East of England Ambulance Service NHS Trust

Patient Safety Incident Response Plan

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Introduction

The NHS Patient Safety Strategy published in 2019 describes the Patient Safety Incident Response Framework (PSIRF).

This Patient Safety Incident Response Plan (PSIRP) sets out how East of England Ambulance Service NHS Trust (known as 'the Trust') intends to respond to patient safety incidents as part of the PSIRF. This is a dynamic plan reviewed annually documenting how the Trust will manage its identified patient safety risks.

It will allow adaptation and change to how patient safety incidents are managed. The PSIRF encourages us to enhance our investigations, improving the learning gathered, resulting in better outcomes for patients.

The plan covers how the Trust will manage patient safety incidents and use the learning gathered to improve. The information will be anonymised to focus on system-based learning; it will not set out to apportion blame or determine liability. We will triangulate information received with other data such as complaints and claims as this will allow us to track how effective we are at learning from incidents and how successful change has been.

We will also use this plan to address the causal, systemic factors and use quality improvement opportunities to reduce repetition of our most reported safety incidents.

It is the Trust's aim to provide the best quality of care, every hour of every day. The Trust recognises that there are occasions when things don't go to plan or when people are unhappy with the care and service provided. The Trust aims to learn from these occasions and respond to people to address the matters they have raised with a transparent and honest approach. We can also link our core values to the key aims of PSIRF, as demonstrated below.

Our core values

We value warmth, empathy and compassion in all our relationships.

Together as one, we work with pride and commitment to achieve our vision.

We strive to consistently achieve high standards through continuous improvement.

We value individuals, including our patients, our staff and our partners in every interaction.

We value a culture that has trust, integrity, and transparency at the centre of everything we do.

PSIRF key aims

Compassionate engagement and involvement of those affected by patient safety incidents.
CARE, RESPECT, HONESTY.

Application of a range of system-based approaches to learning from patient safety incidents.
TEAMWORK, QUALITY.

Considered and proportionate responses to patient safety incidents.
CARE, RESPECT, HONESTY.

Supportive oversight focused on strengthening response system functioning and improvement.
TEAMWORK, QUALITY, HONESTY.

This plan also describes what the Trust has done in preparation for the implementation of PSIRF in September 2023.

Our services

The Trust provides a wide range of services to the public such as emergency and urgent care, patient transport services, and commercial call handling services. Patient transport services are not provided for all counties which is reflected in this plan. The Trust serves the counties of Bedfordshire, Cambridgeshire, Essex, Hertfordshire, Norfolk and Suffolk which covers an area of 7,500 square miles and a population of more than 5.9 million people. The variation of geographical location impacts the way the services are provided. The variation includes rural areas with limited road access and urban areas with good access, road networks and availability of hospital and community services.

Who we engaged with

Stakeholder engagement included discussions with the Trust's patient safety and patient experience teams, regional NHS resolution and learning team, our legal and safeguarding teams; and all local Integrated Care Systems (ICS), to understand the key concerns raised by those teams. Workshops with our acute hospital partners and other ambulance organisations have allowed us to compare our data with theirs to identify common priorities which will in the future facilitate whole system learning. We met with all six ICSs which cover our region to understand the issues pertinent to their areas.

This plan has been developed in consultation with the Trust's patient safety, patient experience, legal and quality improvement teams. It will be scrutinised by senior leaders including the executive leadership team. It will be signed off by our ICBs prior to final sign off by the Trust Board.

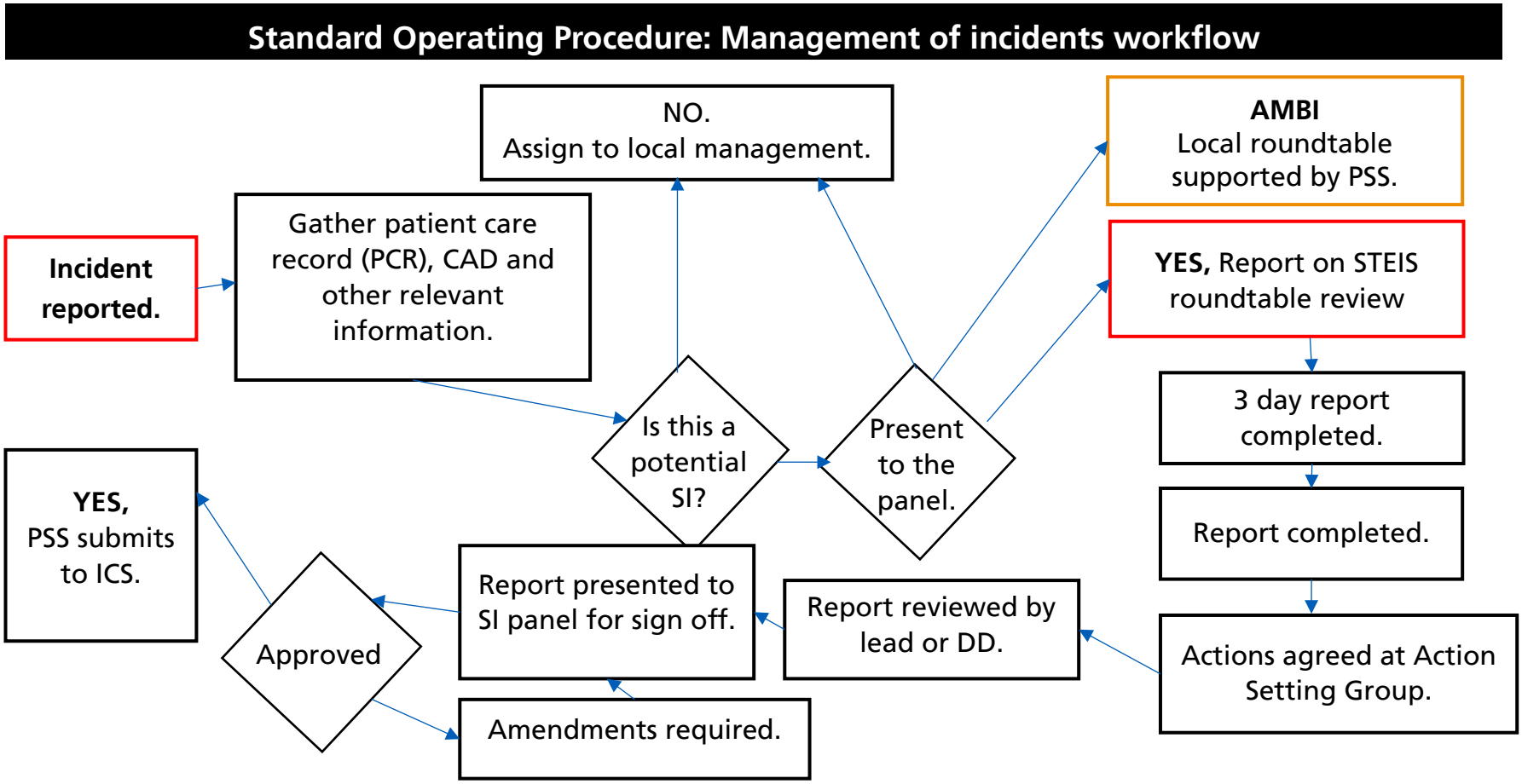
How we manage patient safety now?

