NHS
South East Coast Ambulance Service
NHS Foundation Trust

Patient Safety Incident Response Plan 2024/25

South East Coast Ambulance Service NHS Foundation Trust

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Part One


EMERGENCY
AMBULANCE
999
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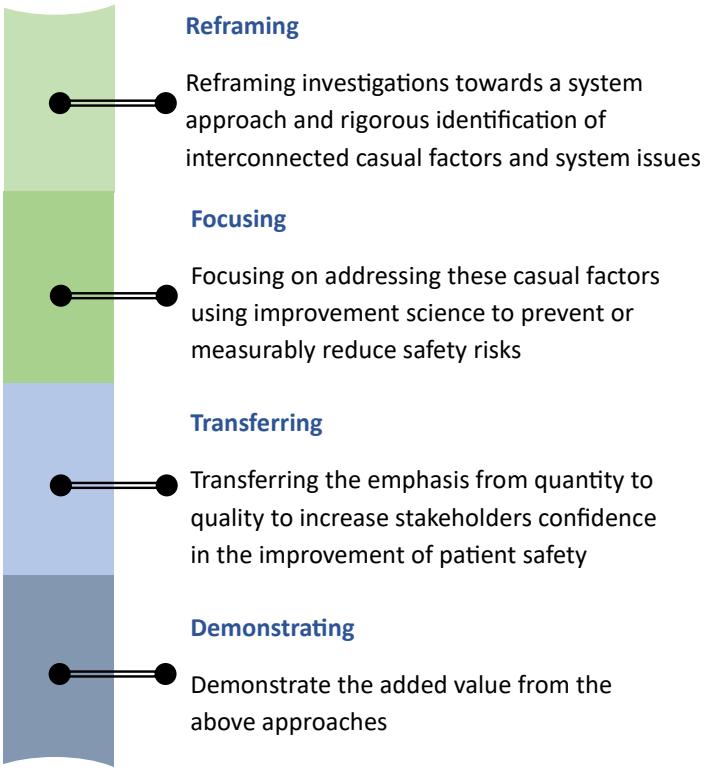
Introduction

This Patient Safety Incident Response Plan (PSIRP) sets out how South East Coast Ambulance Service NHS Foundation Trust (We) intends to respond to patient safety incidents over these next 12 to 18 months. The plan is live and may be subject to change. We will remain flexible and consider the specific circumstances in which patient safety incidents occur and the needs of those affected.

This plan will help us measurably improve the value of both local and cross-system patient safety incident investigations (PSII's) by:



About us

Our call centre staff are trained to assess patients over the phone and respond with the most appropriate response to meet the needs of patients. This could be:

- An emergency ambulance response for life-threatening situations
- A Critical Care Paramedic who can provide treatment on scene for the critically injured.
- A Paramedic Practitioner who can provide specialist treatment in person or by phone
- Clinical advice provided over the phone by a GP, Nurse, or Paramedic when appropriate.
- We also work with our partners to provide referrals to a GP, Nurse, Mental Health, or Maternity team.

We have **110 sites** across the 3,600 miles of Kent and Medway, Surrey, Sussex and North East Hampshire

We have over **5,000** employees at SECAmb from 49 nations

We have **two** Emergency Operational Call Centres that include 999 and 111 services

We receive over 2.1 million calls per year, responding to over 700,000 incidents

Our Stakeholders

We aspire to be a trusted partner in our region and will continue to embrace this philosophy, whilst developing our Patient Safety Incident Response Plan.

We recognise we have several key partners and prioritise engagement with those directly linked to our 999 and 111 services such as:

- MEDDocc
- HERE Brighton
- ABC Healthcare Ltd
- Practice Plus Surrey
- IC24
- Kent, Surrey, Sussex Air Ambulance
- Private Ambulance Providers

We are committed to identifying and supporting cross-provider, or cross-system patient safety incidents to make healthcare safer for everyone.

We have also developed a 'PSIRF Ambulance Network' and aim to facilitate the sharing of learning across this network with other NHS Ambulance Trusts.

We developed and utilised this stakeholder engagement map when defining our safety profile and improvement plans, through workshops, presentations, and face-to-face meetings.

