NHS
South East Coast Ambulance Service
NHS Foundation Trust

Patient Safety Incident Response Plan

2026/27

Contents

Introduction

The Patient Safety Incident Response Plan explains how South East Coast Ambulance Service NHS Foundation Trust (SECAmb) will respond to patient safety incidents over the next 12 to 18 months. It is a live document, meaning it may change as learning and circumstances evolve. This plan is a revision of the version published in 2024 and reflects the lessons learned from delivering the 2024/25 plan in practice. The plan will remain flexible and consider the specific circumstances of each safety issue, as well as the needs of the patients, families and staff who are affected.

The plan will help the Trust to measurably improve the effectiveness of both local and cross system patient safety incident investigations by:

- Involving people affected by incidents including patients, families, carers and colleagues, with empathy and openness, so that their experiences guide the investigation and help build trust.
- Using the most appropriate investigative methods for each situation, to support understanding of how the whole system contributed to what happened rather than focusing only on individuals.
- Responding in a proportionate way, directing efforts to the areas where learning will have the biggest impact and help prevent repeated harm.
- Provide supportive oversight that encourages learning, improvement and a stronger safety culture across the organisation.

About us

SECAmb provides services across four Integrated Care Systems (ICSs) delivering urgent and emergency care to over 5 million people across 3,670 square miles.

- The Trust employs over 5,000 staff
- Our patients range from the critically ill and injured who need specialist treatment, to those with minor healthcare needs who can be treated virtually, at home or in the community.
- We receive over 2.1 million calls per year, responding to over 700,000 incidents.
- As well as a 999 service, the Trust also provides the NHS 111 service across Sussex, Kent & Medway.

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
- An advanced 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 community teams

What we learnt from the previous PSIRP

The Trust has evaluated how the previous Patient Safety Incident Response Plan (PSIRP) worked in practice supporting an understanding of what went well and where the patient safety approach can be strengthened. The insights below show how we are continuing to develop our systems so that learning is more consistent, timely and useful across the organisation.

Getting the right group size for decision making

We learned that the size and makeup of our Incident Response Groups matter. Having too many or too few people can affect how well we capture different viewpoints and how efficiently we make decisions. We are now working to ensure each group is balanced, effective and well represented.

Tracking actions and checking their impact

We recognised the need for clearer ways to track safety actions and understand whether they are making a real difference. This continues to evolve. Alongside this, we have completed an organisational quality improvement project on Inter-Facility Transfers which has generated insight and learning to drive improvements moving forward.

Sharing learning more consistently

We identified that learning from investigations and reviews needed to be shared more consistently and with a wider audience. We are improving how we share learning so that teams across the trust can benefit.

Keeping investigator skills up to date

We learned that our investigators need regular opportunities to refresh their skills. We are improving access to training so that our investigators stay current and confident in their practice.

Making sure learning reaches the right governance structures

We found that lessons from learning responses need a clearer route into our governance processes. Work is underway to make sure important findings are consistently escalated and acted on at the right level. Appendices B and C show our new approach.

Highlighting good practice, not just problems

We learned that our learning responses should celebrate good practice as well as examine what went wrong. This helps us recognise what is working well and spread effective approaches across the organisation.

Balancing multiple factors when selecting incidents for review

We also recognised the need to balance several competing factors when reviewing incidents and selecting learning responses. This includes ensuring the right people are in the room, avoiding unnecessary complexity and being mindful of efficiency. We are now taking a more structured approach to achieving that balance.

Our stakeholders

Patient Engagement

The Trust is committed to involving patients, families and carers in a way that is compassionate, clear and respectful. National guidance requires organisations to be open and supportive throughout the whole investigation process. We are making our information easier to understand, helped by the clear glossary in our Patient Safety Incident Response Plan (included in the Glossary of Terms on page 14). Plans are underway to recruit Patient Safety Partners so that patients can continue to shape how we learn and improve.

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

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

The Trust belongs to a 'PSIRF Ambulance Network' that includes every ambulance service in England and facilitates the sharing of learning across this network.

Stakeholder involvement has been central throughout our priority setting process, including surveys, public and staff feedback, patient and carer insights, workshops and meetings with clinical, operational and corporate teams.

