

Patient Safety Incident Response Plan

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Introduction

This patient safety incident response plan sets out how West Midlands Ambulance Service intends to respond to patient safety incidents over a period of 12 months. The plan is not a permanent rule that cannot be changed. We will remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected. This is because patient safety themes and trends change which means our local priorities will need to be under review.

The NHS Patient Safety Strategy was published in July 2019 and introduces the Patient Safety Incident Response Framework (PSIRF) as a replacement for the NHS Serious Incident Framework. The Serious Incident Framework provided structure and guidance on how to identify, report and investigate an incident resulting in severe harm, or death. PSIRF is best considered as a learning and improvement framework with the emphasis placed on systems and encouraging a culture that supports continuous improvement in patient safety. PSIRF encourages us to enhance our investigations, improving the learning gathered and reducing the risk of future harm.

PSIRF recognises the need to ensure we have support structures for those involved in patient safety incidents (patients, families and our staff) part of which is fostering a psychologically safe culture encouraged by all our leaders and supported by Trust-wide strategies.

Our PSIRP should be read in conjunction with our Patient Safety Incident Response Policy.

Our services

The Trust provides a wide range of services to the public such as emergency care, patient transport services, 999 call handling services and remote clinical assessment services based in our Emergency Operations Centre (EOC). Patient transport services are not provided for all counties, which is reflected in this plan.

The Trust serves a population of 5.6 million people covering an area of more than 5,000 square miles made up of Shropshire, Herefordshire, Worcestershire, Staffordshire, Warwickshire, Coventry, Birmingham and the Black Country. It includes the second largest urban area in the country (Birmingham, Solihull and the Black Country) yet over 80% of the area is rural. We are the second most ethnically diverse region in the country after London, which makes it vital that we work closely with the many different communities we serve.



Defining our patient safety incident profile

West Midlands Ambulance Service has a commitment to learning from patient safety incidents and we have continuously developed our understanding and insights into patient safety matters over several years.

PSIRF sets no rules or thresholds to determine what needs to be learnt to improve except for the national requirements. Upon implementing PSIRF in 2024, we completed a holistic review of patient safety data insights to target areas of learning for improvement. We engaged with key internal and external stakeholders and reviewed data from our Serious Incidents, Learning From Deaths cases and internal reporting system to arrive at our patient safety profile. This led to the development of our first PSIRP which was published in April 2024.

As our organisation has matured through PSIRF, to develop our second set of PSIRF priorities, we reviewed our emerging themes and trends through incident reporting, Learning From Deaths and Clinical Audit. We also listened to our staff during learning responses and recognised a need for a further deep dive into the three local priorities we have agreed.

Stakeholder engagement

We engaged with our stakeholders through a robust governance process, this included presenting the priorities for thorough discussion at multiple governance groups:

- Senior Clinical Leads
- Professional Standards Group
- Learning Review Group
- Quality Governance Committee
- Executive Management Board

Membership of these groups is held by various leaders across the organisation.

Shared Learning Events with our healthcare partners and other ambulance services have allowed us to compare our data with theirs to identify and share themes which will in the future facilitate whole system learning.

Workshops with our acute hospital partners and other ambulance services have allowed us to compare our data with theirs to identify common priorities which will in the future facilitate whole system learning.

The plan has been presented to our ICB and amongst the ICBs who serve the region in which we operate.

These discussions will continue as our second PSIRP evolves.

Data Sources

We have analysed data over the last 12 months but also analysed what we have learnt from our PSIRF Learning Responses commissioned under our first PSIRP.

We have also considered feedback and information provided by our stakeholders and



subject matter experts as part of the data collection process. Data and information (both qualitative and quantitative) have therefore been reviewed from the following sources:

- Ambulance Care Quality Indicators (ACQI)
- Business Intelligence Reports
- CQC Reports
- Clinical Audit
- Complaints and Compliments
- Coroner's Inquests
- Freedom To Speak Up
- Incident Reporting – Internally and Externally
- Learning From Deaths
- PSIRF Learning Responses
- Risk registers
- Safeguarding
- Staff survey results

Where it has been possible, we have considered elements of the data regarding health inequalities. As part of our governance process, we have also considered new and emerging risks that other stakeholders may identify.

