



NHS

**Yorkshire
Ambulance Service**
NHS Trust



Patient Safety Incident Response Policy

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1.2	May 2026	Simon Davies Patient Safety Specialist	D	Additional diagram (15.4) added to provide clarity on upward reporting structure
2.0	May 2026	Risk Team	A	Policy approved within May 2026 Clinical Governance Group

A = Approved D = Draft

Author = Simon Davies, Patient Safety Specialist

Associated Documentation:

- Being Open (Duty of Candour) Policy
- Claims Management Policy
- Courts and Evidence Policy
- Dignity, Civility and Respect at Work Policy
- Disciplinary Policy, Procedure and Guidance
- Disclosure Policy
- Freedom of Information Policy
- Freedom to Speak Up (Raising Concerns) Policy
- Grievance Policy and Procedure
- Incident Management Policy
- Patient Feedback Policy and Associated SOP's
- Patient Safety Incident Response Plan
- Post Incident Care and Support Guidance
- QI Enabling Plan 2024-29
- Risk Management Policy
- Safeguarding Policy

Section	Contents	Page No.
	Staff Summary	4
1.0	Introduction	4
2.0	Purpose	4
3.0	Scope	5
4.0	Our Patient Safety Culture	6
5.0	Patient Safety Partners (PSP)	7
6.0	Addressing Health Inequalities	7
7.0	Engaging and Involving Patients, Families and Staff Following a Patient Safety Incident	8
8.0	Patient Safety Incident Response Planning	9
9.0	Resources and Training to Support Patient Safety Incident Response	9
10.0	Our Patient Safety Incident Response Plan	10
11.0	Timeframes for Learning Responses	11
12.0	Safety Action Development and Monitoring Improvement	11
13.0	Training Expectations for Staff	12
14.0	Implementation Plan	13
15.0	Monitoring Compliance with this Policy	13
16.0	Appendices	14
	Appendix A - Safety Improvement Plans	15
	Appendix B - References	16
	Appendix C - Oversight Roles and Responsibilities	17
	Appendix D - Complaints and Appeals	18

Staff Summary

This policy supports the requirements of the Patient Safety Incident Response Framework (PSIRF) and sets out Yorkshire Ambulance Service NHS Trust's approach to developing and maintaining effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety
There is no remit to apportion blame or determine liability, preventability or cause of death in a response conducted for the purpose of learning and improvement.
Investigations should be conducted with an independent view, with the main aim of identifying where something has gone wrong and how learning can be implemented.
All Trust Policies relating to incident investigation, reference the NHS 'Being Fair' tool (Formally 'Just Culture guide') and promote its use in learning responses where staff members are identified as a contributory factor.
The Trust has recruited a number of 'Patient Safety Partners' to provide oversight and engagement
Diversity and Inclusion are at the heart of the Trust's core values, and our values contribute to making YAS the unique place it is.
A full-time family and staff engagement officer is in post within the central patient safety team who supports colleagues in the governance functions to comply with national regulatory requirements and beyond.
YAS will take a proportionate approach to its response to patient safety events, ensuring the focus is on maximising improvement
A rigorous planning exercise will be undertaken every two years and more frequently if appropriate (as agreed with our integrated care board (ICB) to ensure efforts continue to be balanced between learning and improvement.
The time needed to conduct a response must be balanced against the impact of long timescales on those affected by the incident, and the risk that for as long as findings are not described, action may not be taken to improve safety, or further checks will be required to ensure the recommended actions remain relevant.
Quality Improvement to support embedded learning and improvement following a patient safety investigation is key to improving patient outcomes.
Responsibility for oversight of the PSIRF for provider organisations sits with the Trust Board. Executive lead is the Executive Director of Quality and Chief Paramedic who will hold responsibility for effective monitoring and oversight.

1.0 Introduction

- 1.1 The Patient Safety Incident Response Framework (PSIRF) sets out the NHS approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.
- 1.2 There are four key aims:
- Compassionate engagement and involvement of those affected by patient safety incidents.
 - Application of a range of system-based approaches to learning from patient safety incidents.
 - Considered and proportionate responses to patient safety incidents.
 - Supportive oversight focused on strengthening response system functioning and improvement.