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

- MedOCC
- HERE Brighton
- ABC Healthcare Ltd
- Practice Plus Group
- IC24
- Kent, Surrey, Sussex Air Ambulance
- System providers
- Police, fire and coastguard services
- Health Innovation Kent, Surrey, Sussex
- Care Quality Commission (CQC)
- HM Coroner
- Local authorities
- Integrated care boards
- Ambulance PSIRF Network

Defining our patient safety incident profile

For 2026/27 new priorities have been identified for patient safety incident investigations.

The priorities have been shaped through a review of data and robust stakeholder engagement. Views have been gathered from patients, families, carers, staff, community groups and partner organisations, making sure that everyone who uses or supports our services had the chance to be heard. Their feedback, along with what we learned from patient safety incidents, performance information, risk data and our wider health goals, has supported understanding of where improvements are most needed.

Lessons Learned

We learned some important lessons from how we set priorities in the past and we used these to improve our approach this time. Instead of creating separate lists for our quality account, quality improvement work and patient safety investigations, we brought everything together into one joined up process. Triangulation of this information supported identification of themes and understanding of the patient safety issues that affect the organisation the most. This helped to avoid duplication and focused effort on the biggest and most important risks.

We have brought together information from many places, including patient safety incidents, complaints, compliments, claims, inquests, patient feedback and informal comments from staff. All of this has been reviewed and grouped into common themes, which are shared in this plan.

To understand where the biggest risks are, we looked at a full year of data from incident reports, complaints, mortality reviews, clinical audits, staff surveys, claims and risk assessments. From this, we identified issues where the underlying causes are already well understood. Once these were removed, three key areas remained which posed the greatest risk.

We believe there is still important learning to be gained by looking at these areas more closely using a structured method called the Systems Engineering Initiative for Patient Safety (SEIPS). Our approach also ensures we pay just as much attention to incidents that caused little or no harm as we do to the most serious cases.

Priorities identified
Mental Health
Major Trauma
Transfer of care

We kept our PSIRP priorities broad by design so we can adapt to emerging themes, avoid overlooking cross cutting issues and focus on areas with the greatest potential impact as better data becomes available. Narrowing the scope too early risks missing important patterns and makes it harder to adjust course if initial assumptions prove incorrect. Therefore, 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.

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.

Staff Engagement

Engaging staff in safety work has been more challenging. We have learned from our previous Patient Safety Incident Response Plan that some colleagues still feel unsure or anxious about speaking openly, especially where psychological safety is fragile. This is not the culture we want. We are now working openly and honestly to build a safer, more confident environment where staff feel able to share their experiences and take part in learning without fear of punitive responses.

Defining our patient safety improvement profile

We recognise that there is still more we can do to improve how we learn from patient safety incidents. We are moving in the right direction but we now need to make sure our actions lead to real, measurable improvements. This update to our Patient Safety Incident Response Plan represents meaningful progress. We plan to check regularly that the safety improvement actions recorded in our central system are working and we will use a clear process for signing off learning responses once they are complete. We have already written this process and have included it in the Appendix C. Publishing it will make expectations clearer and ensure learning is followed through consistently. Alongside this, several Trust-wide programmes and local improvement plans are already under way, all designed to address known issues using findings from previous incidents, reviews, audits and risk assessments.

We continue to link what we learn from patient safety incidents with our quality improvement (QI) work, using a simple approach that helps us define problems, measure what is happening, understand the causes (analyse), improve the system and make sure those improvements last (control).

As part of our patient safety incident response plan 2024/2025, we launched two organisational improvement programmes: Safe in the Back, which looks at how we keep people safe during ambulance journeys, and Inter Facility Transfers (IFT), which focuses on safety when patients are moved between hospitals. Both programmes are already giving us valuable insights that are helping us make care safer.

Our joined up approach to setting priorities, as described earlier, made it much easier to spot common themes, understand the issues that affect the organisation the most, avoid repeating work and concentrate our efforts on the risks that matter most.

The Improvement Journey for our current priorities has commenced and will be monitored by the groups below, reporting to the Quality and Patient Safety Committee (QPSC).

