NHS
Yorkshire
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NHS Trust


# 2023-2025
# Patient Safety Incident Response Plan v1.1 Final

Document Authors: Head of Investigations and Learning / Clinical Directorate Manager

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| **Document Authors (title)** | Head of Investigations & Learning/Patient Safety Specialist<br><br>Clinical Directorate Manager |
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| 0.2 | June 2023 | Simon Davies<br>Head of Investigations and Learning | D | Amended reporting lines in lieu of organisational restructure.<br><br>Included draft Patient Safety Profile |
| 0.3 | June 2023 | Dave Green<br>Associate Director Quality and Safety (Interim) | D | Reviewed and final draft for Quality Committee |
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| 1.0 | July 2023 | Simon Davies<br>Head of Investigations and Learning | A | Trust Board 27th July 2023 – Approved Document |
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A = Approved D = Draft

Associated Documentation:

- Patient Safety Incident Response Policy
- Risk Management Procedures
- Incident & Serious Incident Management Policy
- Policy for Managing Compliments, Comments, Concerns and Complaints
- Safeguarding Policy
- Courts and Evidence Policy
- Claims Management Policy
- Disclosure Policy
- Freedom of Information Policy
- Supporting Staff Involved in an Incident, Complaint or Claim Policy
- Being Open (Duty of Candour) Policy
- Disciplinary Policy & Procedure
- Issue Resolution (Grievance) Policy
- Freedom to Speak Up (Raising Concerns) Policy
- Bullying and Harassment Policy
- Clinical Incident Review Policy
- Post Incident Care Guidance

# Foreword

The NHS Patient Safety Strategy (2019) describes the Patient Safety Incident Response Framework (PSIRF) as a “foundation for change”, and as such, it challenges us to think and respond differently when a patient safety incident occurs.

Unlike earlier revisions to NHS investigation techniques, PSIRF is a complete system review and change to how we think, how we respond and how we learn when something has not gone as we would have expected.

A summary of the principles is shown below:

- Improved opportunities to engage with our patients, families, and staff throughout any patient safety investigation.
- The removal of time pressures and external oversight, in favour of partnership collaboration with the wider Integrated Care System (ICS).
- Proportional response to incidents as they occur, with different options to respond and to replace the ‘one size fits all’ approach of the past.
- A focus on ‘System’ learning with tools to enable increased emphasis on culture and environments that we oversee to enable healthcare to happen safely in our organisation.
- Adoption of the research based ‘Systems Engineering Initiative in Patient Safety’ (SEIPS) model for investigation, replacing ‘Root Cause Analysis’ (RCA).

# 1. Introduction

1.1 This patient safety incident response plan sets out how Yorkshire Ambulance Service NHS Trust intends to respond to patient safety incidents over a period of 12 to 18 months. The plan can be adapted, and we will remain flexible; considering the specific circumstances in which patient safety issues and incidents occur and the needs of those affected.

1.2 This plan will improve the efficacy of our local patient safety incident investigations (PSIIs) by:

a. Refocusing PSII towards a systems approach and the rigorous identification of interconnected causal factors and systems issues.

b. Focusing on addressing these causal factors and the use of improvement science to prevent or reduce repeat patient safety risks and incidents.

c. Transferring the emphasis from the quantity to the quality of PSIIs such that it increases confidence in the improvement of patient safety through learning from incidents.

1.3 This document should be read alongside the Patient Safety Incident Response Framework (PSIRF) 2022, which sets out the requirement for this plan to be developed:

NHS England » Patient Safety Incident Response Framework and supporting guidance

# 2. Our services

2.1 Yorkshire Ambulance Service NHS Trust (YAS) covers nearly 6,000 square miles of varied terrain, from isolated moors and dales to urban areas, coastline and inner cities.

Serving a population of over five million people across Yorkshire and the Humber and strive to ensure that patients receive the right response to their care needs as quickly as possible, wherever they live.

We employ more than 7,200 staff, who together with over 1,300 volunteers, enable us to provide a 24-hour, seven-days-a-week, emergency and healthcare service.

In Our 999 Emergency services we receive an average of over 3,500 emergency and routine calls a day. In 2021-22 we responded to a total of 849,173 incidents through either a vehicle arriving on scene or by telephone advice. Clinicians based in our

Clinical Hub which operates within the Emergency Operations Centre (EOC) triaged and helped around 90,700 callers with their healthcare needs.

Our Patient Transport Service made over 706,100 journeys in 2021-22, transporting patients to and from hospital and treatment centre appointments.

Our NHS 111 service helped more than 1.6 million patients across Yorkshire and the Humber, Bassetlaw, North Lincolnshire and North East Lincolnshire during 2021-22.

## 2.2 Our Purpose

To save lives and ensure everyone in our communities receives the right care, whenever and wherever they need it.

