NHS
Yorkshire
Ambulance Service
NHS Trust

Patient Safety Incident Response Plan 2025/26

Author: Head of Investigations & Learning

Approved: May 2025

Document Reference	FR – Patient Safety Incident Response Plan 25/26 – May 2026
Version	V2.0
Responsible Director (title)	Executive Director of Quality & Chief Paramedic
Document Authors (title)	Head of Investigations & Learning
Approved By	Clinical Governance Group (CGG)
Date Approved	May 2025
Review Date	May 2026
Equality Impact Assessed (EIA)	Not Applicable
Document Publication	Internal and Public Website

Document Control Information

Version	Date	Author	Status (A/D)	Description of Change
1.0	July 2023	Simon Davies	A	Trust Board 27th July 2023 – Approved Document
1.1	January 2024	Simon Davies	A	Triparty ICB approval granted (Led by West Yorkshire ICB) 30th January 2024
1.2	March 2025	Simon Davies	D	Annual revision of priorities - DRAFT
1.3	April 2025	Simon Davies	D	Amending local priorities and added annual thematic review / AAR plan.
1.4	April 2025	Simon Davies	D	Amendments following PSLG/CQDF
2.0	May 2025	Simon Davies	A	Approved at May 2025 CGG.

A = Approved D = Draft

Document Author = Simon Davies, Head of Investigations and Learning

Associated Documentation:

Risk Management Policy
Incident Management Policy
Complaints, Concerns, Compliments and Comments Policy
Safeguarding Policy
Courts and Evidence Policy
Claims Management Policy
Disclosure Policy
Freedom of Information Policy
Being Open (Duty of Candour) Policy
Disciplinary Policy, Procedure & Guidance
Grievance Policy & Procedure
Freedom to Speak Up (Raising Concerns) Policy
Dignity, Civility & Respect at Work Policy
Post Incident Care & Support Guidance

Current published versions of trust documents can be found at the following link: Library - Policies - PowerApps

Section	Contents	Page No.
1.0	Introduction	4
2.0	Purpose/Scope	4
	2.1 Our Services	4
	2.2 Our Core Purpose	5
	2.3 Our Values	5
3.0	Defining our Patient Safety Incident Profile	5
4.0	Defining our Patient Safety Improvement Profile	6
5.0	Our Patient Safety Incident Response Plan – National Requirements	7
6.0	Our Patient Safety Incident Response Plan – Local Trust Focus	8
7.0	Our Planned Thematic Analysis	9
8.0	Our Planned After-Action and Multi-Disciplinary Team Reviews	9
9.0	Review and Evaluation	10
10.0	Appendices	10
	Appendix A – Definition	11
	Appendix B – PSIRF Response Flowchart	13
	Appendix C – Learning Response Toolkit	14
	Appendix D – Thematic Review Flow	18

1.0 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 following national guidance documents which set out the requirement for this plan to be developed:

- NHS England » Patient Safety Incident Response Framework and supporting guidance
- NHS England » The NHS Patient Safety Strategy

2.0 Purpose/Scope

2.1 Our Services

2.1.1 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.

2.1.2 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.

2.1.3 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.

2.1.4 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.

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

2.1.6 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 Core Purpose**

2.2.1 To provide and co-ordinate safe, effective, responsive, and patient centred out-of-hospital emergency, urgent and non-emergency care, so all our patients can have the best possible experience and outcomes.

2.3 **Our Values**

2.3.1 **'Living our values'** is our personal commitment to demonstrate the YAS values and behaviours in a meaningful and practical way in everything that we do.

3.0 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 Central Incident Review Group (CIRG) and weekly Low and no Harm group (LnHg) to review incidents as they occur. Our Trust Patient Safety Learning Group (PSLG) was created to give oversight of the Trust's patient safety improvement activity by ensuring actions correlate to learnings.

3.2 PSIRF sets no rules or thresholds to determine what needs to be learned from to inform improvement apart from the national requirements listed in section 7.0, 8.0 and 9.0.

3.3 To fully implement the Framework the Trust has committed to a review of patient safety incidents on an annual basis to allow understanding of where improvements are required.

3.4 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, listed in section 6.0.

3.5 **Stakeholder Engagement** - PSLG has been the sponsor of work associated with PSIRF implementation, and all metrics and discussion have fed into this group for oversight. Several 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. PSLG has reviewed the data and worked to gain a consensus on the Trust focus for the PSIRF plan.