2.0 Purpose

- 2.1 This policy supports the requirements of the Patient Safety Incident Response Framework (PSIRF) and sets out Yorkshire Ambulance Service NHS Trust's approach

to developing and maintaining effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety.

- 2.2 The PSIRF advocates a coordinated and data-driven response to patient safety incidents. It embeds patient safety incident response within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management.
- 2.3 This policy supports development and maintenance of an effective patient safety incident response system that integrates the four key aims of the PSIRF:
- compassionate engagement and involvement of those affected by patient safety incidents.
 - application of a range of system-based approaches to learning from patient safety incidents
 - considered and proportionate responses to patient safety incidents and safety issues
 - supportive oversight focused on strengthening response system functioning and improvement.

3.0 Scope

- 3.1 This policy is specific to patient safety incident responses conducted solely for the purpose of learning and improvement across Yorkshire Ambulance Service NHS Trust. Responses under this policy follow a systems-based approach. This recognises that patient safety is an emergent property of the healthcare system: that is, safety is provided by interactions between components and not from a single component. Responses do not take a 'person-focused' approach where the actions or inactions of people, or 'human error', are stated as the cause of an incident.
- 3.2 There is no remit to apportion blame or determine liability, preventability or cause of death in a response conducted for the purpose of learning and improvement. Other processes, such as claims handling, human resources investigations into employment concerns, professional standards investigations, coronial inquests and criminal investigations, exist for that purpose. The principle aims of each of these responses differ from those of a patient safety response and are outside the scope of this policy. Information from a patient safety response process can be shared with those leading other types of responses, but other processes should not influence the remit of a patient safety incident response.
- 3.3 This policy should be read in conjunction with other Trust policies referencing investigation and incident management, currently these are:
- Incident Management Policy
 - Being Open (Duty of Candour) Policy
 - QI Enabling Plan 2024-29
- 3.4 NB – Policy review takes place on a regular basis therefore reference should be made to the Trust intranet for the most up to date version [Library - Policies - PowerApps](#)
- 3.5 Responses **outside** of this policy include (but are not limited to):
- Complaints, Comments, Concerns, Compliments (4C's)
 - Human Resources Investigations
 - Professional Standards Investigations
 - Coronial Inquests / Claims Management
 - Financial Investigation and Audit

- Safeguarding Concerns
- Information Governance Concerns
- Estates and Facilities Issues

4.0 Our Patient Safety Culture

- 4.1 At Yorkshire Ambulance Service NHS Trust (YAS), we believe improvement is a commitment to learning, developing and implementing best practice to deliver better care and services. This is supported by our Trust value of improvement
- 4.2 Investigations should be conducted with an independent view, with the main aim of identifying where something has gone wrong and how learning can be implemented. The Trust works within the principles of 'No Blame' with a focus on learning, restorative practice and systems learning.
- 4.3 All Trust Policies relating to incident investigation, reference the NHS 'Being Fair' tool (Formally 'Just Culture guide') and promote its use in learning responses where staff members are identified as a contributory factor.
- 4.4 The process of investigating should be conducted with openness and transparency from all involved.
- 4.5 The Trust advocates use of system-based investigation approaches which promotes the avoidance of blame towards individuals.
- 4.6 Encouraging colleagues to utilise Trust incident reporting methods is included in induction for all new starters. Refresher programs are also delivered on an ad hoc basis throughout the year.
- 4.7 The Trust will always encourage and support incident reporting where an incident may have, or is likely to occur which has caused, contributed to or may lead to harm of a patient or colleague – furthermore a learning response should always be considered for patient safety incidents that signify an unexpected level of risk and/or potential for learning and improvement but fall outside the issues or specific incidents described in the organisation's plan.

5.0 Patient Safety Partners (PSP)

Please note that, within the organisation, the acronym 'PSP' is also used to refer to the Professional Standards Panel which is a separate and unconnected workstream.

5.1 The Trust has recruited a number of 'Patient Safety Partners' to provide oversight and engagement with the following processes:

- Supporting improvements to patient safety and the overall patient experience.
- Providing alternative perspective to patient safety – championing the patient, carer and family perspective to ensure a diversity of views support improvements.
- Supporting development and implementation of relevant strategies and policy.
- Supporting compliance monitoring and how safety issues should be addressed – supporting learning lessons and how they are implemented.
- Providing appropriate challenges to ensure learning and change within the Trust by advocating patient perspective and voice.

