East of England Ambulance Service NHS Trust

Patient Safety Incident Response Plan

Patient Safety Team

Report Period: February 2025 – February 2026
Date of Report: February 2025

#WeAre EEAST

Contents

Introduction

The NHS Patient Safety Strategy published in 2019 describes the Patient Safety Incident Response Framework (PSIRF).

This Patient Safety Incident Response Plan (PSIRP) sets out how East of England Ambulance Service NHS Trust (known as 'the Trust') intends to respond to patient safety incidents as part of the PSIRF.

The dynamic plan is reviewed every twelve to eighteen months and covers how the Trust will manage patient safety events and use the learning gathered to drive organisational improvements. We will also use this plan to address the causal, systemic factors and use quality improvement opportunities to reduce repetition of our most reported safety incidents. It is the Trust's aim to provide the best quality of care, every hour of every day. The Trust recognises that there are occasions when things don't go to plan or when people are unhappy with the care and service provided. The Trust aims to learn from these occasions and respond to people to address the matters they have raised with a transparent and honest approach.

The East of England Ambulance Service has three values, awareness of these values are pivotal during an incident review process.

Our services

The Trust provides a wide range of services to the public such as Emergency and Urgent Care, Patient Transport Services, and Commercial Call Handling Services. Patient Transport Services are not provided for all counties which is reflected in this plan. The Trust serves the counties of Bedfordshire, Cambridgeshire, Essex, Hertfordshire, Norfolk and Suffolk which covers an area of 7,500 square miles and a population of more than 5.9 million people. The variation of geographical location impacts the way the services are provided. The variation includes rural

areas with limited road access and urban areas with good access, road networks and availability of hospital and community services.

Who we engaged with

This plan has been developed in consultation with the Trust's Patient Safety, Patient Experience, Legal and Quality Improvement Teams. It has been scrutinised by senior leaders including the Executive Leadership Team. Following the internal approval this plan will be shared with, and signed off by our ICB colleagues prior to final sign off by the Trust Board.

Our PSIRF journey so far

The organisation has a Clinical Strategy which includes the management of patient safety. There is a departmental workplan which enables the clinical strategy. We also have a Safety Enabling Strategy which covers all aspects of safety for staff and patients, which links with the National Patient Safety Strategy and PSIRF.

During our first twelve months of PSIRF the EEAST Patient Safety Team have completed two thematic reviews, these reviews looked at themes and trends included in the 2023 PSIRF plan. Our first thematic review looked at the theme of Missed ST segment myocardial infarctions, secondly we have completed a thematic review on the theme of Non Conveyance. All thematic reviews that are completed are shared with patients, families, internally with staff as well as our Integrated Care Board (ICB) colleagues. The feedback gained in our first twelve months has been extremely positive and evidences that EEAST have appropriately embedded PSIRF within the organisation.

In addition to the completed thematic reviews, the EEAST Patient Safety Team have completed 79 individual reviews outside of the identified themes where it has been decided that patient harm has occurred, this is in addition to the 21 Serious Incident reviews that were previously declared under the Serious Incident Framework. These reviews are at varying levels, those that required full reports were shared with patients, families, internally with staff as well as our ICB colleagues on completion.