The trends and themes from the data sources were considered and our Local Priorities were identified and then agreed in conjunction with our Trust Board and the ICB. We acknowledge that whilst the defined list of Local Priorities has been agreed, this list is not exhaustive.

Where a new risk emerges, this will be discussed at the Patient Safety Assessment Review Group (PSARG) and if necessary, a learning response will be initiated.



Defining our patient safety improvement profile

Current Patient Safety processes are in place, such as Learning From Deaths, which will be reviewed and adapted to meet the requirements of the PSIRF.

We have learnt valuable lessons from our first 2 years under PSIRF. We have adjusted our processes, and our new set of priorities are more specific so we can focus on quality improvement work as PSIRF advocates rather than repeated investigative work.

Learning Responses as a result of our local PSIRF Priorities:

Our new priorities will primarily be led by a Thematic MDT Review to investigate the theme and include “work as prescribed vs work as done”. A Systems Engineering In Patient Safety (SEIPS) will be conducted with representatives across the organisation with individual After Action Reviews utilised if appropriate. Otherwise, we will lean on local case reviews conducted by Clinical Team Mentors which align with the questioning of the After Action Review.

At the end of the Learning Response timeframe, The Patient Safety Incident Review Group (PSIRG) will review and initially approve the Thematic MDT Reviews for each PSIRF Priority. At this meeting the reports will be complete, the quality improvement work underway and improvement will be measured.

The Thematic MDT Reviews will have final approval at The Professional Standards and Learning Group (PSLG).

Learning Responses outside of our local PSIRF Priorities:

The Patient Safety Assessment & Response Group (PSARG) will meet to undertake the scrutiny of incidents meeting the national priorities to plan the PSII and agree the Terms Of Reference.

PSARG will also review cases that fall outside of our local priorities where organisational learning and/or organisational risk has been identified. The group will agree if a Learning Response is required and agree what form that will take.

The Patient Safety Incident Review Group (PSIRG) will initially approve Learning Responses outside of our PSIRF priorities and agree any actions prior to final review at the Professional Standards and Learning Group (PSLG).

Identifying areas of improvement following Learning Responses.

Learning responses will aim to find gap in areas of the system that can be improved to improve safety, care and patient outcomes.

These areas of learning should be translated into effective and sustained improvement work focused on reducing risk.

We will identify:

- What improvement(s) are needed
- What change(s) are needed
- How this will be implemented
- How the impact of the change(s) will be monitored
- If there are any unintended consequences

Other workstreams across the organisation will be considered before suggesting new actions and relevant stakeholders engaged to agree a suitable timeframe for completion and agreement for monitoring effectiveness.

Learning from Patient Safety Learning Responses can be translated into the following:

Safety Actions:

Safety Actions are actions requiring immediate attention to reduce risk.

If a Safety Action is identified requiring immediate action, this will be raised to the Patient Safety Specialist and the Head of Patient Safety. This will then be submitted as an agenda item to the clinical Senior Management Team meeting (SMT) for wider discussion, action planning and organisational dissemination if required.

Patient Safety Recommendations:

A Patient Safety Recommendation is specific, actionable guidance to address identified risks, prevent recurrence of adverse events, and enhance the overall safety of care delivery.

Quality Improvement Initiatives:

A Quality Improvement Initiative is a planned, evidence-based, and data-driven project or program designed to improve the quality of care, patient outcomes, and system efficiency by identifying problems, testing changes, and implementing sustainable solutions. This will be led by the Patient Safety Learning Leads.

The Clinical Audit and Research Programme Group (CARPG) will review the Quality Improvement initiatives from the associated PSIRF audit and monitor progression. This will also allow the PSIRF priorities to be measured against the Clinical Audits to identify improvement.

Where a Quality Improvement Initiative sits outside of the PSIRF priority, this will be monitored through the PSLG.

The Patient Safety Team is responsible for the tracking and monitoring of all Learning from Patient Safety Learning Responses.

Our patient safety incident response plan: national requirements

The Trust has finite resources for patient safety incident learning responses, we intend to use those resources to maximise learning and improvement outcomes. PSIRF allows organisations to do this, rather than repeatedly responding to patient safety incidents based on subjective thresholds and definitions of harm, from which new learning will be limited.