5.2 This will be achieved through:

- Attending Trust meetings and committees whereby colleagues leading on safety improvement work deliver safety objectives and monitor outcomes that are patient centered.
- Occasional patient facing responsibilities.
- Constructively query staff around the safety of organisational procedures and systems that impact patient and staff safety.
- Being involved in certain aspects of staff training to advocate patient, carer and family perspective on the impact of patient safety.
- Being involved in staff recruitment to help explore a candidate's understanding and commitment to involving patients in their own safety and in the safety governance of the organisation.
- Staffside or recognised trade union support is available to provide independent advice and reassurance to staff in these circumstances, should they wish to access this support.

5.3 This list is not intended to be exhaustive, and it is likely that duties may be altered from time to time considering changing circumstances.

6.0 Addressing Health Inequalities

6.1 YAS prides itself not only on the diverse range of services that it offers as a regional healthcare provider, but also on the diverse range of people within YAS who provide patient care and support the organisation. We are proud of our ability to harness the different experiences, backgrounds and personalities of the people working here in order to create a workplace culture that we all value, and that leads us to providing the best possible care to the people who we serve.



6.2 Diversity and Inclusion are at the heart of the Trust's core values, and our values contribute to making YAS the unique place it is.

6.3 We want to ensure that we continue to be an employer of choice for individuals regardless of their age, disability, gender re-assignment, sexual orientation, religion and belief, sex, race, maternity and pregnancy, and marriage and civil partnerships, social

economic background or any other distinction. We want to deliver high quality services and compassionate care to all patients and service users.

- 6.4 Diversity and inclusion is an integral part of our culture and values and we strive to make them visible in everything we do:
- We aim to attract, select and retain a diverse range of talented people to work at the Trust and value the contribution made by everyone.
 - We embrace the diversity of all our staff, patients, service users, visitors and everyone associated with the Trust to create a harmonious environment where people are comfortable being themselves and are able to realise their full potential.
 - We challenge inequality in all its forms and promote dignity, respect and understanding within the Trust and the wider community.
- 6.5 Engagement of those involved (patients, families/carers, and our people) following a patient safety event is crucial to our patient safety learning responses. We will ensure that we use available tools to include easy read, translation, and interpretation services alongside any other method appropriate to meet their needs and maximise the potential of being involved.
- 6.6 We will look to address health inequalities as part of our safety improvement work, understanding our services provide care to a proportion of the Core20PLUS5 population cohort identified by NHS England (2021). In establishing our future policy and plan we will work to identify variations of inequality by using our population and patient safety data to ensure it is considered as part of the development process for the future.



- 7.0 Engaging and Involving Patients, Families and Staff Following a Patient Safety Incident**
- 7.1 The PSIRF recognises that learning and improvement following a patient safety incident can only be achieved if supportive systems and processes are in place. It supports the development of an effective patient safety incident response system that prioritise compassionate engagement and involvement of those affected by patient safety incidents (including patients, families, and staff).
- 7.2 This involves working with those affected by patient safety incidents to understand and answer any questions they have in relation to the incident and signpost them to support as required.
- 7.3 The Trust will, in accordance with fair 'no blame' culture, continue to promote, support, and encourage incident reporting, including near misses and all levels of harm into the RLDatix system.

- 7.4 A full-time family and staff engagement officer is in post within the central patient safety team who supports colleagues in the governance functions to comply with national regulatory requirements and beyond.
- 7.5 Support for colleagues, patients and families involved in adverse events is provided under the following Trust policies and can be found on the Trust Library, [Library - Policies - PowerApps](#):
- Being Open (Duty of Candour) Policy
 - Health and Wellbeing Guidance
 - Post Incident Care and Support Guidance
 - Staffside or recognised trade union colleagues are available

8.0 Patient Safety Incident Response Planning

- 8.1 PSIRF supports organisations to respond to patient safety events and issues in a way that maximise learning and improvement, rather than basing responses on arbitrary and subjective definitions of harm. Beyond nationally set requirements, we can explore patient safety events relevant to their context and the populations we serve rather than only those meeting a defined threshold.
- 8.2 YAS will take a proportionate approach to its response to patient safety events, ensuring the focus is on maximising improvement. To fulfil this, we will proactively undertake planning of our current resources for patient safety learning response and our existing safety improvement workstreams.
- 8.3 Our Patient Safety Incident Response Plan (PSIRP) will detail how this will be achieved alongside how we intend to meet both National requirements and our YAS Local Priorities for patient safety incident responses.