The Divisional Governance Groups (DGGs) will also be responsible for testing the effectiveness of improvement workstreams derived from new learning at a place-based level.

No.	Incident Type – PSIRF priorities	Monitoring Group
1	Mental Health	Patient Safety and Experience Group (PSEG)
2	Major Trauma	Clinical Effectiveness Group (CEG)
3	Transfer of Care	Patient Safety and Experience Group (PSEG)

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 transition. Operational staff from each divisional footprint have joined corporate colleagues completing the core modules, which are being delivered by an NHSE approved supplier. Phase 1 of the spread was completed in quarter 4, 2023/24. As from 2026/2027, Level One and Two of the NHS Patient Safety Syllabus training are now mandatory for all staff.

Core Modules

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

The Trust recognises 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 Patient Safety Incident Investigation (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	PSII unless death is clinically assessed as more likely than not due to delayed 999 calls answering, incorrect triage and delayed ambulance response	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

We stated earlier in this plan that we selected our priorities for quality improvement, the quality account and patient safety investigations by bringing all our information together into one joined up process. These local priorities will be reviewed on an ongoing basis via the Patient Safety and Experience Group with a formal review of the PSIRP no later than 18 months from the date of issue.

We will complete at least one Patient Safety Incident Investigation (PSII) for each of our three priorities. Additional PSIIs where learning may be extracted will be considered by our Incident Review Group(s) and prescribed by our Patient Safety and Experience Group (PSEG). This group is also responsible for PSII closure as shown in Appendix C.

Patient safety incident type	Required response	Anticipated improvement route
Mental health	Swarms, AARs, MDTs and potentially thematic analysis with at least one PSII being completed by the end of the PSIRP for patients with mental health needs who are at risk of, or experience, harm during virtual or in person contact with our services, especially where suicidal thoughts or disengagement are involved.	Feed into Trust wide improvement plan utilising QI methodology
Major Trauma	Swarms, AARs, MDTs and potentially thematic analysis with at least one PSII being completed by the end of the PSIRP for patients with traumatic injuries who are at risk of, or experience, harm during contact with our services, particularly where correct triage, timely assessment, intervention or conveyance to the most appropriate trauma centre may be affected.	Feed into clinical pathways improvement work
Transfer of care	Swarms, AARs, MDTs and potentially thematic analysis with at least one PSII being completed by the end of the PSIRP for patients who are at risk of, or experience, harm during transfers of care or interactions with other healthcare professionals, especially where communication, handover, shared decision making or timely information exchange may affect safety.	Feed into Trust wide improvement plan utilising QI methodology

Locally defined incidents requiring alternative responses

Patient safety incident type	Required response	Anticipated closure route
Infection Prevention and Control Incident	Review at Incident Review Group and support partners with system bases learning response	Commissioning Infection, Prevention and Control 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 presents an extreme level of risk to patients, families, carers, staff or partner organisations and when there is clear potential for new learning and improvement.

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 D).

- 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 D. The IRG will ratify where our leaders proactively implement immediate safety actions and/or learning responses following a Patient Safety Incident (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 E but include:

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

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 ourTrust-wide Improvement Plan. Learning will be identified using the proportionate response set by the Incident Review Group (IRG).

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 PSEG, 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 progress

The Patient Safety and Experience Group (PSEG) 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 Patient Safety Incidents (PSIs). Compliance with timeframes, duty of candour and where open and honest conversations are recommended will be reported to the PSEG. Feedback from patients, their families and staff will be collected to improve responses.