The organisation has a Clinical Strategy which includes the management of patient safety. There is a departmental workplan which enables the clinical strategy. We also have a Safety Enabling Strategy which covers all aspects of safety for staff and patients, which links with the National Patient Safety Strategy and PSIRF.

Serious incidents (SI) are currently reviewed at the Incident Review Panel which meets three times a week. It enables in depth discussions about incidents which may be declared as a serious incident. Once identified and declared the investigation process is initiated. When completed the SI is presented the Action Setting Group which takes the key learning points and identifies actions to be taken. This is a multidisciplinary meeting, where operational and corporate colleagues identify how those actions will be managed. It is a well-attended forum and facilitates sharing of information and projects in the organisation. This demonstrates how we respond to incident findings which in turn leads to quality improvement.

We also undertake local incident reviews for those not identified as SIs, which are lead locally by Operational Teams so that learning can be shared through local teams and at meetings. We also share learning through Trust wide sources which includes a monthly newsletter and videos with clinical staff discussing key clinical messages identified as learning responses to incidents.

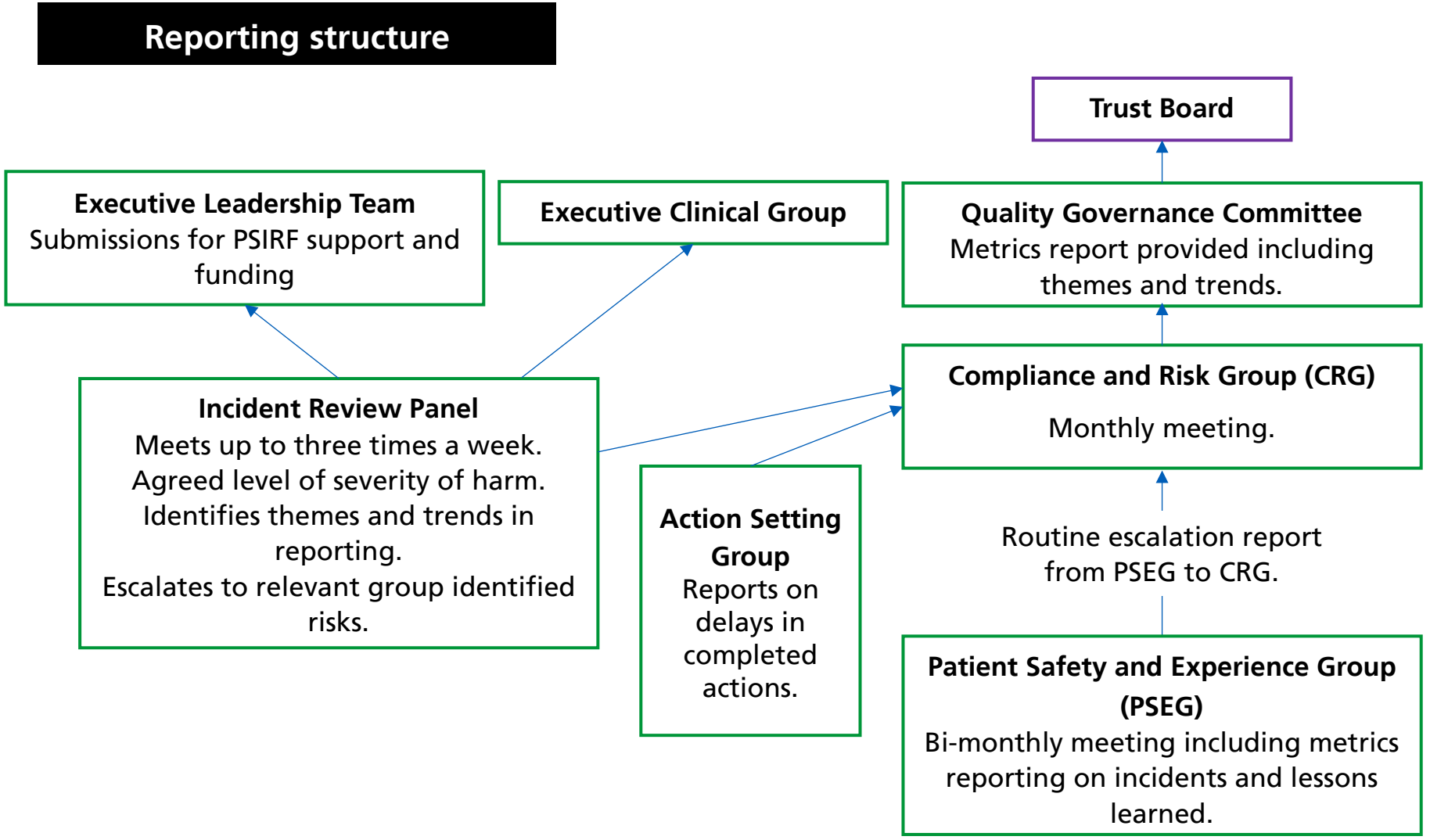
Diagram one: Current process used to manage incidents.