9.0 Resources and Training to Support Patient Safety Incident Response

- 9.1 YAS has committed to ensuring that we fully embed PSIRF and meet the national training requirements. We have utilised NHS England Patient Safety Response Standards (2022) to provide resources and the training required for this to happen.
- 9.2 We will have governance arrangements in place to ensure patient safety learning responses are not led by YAS staff who were involved in the patient safety event itself. Responsibility for patient safety learning responses from our locally agreed YAS priorities sits with the Patient Safety Team.
- 9.3 Patient Safety Learning Responses (PSLRs) sitting outside of our priorities will be led by suitable senior leaders within the relevant service lines. Patient Safety Incident Learning Response Leads will have an appropriate level of seniority to influence within the Trust; this may depend on the nature and complexity of the patient safety event and the learning response required.
- 9.4 The governance arrangements will ensure patient safety learning responses are not undertaken by staff working in isolation. The Patient Safety Incident Response Team will support patient safety learning responses wherever possible and can provide advice on cross-system and cross-area work where this is required.
- 9.5 A training needs analysis will be continuously monitored to ensure that all individuals responsible for responding to and supporting patient safety events maintain current competencies. This includes colleagues working in the roles of Quality Governance

Assurance Manager (QGAM) / Quality Governance Assurance Coordinator (QGAC) as well as members of the patient safety team. Elements of the Patient Safety Syllabus are integrated into the Trust's statutory and mandatory training programmes for all staff, with compliance regularly tracked through Trust reporting mechanisms.

- 9.6 Our people affected by patient safety events will be afforded the necessary support and given time to participate in patient safety learning responses. All YAS leaders will work within our 'being fair' principles and utilise other teams to ensure our people are supported. YAS service lines will ensure processes are adopted so leaders work within this framework to ensure psychological safety.
- 9.7 We will utilise both internal and (where necessary) external subject matter experts with relevant experience, knowledge, and skills.

10.0 Our Patient Safety Incident Response Plan

- 10.1 Our 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 is not a permanent set of rules that cannot be changed. We will remain flexible and consider the specific circumstances in which each patient safety incident occurred and the needs of those affected, as well as the plan.
- 10.2 Reviewing our Patient Safety Incident Response Policy and Plan
- 10.2.1 Our patient safety incident response plan is a 'living document' that will be appropriately amended and updated as we use it to respond to patient safety incidents. We will review the plan every 12 to 18 months to ensure our focus remains up to date; with ongoing improvement work our patient safety incident profile is likely to change. This will also provide an opportunity to re-engage with stakeholders to discuss and agree any changes made in the previous 12 to 18 months.
- 10.2.2 Updated plans will be published on our website, replacing the previous version.
- 10.2.3 A rigorous planning exercise will be undertaken every two years and more frequently if appropriate (as agreed with our integrated care board (ICB) to ensure efforts continue to be balanced between learning and improvement. This more in-depth review will include reviewing our response capacity, mapping our services, a wide review of organisational data (for example, patient safety incident investigation (PSII) reports, improvement plans, complaints, claims, staff survey results, inequalities data, and reporting data) and wider stakeholder engagement.
- 10.3 Patient safety incident reporting arrangements and Patient safety incident response decision-making
- 10.3.1 Please refer to the Incident Management Policy - [Library - Policies - PowerApps](#)
- 10.4 Responding to cross-system incidents/issues
- 10.4.1 'Quality and Professional Standards' colleagues liaise regularly with external organisations on matters relating to cross-system incidents.
- 10.4.2 The Trust has processes in place to progress outbound and inbound service to service queries which are managed via the Quality team and Patient Relations concurrently.