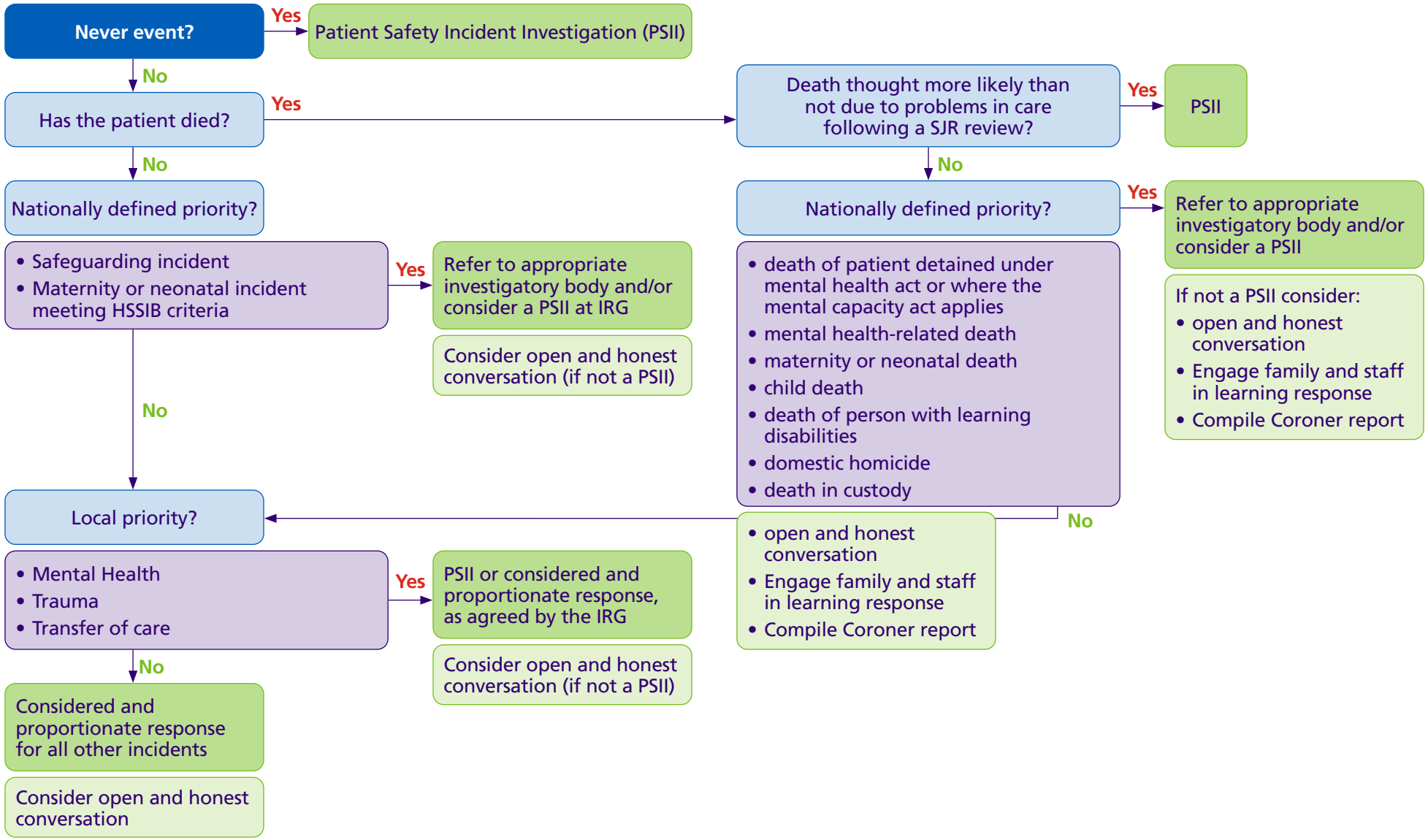
Glossary of Terms

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
CNO	Chief Nursing Officer
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
HOC	Head of Compliance
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
LGM	Local Governance Manager
MDT	Multi-disciplinary team
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

Term/Acronym	Definition
PSIRF	Patient Safety Incident Response Framework
PSIRP	Patient Safety Incident Response Plan
QL	Quality Lead
RIDDOR	Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013
RCA	Root Cause Analysis
SIS	Safety Improvement Specialist
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

