to you and talk to you. You can find more information at https://www.samaritans.org/. You can email them at jo@samaritans.org or you can call free on 116 123. Their support is available 24 hours a day, 7 days a week, 365 days a year.

Dissatisfaction and resolution.

What if I'm unhappy?

If you are unhappy with our response, speak to your main point of contact in the first instance. They will help to see what can be done to provide resolution.

If you want to make a formal complaint, you can contact our Complaints Team by or you can make a complaint to the local Integrated Care Board (ICB) who oversee NHS services.

Alternatively, here are some services and organisations that might help you:

Action against Medical Accidents (AvMA) is an independent charity which provides free specialist advice to people who have been affected by patient safety incidents. They can advise you about your investigation as well as other processes that you may be faced with or be considering (for example, inquests; complaints; fitness to practice/regulatory issues raised by the incident; or legal action). They can also give you details of other organisations providing different sorts of support. For further details, please visit: **www.avma.org.uk**

Patient Advice and Liaison Service (PALS) can be found in each NHS Trust. You can talk to a PALS member of staff about the incident and they will try to help you resolve any issues with the trust informally. PALS can be particularly useful if you need action immediately. For more information you can ask a member of the team or further information can be found at: **www.nhs.uk/nhs-services/hospitals/what-is-pals-patient-advice-and-liaison-service/**

The Parliamentary and Health Service Ombudsman (PHSO) responds to unresolved complaints. They can support you if you have made a complaint following your patient safety incident and the organisation has not responded or you are dissatisfied with their response. You can find more information at **www.ombudsman.org.uk**

Key words and phrases.

Adverse event: An event which resulted in an undesirable clinical outcome which may have caused harm to a patient.

Commissioners: Commissioners might include people who have been general practitioners or other clinicians such as nurses and consultants. Commissioners will sit on governing bodies which might also include patient representatives, general managers, and practice managers.

Common themes: Common themes are recurring ideas, subjects or topics, relevant to the incident and the Terms of Reference. The investigator identifies themes when they are reading all of the information they have collected about the incident.

Coroner: A coroner is a government official or member of the judicial system who carries out inquests.

Engagement lead: A member of staff whose primary role is to provide compassionate support and advice to patients and their families during a patient safety incident investigation.

Governance Team: Governance Teams work in NHS organisations and are responsible for monitoring the quality of services and for safeguarding high standards of care.

General Data Protection Regulation (GDPR): A regulation in EU law on data protection and privacy

Healthcare incident: Any unplanned or unintended incident which could have resulted or did result in harm to a patient.

Integrated Care Board (ICB): The integrated care board is an NHS organisation responsible for developing a plan for meeting the health needs of the population.

Inquest: An inquest is a formal investigation conducted to determine how someone died.

Legal team: Most NHS trusts have legal teams to manage a wide range of legal matters for the trust including claims brought against them; inquests; any proceedings involving trust witnesses; medical treatment applications to the High Court; medical records requests from solicitors.

Near miss: An incident that does not cause harm, but which has the potential to cause injury or ill health if it had not been caught in time.

Never event: Serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.

Patient safety event: Unintended or unexpected events in healthcare that could or did harm one or more patients.

Patient safety specialist: Individuals in healthcare organisations who have been designated to provide senior patient safety leadership.

Patient Safety Team: Most NHS trusts will have a patient safety team dedicated to working within the service to minimise the risk and impact of incidents.

Policy: An official document that includes a set of guidelines to guide decisions and achieve specific outcomes.

System partners: Other health or social care provider organisations. (i.e., acute hospitals, community health services, mental health or local authorities).

Terms of Reference: These are guidelines that define the scope and purpose of the investigation.

The Health Services Safety Investigation Body (HSSIB): HSSIB is funded by the Department for Health and Social Care and is responsible for carrying out independent investigations into NHS-funded care across England.

Risk analysis: Risk analysis involves finding things and situations that could potentially cause harm to people.

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Without their support, it would not have been possible to produce this information booklet.

Access this information digitally

You can access this information electronically at: **www.nwas.nhs.uk/publications/**

Your feedback

If you have any feedback on this leaflet, or require a list of references, please e-mail **ps.irf@nwas.nhs.uk**

Alternative formats

This leaflet is available in large print. If you need this leaflet in an alternative format or language, please email talk.tous@nwas.nhs.uk.