In addition to this we have an Innovation and Improvement Strategic Workplan and Change Framework which is our mechanism for change once learning has been identified.

Incident management activity is reported through the governance structure below.

Diagram two: Governance reporting structure



How will we change?

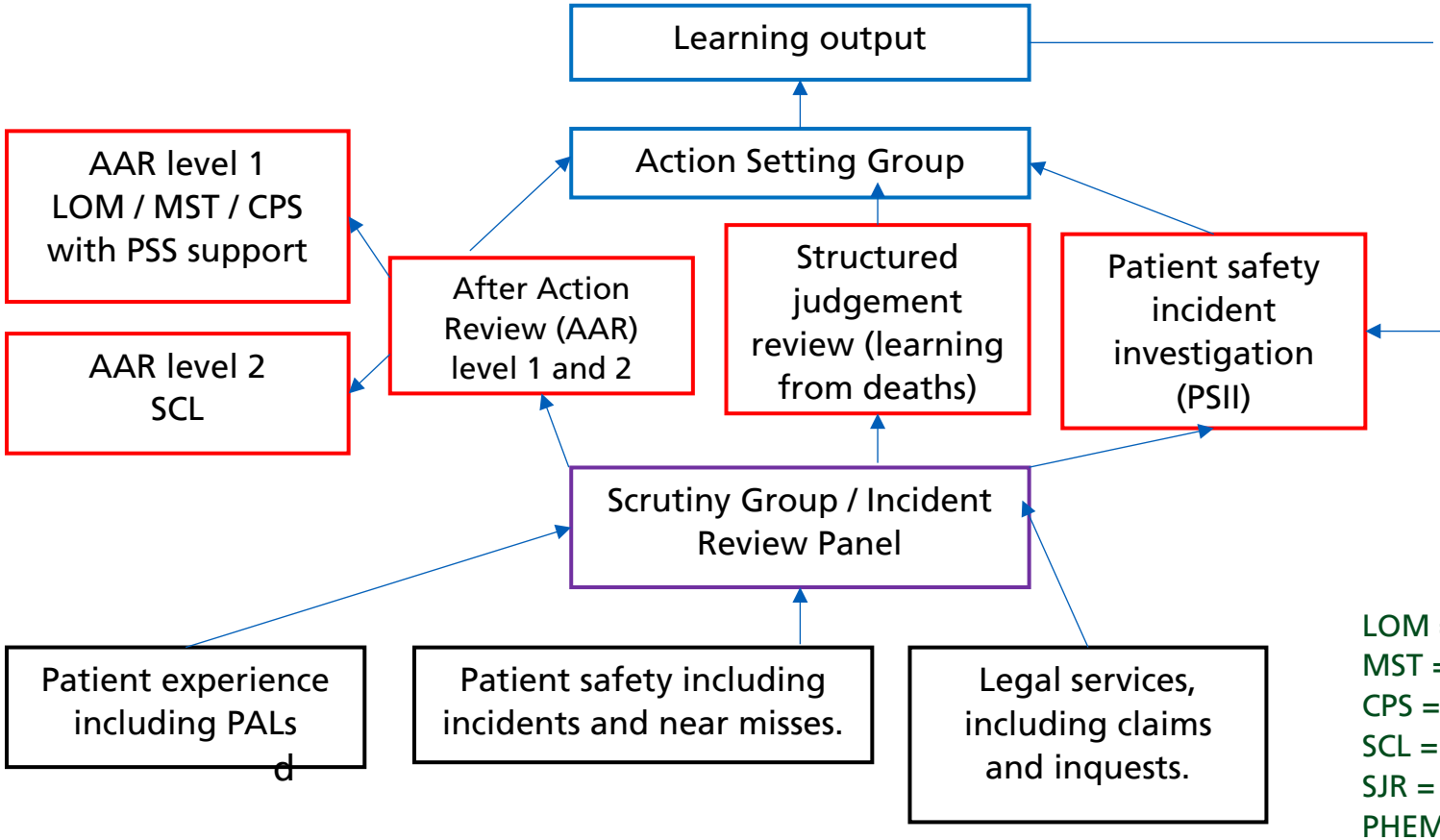
Well embedded strategies and processes are in place which will be reviewed and adapted to meet the requirements of PSIRF. Terms of reference (ToR) are being reviewed to ensure they are updated appropriately.