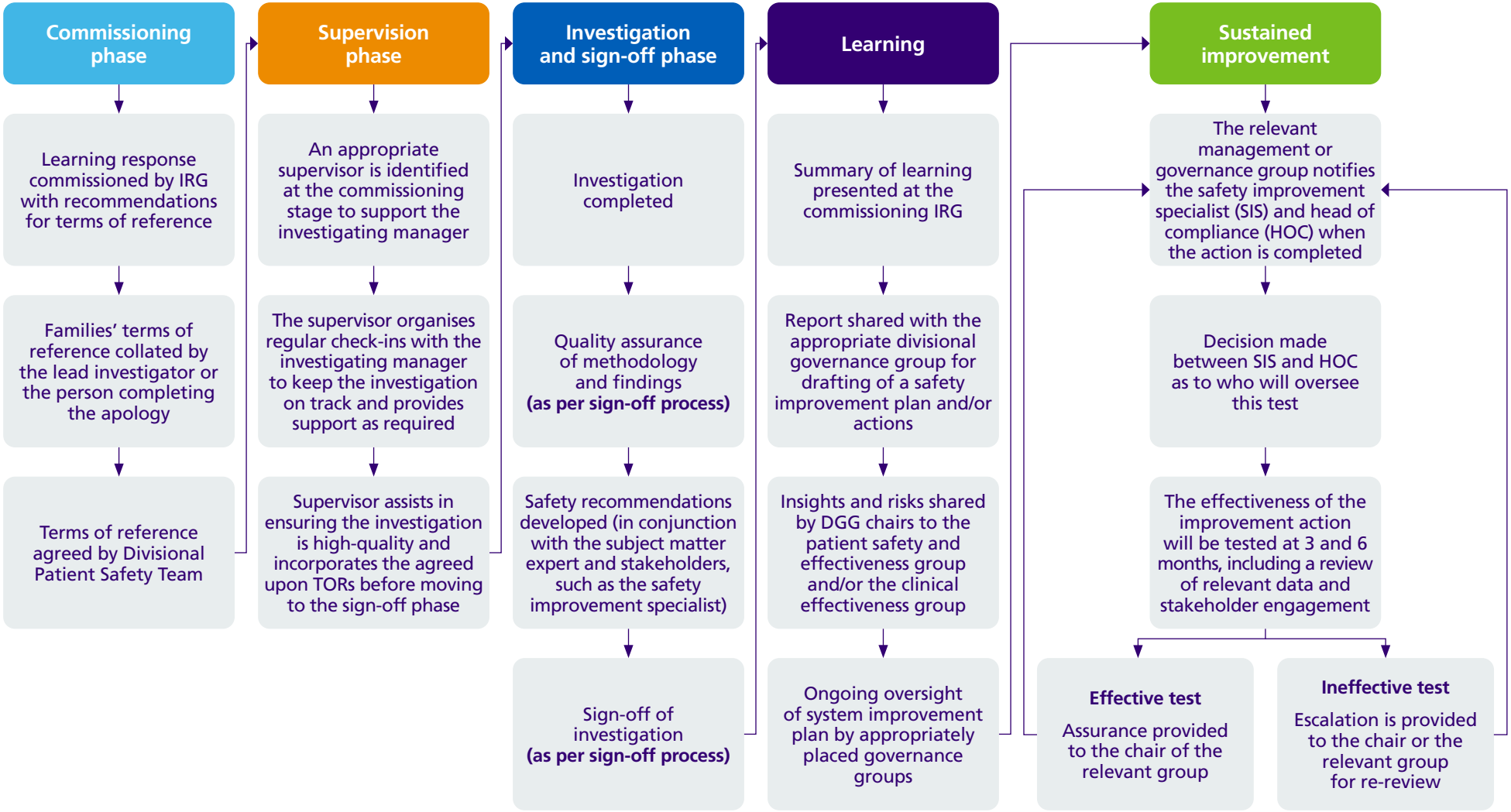
Appendix A

Patient Safety Incident Response Plan Process



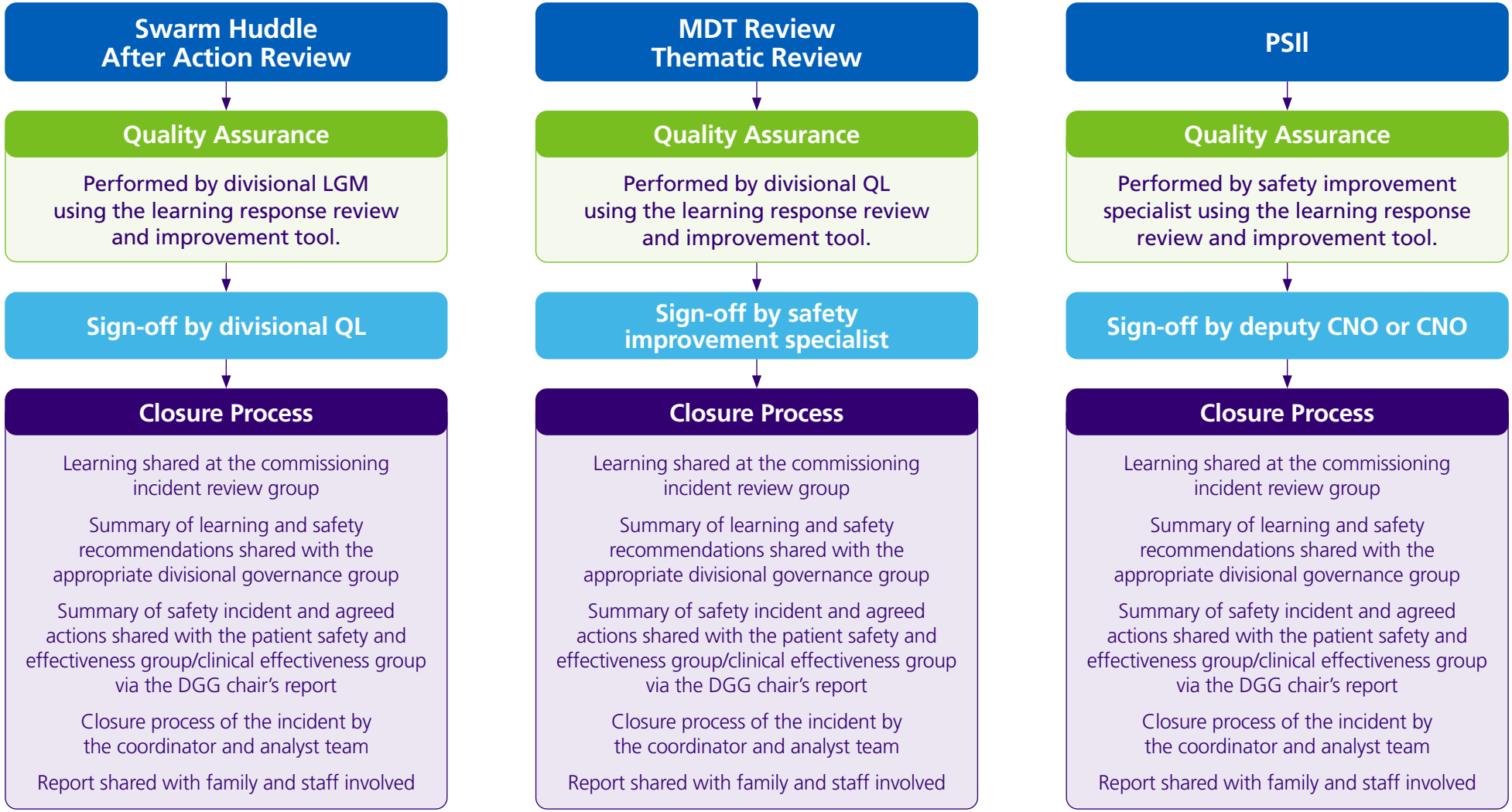
Appendix B

Commissioning and Process of a PSIRF Learning Response



Appendix C

Patient Safety Investigations Sign-Off and Closure Process



Appendix D

Commonly used Learning Responses for investigation of incidents

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.		

After Action Review (AAR)

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?
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 trained AAR Conductor - this could be anyone from within the MDT, local or remote to the participants	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. Patients and family members may be included

Strengths	Weaknesses
• 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.	• 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.

SWARM Huddle					
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?**
"A novel rapid approach to RCAs to establish a consistent approach to investigate adverse or other undesirable event"	After any event where patient safety was at risk	No more than 30 minutes	Normally chaired by a senior lead who generates a report	There is some research literature on its use in healthcare	Those directly involved in these events
Strengths			**Weaknesses**		
• 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.			• 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.		

Appendix E

Other forms of responses to incidents

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.

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