3.6 **Data Sources** - Comprehensive review of data (qualitative and quantitative) was conducted, incorporating information from the following Trust departments:

- Patient Safety Team
- Complaints/Patient Relations
- Academy
- A&E Operations HNY/South/West
- Legal Services / Claims
- Patient Transport Services
- Emergency Operations Centre
- Facilities/Equipment & Devices
- Artificial Intelligence (AI) powered data theming*
  ***Disclaimer** - Users were advised to independently verify the data and consult with relevant experts or professionals before making any decisions based on this information.*

3.7 Where possible we considered what the data was telling us regarding inequalities in patient safety, with particular focus towards underrepresented groups and patients living in social deprivation.

3.8 Thematic review of patient related data was discussed from between 1st November 2024 and 1st February 2025, themes and trends from each individual corporate team has produced rationale for each criterion to be included in this patient safety profile.

3.9 This data was presented to PSLG on 19th February 2025 and suggestions for topics to be included in the safety profile were discussed.

3.10 The final Trust PSIRF topics were agreed by members of PSLG on the 29th April 2025.

3.11 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.

3.12 The Trusts central investigations team will be instrumental in supporting the PSIRF plan and will use 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)

4.0 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 (CGG). Assurance against progress with the PSIRF plan will be reported into Quality Committee with escalations to Board as required. CGG 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.

5.0 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
National PSIRF Requirements	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 the Maternity and Newborn Safety Investigation (MNSI) criteria or Special Healthcare Authority (SpHa) criteria when in place	Refer to MNSI or SpHa for independent PSII	Respond to recommendations as required and feed actions into the quality improvement strategy
	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 needs from their local authority • The incident relates to FGM, Prevent (radicalisation to terrorism), modern slavery and human trafficking or domestic abuse/violence	Refer to local authority safeguarding lead. Healthcare organisations must contribute towards domestic independent inquiries, 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 adults boards	Refer to the YAS designated professionals for child and adult safeguarding
	Child deaths	Refer for Child Death Overview Panel review. Locally-led PSII (or other response) may be required alongside the panel review – organisations should consult 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) Locally-led PSII (or other response) may be required alongside the LeDeR – organisations should consult with this	Create local organisational actions and feed these into the quality improvement strategy

5.3 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: b1465-3.-guide-to-responding-proportionately-to-patient-safety-incidents-v1.2.pdf

6.0 Our Patient Safety Incident Response Plan – Local Trust Focus

6.1 Through our analysis, based on the review of incidents and engagement meetings we have identified four areas of focus that require local patient safety priorities:

	Patient safety incident type or issue	Criteria	Planned response / Lead	Senior Responsible Officer (SRO)	Anticipated improvement route
Patient Safety Incident Investigations (PSII)	**Patient Care & Safety Concerns**	Non conveyance of a patient leading to reattendance within 24 hours AND Major or above harm.	**PSII Patient Safety Team**	**Associate Director for Paramedic Practice**	PSII will generate service and organisational recommendations. Create local safety actions which will feed into the Patient Safety Learning Group workplan. This work will Inform ongoing improvement efforts and learning decisions; it may also inform appropriate purchasing and contractual decisions when relating to services/equipment provided by external agencies.
		A patient experiences deterioration during an unplanned delay episode, such as a hospital handover delay, resulting in moderate or higher levels of patient harm that has the potential to generate significant new learning.			
	Communications & Documentation	Miscommunication between YAS colleagues and any other party which leads to Major or above patient harm	**PSII Patient Safety Team**	**QGAM Group / Senior Leadership Team EOC/IUC/PTS**	
		Incorrect identification of the correct location for a patient during a 999 or 111 call leading to delayed response and major or above harm			
	Medication Safety Concerns	Administration of an incorrect medication, dosage, or via an improper route during a YAS care episode that results in patient harm of moderate severity or greater.	**PSII Patient Safety Team**	**Trust Pharmacist / Medications Safety Officer**	
	Equipment Failures	Unexpected failure of any piece of YAS standard equipment leading to Major or above patient harm because of the failure.	**PSII Patient Safety Team**	**Medical Devices Manager / Fleet and Estates Lead**	
	Exceptional Patient Safety Event	Any unexpected patient safety incident, group of incidents, or identified emerging risks that do not fit within the scope of other priorities but have the potential to generate extensive new learning.	**Proportionate learning response which could be PSII Patient Safety Team**	**Case-by-Case Basis**	Individually determined and fed into trust learning as and where proportionate.

7.0 Our Planned Thematic Analysis

7.1 Thematic analysis is a widely utilised method by researchers for the examination of qualitative data, typically consisting of detailed descriptive data.