Over the last three years the work undertaken by the safety teams has put the Trust in a good position to lead to a smooth transition to the PSIRF way of working. We have undertaken more thematic reviews and the changes made to current round table discussions has improved the way staff discuss their involvement in incidents, allowing them to be honest and open without fear of punishment. We have worked hard to reduce the number of staff suspended though clinical events and by using a systems approach to incident investigations the language used to describe causation for incidents in moving towards an embedded just culture.

How we will review incidents

Diagram three: Incident triage – national requirements

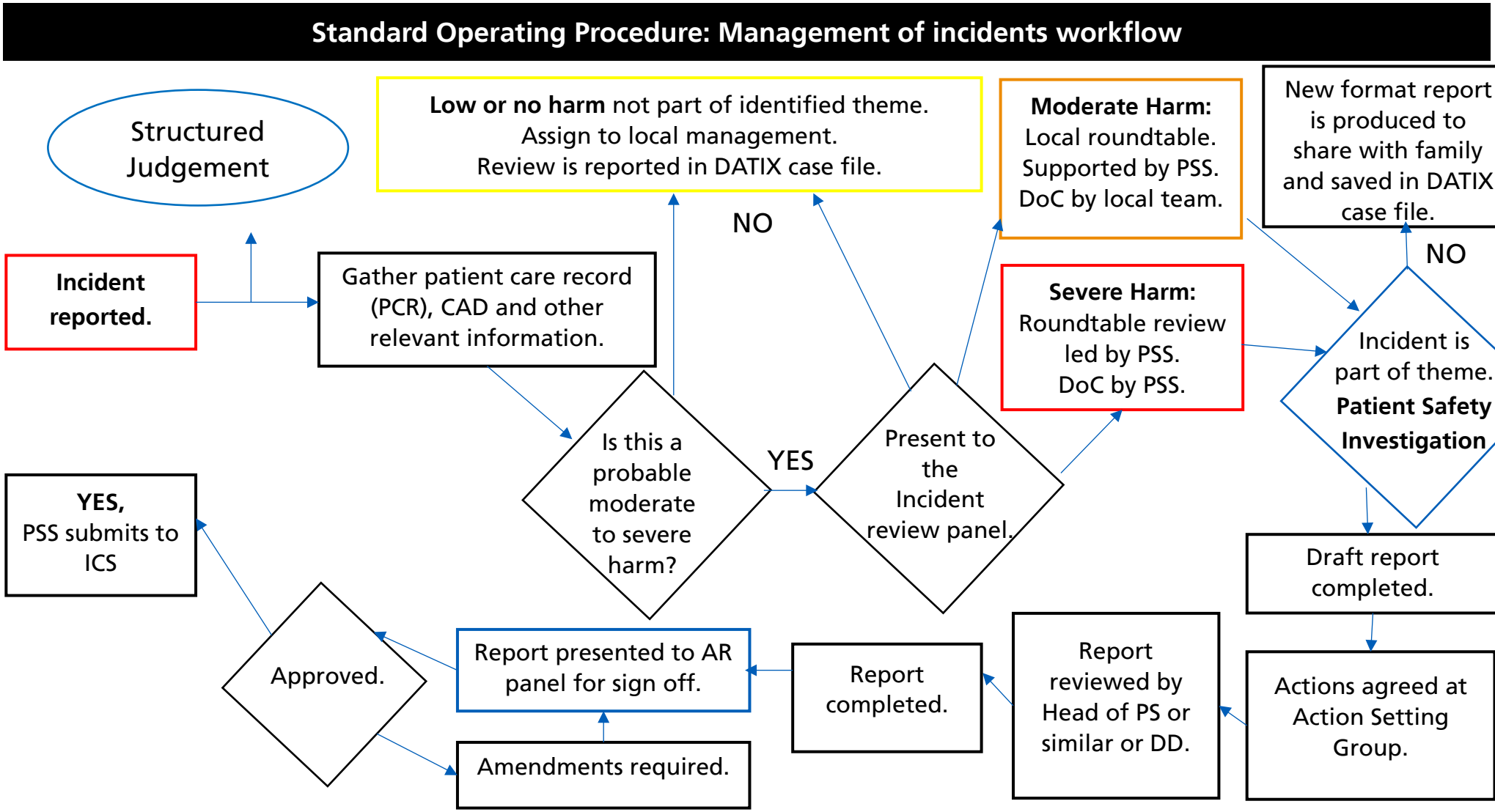
Patient Safety Incident Investigation Framework (PSIRF) Workflow:
Dashboard with risk management information for LOM and SCL



- Non conveyance audit
- PHEM feedback
- Staff engagement
- Other QI projects

LOM = Leading operations manager
MST = Mentor support team
CPS = Clinical practice supervisors
SCL = Sector clinical lead
SJR = Structured judgement review
PHEM = Pre-hospital emergency medicine

Diagram four: How our reporting will change



The Trust already undertakes thematic reviews, and we will continue to monitor trends and themes in relation to our top 6 priorities. The Incident Review Panel will continue to undertake the scrutiny of incidents and decide which type of review will be required (see diagram 4). The Incident Review Panel will initially sign off Patient Safety Incident Investigations (PSIIs) prior to Board approval.