- 10.4.3 Reciprocal support will be provided to any agency requesting cross-system working, with special arrangements in place with national bodies such as the Healthcare Services Safety Investigations Body (**HSSIB**), Maternity and Newborn Safety Investigations (**MNSI**), Health and Safety Executive (**HSE**), Reporting of Injuries, Diseases and Dangerous Occurrences Regulation (**RIDDOR**) and Medicines and Healthcare Products Regulatory Authority (**MHRA**).
- 10.4.4 The 'National Patient Safety Learning Group' (**NPSLG**) provides system wide learning and oversight which reports into the Quality Improvement, Governance and Risk (QGARD) workstream within the overarching strategic framework of the Association of Ambulance Chief Executives (**AACE**).

11.0 Timeframes for Learning Responses

- 11.1 Timescales **must** be set where possible for all response methods.
- 11.2 A response must start as soon as practical after an incident is identified and usually completed within one to three months. The timeframe for completing a PSII should be agreed with those affected by the incident, as part of setting the terms of reference for the PSII, provided they are willing and able to be involved in that decision.
- 11.3 PSII's (and other local responses) should take no longer than six months, but this must not become a new default target. If an organisation's local responses are often taking more than 6 months, or exceeding timeframes set with those affected, then processes should be reviewed to understand how timeliness can be improved. In exceptional circumstances (e.g. when a partner organisation requests an investigation is paused), a longer timeframe may be needed to respond to an incident. In this case, any extension to timescales should be agreed with those affected (including the patient, family, carer, and staff).
- 11.4 The time needed to conduct a response must be balanced against the impact of long timescales on those affected by the incident, and the risk that as long as findings are not described, action may not be taken to improve safety, or further checks will be required to ensure the recommended actions remain relevant. Where external bodies (or those affected by patient safety incidents) cannot provide information, to enable completion within six months or the agreed timeframe, the local response leads should work with all the information they have to complete the response to the best of their ability; it may be revisited later, should new information indicate the need for further investigative activity.
- Indicative local timeframes are below:
 - After Action Review (AAR): 14 working days
 - Swarm Huddle: Within 72 hours of incident
 - Multi-Disciplinary Team (MDT): As soon as practicable
 - Clinical Case Review (CCR) / Clinical Based Discussion (CBD): Within 4 weeks of incident (per policy)
 - Patient Safety Incident Investigation (PSII): 60 – 90 working days
 - Please refer to the Incident Management Policy - [Library - Policies - PowerApps](#)

12.0 Safety Action Development and Monitoring Improvement

- 12.1 Learning response methods enable the collection of information to acquire knowledge. This is important, but it is only the beginning. A thorough human factors analysis of a patient safety incident does not always translate into better safety actions to reduce risk.

You must move from identifying the learning to implementation of the lessons. Without an integrated process for designing, implementing, and monitoring safety actions, attempts to reduce risk and potential for harm will be limited.

- 12.2 The process starts by identifying and agreeing those aspects of the work system where change could reduce risk and potential for harm (i.e. areas for improvement' or system issues). Actions to reduce risk (i.e. safety actions) are then generated in relation to each defined area for improvement. Following this, measures to monitor safety actions and the review steps are defined.
- 12.3 The term 'areas for improvement' is used instead of 'recommendations' to reduce the likelihood of solutionising at an early stage of the safety action development process.
- 12.4 Understanding contributory factors and work as done should not be confused with developing safety actions. Areas for improvement set out where improvement is needed without defining how that improvement is to be achieved. Safety actions in response to a defined area for improvement depend on factors and constraints outside the scope of a learning response.
- 12.5 Quality Improvement to support embedded learning and improvement following a patient safety investigation is key to improving patient outcomes. Close links have been and will continue to be developed and maintained with the Quality Improvement team. PSIRF provides an opportunity to strengthen this and for QI & patient safety functions to work hand in hand.
- 12.6 Monitoring improvements relating to incident / actions, and progression of learning responses will be maintained via Patient Safety Learning Group (Quality Governance Forum from April 2026).

12.7 Please refer to the Incident Management Policy - [Library - Policies - PowerApps](#)

13.0 Training Expectations for Staff

- 13.1 YAS has invested in one of the nationally mandated training providers from NHS England to ensure those with responsibility for responding and supporting patient safety events had adequate skills and knowledge to support those involved.
- 13.2 All staff directly involved with patient safety investigations will be expected to maintain their skills and knowledge by means of routine CPD and updates in line with the national 'Patient Safety Incident Response Standards', making use of personally allocated training budgets and departmental funds as and when necessary (diagram 1).