	Priority Case Type	Criteria	Planned Response	Number of Responses	Lead Role	Anticipated Improvement Route
Thematic Analysis (TA)	**Medication Safety Concerns**	Quarterly review of all mediation safety incidents in the following order: Q1 – Controlled Drugs Q2 – Non-Controlled Drugs Q3 – Controlled Drugs Q4 – Non-Controlled Drugs	**Thematic Analysis**	**All cases reported in the trust Datix system**	**Medications Safety Officer Patient Safety Team Investigator**	To create actions and recommendations which inform improvements and feed into the PSLG workplan on a quarterly basis.
	Translation Concerns	Biannual review of all incidents associated with communication challenges between YAS colleagues and patients whose first language is not English.	**Thematic Analysis Biannual**	**Random selection of 33% of cases (minimum 3)**	**Patient Safety Team Investigator**	
	Moving and Handling Incidents	Biannual review of incidents associated with injuries caused to both staff or patients and logged as relating to a moving and handling device or procedure.	**Thematic Analysis Biannual**	**Random selection of 33% of cases (minimum 3)**	**Patient Safety team Investigator**	
	Equipment Failures	Biannual review of issues/concerns/failures and faults associated with the 'Corpuls' defibrillation device or its peripherals.	**Thematic Analysis Biannual**	**Random selection of 33% of cases (minimum 3)**	**Patient Safety team Investigator**	

8.0 Our Planned After-Action and Multi-Disciplinary Team Reviews

	Priority Case Type	Criteria	Planned Response	Number of Responses	Lead Role	Anticipated Improvement Route
After Action / Multi-Disciplinary Team Review	Notable Patient Safety Event	Any unexpected patient safety event causing, or with the potential to cause, harm that is outside of the scope of other review methods and has the potential to generate new learning.	**AAR or MDT**	**Cases to be identified by LIRG's**	**Patient Safety Team Investigators QGAM & AOM**	To identify and strengthen areas for improvement. Where appropriate to feed into the PSLG workplan on a quarterly basis
	Fact-Find or Confirmation of PSII decision	Any incident which may be subject to a PSII but requires exploration prior to decision making to establish if events are linked to care provision	**AAR or MDT**	**Ad-Hoc**	**Patient Safety Team Investigators QGAM & AOM**	

9.0 Review and Evaluation

9.1 Incidents managed using the above matrices will form the full suite of PSIRF reviews for the period of the plan; however, regular review and monitoring is in place to ensure gaps do not develop between the ‘known/controlled’ and ‘unknown/uncontrolled’ safety focus of the Trust.

9.2 The following teams/departments/groups are responsible for routine and regular review of ‘unknown/uncontrolled’ Trust activities:

- Clinical Informatics & Audit
- Low and no Harm Group (LnHg)
- Central Incident Review Group (CIRG)
- Local Incident Review Group (LIRG) EOC / IUC / PTS / A&E HNY, WY, SY

9.3 Any change in the ‘unknown/uncontrolled’ should be reviewed by PSLG for relevance and impact on the Trusts current PSIRP.

9.4 The trust commits to reviewing the PSIRP on a yearly basis and to refreshing the local themes as and when appropriate; no less than biennially.