Some patient safety incidents such as Never Events and deaths thought more likely than not due to problems in care will always require a Patient Safety Incident Investigation (PSII) to learn and improve. For other types of patient safety incidents which may affect a particular cohort of patient, a PSII will also be required, these have been determined nationally.

Some patient safety incident types also require specific reporting and/or review processes to be followed such as Learning From Deaths mortality reporting. For clarity, these are listed in the table below. National guidance recommends 20-25 Patient Safety Incident Investigations per year. Attempting to do more than this will impede our ability to adopt a systems-based approach from thematic analysis and learning from excellence.

Patient safety incident type	Required response	Anticipated improvement route
Incidents meeting the Never Events criteria	PSII	Create local organisational actions and feed these into the quality improvement strategy
Deaths thought more likely than not due to problems in care <i>(incidents meeting the Learning From Deaths criteria for patient safety incident investigations (PSIIs))</i>	PSII	Create local organisational actions and feed these into the quality improvement strategy



Deaths of patients detained under the Mental Health Act (1983) or where the Mental Capacity Act (2005) applies <i>(where there is a reason to think that the death may be linked to problem in care, incidents meeting the Learning From Deaths criteria)</i>	PSII	Create local organisational actions and feed these into the quality improvement strategy
Mental health-related homicide	Referred to the NHS England Regional Independent Investigation Team (RIIT) for consideration for an independent PSII. Locally-led PSII may be required	Respond to recommendations from external referred agency/organisation as required. Feed actions into quality improvement work.
Maternity and neonatal incidents meeting Maternity and Newborn Safety Investigations Special Health Authority (MNSI) criteria	Refer to MNSI for independent PSII If a death has occurred, to be reviewed under the Learning From Deaths Policy	Respond to recommendations from external referred agency/organisation as required. Feed actions into quality improvement work.
Child deaths	Refer to Child Death Overview Panel (CDOP) for review. To be reviewed under the Learning From Deaths Policy Locally led PSII (or other response) may be required alongside the CDOP review. We will liaise with the	Respond to recommendations from external referred agency/organisation as required. Feed actions into quality improvement work.



	CDOP coordinator.	
Death of persons with Learning Disabilities, or Autism	Refer for Learning Disability Mortality Review (LeDeR) To be reviewed under the Learning From Deaths Policy Locally led PSII (or other response) may be required alongside the LeDeR review. We will liaise with the LeDeR coordinator.	Respond to recommendations from external referred agency/ organisation as required. Feed actions into quality improvement work.
Safeguarding incidents in which: <i>babies, children or young people are on a child protection plan, looked after plan or a victim of willful neglect or domestic abuse/violence</i> <i>adults (over 18 years old) are in receipt of care and support needs from their local authority</i> <i>the incident relates to FGM, Prevent (radicalisation to terrorism), modern slavery and human trafficking or domestic abuse/violence</i>	Refer to Local Authority Safeguarding Lead via The Safeguarding Team who will contribute towards: domestic independent inquiries, joint targeted area inspections, child safeguarding practice reviews, domestic homicide reviews and any other safeguarding reviews (and inquiries) as required to do so by the local safeguarding partnership (for children) and local safeguarding adult boards.	Respond to recommendations from external referred agency/ organisation as required. Feed actions into quality improvement work.



Deaths in custody (eg police custody, in prison, etc) where health provision is delivered by the NHS	Any death in prison or police custody will be referred (by the relevant organisation) to the Prison and Probation Ombudsman (PPO) or the Independent Office for Police Conduct (IOPC) to carry out the relevant investigations. Healthcare organisations must fully support these investigations where required to do so	PPO or IOPC
Domestic homicide	A domestic homicide is identified by the police usually in partnership with the community safety partnership (CSP) with whom the overall responsibility lies for establishing a review of the case. Where the CSP considers that the criteria for a domestic homicide review (DHR) are met, it uses local contacts and requests the establishment of a DHR panel The Domestic Violence, Crime and Victims Act 2004 sets out the statutory obligations and requirements of organisations and commissioners of health services in relation to DHRs	CSP