Keep completely informed	Manage most thoroughly
Senior Management Group	Consultant Paramedics
Serious Incident Group	Operating Unit(s)
Quality Governance Group	Patient Experience Group
Trust Board	Ambulance PSIRF Network
Integrated Care Board	Staff Networks
Learning from Death Group (LfD)	Emergency Operations Centre / 111 Teams
Quality, Patient Safety Committee	Subject matter experts i.e., safeguarding / IPC etc
Freedom to Speak Up Guardians (F2SU)	Health Watch

Minimal contact	Anticipate and meet needs
Coroner	System providers
CQC	SECAmb Legal Team
Trust Governors	Local Authority

Part Two

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Defining our patient safety incident profile

We have profiled our patient safety incident risks using three years of organisational data from patient safety incident reports (36,000 DATIX reports), complaints, freedom to speak up reports, mortality reviews, Prevention of Future Deaths (PfD) reports, clinical audit, staff survey results, claims and risk assessments.

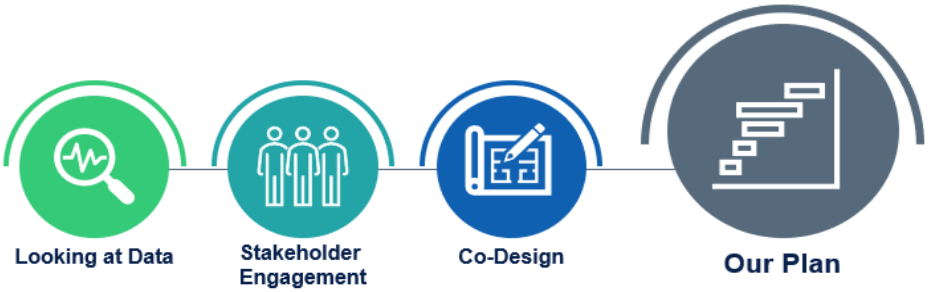
The Trusts Incident Management and Response Steering Group engaged with Staff Network Chairs, subject matter experts, representatives from the Patient Experience Group, and Clinical and Operational teams to identify our priorities.

Our plan was consulted internally via leadership team meetings at each Operating Unit, the Trust's Patient Safety Oversight Group (PSOG), Quality Governance Group (QGG), Quality and Patient Safety Committee (QPSC), Trust Board and externally with Surrey Heartlands Integrated Care Board (ICB), as our lead commissioner.

We have identified themes where the systemic causes are believed to be well understood. Through this elimination process, these five priorities remain due to the risk they continue to pose. It is believed further learning can be extracted using the Systems Engineering Initiative for Patient Safety (SEIPS) framework. Our plan enables equal focus on every incident regardless of harm.

Priorities identified
ST Segment Elevation Myocardial Infarction
Prioritising safe discharge
Inter-Facility Transfer (IFT)
Delays to 'hands on chest'

We acknowledge the value in recognising emerging themes and remaining flexible with our priorities. Our policy reflects how our Incident Review Groups will do this at system-level.



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Improving our patient safety culture

Research into organisational safety has repeatedly found that an open and transparent culture, where colleagues feel able to report incidents and raise concerns without fear of recrimination, is essential to improving safety.