10.0 Appendices

10.1 This framework includes the following appendices:

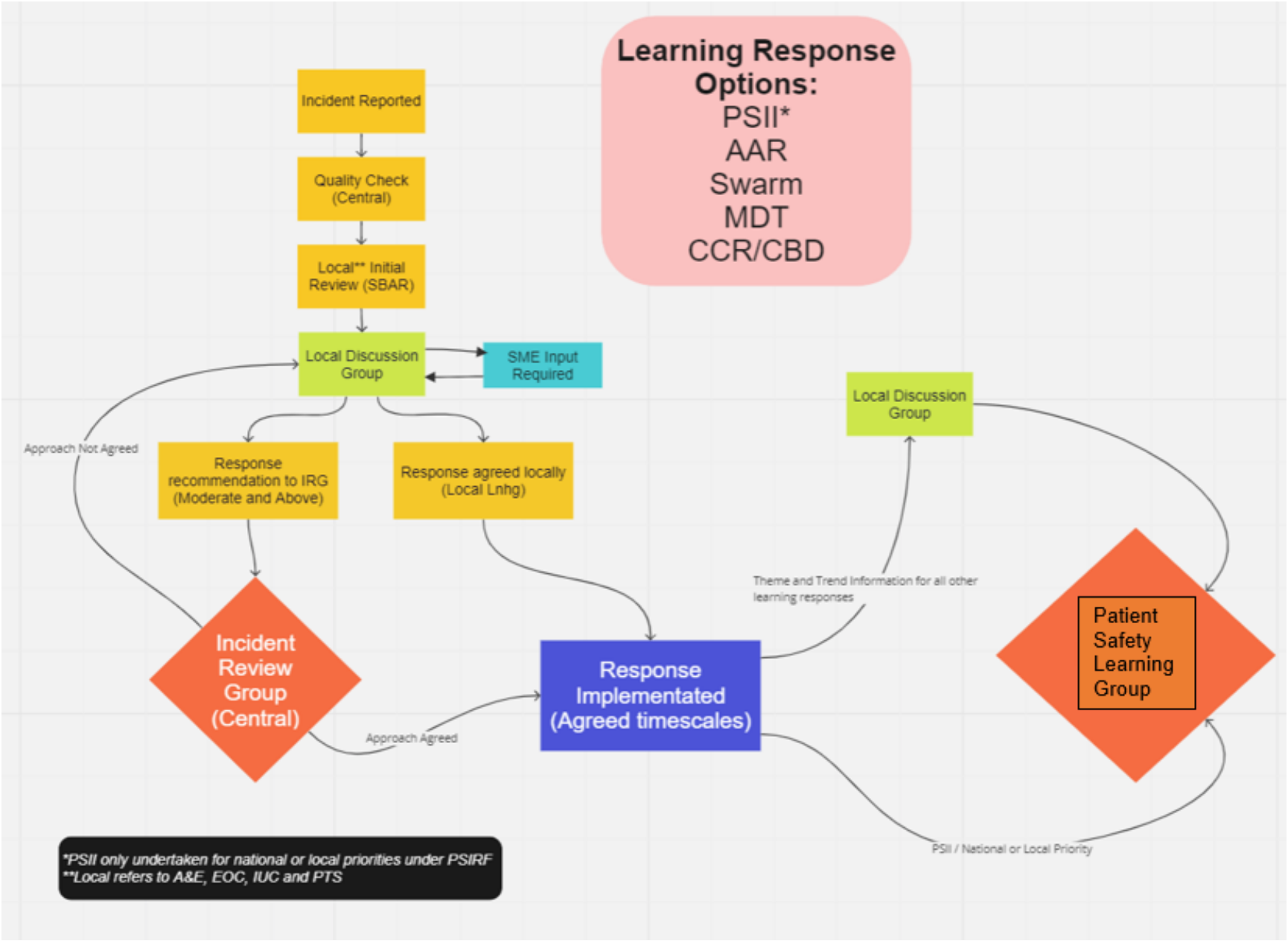
Appendix A – Definition
Appendix B – PSIRF Response Flowchart
Appendix C – Learning Response Toolkit
Appendix D – Thematic Review Flow

Appendix A – Definitions

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.
AOM	Trust Role – **Area Operations Manager**
CGG	Trust Group – **Clinical Governance Group**
CIRG	Trust Group – **Central Incident Review Group**
LeDeR	**Learning from Lives and Deaths – People with a learning disability and autistic people.** The programme was set up as a service improvement project to look at why people are dying and what we can do to change services locally and nationally to improve the health of people with a learning disability and reduce health inequalities. By finding out more about why people died we can understand what needs to be changed to make a difference to people's lives.
LIRG	Trust Group – **Local Incident Review Group**
LnHg	Trust Group – **Low and No Harm Group**
MDT	**Multi Disciplinary Team Review –** The multidisciplinary team (MDT) review supports health and social care teams to identify learning from multiple patient safety incidents (including incidents where multiple patients were harmed or where there are similar types of incidents).
MNSI	**Maternity and Newborn Safety Investigations –** The Maternity and Newborn Safety Investigations (MNSI) programme is part of a national strategy to improve maternity safety across the NHS in England. Maternity and Newborn Safety Investigations (MNSI)
Never Event	Patient safety incidents that are 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. 2018-Never-Events-List-updated-February-2021.pdf
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 conduct 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.
PSLG	Trust Group – **Patient Safety Learning Group**
SpHa	**Special Healthcare Authority –** A special health authority is a preparatory body responsible for putting all the arrangements in place to allow an NHS Commissioning Board to operate successfully as an independent body. It plays a key role in the Government's vision to modernise the health service and secure the best possible outcomes for patients.

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.
TA	**Thematic Review –** A thematic review can identify patterns in data to help answer questions, show links or identify issues. Thematic reviews typically use qualitative rather than quantitative data to identify safety themes and issues. Thematic reviews can sometimes use a combination of qualitative data with quantitative data. Quantitative data may come from closed survey responses or audit, for example.
QGAM	Trust Role – **Quality, Governance and Assurance Manager**

