

# Patient safety incident response plan

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<b>Author</b>	Leah Harris Stephen Jeffries	Patient Safety Specialists		
<b>Reviewer</b>				
<b>Authoriser</b>				

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## Introduction

This patient safety incident response plan sets out how West Midlands Ambulance Service intends to respond to patient safety incidents over a period of 12 months. 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. This is because patient safety themes and trends change which means our local priorities will need to be under review.

The NHS Patient Safety Strategy was published in July 2019 and introduces the Patient Safety Incident Response Framework (PSIRF) as a replacement for 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. The PSIRF is best considered as a learning and improvement framework with the emphasis placed on systems and encouraging a culture that supports continuous improvement in patient safety. The PSIRF encourages us to enhance our investigations, improving the learning gathered reducing the risk of future harm.

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

Our PSIRP should be read in conjunction with our Patient Safety Incident Response Policy.

## Our services

The Trust provides a wide range of services to the public such as emergency care, patient transport services, 999 call handling services and remote clinical assessment services based in our Emergency Operations Centre (EOC). Patient transport services are not provided for all counties which is reflected in this plan.

The Trust serves a population of 5.6 million people covering an area of more than 5,000 square miles made up of Shropshire, Herefordshire, Worcestershire, Staffordshire, Warwickshire, Coventry, Birmingham and the Black Country. It includes the second largest urban area in the country (Birmingham, Solihull and the Black Country) yet over 80% of the area is rural. We are the second most ethnically diverse region in the country after London which makes it vital that we work closely with the many different communities we serve.

## Defining our patient safety incident profile

West Midlands Ambulance Service has a commitment to learning from patient safety incidents and we have continuously developed our understanding and insights into patient safety matters over a number of years.

The PSIRF sets no rules or thresholds to determine what needs to be learned from to improve except for the national requirements listed on pages 8-10. To implement PSIRF, we have completed a holistic review of patient safety data insights to target areas of learning for improvement.

We have engaged with key internal and external stakeholders and reviewed data from our Serious Incidents, Learning From Deaths cases and internal reporting system to arrive at our patient safety profile. This has led to the development of our Local Priorities (See page 12).

### Stakeholder engagement

To understand the process and ally key concerns raised, discussions took place with the Patient Safety Team, the Patient Experience Team and our Claims and Coroner's Department.

Workshops with our acute hospital partners and other ambulance services have allowed us to compare our data with theirs to identify common priorities which will in the future facilitate whole system learning.

This plan has been developed in consultation with the Trust's patient safety, patient experience and legal teams with input from various stakeholders across the whole of the organisation including our executive directors. It has also been agreed with our ICB prior to final approval by the Trust Board.

These discussions will continue as PSIRF evolves.

### Data Sources

The Trust collated and analysed data over a period of 24 months from a variety of sources.

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)
- Business Intelligence reports
- Care Quality Commission (CQC) reports
- Claims
- Complaints
- Compliments
- Coroner's Inquests
- Freedom to Speak Up
- Human resources/employee relations investigations
- Incidents reporting both internally and externally
- Learning From Deaths

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- Quality Improvement initiatives
- Risk registers
- Safeguarding
- Serious Incidents and their associated investigation reports
- Staff survey results

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 emerging risks that other stakeholders have identified that our own historical data may not reveal.

The trends and themes from the data sources were considered and our Local Priorities for Patient Safety Incident Investigation (PSII) were identified and then agreed in conjunction with the PSIRF Working Group and the ICB.

We acknowledge that whilst the defined list of Local Priorities has been agreed, this list is not exhaustive.

Where a new risk emerges, this will be discussed at the Patient Safety Incident Review Group and if necessary, a PSII will be initiated.

## Defining our patient safety improvement profile

Current Patient Safety processes are in place, such as Learning From Deaths, which will be reviewed and adapted to meet the requirements of the PSIRF.

Over the last 24 months the work undertaken by the Patient Safety Team has put the Trust in a good position to lead to smooth transition to the PSIRF way of working. We have completed more thematic reviews, began using LFPSE and started work to improve engagement with our staff. The Patient Safety Incident Review Group will undertake the scrutiny of incidents and decide which type of review will be required. The Patient Safety Panel will initially sign off PSIRs prior to final review at the Learning Review Group.

Recommendations from Patient Safety Incident Learning Responses and PSIRs must be translated into effective and sustained improvement action(s) focussed on reducing risk. This will be discussed at The Patient Safety Panel where we will identify:

- What improvement(s) are needed
- What change(s) are needed
- How this will be implemented
- How the impact of the change(s) will be monitored
- If there are any unintended consequences

## Our patient safety incident response plan: national requirements

The Trust has finite resources for patient safety incident learning responses, we intend to use those resources to maximise learning and improvement outcomes. The 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 patient, a PSII will also be required, these have been determined nationally.

Some patient safety incident types also require specific reporting and/or review processes to be followed such as Learning From Deaths mortality reporting. For clarity, these are listed in the table below. National guidance recommends 20-25 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.