(Diagram 1 - <https://www.england.nhs.uk/long-read/patient-safety-incident-response-standards/>)

Topic	Minimum duration	Content	Learning response leads	Engagement leads	Those in PSIRF oversight roles
Systems approach to learning from patient safety Incidents	2 days/ 12 hours	Introduction to complex systems, systems thinking and human factors Learning response methods: including interviewing and asking questions, capturing work as done, data synthesis, report writing, debriefs and after-action reviews Safety action development, measurement, and monitoring	Yes		
Oversight of learning from patient safety incidents	1 day/ 6 hours	NHS PSIRF and associated documents Effective oversight and supporting processes Maintaining an open, transparent and improvement focused culture PSII commissioning and planning			Yes

Involving those affected by patient safety incidents in the learning process	1 day/ 6 hours	Duty of Candour Just Culture Being open and apologising Effective communication Effective involvement Sharing findings Signposting and support		Yes	
Patient safety syllabus level 1: Essentials for patient safety (for all staff)	eLearning	Listening to patients and raising concerns The systems approach to safety: improving the way we work, rather than the performance of individual members of staff Avoiding inappropriate blame when things don't go well Creating a just culture that prioritises safety and is open to learning about risk and safety	Yes	Yes	Yes
Patient safety syllabus level 1: Essentials for patient safety (for boards and leadership teams)	eLearning	The human, organisational and financial costs of patient safety The benefits of a framework for governance in patient safety Understanding the need for proactive safety management and a focus on risk in addition to past harm Key factors in leadership for patient safety The harmful effects of safety incidents on staff at all levels			Yes
Patient safety syllabus level 2: Access to practice	eLearning	Introduction to systems thinking and risk expertise Human factors Safety culture	Yes	Yes	Yes
Continuing professional development (CPD)	At least annually	To stay up to date with best practice (e.g. through conferences, webinars, etc) Contribute to a minimum of two learning responses	Yes	Yes	Yes

13.3 Monitoring individual compliance will be achieved via annual appraisals and team management.

14.0 Implementation Plan

14.1 The latest approved version of this document will be posted on the Trust Intranet site for all members of staff to view. New members of staff will be signposted to how to find and access this guidance during Trust Induction.

15.0 Monitoring Compliance with this Policy

15.1 The incident module of Datix will serve as a repository for information relating to PSIRF compliance, relying on accurate and timely reporting and maintenance.

15.2 The effectiveness of this policy is monitored against adherence to national frameworks and requirements. Key Performance Indicators (KPIs) based on national and local standards have been agreed and performance against these KPIs is monitored through reports to executive committees and through dashboards.

15.3 Audit, assurance activities, and information related to PSIRF, this policy, and its components are regularly reported to the Patient Safety Learning Group (PSLG).

15.4 The Trust have a defined governance structure for PSIRF with a clear line of sight to the Trust Board. This is defined in the Patient Safety Learning Group terms of reference and in the Incident Management Policy, as detailed below:



16.0 Appendices

- 16.1 This Policy includes the following appendices:
- Appendix A – Safety Improvement Plans
 - Appendix B – References
 - Appendix C – Oversight Roles and Responsibilities
 - Appendix D – Complaints and Appeals

Appendix A – Safety Improvement Plans

The PSIRP details how the Trust will ensure patient safety incidents are investigated in a holistic, and inclusive way to identify key learning and safety actions which will reduce risk, improve safety / quality of services and quality of patient outcomes.

The patient safety themes for the relevant period are clearly detailed in the PSIRP.

QI Strategy Document – Plan on a page

QI – Yorkshire Ambulance Service NHS Trust

Plan on a page

Our Strategy 2024-29 Great Care, Great People, Great Partner



QI Enabling Plan

'We strive to **excel together** so we can find ways to improve and innovate, relentlessly pursuing excellence in what we do.'



If we... adopt quality improvement as the primary method for addressing challenges.

We will... create optimum conditions for continuous improvement and high performance.