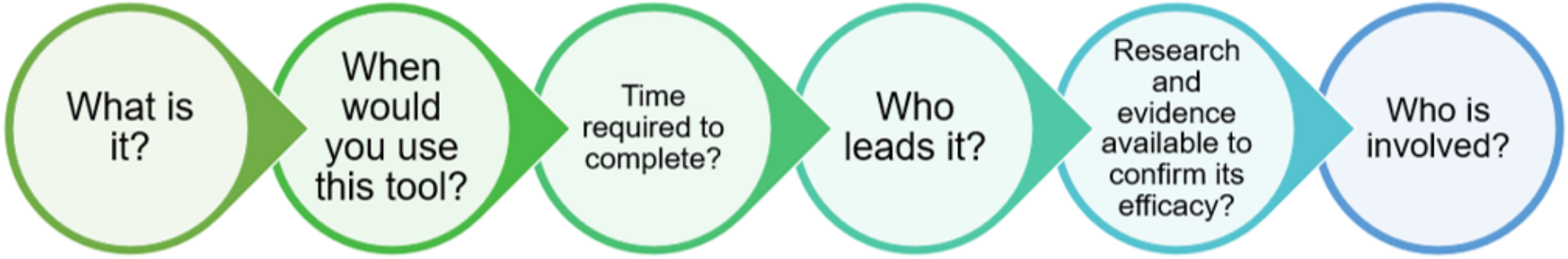
Appendix B - PSIRF Response Flowchart



Appendix C - Learning Response Toolkit

Patient Safety Incident Investigation (PSII)

NHS Yorkshire Ambulance Service NHS Trust



What is it?	When would you use this tool?	Time required to complete?	Who leads it?	Research and evidence available to confirm its efficacy?	Who is involved?
An in-depth review of a single patient safety incident or cluster of events to understand what happened and how.	When there has been serious harm to a patient or patients	Approximately 20 to 80 hours, over several weeks	Undertaken by a trained patient safety investigator who collates data, conducts interviews, undertakes analysis and writes the recommendations report	Extensive research has been undertaken into the structures processes and outcomes of PSII across the world.	People directly involved in the incident, senior clinicians, the patient, or family members of the involved patients.

Strengths?

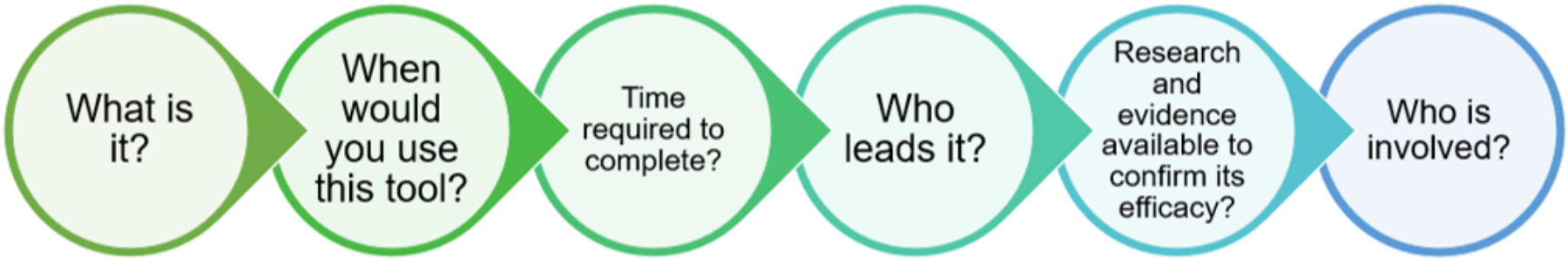
- It is a well-established approach which is widely recognised and valued by patients and their families.
- PSIIs provide a thorough analysis of an event where harm happened and ensure specific causes are identified.
- Responsibility for the investigation and the completion of the actions arising is clearly articulated in the governance arrangements.

Weaknesses?

- Investigations take a long time to complete and actions arising in the PSII report can take many more months to be completed.
- Outcomes are less system focused than other tools.
- The quality of PSIIs varied before PSIRF mandated training for investigators.
- Staff are only involved when they are interviewed, and this can feel very stressful.

SWARM Huddle

NHS Yorkshire Ambulance Service NHS Trust



"A novel rapid approach to RCAs [root cause analysis] to establish a consistent approach to investigate adverse or other undesirable event" (Jing Li et al 2015)

After any event where patient safety was at risk

No more than 30 minutes

Normally chaired by a senior lead who generates a short report.

There is some research literature on its use in healthcare. Link

People directly involved in the incident

Strengths?