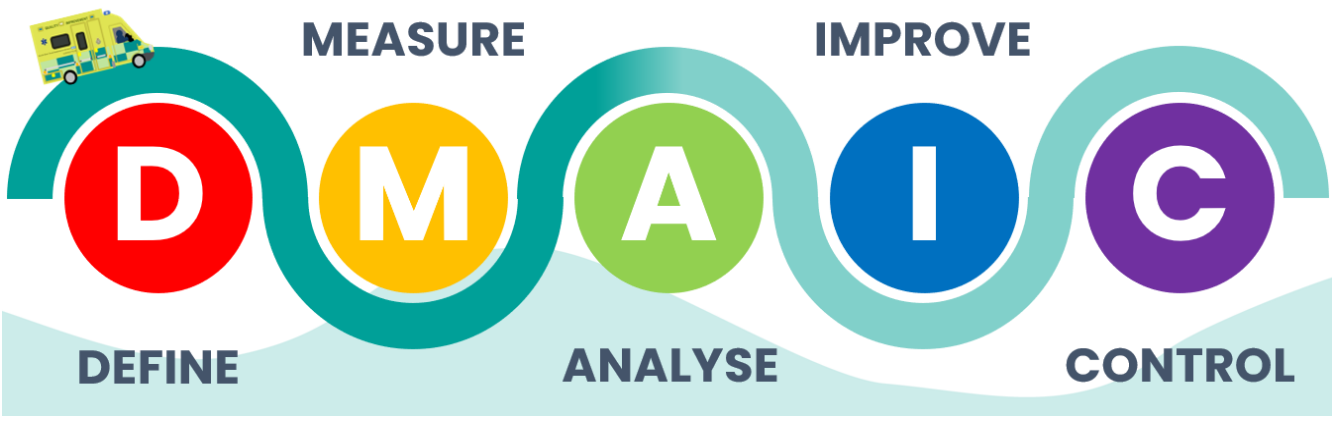
We encourage and support incident reporting where any member of staff feels something has happened, or may happen, which has led to, or may lead to, harm to patients (or staff). We are empowering our managers and leaders to respond directly, and support change in local areas, while also sharing learning across the Trust. The Trust promotes a 'just culture' approach to any work planned or underway to improve patient safety.

Defining our patient safety improvement profile

We recognise that the findings from learning responses including Patient Safety Incident Investigations (PSIIs), and other related activities must be translated into effective and sustainable actions that reduces risk to our patients.

To achieve this, we will apply knowledge of the science of patient safety and improvement to develop a robust patient safety improvement plan.

We have begun rolling out our Quality Improvement training using the 'Define, Measure, Analyse, Improve and Control (DMAIC) methodology to provide staff with the skills to initiate sustainable improvement at every level of the organisation in line with our Quality Improvement strategic aim.



Several strategic programmes and projects as well as locally designed patient safety improvement plans are underway across the Trust.

These relate to full plans, rather than individual actions, designed and prescribed to address known issues with all of them incorporating previous PSIs, review, audit, or risk assessment.

Our Patient Safety incident profile identified harm related to delays in call-answering, ambulance attendance and issues with triage, as an area of concern. In line with the Patient Safety Incident Response Framework, our focus will be on sustainable, meaningful quality improvement in this area, and this has begun.

We are developing a learning framework to complement our co-designed patient safety incident response plan. We aim to identify 'best practice' and 'outstanding care' through our learning responses and not solely following patient safety incidents. Whilst the learning framework remains in development, the Trust will continue to utilise current methodology, such as clinical bulletins, short videos, and face to face training at key skills.

The Improvement Journey for our current priorities has commenced and will be monitored by the groups below, reporting to the QGG, as per our PSIRF policy.

The PSOG will be responsible for testing the effectiveness of improvement workstreams derived from new learning.

No.	Incident Type – PSIRF priorities	Monitoring Group
1	ST Segment Elevation Myocardial Infarction (STEMI)	Quality Governance Group
2	Prioritising safe discharge	Post-discharge review project
3	Inter-Facility Transfer (IFT)	IFT QI project
4	Delays to 'hands on chest'	Cardiac arrest improvement plan

Part Three

Our patient safety incident response plan: national requirements

A core cohort of staff are compliant with the standards set out in the patient safety syllabus, to support our transition. Clinical and Operational staff from each ICS footprint were invited to join corporate colleagues completing the core modules, delivered by an approved NHSE supplier. Phase 1 of the roll out was completed in Q4, 2023/24. Training compliance in year one will be monitored by the Incident Reporting and Management Steering Group before moving to the System Governance Group to become business as usual.

Core Modules

- Patient safety syllabus level 1: Essentials for patient safety
- Patient safety syllabus 2: Access to practice
- Involving those affected by patient safety incidents in the learning process
- System approach to learning from patient safety incidents
- Oversight of learning from patient safety incidents

The Trust recognise the Patient Safety Syllabus and have one nominated Patient Safety Specialist with additional staff undertaking the patient safety specialist training being delivered nationally.