So that... we can provide high quality health and care services that meet the evolving needs of our patients and communities. [NHS IMPACT](#)

Appendix B – References

- Care Quality Commission (2022) *Regulation 20: Duty of candour (regulation in full)*. Available at: [Regulation 20: Duty of candour \(regulation in full\) - Care Quality Commission](#) (Accessed: 31st Dec 2025)
- Improvement Academy (2022) *The Yorkshire contributory factors framework*. Available at [Yorkshire Contributory Factors Framework - Improvement Academy](#) (Accessed: 31st Dec 2025).
- NHS England (2022) *Patient Safety Incident Response Framework supporting guidance – Engaging and involving patients, families and staff following a patient safety incident*. Available at: [B1465-2.-Engaging-and-involving...-v1-FINAL.pdf](#) (Accessed: 31st Dec 2025).
- NHS England (2022) *Patient Safety Incident Response Framework supporting guidance – Guide to responding proportionately to patient safety incidents*. Available at: [b1465-3-guide-to-responding-proportionately-to-patient-safety-incidents-v1.3.pdf](#) (Accessed: 31st Dec 2025).
- NHS England (2022) *Patient Safety Incident Response Framework supporting guidance – Oversight roles and responsibilities specification*. Available at: [B1465-4.-Oversight-roles-and-responsibilities-specification-v1-FINAL.pdf](#) (Accessed: 31st Dec 2025).
- NHS England (2022) *Safety action development guide*. Available at [B1465-Safety-action-development-v1.1.pdf](#) (Accessed: 31st Dec 2025).
- NHS England (2024) *Patient safety incident response standards*. Available at [NHS England » Patient safety incident response standards](#) (Accessed: 31st Dec 2025).
- NHS England (2025) *Being fair tool: Supporting staff following a patient safety incident*. Available at: <https://www.england.nhs.uk/wp-content/uploads/2025/05/prn01822-i-being-fair-tool.pdf> (Accessed: 31st Dec 2025).
- NHS England (2025) *Patient safety healthcare inequalities reduction framework*. Available at [NHS England » Patient safety healthcare inequalities reduction framework](#) (Accessed: 31st Dec 2025)

Appendix C – Oversight Roles and Responsibilities

“When working under PSIRF, NHS providers, integrated care boards (ICBs) and regulators should design their systems for oversight “in a way that allows organisations to demonstrate [improvement], rather than compliance with prescriptive, centrally mandated measures”. To achieve this, organisations must look carefully not only at what they need to improve but also what they need to stop doing (e.g., panels to declare or review Serious Incident investigations). Oversight of patient safety incident response has traditionally included activity to hold provider organisations to account for the quality of their patient safety incident investigation reports. Oversight under PSIRF focuses on engagement and empowerment rather than the more traditional command and control.”

Responsibility for oversight of the PSIRF for provider organisations sits with the Trust Board. Executive lead is the Executive Director of Quality and Chief Paramedic who will hold responsibility for effective monitoring and oversight.

The Trust is committed to working with the Integrated Commissioning Boards and other national bodies as required.

Oversight and assurance arrangements will be developed through joint planning and arrangements must incorporate the key principles detailed in the guidance namely:

1. Compassionate engagement and involvement of those affected by patient safety incidents.
2. Policy, planning and governance.
3. Competence and capacity.
4. Proportionate responses.
5. Safety actions and improvement.

Appendix D – Complaints and Appeals

The Trust's Patient Safety Specialist can be contacted for an informal conversation about this policy, or the process in general.

They can be contacted by emailing yas.siri-yas@nhs.net

Formal queries from patients or families relating to the Trust's arrangements for responding to patient safety incidents, should be lodged through the public complaint's procedure using the following routes:

[Contact Us | Yorkshire Ambulance Service \(yas.nhs.uk\)](#)

Raising a Concern or Complaint for 999 or Patient Transport Service

Phone 0330 678 4140

Email yas.patientrelations@nhs.net

Patient Relations Team

Yorkshire Ambulance Service NHS Trust

Springhill 2

Brindley Way

Wakefield 41 Business Park

Wakefield

WF2 0XQ

Raising a Concern or Complaint for NHS 111

Phone 0330 678 4140 option 2

Email yas.111governance@nhs.net

NHS 111 Clinical Governance and Quality Team

Yorkshire Ambulance Service NHS Trust

Springhill

Brindley Way

Wakefield 41 Business Park

Wakefield

WF2 0XQ