Diagram one: Governance Reporting Structure

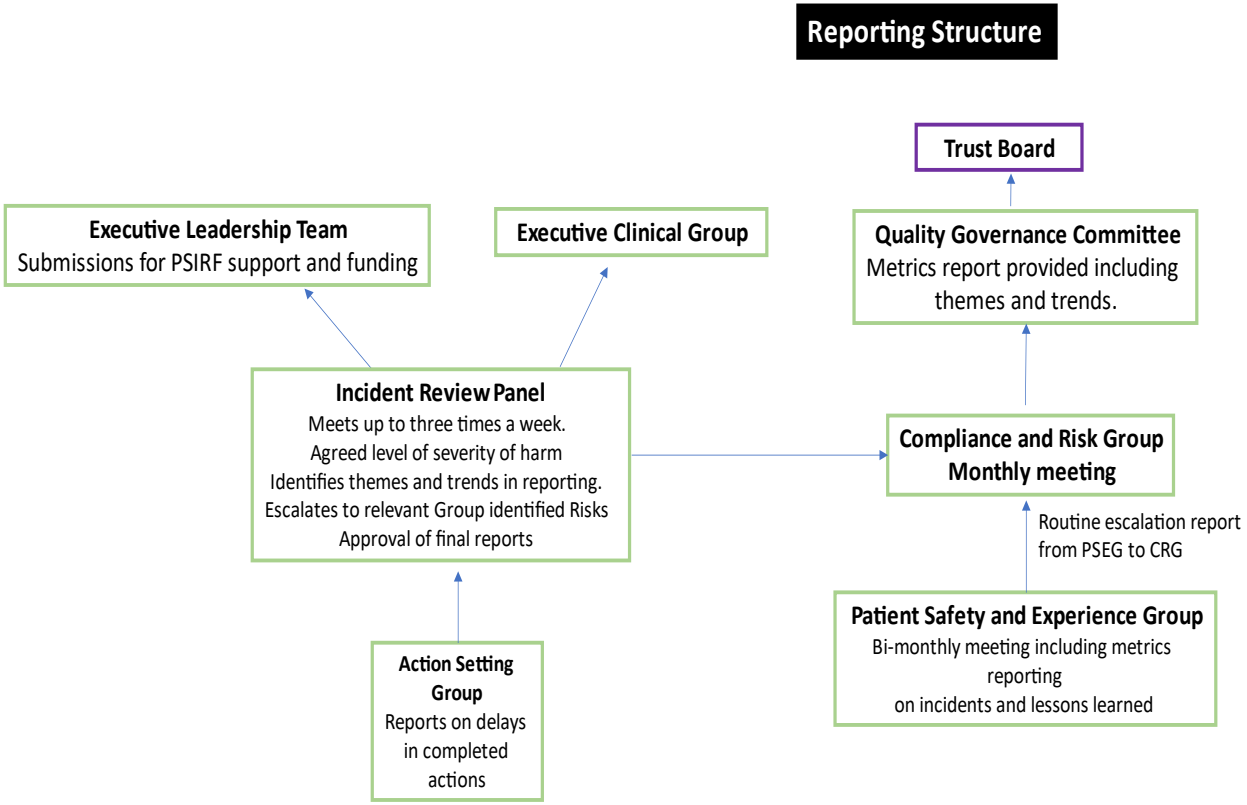


Diagram two: Incident