Nationally defined incidents requiring local PSII

Patient safety incident type	Required response	Anticipated improvement route
Incidents that meet the criteria set in the Never Events list 2021	PSII	Create local organisational actions and feed these into the quality improvement strategy
Incidents that meet the 'Learning from Deaths' criteria; that is, deaths clinically assessed as more likely than not due to problems in care	As guided by local Incident Review Group (IRG) unless solely related to ambulance response delay, where local management may be appropriate	Create local organisational actions and feed these into the quality improvement strategy

Nationally defined priorities for referral to other bodies or teams for review and/ or PSII

Patient safety incident type	Requirement
Maternity and neonatal incidents: 'Each Baby Counts', Maternal Deaths	Healthcare Services Safety Investigation Branch (HSSIB)
Maternity and neonatal incidents: all cases of severe brain injury	NHS Resolution's Early Notification Scheme
Maternity and neonatal incidents: all cases of severe brain injury all perinatal and maternal deaths	Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE)
Mental health related homicides by persons in receipt of mental health services or within 6 months of their discharge	NHSE Regional independent investigation team (RIIT)
Child deaths	Child Death Overview Panel (CDOP)
Deaths of persons with learning disabilities	Learning from lives and deaths – people with learning disabilities and autistic people (LeDeR)
Safeguarding incidents	Local authority
Deaths of patients in custody, in prison or on probation where healthcare is/was NHS funded and delivered through an NHS contract	Prison and Probation Ombudsman and Care Quality Commission (CQC)

Our patient safety incident response plan: local focus

Locally defined incidents requiring local PSII

Based on the local situational analysis and review of the local incident reporting profile, local priorities for PSII have been agreed by the Trust for the next 12 to 18 months. These local priorities will be reviewed on an ongoing basis via the Patient Safety Oversight Group with a formal review of the PSIRP at no later than 18 months from the date of issue.

We will complete at least **one PSII** for each of our 5 priorities. Additional PSII's where learning may be extracted will be considered by our Incident Review Group(s). The PSOG is responsible for PSII closure, at per our policy.

Patient safety incident type	Planned response	Anticipated improvement route
ST Segment elevation myocardial infarction (STEMI)	PSII where STEMI is not recognised, managed appropriately and/or conveyed to the most appropriate receiving centre	Feed into clinical pathways improvement work
Prioritising safe discharge	PSII where concerns are raised following discharge on scene including 'hear and treat'	Feed into Trust wide improvement plan utilising QI methodology
Delays to 'hands on chest'	PSII where a patient safety incident occurs where there is a delay initiating CPR by EOC once a cardiac arrest is identified	Feed into Trust wide improvement plan utilising QI methodology
Inter facility transfer (IFT)	PSII where a patient safety incident occurs when the service is unable to complete an IFT in a timely manner	Feed into Trust wide improvement plan utilising QI methodology

Locally defined incidents requiring alternative response

Patient safety incident type	Planned response	Anticipated closure route
Infection Prevention and Control Incident	Review at Incident Review Group and support partners with system bases learning response	Commissioning IPC Panel

Locally defined emergent patient safety incidents requiring PSII.

The Incident Review Group have a responsibility to monitor and respond to emerging themes. A PSII should be considered when an unexpected patient safety incident that represents an extreme level of risk for patients, their families and carers, our staff, or partner organisations, where the potential for new learning and improvement is identified.

Local patient safety incidents requiring investigation.

It is important to note that incidents not identified as priorities within this PSIRP will be investigated using appropriate and proportionate techniques.

The investigation methods for this category of investigation will be agreed by the Incident Response Group (IRG). This non-exhaustive list offers some examples of planned responses (appendix A).

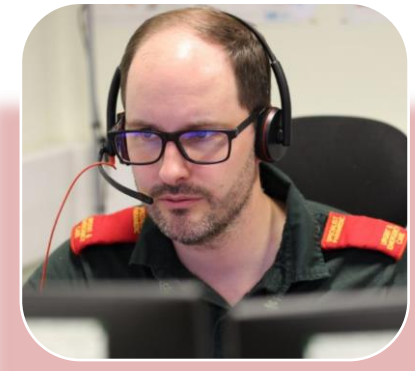
- Patient safety incident investigations
- After Action Review
- Multi-Disciplinary Team review

This plan provides a detailed explanation of the various learning methods available to us in appendix B. The IRG will ratify where our leaders proactively implement immediate safety actions and/or learning responses following a PSI.