Patient Safety Incident Investigations (PSIIs):

These will be undertaken on those priority areas regardless of severity or outcome.

The PSII will include at least one incident categorised as a near miss or low harm and will be based on:

- actual and potential impact of the incident's outcome (harm to people, service, quality, reputation and public confidence, etc.)
- likelihood of recurrence
- potential for new learning

Incidents not included on the priority list will be investigated locally using one of the agreed methods outlined above.

For each group of PSIIs completed the Trust will:

- Develop actions plans for the implementation of planned improvements through the action setting group.
- Monitor the effectiveness of improvements over time through the quality improvement team

The type of response will depend on:

- the views of those affected, including patients and their families
- capacity available to undertake a learning response
- what is known about the factors that lead to the incident(s)
- whether improvement work is underway to address the identified contributory factors

Timescales:

There are no prescribed time limits for the completion of PSIIs; good practice is that they should be started as soon as possible after the incident or incidents have been identified. Ideally, they should be completed within one to three months from the start date. In exceptional circumstances a longer timeframe can be negotiated in agreement between the patient/family/carer and the Trust. No PSII should take longer than six months to complete.

After Action reviews:

These will be facilitated by the patient safety specialists for the locality, which are currently covered by round table discussions.

Patient Safety Specialists (PSSs):

They will be assigned to each business unit and be responsible for all aspects of this plan within their ICS locality. Working alongside them will be patient safety advisors who will assist with reviews and the development of learning responses. The PSS will guide, facilitate, and train local leaders to undertake requirements of the PSIRP specific to their locality. Training for staff is detailed in appendix two.

Structure judgment reviews:

The learning from deaths team will identify the structured judgment reviews and where appropriate link with the patient safety team where an incident has been raised.

The patient safety, patient experience, legal and quality improvement teams will continue to work closely together to triangulate themes and trends to develop co-ordinated learning responses. This will be reported through the patient safety and experience group which reports through the quality governance assurance structure (see diagram two above).

Duty of Candour (DoC):

This will continue to be discharged as a statutory requirement. Following triage, the decision to discharge DoC will be made and undertaken within the required time frame.

Who will be involved?

The Board: will be responsible for the oversight and final sign off for Patient Safety Incident Investigations (PSIIs), which will be shared with the relevant ICS to provide assurance that we are effectively managing patient safety.

Director of nursing, quality and improvement: is the executive sponsor for quality and patient safety providing assurance to the Board that robust arrangements for patient safety are in place, which are effectively monitored and updated as the risk profile and the PSIRP changes.

Deputy directors: will be responsible for ensuring the operational teams managing patient safety, patient experience and quality manage the day-to-day oversight of incidents effectively, reporting to the Board to provide that assurance.

Patient safety team: will be responsible for the administrative management of incident investigations under the leadership of the head of patient safety. The team will ensure that the day-to-day administrative duties relating to incident investigations are appropriately documented and the maintenance of relevant databases are kept up to date.

Patient safety partners (PSPs): Patient safety partners are critical to the success of PSIRF, with their involvement in the review of incidents and development of learning. Recruitment of PSPs will be on a continuous basis, in order for the organisation to develop group of PSPs who have had lived experiences of the ambulance service and are also representative of their local communities and groups. There will be 2 or 3 PSPs appointed in the first wave of recruitment. Our overall aim to have one for each business unit to work with the PSSs.

Patients and families: we will engage with patients and their families involved incidents to ensure that we hear about their experience during the pathway of care and use that information to provide a full picture of what happened to assist with a robust and complete review.

Incident review panel: this will continue to meet and will identify which pathway is appropriate for the incident review (see diagram 3).

Action setting group: This will continue to meet and after review of its ToR will identify how actions developed from different review pathways will be managed.

Quality improvement team: The QI team has set up innovation hubs within the organisation and these will be crucial in helping to drive forward the learning and local improvement work follow incident reviews. With well-established links with the patient safety team national and local improvement projects will be linked to patient safety and experience learning responses.

Our data

Information was gathered using the Trust's electronic risk management system for the period from 1st April 2018 to 31st March 2023. Information was collated from the incident, claims and patient experience modules of the system for the time period given. Key themes identified are included in the following section under local profile.

It is important that we continue to use data from various sources such as patient experience surveys, including health safety and security learning outcomes. We will also continue to use a multi-platform approach to shared learning including learning from good practice.

Our patient safety incident profile

National requirements

National incident types below may change considering patient safety developments reported, which in turn will change our profile. Our plan will be reviewed to the national requirements when defined and change is needed.

Patient safety incident type
Incidents meeting the Never Events criteria.
Death thought more likely than not due to problems in care (incident meeting the learning from deaths criteria for patient safety incident investigations (PSIIs)) – including child deaths and those with learning disabilities.
Incidents meeting 'Each Baby Counts' criteria.
Mental health-related homicides by persons in receipt of mental health services or within 6 months of their discharge
Mental health-related homicides by persons in receipt of mental health services or within 6 months of their discharge.

Local profile

Six key themes have been identified, which will be included in our risk profile for the first 12 months. The plan will then be reviewed internally, and with our lead commissioner. Further detail is in appendix one.

The subjects were identified using analysis of risk management data, agreed within the organisation and with our lead commissioner. The list below is not exhaustive and should an incident outside the list be identified as a new area for concern it will be investigated using the PSII methodology and where appropriate amendments to the PSIR Plan made.