Infection Prevention Control <i>Ambulance Services are exempt from the mandatory reporting of bloodstream infections and as a result, are not set BSI trajectories by NHS England. Other IPC related incidents may be applicable to the Infection Prevention and Control (IPC) Patient Safety Incident Response Framework (PSIRF) Matrix and should be considered on a case-by- case basis by the Trusts lead for IPC and Patient Safety lead</i>	PSII – Where there is a severe or significant outbreak which may impact on the Trusts ability to deliver emergency services. PSII – Where there is lapse in process or exposure to others in High Consequence Infectious Disease (HCID)	Respond to recommendations from external referred agency/ organisation as required. Create local organisational actions.
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Our patient safety incident response plan: local priorities

Through analysis of our patient safety insights, based on the review of our data and engagement workshops held, we have determined that the Trust will focus on four local priorities. The list below is not exhaustive and should an incident outside the list be identified as a new area for concern, it will be investigated using the PSII methodology and where appropriate, amendments to this plan will be made.

Local priorities requiring a Learning Response.

These local priorities identified for a Learning Response have been agreed by the Trust and our ICB for the next 12 months.

Please see appendix 1 for more in-depth information surrounding our local PSIRF priorities.

Patient safety incident type or issue	Planned response	Anticipated improvement route
Enhancing Safety and Quality in End-Of-Life Care decision making.	Initially an MDT or thematic review to investigate the theme, but any appropriate PSIRF response may be utilised.	Create organisational safety actions and feed these into quality improvement work.
Improving safety and outcomes in Paediatric Pain Management.	Initially an MDT or thematic review to investigate the theme, but any appropriate PSIRF response may be utilised.	Create organisational safety actions and feed these into quality improvement work.
Improving safety and outcomes in obstetric emergencies that fall outside of MNSI	Initially an MDT or thematic review to investigate the theme, but any appropriate PSIRF response may be utilised.	Create organisational safety actions and feed these into quality improvement work.

Important note in relation to cases that fall inside MNSI criteria.

West Midlands Ambulance Service have an agreement with MNSI that in the event of an MNSI Investigation, we will conduct our AAR to identify our own organisational actions which will feed into their investigation.

Delayed ambulance responses

Delayed ambulance responses continue to be prevalent in our themes of incident reporting. There is a national improvement programme in progress, and we are aware of the themes relating to this area. Delays will continue to be monitored and investigated where appropriate. We will also continue to take part in the national quality improvement programme.

During our first PSIRF plan, we completed 3 Multidisciplinary Team Reviews (MDT Reviews) into delayed responses to capture the work the Trust is undertaking to mitigate delayed ambulance responses.

We will continue to review delayed ambulance responses in line with the Learning From Deaths policy and our Incident Reporting policy, completing statutory Duty of Candour as required, which will include sharing our actions with those involved. This will be completed by the Patient Safety Team.

Unexpected patient safety incidents requiring a PSII outside of our priorities. Any unexpected safety incident that carries a level of risk and/or learning opportunities that are so great, where the contributory factors are not widely understood and therefore warrants the use of extra resources to undertake a PSII response. These cases will be reviewed by PSARG.

Patient safety incidents requiring a learning response

For any patient safety incident not meeting the PSII response, or any other incident, we will use appropriate and proportionate approaches as outlined within the PSIRF.

We will use the following Patient Safety Learning Responses:

- Patient Safety Incident Investigations (PSIIs)
- After Action Reviews (AARs)
- Multidisciplinary Team Review (MDT Review)
- Thematic Review

For patient safety incidents resulting in moderate or severe harm, we will undertake the Statutory Duty of Candour.

Appendix 1:

Our PSIRF Local Priority Statement.

Enhancing Safety and Quality in End-of-Life Care Decision-Making:

Priority statement:

To ensure End of Life care is delivered with compassion, dignity, and in alignment with patients' individual wishes and clinical needs, we will prioritise empowering staff to confidently identify when patients are approaching the end of their natural life, and to make timely, informed decisions that reflect the best interests of the patient and the values of their family.

Why this is a priority:

End of Life care is a sensitive and critical aspect of healthcare where safety, communication and coordination are paramount. Inappropriate escalation, delays in recognising the dying phase or reluctance to implement personalised care plans can cause avoidable harm and distress to patients and their families.