Some additional proportionate responses not noted in the PSIRP may also benefit those effected by patient safety incidents and support the Trust to identify new learning. These can be found in Appendix C but include;

- End-to-end review
- Debrief
- Clinical audit

Where a structured judgment review (SJR) does not indicate a PSII should be completed, the Trust will prepare a factual report upon request from the coroner. The report should focus on the chronology, analysis, and link to our Trust Wide Improvement Plan. Learning should be identified using the proportionate response set by the IRG.



Safeguarding

The Mental Capacity Act (MCA, 2005) also requires specific consideration throughout all patient safety incidents. An individual's capacity to consent or ability to make an informed decision relating to care/treatment may influence their level of involvement in learning responses.

Locally defined emergent patient safety incidents requiring cross-system response

The Trust are committed to responding to cross-system PSIs and will lead and/or support partners in carrying out learning responses, noting the value of this multi-disciplinary team approach. Cross system learning will be highlighted at relevant Patient Safety Networks across the region and outcomes shared at PSOG, which include commissioning colleagues. The Trust aim to identify and address health inequalities when reviewing cross-system PSIs.

Additional learning responses

The Trust recognise the value in undertaking learning responses where care has been recognised as positive or good. It is vital the Trust understand how and why good outcomes are achieved and focus on maintaining this standard of care.

Monitoring our progress

The PSOG have drafted a quality assurance template to ensure learning responses are produced to a quality standard, which includes (a) engagement with patients, their families, and staff, (b) the effectiveness and sustainability of safety improvement actions identified by learning response leads and (c) the training compliance for those involved in PSIs.

Compliance with timeframes, duty of candour and where open and honest conversations are recommended will be reported to PSOG.

Feedback from patients, their families and staff will be collected to improve our responses.

The Incident Management and Response Steering Group will continue reporting progress on implementation to the Senior Management Group (SMG), and where required, to QPSC.