Patient safety incident type	Required response	Anticipated improvement route
<b>Incidents meeting the Never Events criteria</b>	PSII	Create local organisational actions and feed these into the quality improvement strategy
<b>Deaths thought more likely than not due to problems in care</b> ( <i>incidents meeting the Learning From Deaths criteria for patient safety incident investigations (PSIIs)</i> )	PSII	Create local organisational actions and feed these into the quality improvement strategy
<b>Deaths of patients detained under the Mental Health Act (1983) or where the Mental Capacity Act (2005) applies</b> ( <i>where there is a reason to think that the death may be linked to problem in care, incidents meeting the Learning From Deaths criteria</i> )	PSII	Create local organisational actions and feed these into the quality improvement strategy

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<p><b>Mental health-related homicide</b></p>	<p>Referred to the NHS England Regional Independent Investigation Team (RIIT) for consideration for an independent PSII</p> <p>Locally-led PSII may be required</p>	<p>Respond to recommendations from external referred agency/organisation as required. Feed actions into quality improvement work.</p>
<p><b>Maternity and neonatal incidents meeting Maternity and Newborn Safety Investigations Special Health Authority (MNSI) criteria</b></p>	<p>Refer to MNSI for independent PSII</p> <p>If a death has occurred, to be reviewed under the Learning From Deaths Policy</p>	<p>Respond to recommendations from external referred agency/organisation as required. Feed actions into quality improvement work.</p>
<p><b>Child deaths</b></p>	<p>Refer to Child Death Overview Panel (CDOP) for review.</p> <p>To be reviewed under the Learning From Deaths Policy</p> <p>Locally led PSII (or other response) may be required alongside the CDOP review.</p> <p>We will liaise with the CDOP coordinator.</p>	<p>Respond to recommendations from external referred agency/organisation as required. Feed actions into quality improvement work.</p>
<p><b>Death of persons with Learning Disabilities, or Autism</b></p>	<p>Refer for Learning Disability Mortality Review (LeDeR)</p> <p>To be reviewed under the Learning From Deaths Policy</p> <p>Locally led PSII (or other response) may be required alongside the LeDeR review.</p> <p>We will liaise with the LeDeR coordinator.</p>	<p>Respond to recommendations from external referred agency/organisation as required. Feed actions into quality improvement work.</p>
<p><b>Safeguarding incidents in which:</b></p> <ul style="list-style-type: none"> <li>• <i>babies, children or young people are on a child protection plan, looked</i></li> </ul>	<p>Refer to Local Authority Safeguarding Lead via The Safeguarding Team who will contribute towards: domestic independent inquires, joint targeted area</p>	<p>Respond to recommendations from external referred agency/organisation as required. Feed actions into quality improvement work.</p>

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<p><i>after plan or a victim of wilful neglect or domestic abuse/violence</i></p> <ul style="list-style-type: none"> <li>• <i>adults (over 18 years old) are in receipt of care and support needs from their local authority</i></li> <li>• <i>the incident relates to FGM, Prevent (radicalisation to terrorism), modern slavery and human trafficking or domestic abuse/violence</i></li> </ul>	<p>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.</p>	
<p><b>Deaths in custody</b> (e.g. <i>police custody, prison etc</i>) where health provision is delivered by the NHS</p>	<p>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.</p> <p>We will fully support these investigations where required to do so.</p>	<p>Respond to recommendations from external referred agency/organisation as required. Feed actions into quality improvement work.</p>
<p><b>Domestic homicide</b></p>	<p>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.</p> <p>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. We will contribute as required by the DHR panel.</p>	<p>Respond to recommendations from external referred agency/organisation as required. Feed actions into quality improvement work.</p>
<p><b>Infection Prevention Control</b></p> <p><i>Ambulance Services are exempt from the mandatory reporting of bloodstream infections and as a result, are not set BSI trajectories by</i></p>	<p>PSII – Where there is a severe or significant outbreak which may impact on the Trusts ability to deliver emergency services.</p> <p>PSII – Where there is lapse in process or exposure to</p>	<p>Respond to recommendations from external referred agency/organisation as required.</p> <p>Create local organisational actions</p>

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<p><i>NHS England. Other IPC related incidents may be applicable to the Infection Prevention and Control (IPC) Patient Safety Incident Response Framework (PSIRF) Matrix and should be considered on a case-by-case basis by the Trusts lead for IPC and Patient Safety lead.</i></p>	<p>others in High Consequence Infectious Disease (HCID)</p>	
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## Our patient safety incident response plan: local priorities

Through analysis of our patient safety insights, based on the review of our data and engagement workshops held, we have determined that the Trust will focus on four local priorities. 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 this plan will be made.

### Local priorities requiring a PSII

These local priorities identified for a PSII have been agreed by the PSIRF Working Group and our ICB for the next 12 months.

Patient safety incident type or issue	Planned response	Anticipated improvement route
<b>Non-conveyance where there is a concern around informed consent and/or capacity to consent.</b>	PSII	Create local safety actions and feed these into the quality improvement strategy
<b>Incidents where patients have been injured because of, or an absence of, moving and handling principles.</b>	PSII	Create local safety actions and feed these into the quality improvement strategy
<b>Management of the critically ill patient where deterioration has not been identified/prevented.</b>	PSII	Create local safety actions and feed these into the quality improvement strategy
<b>Where a case is referred to CVT that has a delayed response and where an ambulance was available at the point of the initial call.</b>	PSII	Create local safety actions and feed these into the quality improvement strategy

### Delayed ambulance responses

Delayed ambulance responses leading to harm have consistently been the highest reported incident category during the analysis of our data. 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 and investigated where appropriate. We will also continue to take part in the national quality improvement programme.

### Unexpected patient safety incidents requiring a PSII outside of our priorities

Any unexpected safety incident that carries a level of risk and/or learning opportunities that are so great, where the contributory factors are not widely understood and therefore warrants the use of extra resources to undertake a PSII response.

### **Patient safety incidents 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.

We will use the following Patient Safety Learning Responses:

- Patient Safety Incident Investigations (PSIIs)
- After Action Reviews (AARs)
- SWARM Huddle
- Multidisciplinary Team Review (MDT Review)
- Thematic Review

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