	Incident type	Specific area for investigation
1	Non conveyance – shared decision making	Face to face assessment which resulted in the patient not being conveyed to hospital with no evidence of shared decision making with other Health Care Professional (HCP)
2	Clinical Treatment/Assessment – missed ST-elevation Myocardial Infarction (STEMI)	Clinical assessment which led to patient being treated using the wrong pathway or not conveyed to the appropriate care setting
3	Clinical Treatment/Assessment – atypical stroke symptoms	Clinical assessment which led to patient being managed down the wrong pathway or not conveyed within the appropriate timeframe
4	Clinical Treatment/Assessment – mental health & capacity	Clinical assessment where MCA assessment was not completed or documented appropriately which led to probable harm following patient treatment decisions
5	Communication – shared decision making with other HCP	Clinical assessment or treatment pathway leading to probable harm when not discussed with another appropriate HCP e.g., senior paramedic staff, GP.
6	Communication – patient decision not to attend hospital.	Clinical assessment where patient made the decision not to attend hospital when there is insufficient evidence to show an informed decision was made, which lead to probable harm.

Other local incident themes

Delayed ambulance responses leading to harm have consistently been the highest reported incident category during the review period. There is a national improvement programme in progress, and we are aware of the themes relating to this area. Delays will continue to be monitored closely and investigated where appropriate. We will also continue to take part in the national quality improvement programme.

The organisation provides various services, including patient transport services in some locations. Whilst patient transport services are not included in the local profile, the organisation will continue to monitor these incidents closely as requested by those ICSs where we provide the service.

References

2022 Patient Safety Incident Response Framework - and supporting guidance (NHSE August 2022)

- Engaging and Involving patient families and staff following a patient safety incident
- Guide to responding proportionately to patient safety incidents
- Oversight roles and responsibilities
- Patient safety incident response standards

2019 The NHS Patient Safety Strategy. Safer culture, safer systems, safer patients. (NHSE July 2019)

2021 NHS Complaints Standards (Parliamentary Health Service Ombudsman March 2021)

2021 Safety Enabling Strategy 2021-2024 (East of England Ambulance Service NHS Trust)

2015 The NHS Serious Incident Framework (NHSE 2015)

Appendices

Appendix one: Analysis from DATIX.

Chart one: Serious incidents declared compared to incidents reported 1st April 2018 to 31st March 2023.