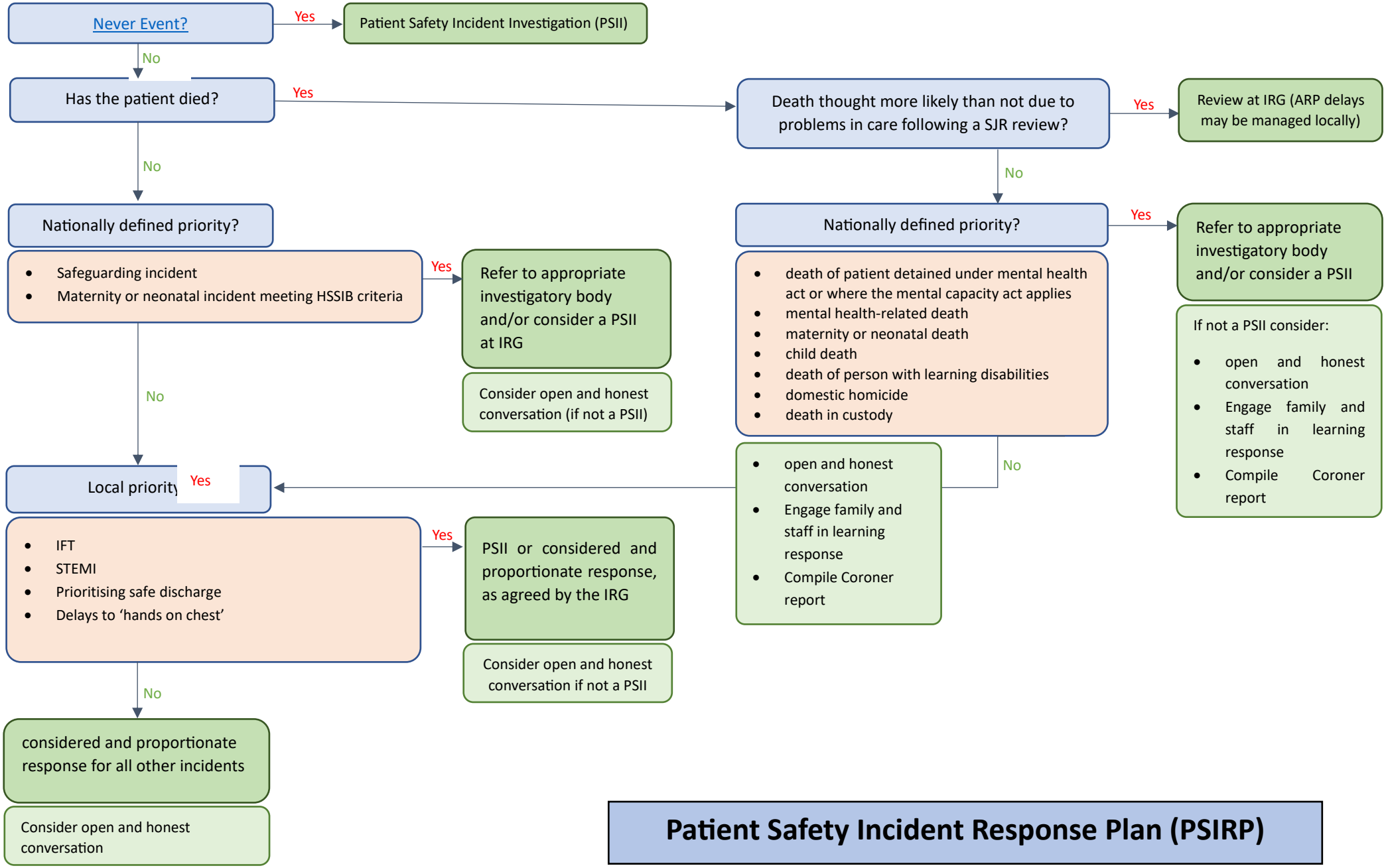
Part Four

Glossary of Terms

Term/Acronym	Definition
AAR	After Action Review is a method of evaluation that is used when the outcomes of an activity or event have been particularly successful or unsuccessful.
Arbitrary or Subjective	Chosen randomly or influenced by/based on personal beliefs or feelings, rather than on facts
Being open	Being open and transparent with patients and families when treatment or care goes wrong.
Care Group	A grouping of multi-disciplinary staff working together to provide care within a certain area.
CQC	Care Quality Commission - independent regulator of health and social care in England
Definitions of Harm	Unanticipated, unforeseen accidents (e.g., patient injuries, care complications, or death) which are a direct result of the care dispensed rather than the patient's underlying disease
Duty of Candour	Statutory duty of candour legislation requiring the Trust to be open and honest when moderate or greater harm occurs.
HSE	Health and Safety Executive, an independent regulator for workplace health and safety.
HSSIB	Health Service Safety Investigation Body (formally HSIB)
Human Error	A human error is an action or decision which was not intended that has negative consequences or fails to achieve the desired outcome
Inequalities data	Facts and statistics collected relating to health inequalities which are unfair and avoidable differences in health across the population, and between different groups within society.
Integrated Care Board (ICB)	Statutory organisation that brings NHS and care organisations together locally to improve population health and establish shared strategic priorities within the NHS.
Just Culture Approach	The treating of staff involved in a patient safety incident in a consistent, constructive, and fair way.
MDT	Multi-Disciplinary team

Term/Acronym	Definition
Neonatal Death	A baby born at any time during the pregnancy who lives, even briefly, but dies within four weeks of being born
Never Events	Never Events are defined as Serious Incidents that are wholly preventable because guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
NHSE	National Health Service England
Principles of Proportionality	The least intrusive response appropriate to the risk presented
PSI	Patient Safety Incident (unintended or unexpected incidents which could have or did lead to harm for one or more patients receiving healthcare)
PSII	Patient Safety Incident Investigation (PSII) is a formal investigation tool which aims to provide a clear explanation of how an organisation's systems and processes contributed to a patient safety incident.
PSIRF	Patient Safety Incident Response Framework
PSIRP	Patient Safety Incident Response Plan
RIDDOR	Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013
SEIPS	System Engineering Initiative for Patient Safety - a framework for understanding outcomes within complex socio-technical systems.
SOP	Standard Operating Procedures
Stakeholder	People or groups who have an interest in what an organisation does, and who are affected by its decisions and actions.
Swarm Huddle	Swarm-based huddles are used to identify learning from patient safety incidents. Immediately after an incident, staff 'swarm' to the site to quickly analyse what happened and how it happened and decide what needs to be done to reduce risk.