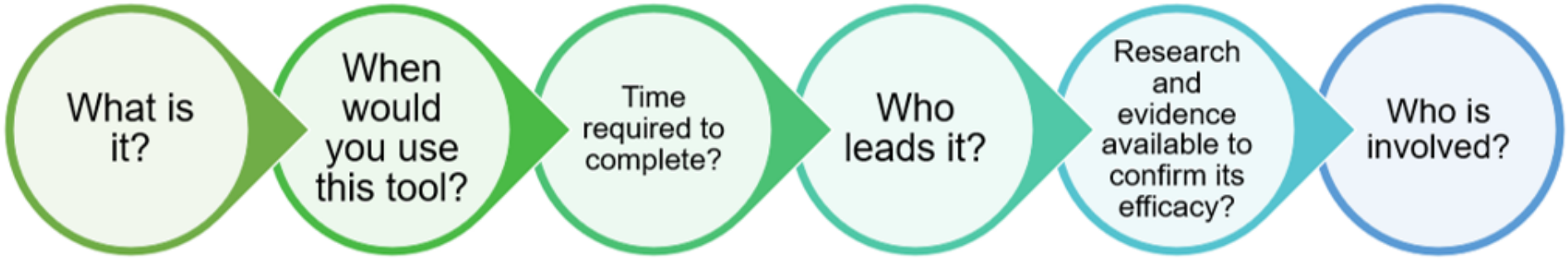
- Immediate learning occurs with early actions identified.
- Connecting immediately after event may reduce social isolation/ruminating/stress for staff.
- Evidence shows it can increase the reporting of incident.
- Quick and responsive.
- Quick and easy to undertake so increases likelihood of being done.
- Reduces key information being lost by its immediacy.

Weaknesses?

- Scope of learning narrowed by limits on who is participating.
- Learning is focused on a single event rather than the interactions in the system that come with wider participation.
- Psychological safety is assumed to be present so full participation may not be achieved.
- It seeks learning to reduce the risk of a single event reoccurring and not wider learning about behaviours, team interactions and system weaknesses.
- Weak governance arrangements for tracking actions and collating learning through many SWARMs.

After Action Review (AAR)

NHS Yorkshire Ambulance Service NHS Trust



A structured, facilitated discussion of an event, the outcome of which gives the individuals involved in the event understanding of why the outcome differed from that expected and the learning to assist improvement. AAR generates insight from the various perspectives of the MDT.

After any event, where patient care or service was not as effective or safe as expected, or when events turned out better than expected.

Likely to take 45 minutes to 90 mins depending on complexity of the issue and the numbers participating.

Led by a facilitator trained in AAR techniques.

Extensive research evidence base available on the structures, processes and outcomes demonstrating its effectiveness in improving team performance and patient safety.

Those directly involved in the event and others connected to them or the patient pathway. YAS also includes a PSP on every AAR where practicable.

Strengths?

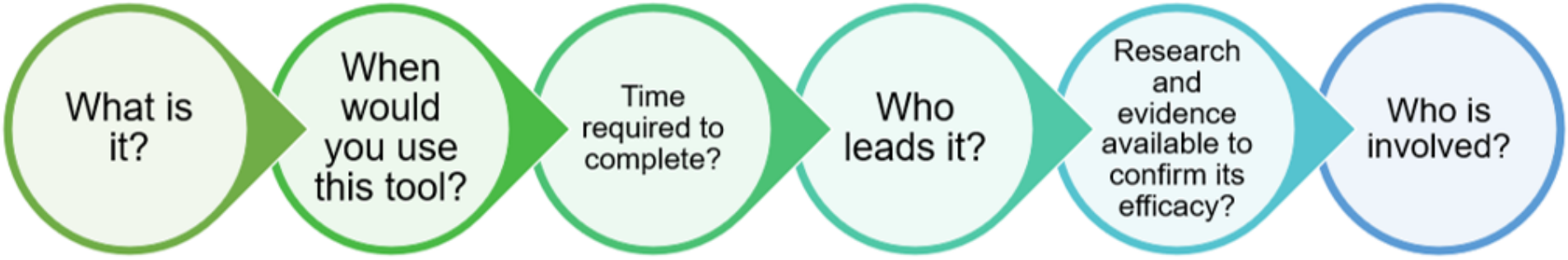
- The individuals learn for themselves what was happening and identify similarities and differences between themselves and others.
- Learning during the AAR is the focus, not the report, with those participating positioned as the agents of change and improvement.
- It's a group learning process, so the interactions between members of the team are available to learn from and improve. This has a strong effect on team performance and patient safety.
- It is highly adaptable, suitable for a wide range of events.
- Psychological safety is actively created and maintained throughout.
- Provides a safe reflective environment which staff experience as supportive, reducing isolation and rumination after events.

Weaknesses?

- Whilst lessons learned and actions arising are shared outwards and upwards, primary responsibility for change rests with those involved reducing central authority.
- There are limited ways to track if individuals have changed their behaviour or completed actions because of the AAR.
- Governance processes for tracking AAR activity and outputs are not established in many providers. This means the value of collated learning may not be available.

Multi-Disciplinary Team (MDT) Review

NHS Yorkshire Ambulance Service NHS Trust



An in-depth process of review, with input from different disciplines, to identify learning from multiple patient safety incidents, and to explore a safety theme, pathway, or process.