Triage – National Requirements

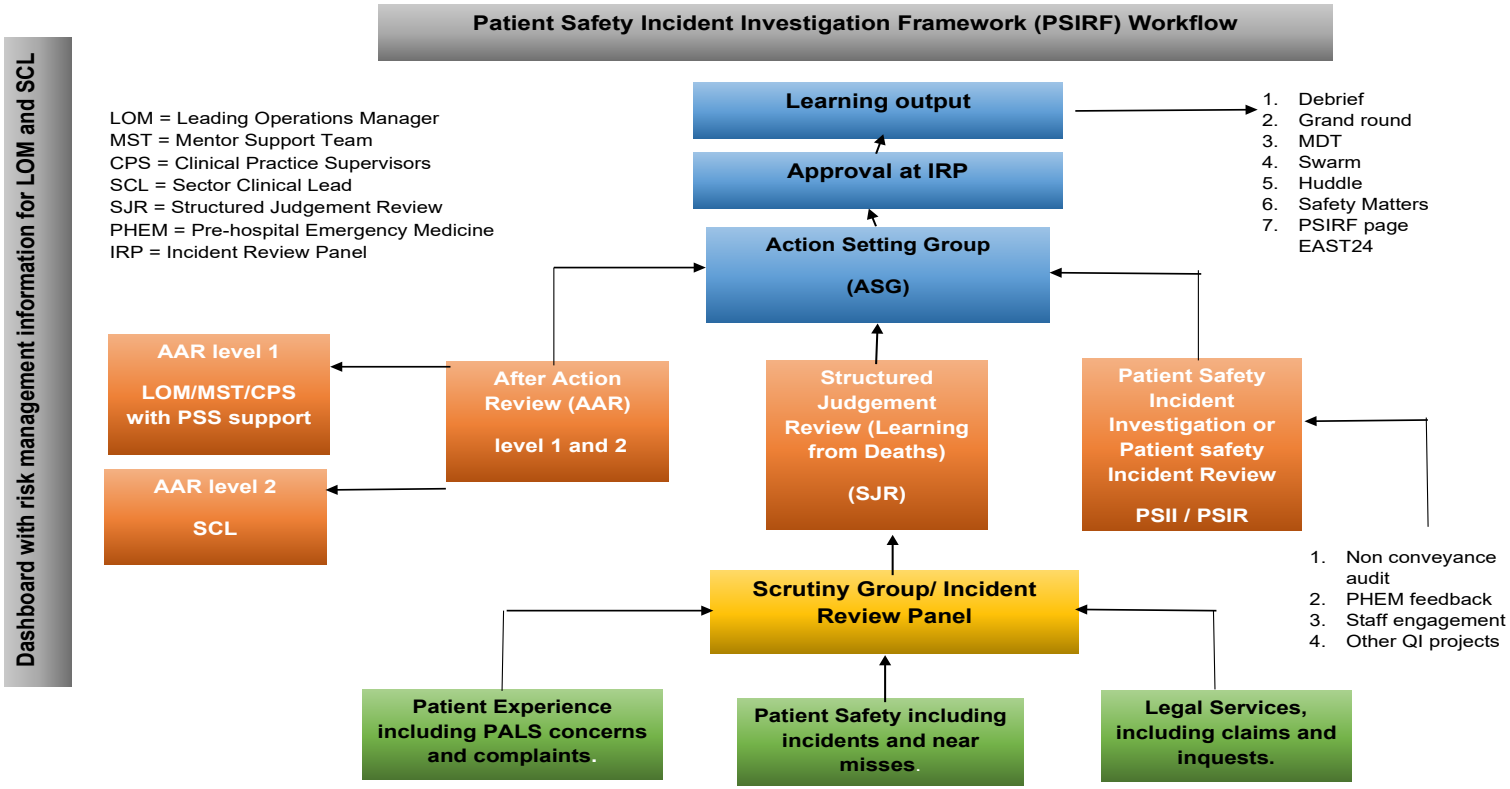
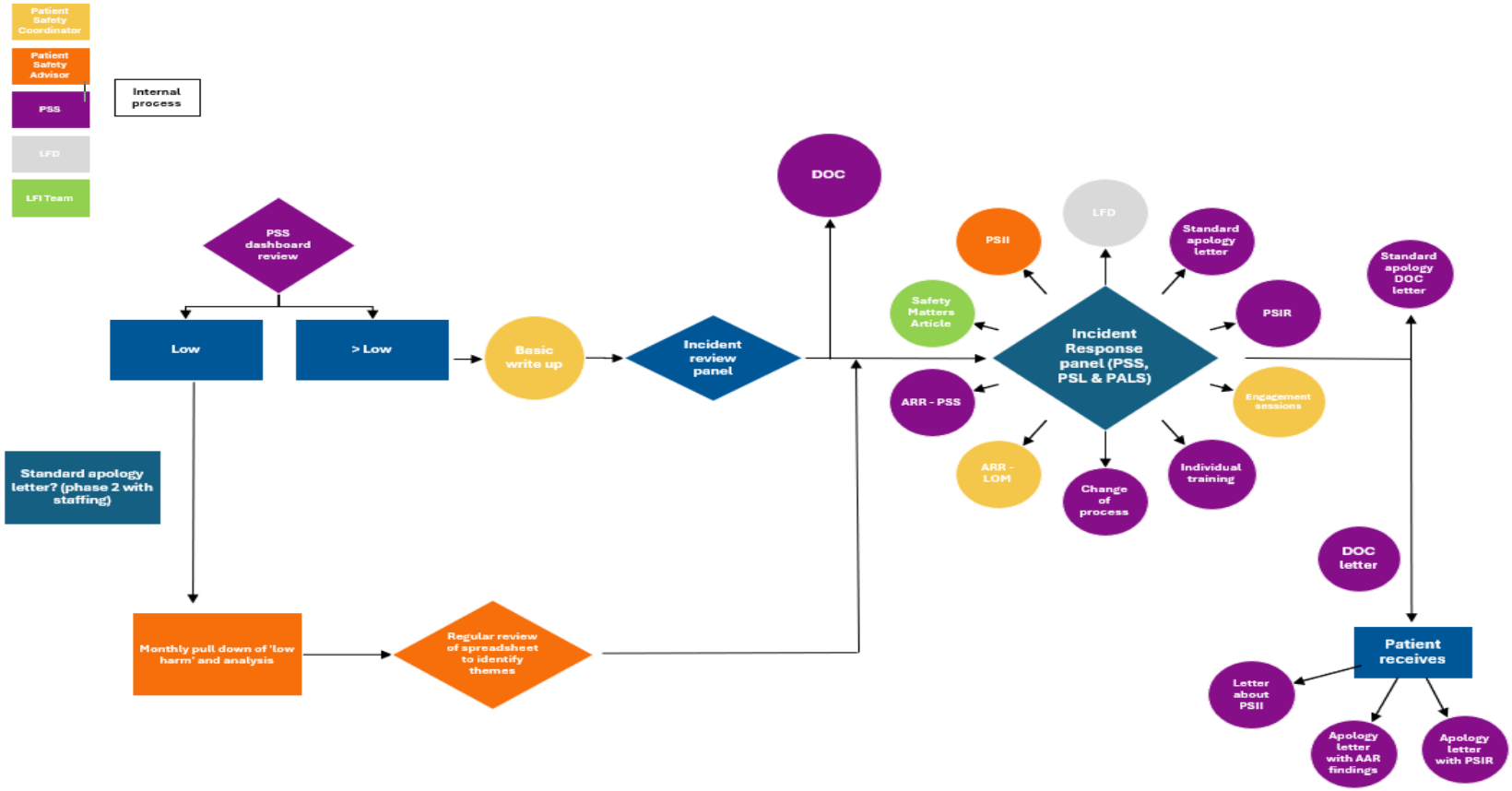