By focusing on this area, we aim to empower our clinicians to have confidence when making complex decisions and strengthen our systems for recognising deterioration and reducing inappropriate escalation to hospital.

Areas of focus may include:

- Timely recognition and communication of End of Life status.
- Safe and appropriate use of medications.
- Strengthened coordination between our service and other care providers, particularly out of hours.
- Better support for prehospital clinicians, such as work to strengthen RESPECT forms and DNACPR.
- Supporting families and carers during the dying process.
- Support with decision making surrounding the resuscitation and conveyance of patients who are approaching the end of their natural life.

What success looks like:

- Increased confidence and capability amongst staff to provide high-quality, person-centered End of Life care.
- Improved on scene care as a coordinated response with other care providers, focused on the patient's wishes and reducing unnecessary hospital conveyance.

Proposed PSIRF responses:

- After Action Review if appropriate.
- Appreciative enquiry through Learning From Deaths where excellent care is identified.
- Audit through Learning From Deaths or Clinical Audit.
- Quality Improvement Project in conjunction with ICBs to encompass frailty teams, community care teams and palliative care teams.



Improving Safety and Outcomes in Paediatric Pain Management.

Priority statement:

To ensure that pain in children is consistently recognised, assessed and effectively managed, we will prioritise the identification, response and learning from patient safety incidents and clinical audits relating to paediatric pain management.

Why this is a priority:

Effective pain management is essential to the safety and wellbeing of children. Undetected or inadequately treated pain can cause immediate distress and long-term physical and psychological harm. Children's pain can be under-recognised due to communication challenges, developmental factors or assumptions about pain expression. A safety focus on paediatric pain will help us understand and address systemic barriers, improve clinical practice and support child-centred care.

Areas of focus may include:

- Timely and appropriate pain assessment using age and developmentally appropriate tools.
- Safe provision and/or advice relating to paediatric analgesia within the Clinical Validation Team.
- On scene administration and/or monitoring of analgesia.
- Staff confidence and training in identifying and managing pain in children.
- Effective communication with children and their carers about pain and its management.

What success looks like:

- Improved clinical audits in relation to paediatric pain management.
- Removal of CQC regulation 12.
- Improved consistency and confidence in pain assessment and management practices.
- *Proposed PSIRF response:*
- Large Quality Improvement Project alongside an MDT spanning 12 months focused on improving pain identification, assessment and treatment utilising Clinical Audit.

Improving Safety and Outcomes in obstetric emergencies that fall outside of Maternity and Neonatal Safety Investigations (MNSI)

Priority statement:

To improve safety and clinical outcomes in obstetric emergencies that occur outside of the scope of the MNSI by enhancing staff training, increasing situational awareness and embedding robust governance processes alongside Clinical Audit that ensure timely review to identify learning and organisational safety actions. This priority aims to close safety gaps, reduce preventable harm and promote equitable, high-quality care where obstetric emergencies may arise.

Why this is a priority:

Obstetric emergencies represent a critical area of patient safety that requires focused attention. These are a small percentage of cases that paramedics will attend, leading to



skill fade and lack of exposure. Recent trends indicate an increase in incidents involving complex presentations such as breech births and placental abruption, alongside inappropriate misoprostol use which carry significant risks for both maternal and neonatal outcomes. By prioritising this area, we aim to strengthen system-wide preparedness, increase knowledge and ensure that all patients receive timely, safe and effective care in the prehospital environment.

Areas of focus may include:

- An assigned Patient Safety Learning Lead to lead on the maternity audit in conjunction with the Maternity Lead to review cases that fall into the priority quickly to identify areas of improvement.
- Collaborative working with maternity services to ensure safe and effective transitions of care.
- Availability of Senior Clinical Support to those on scene.
- Further education on different presentations of obstetric emergencies.

What success looks like:

- Fewer safety incidents involving obstetric emergencies.
- Improved Clinical Audit outcomes.
- An empowered, confident clinical workforce.

Proposed PSIRF responses:

- PSII if falling into national priorities.
- After-Action Review if required.
- Quality Improvement project in conjunction with Clinical Audit under a Multi-Disciplinary Team (MDT) review to identify further themes and trends of learning.