After several similar events have occurred, when it's more difficult to collate staff recollections of events, either because of the passage of time or staff availability

No defined time allocated. Likely to include a workshop lasting 2 to 3 hours.

Likely to be led by a patient safety facilitator who will use the MDT review as one source of data for learning about a series of events or a theme

No specific research on the structures, processes and outcome of MDT reviews has been carried out

Those directly involved in these events from the MDT, plus patient safety experts, other senior clinicians

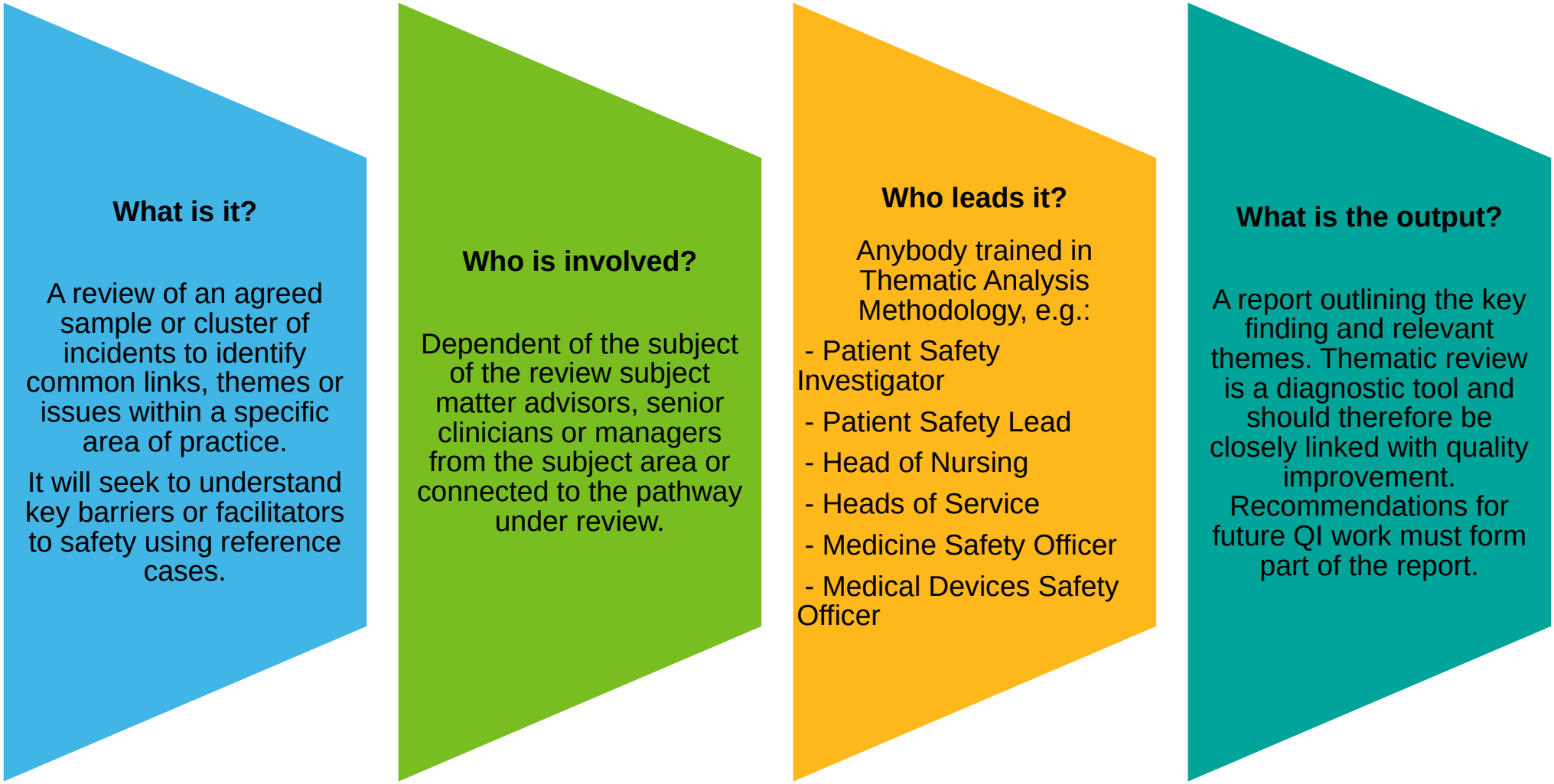
Strengths?