Diagram three: Incident reporting and escalation



The Trust undertakes thematic reviews, and we will continue to monitor trends and themes in relation to our top 4 priorities. The Incident Review Panel will continue to undertake the scrutiny of incidents and assist with deciding what is a proportionate response. The Incident Review Panel will initially sign off Patient Safety Incident Investigations (PSIIs) prior to Board approval.

Patient Safety Incident Investigations (PSIIs):

These will be undertaken on those priority areas regardless of severity or outcome.

The PSII will include at least one incident categorised as a near miss or low harm and will be based on:

- actual and potential impact of the incident's outcome (harm to people, service, quality, reputation and public confidence, etc.)
- likelihood of recurrence
- potential for new learning

Incidents not included on the priority list will be investigated locally using one of the agreed methods outlined above.

For each group of PSIIs completed the Trust will:

- Develop actions plans for the implementation of planned improvements through the Action Setting Group.
- Monitor the effectiveness of improvements over time through the Quality Improvement Team

The type of response will depend on:

- the views of those affected, including patients and their families
- capacity available to undertake a learning response
- what is known about the factors that lead to the incident(s)
- whether improvement work is underway to address the identified contributory factors

Timescales:

There are no prescribed time limits for the completion of PSIIs; good practice is that they should be started as soon as possible after the incident or incidents have been identified. Ideally, they should be completed within one to three months from the start date. In exceptional circumstances a longer timeframe can be negotiated in agreement between the patient/family/carer and the Trust. No PSII should take longer than six months to complete.