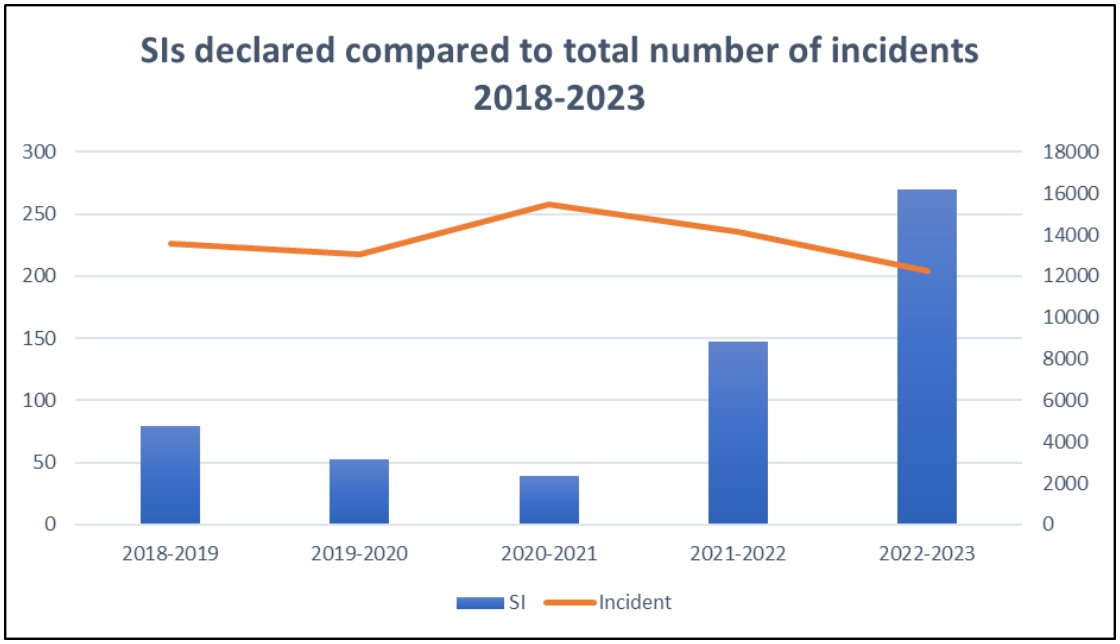


Chart two: Serious incidents by type

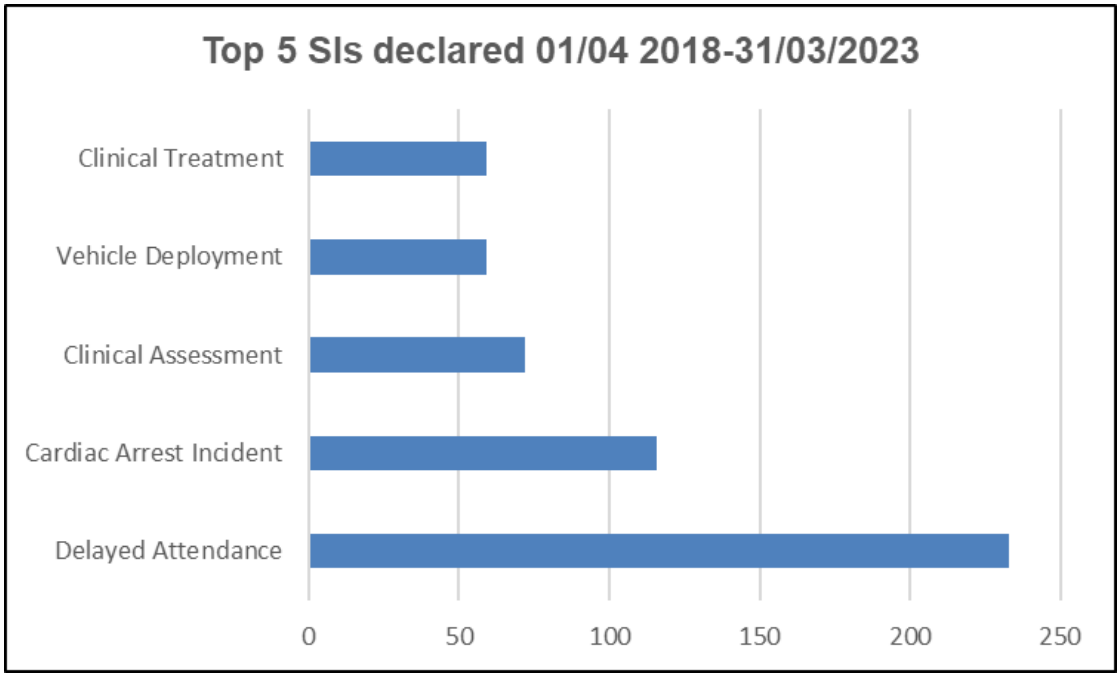


Chart three: Incidents by type and year

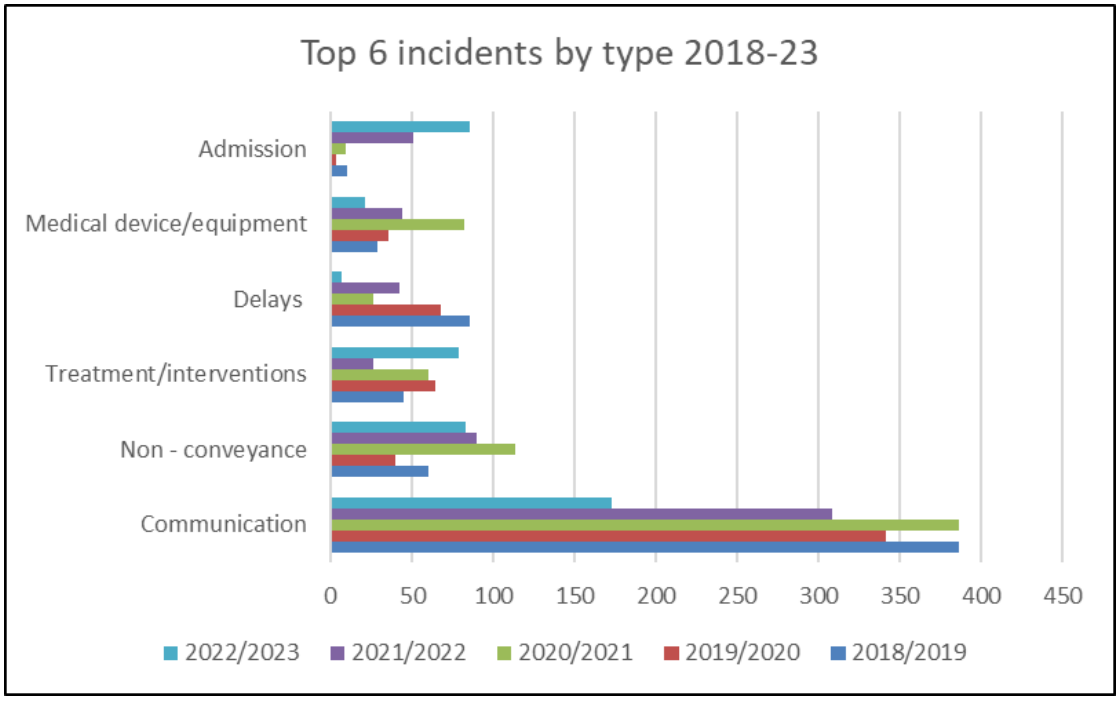
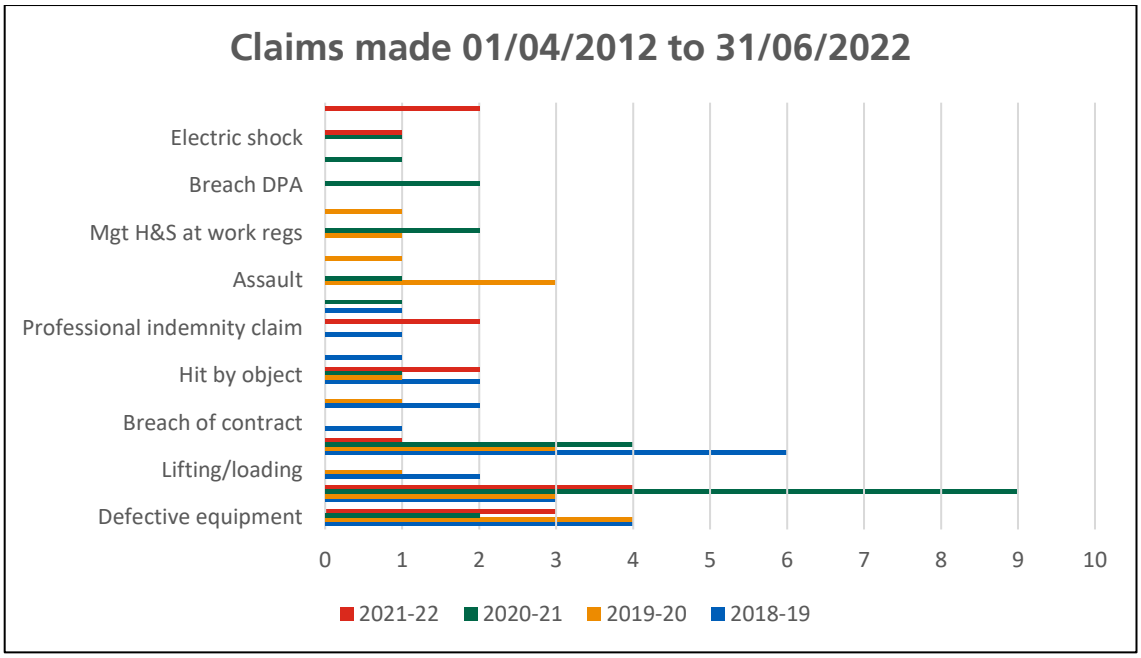
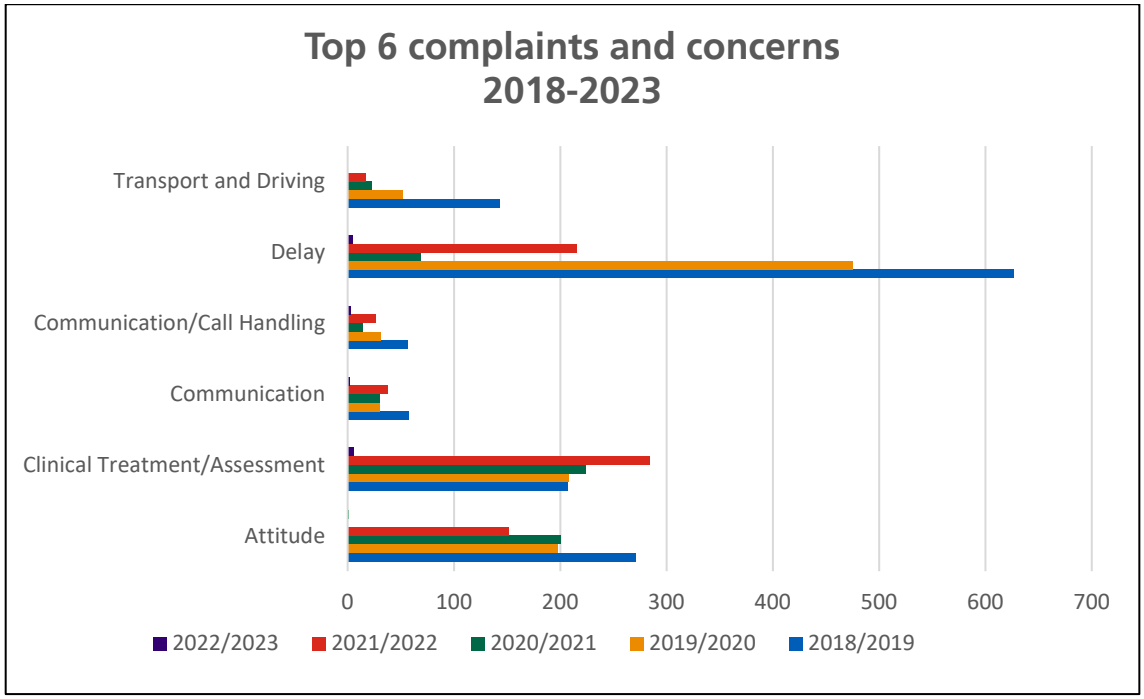


Chart four: Number of claims



The number of claims has declined in the last 5 years. The data for 2022 only includes claims up until 30th June 2022. Figures include staff and patient claims and were no clinical claims.

Chart five: Complaints and concerns raised in the five-year period.



Appendix two: Training for PSIRF

This training plan will be reviewed annually in line with the PSIR Plan review.

	Type of training	**Attendees and information**
May/June/July 2023	**East regional training modules:** • Systems approach to learning from patient safety incidents. • Oversight of learning from patient safety incidents. • Involving those affected by patient safety incidents in the learning process.	Patient safety team reps. Patient experience team reps. QI team reps General managers. Assistant general managers. Director of Nursing.

Autumn 2023	Oversight of learning from patient safety incidents.	Board seminar. Executive and non-executive directors. Deputy clinical directors
From autumn 2023	After Action review. Training to include train the trainer	Staff involved in incident review process including corporate teams and local management teams. Patient safety specialist to roll out training.
From autumn 2023	Introduction to PSIRF Level one patient safety training	Patient safety specialist to roll out training after completing regional training. Training to be agreed with learning and development team to include online and in person training.
June 2023 ongoing	Staff awareness sessions.	Dedicated PSIRF page on staff intranet. Posters with QR code to link to PSIRF page. Page will include webinars and other tools for self-directed learning.
TBC	Training for patient safety partners	To be arranged when in post.