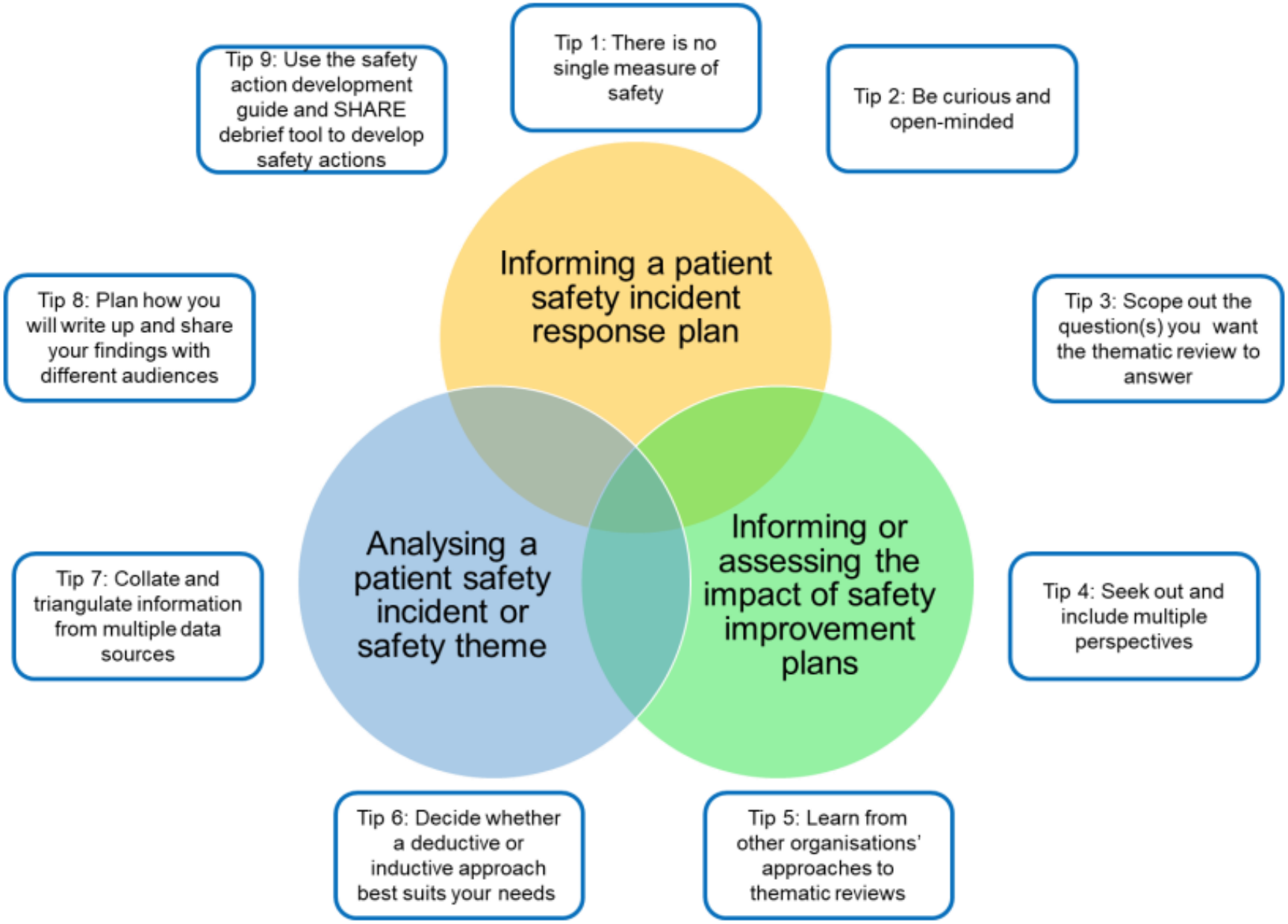
- The participation of many members of the MDT without the spotlight on a single adverse event enables a broad and deep discussion to take place and a system view to be gathered.
- Can be adapted to incorporate the systems engineering initiative for patient safety (SEIPS) framework to structure the review.

Weaknesses?

- Responsibility for learning and acting on the learning primarily rests with the person/s who set up the MDT review reducing the sphere of influence.
- Whilst participants will contribute and learn, it is not the specific purpose of the activity.
- It is a planned event, and it may take many weeks to set up and ensure full MDT representation is available.
- Resource intensive to undertake.

Appendix D - Thematic Review Flow




Tip 1: There is no single measure of safety
Tip 2: Be curious and open-minded
Tip 3: Scope out the question(s) you want the thematic review to answer
Tip 4: Seek out and include multiple perspectives
Tip 5: Learn from other organisations' approaches to thematic reviews
Tip 6: Decide whether a deductive or inductive approach best suits your needs
Tip 7: Collate and triangulate information from multiple data sources
Tip 8: Plan how you will write up and share your findings with different audiences
Tip 9: Use the safety action development guide and SHARE debrief tool to develop safety actions
Informing a patient safety incident response plan
Analysing a patient safety incident or safety theme
Informing or assessing the impact of safety improvement plans