## 2.3 Our Vision and values

To be trusted as the best urgent and emergency care provider, with the best people and partnerships, delivering the best outcomes for patients. We have 6 defined values.


# 3. Defining our patient safety incident profile

3.1 The Trust has a commitment to continuous learning from patient safety incidents and has developed understanding and insights into patient safety learnings over a period of years. We have a regular Executive-led Incident Review Group (IRG) and weekly Low and no Harm group (LnHg) to review incidents as they occur. Our Trust Learning Group (TLG) was created in October 2021 to give oversight of the Trust's patient safety improvement activity by ensuring actions correlate to learnings.
PSIRF sets no rules or thresholds to determine what needs to be learned from to inform improvement apart from the national requirements listed on p10-11. To fully implement the Framework the Trust has completed a review of patient safety incidents to allow understanding of where improvements are required.

The Patient Safety team has engaged with key stakeholders, both internally and externally and undertaken a review of data from various sources to determine a safety profile. This process has allowed the development of the Trust Local focus for our incident responses which is listed at p12-13.

**Stakeholder Engagement**

3.2 TLG has been the sponsor of work associated with PSIRF implementation and all metrics and discussion have fed into this group for oversight. A number of workshops have been held to determine the data sets, triangulate the learnings from different inputs and work undertaken to understand these insights and areas of work where improvement may be required. TLG has reviewed the data and worked to gain a consensus on the Trust focus for PSIRF plan.

3.3 The Commission for Quality and Innovation (CQUIN) framework has been utilised over a period of two years to ensure governance and external oversight has been applied, 'Preparation for PSIRF implementation' in 22/23 and 'Implementation of PSIRF' in 23/24. Stakeholder engagement with Commissioners via this process has allowed their input into the areas selected for Trust focus.

3.4 PSIRF and the differences between it and the SI framework have been presented internally and externally during preparations for implementation. The PSRIF plan allows for continual review, and further stakeholder engagement both internally and externally will take place as we progress the plan and associated improvements.

**Data Sources**

3.5 Comprehensive review of data was conducted, incorporating information from the following Trust departments:

- Serious Incident Team
- Complaints/Patient Relations
- Freedom to Speak Up
- Safeguarding team
- Mortality reviews
- Staff survey results
- Legal Services / Claims
- Staff suspensions
- Risk assessments
- Inequalities data

3.6 Thematic review of the data from 1st October 2020 and the use of Pareto charts and Word Clouding for themes and trends has produced rationale for each criterion to be included in this patient safety profile.

3.7 The data exercise undertaken is included below, which references all the information collated into several pages of the underlying data.

Data Exercise June 2023.pdf

3.8 This data was presented to TLG on 26th June 2023 and suggestions for topics to be included in the safety profile were discussed.

3.9 The final Trust PSIRF topics were agreed by members of TLG on the 26th June 2023. The Trusts PSIRF plan will be approved by Quality Committee and then Board.

3.10 The plan covers the whole organisation, with the intention that it will be amended regularly to ensure that the profile remains current, and evidence based.

3.11 The Trusts central investigations team will be instrumental in supporting the PSIRF plan and will utilise the decision tree and flowchart (Appendix B) that has been introduced to support the plan. A learning response tool kit has been developed to support consistent approach to investigations across the Trust (Appendix C)

# 4. Defining our patient safety improvement profile

4.1 The Trust has developed its governance processes to ensure it gains insight from patient safety incidents and this feeds into our quality improvement activity, using Trust Learning Group. Reporting internally allows for assurance on the agreed workstreams to support improvement. Progress against the PSIRF plan will be reported internally to Clinical Governance Group. Assurance against progress with the PSIRF plan will be reported into Quality Committee with escalations to Board as required. CCG and Quality Committee can influence future direction of patient safety improvements, as we continue to gain further insights using our data. The plan will focus our efforts going forward on development of safety improvement plans across our most significant incident types either those within national priorities, or those we have identified locally.

4.2 We will also continue to draw on guidance and feedback from national and regional level NHS bodies, regulators, commissioners, partner providers and other key stakeholders to identify and define the quality improvement work we need to undertake.

4.3 The plan remains flexible and considers improvement planning as needed where a risk or patient safety issue emerges from our own ongoing internal or external insights.