Appendix A



Patient Safety Incident Response Plan (PSIRP)

Appendix B

MDT Review					
What is it?	**When would you use this tool?**	**Time required to complete?**	**Who leads it?**	**Research and evidence to confirm its efficacy?**	**Who is involved?**
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. To understand how care is delivered in the real world i.e., work as done	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	Normally chaired by a senior lead who generates a report	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			**Weaknesses**		
• 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.			• 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.		

Patient Safety Incident Investigation (PSII)					
What is it?	**When would you use this tool?**	**Time required to complete?**	**Who leads it?**	**Research and evidence 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 outside of the PSIRF priorities	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 and senior clinicians
Strengths			**Weaknesses**		
• 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 in each provider.			• 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. • Staff are only involved when they are interviewed, and this can feel very stressful.		

<table>
<tr><th colspan="6">After Action Review (AAR)</th></tr>
<tr><th>What is it?</th><th>When would you use this tool?</th><th>Time required to complete?</th><th>Who leads it?</th><th>Research and evidence to confirm its efficacy?</th><th>Who is involved?</th></tr>
<tr><td>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</td><td>After any event, where patient care or service was not as effective or safe as expected, or when events turned out better than expected</td><td>Likely to take 45 minutes to 90 mins depending on complexity of the issue and the numbers participating</td><td>Led by a trained AAR Conductor - this could be anyone from within the MDT, local or remote to the participants</td><td>Extensive research evidence base available on the structures, processes and outcomes demonstrating its effectiveness in improving team performance and patient safety</td><td>Those directly involved in the event and others connected to them or the patient pathway. Patients and family members may be included</td></tr>
<tr><th colspan="3">Strengths</th><th colspan="3">Weaknesses</th></tr>
<tr><td colspan="3">The individuals learn for themselves what was happening and identify similarities and differences between themselves and others.
Learning during the AAR is the main 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.</td><td colspan="3">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 as a result 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.</td></tr>
</table>

<table>
<tr><th colspan="6">SWARM Huddle</th></tr>
<tr><th>What is it?</th><th>When would you use this tool?</th><th>Time required to complete?</th><th>Who leads it?</th><th>Research and evidence to confirm its efficacy?</th><th>Who is involved?</th></tr>
<tr><td>"A novel rapid approach to RCAs to establish a consistent approach to investigate adverse or other undesirable event"</td><td>After any event where patient safety was at risk</td><td>No more than 30 minutes</td><td>Normally chaired by a senior lead who generates a report</td><td>There is some research literature on its use in healthcare</td><td>Those directly involved in these events.</td></tr>
<tr><th colspan="3">Strengths</th><th colspan="3">Weaknesses</th></tr>
<tr><td colspan="3">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 incidents.
Quick and responsive.
Prompt and easy to undertake so increases likelihood of being done.
Reduces key information being lost by its immediacy.</td><td colspan="3">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 SWARM Huddles.</td></tr>
</table>

Appendix C

Technique	Method	Objective
"Being open" conversations	Open discussion	To provide the opportunity for a verbal discussion with the affected patient, family, or carer about the incident (what happened) and to respond to any concerns.
Clinical Audit	Clinical document review	To determine whether there were any problems with the care provided to a patient by a particular service.
Debrief	Debrief	To conduct a post-incident review as a team by discussing and answering a series of questions.
Electronic Patient Care Record (EpCR) review	Clinical document review	To determine whether there were any problems with the care provided to a patient by a particular service. To routinely identify the prevalence of issues; or when bereaved families/carers or staff raise concerns about care.
Immediate safety actions	Incident recovery	To take urgent measures to address serious and imminent discomfort, injury, or threat to life damage to equipment or the environment.
Incident timeline	Incident review	To provide a detailed documentary account of an incident (what happened) in the style of a 'chronology'.
Structured judgement review (SJR)	Clinical document review	Used to assess delays in both thematic reviews and individual cases. It is based upon the principle that trained clinicians use explicit statements to comment on the quality of healthcare in a way that allows a judgement to be made that is reproducible.

Contact us

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