# 5. Our patient safety incident response plan: National Requirements

5.1 As well as PSII, some incident types require specific reporting and/or review processes to be followed.

5.2 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.

| Patient safety incident type | Required response | Anticipated improvement route |
|---|---|---|
| **Incidents meeting the** Never Events criteria 2018 or its replacement. | Locally-led PSII | Create local organisational actions and feed these into the quality improvement strategy |
| **Death thought more likely than not due to problems in care** (incident meeting the learning from deaths criteria for patient safety incident investigations (PSIIs) | Locally-led PSII | Create local organisational actions and feed these into the quality improvement strategy |
| **Maternity and neonatal incidents meeting Healthcare Safety Investigation Branch (HSIB) criteria or Special Healthcare Authority (SpHA) criteria when in place** | Refer to HSIB or SpHa for independent PSII | Respond to recommendations as required and feed actions into the quality improvement strategy |
| **Safeguarding incidents in which:**<br>• babies, children, or young people are on a child protection plan; looked after plan or a victim of wilful neglect or domestic abuse/violence | Refer to local authority safeguarding lead.<br>Healthcare organisations must contribute towards domestic independent inquiries, joint targeted area inspections, child safeguarding practice reviews, domestic homicide reviews and | Refer to the YAS designated professionals for child and adult safeguarding |

| | | |
|---|---|---|
| • adults (over 18 years old) are in receipt of care and support needs from their local authority<br>• the incident relates to FGM, Prevent (radicalisation to terrorism), modern slavery and human trafficking or domestic abuse/violence | any other safeguarding reviews (and inquiries) as required to do so by the local safeguarding partnership (for children) and local safeguarding adults boards | |
| **Child deaths** | Refer for Child Death Overview Panel review.<br>Locally-led PSII (or other response) may be required alongside the panel review – organisations should liaise with the panel | Refer to the YAS designated professionals for child and adult safeguarding |
| **Deaths of persons with learning disabilities** | Refer for Learning Disability Mortality Review (LeDeR)<br>Locally-led PSII (or other response) may be required alongside the LeDeR – organisations should liaise with this | Create local organisational actions and feed these into the quality improvement strategy |

A full list of national response priorities can be found at the following link, this includes criteria thought not to be applicable in an ambulance setting:

Guide-to-responding-proportionately-to-patient-safety-incidents-v1.1.pdf

# 6. Our patient safety incident response plan: Local Trust Focus

6.1 Through our analysis, based on the review of incidents and engagement meetings YAS have decided that the Trust requires four patient safety priorities as local focus.

| Patient safety incident type or issue | Planned response | Senior Responsible Officer (SRO) | Anticipated improvement route |
|---|---|---|---|
| **999 Telephony Concerns**<br>• Poor management of patients whose first language is not English.<br>• Address verification incidents resulting in harm or potential harm.<br>• Incorrect duplication or closure of live cases which results in delayed response.<br>• Missed ineffective breathing discriminators during emergency call handling resulting in delayed response. | PSII | Clinical Response and Governance Manager<br>(EOC) | Create local safety actions and feed these into the Trust Learning Group. |
| **IUC Telephony Concerns**<br>• Poor management of patients whose first language is not English.<br>• Address verification incidents resulting in harm or potential harm.<br>• Poor management of patients presenting with either symptoms of stroke OR a predetermined management plan e.g., an end-of-life care pathway. | PSII | Deputy Head of Nursing and Quality Assurance<br>(IUC) | Create local safety actions and feed these into the Trust Learning Group. |
| **Care for patients who have fallen or been injured whilst in our care** | PSII/AAR | Head of Safety | Inform ongoing improvement efforts. |

| | | | |
|---|---|---|---|
| • Moving and handling of patients using equipment provided by the Trust which leads to harm or potential harm. | | (Moving and Handling Specialist) | |
| **On scene Decision Making**<br><br>• Non-Conveyance of a patient resulting in reattendance within 24 hours and identified harm.<br>• Incident resulting in harm associated with a care pathway provided or facilitated by the Trust. | PSII/AAR | Associate Director for Paramedic Practice | Inform ongoing improvement efforts. |

# Appendix A

## Glossary of terms

**PSIRF** - Patient Safety Incident Response Framework
This is a 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.

**PSIRP** - Patient Safety Incident Response plan
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.

**PSII** - Patient Safety Incident Investigation
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.

**AAR – After action review**
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.

**SJR** - Structured judgement review
Originally developed by the Royal College of Physicians. The Trust follows the Royal College of Psychiatrists model for best practice in mortality review. The SJR blends traditional, clinical-judgement based review methods with a standard format. This approach requires reviewers to make safety and quality judgements over phases of care, to make explicit written comments about care for each phase, and to score care for each phase. This allows the Trust to identify deaths assessed as more likely than not due to problems in care. This allows the Trust to identify those deaths which may need to progress to PSII according to the given national priorities.

**Never Event** - Patient safety incidents that are considered to be wholly preventable where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and have been implemented by healthcare providers.
https://improvement.nhs.uk/documents/2266/Never_Events_list_2018_FINAL_v5.pdf

# Appendix B

## PSIRF Response Flowchart

PSIRF Response Flowchart (Simplified)

# Appendix C

## Learning response toolkit

YAS Learning Response Toolkit V0.1