After Action Reviews:

These will be facilitated by the Patient Safety Specialists for the locality until operational managers have completed the trust AAR training.

Patient Safety Specialists (PSSs):

They will be assigned to each business unit and be responsible for all aspects of this plan within their ICS locality. Working alongside them will be Patient Safety Advisors and Patient Safety Coordinators who will assist with reviews and the development of learning responses. The PSS will guide, facilitate, and train local leaders to undertake requirements of the PSIRP specific to their locality. Training for staff is detailed in appendix two.

Structure Judgment Reviews (SJRs):

Structured Judgment Reviews are completed in line with the Learning from Deaths Framework. As an ambulance sector we will complete a minimum of 40 SJR's per quarter to identify points of learning and excellence. Should concerns be raised as part of the SJR process the Patient Safety Team will review the incident in full.

The Patient Safety, Patient Experience, Legal and Quality Improvement Teams will continue to work closely together to triangulate themes and trends to develop co-ordinated learning responses. This will be reported through the Patient Safety and Experience Group which reports through the Quality Governance assurance structure (see diagram one above).

Duty of Candour (DoC):

This will continue to be discharged as a statutory requirement. Following a decision at Incident Review Panel (IRP) DOC will be undertaken within the required time frame. Where contact is not successful after two phone calls, a letter will be sent encouraging those affected by an incident to make contact with the patient safety team.

Who will be involved?

The Board: will be responsible for the oversight and final sign off for Patient Safety Incident Investigations (PSIIs), which will be shared with the relevant ICS to provide assurance that we are effectively managing patient safety.

Chief Allied Health Professional, Quality and Improvement: is the executive sponsor for quality and patient safety providing assurance to the Board that robust arrangements for patient safety are in place, which are effectively monitored and updated as the Risk Profile and the PSIRP changes.

Deputy Directors: will be responsible for ensuring the operational teams managing patient safety, patient experience and quality manage the day-to-day oversight of incidents effectively, reporting to the Board to provide that assurance.

Patient Safety Team: Will be responsible for the administrative management of incident reviews under the leadership of the Head of Patient Safety. The team will ensure that the day-to-day administrative duties relating to incident reviews are appropriately documented and the maintenance of relevant databases are kept up to date.

Patient Safety Partners (PSPs): Patient Safety Partners are critical to the success of PSIRF, with their involvement in the review of incidents and development of learning. Recruitment of PSPs will be on a continuous basis, in order for the organisation to develop group of PSPs who have had lived experiences of the ambulance service and are also representative of their local communities and groups. EEAST have successfully recruited two PSP's and since the transition to PSIRF they have become a pivotal part of the PSIRF process.

Patients and Families: We will engage with patients and their families involved incidents to ensure that we hear about their experience during the pathway of care and use that information to provide a full picture of what happened to assist with a robust and complete review. Where possible a discovery interview will be completed and form part of the end report.

Incident Review Panel: This will continue to meet twice per week and will identify which pathway is appropriate for the incident review (see diagram 3).

Action Setting Group: This will continue to meet twice per month and identifies how actions developed from different review pathways will be managed.

Quality Improvement Team: The QI Team has set up innovation hubs within the organisation and these will be crucial in helping to drive forward the learning and local improvement work follow incident reviews. With well established links with the Patient Safety Team national and local improvement projects will be linked to patient safety and experience learning responses.

Our data

Information has been reviewed using the Trust's electronic risk management system for the past 12 months to identify themes and trends that may require a PSII. Key themes identified are included in the following section under local profile. It is important that we continue to use data from various sources such as patient experience surveys, including health safety and security learning outcomes. We will also continue to use a multi-platform approach to shared learning including learning from good practice.

Our patient safety incident profile (National requirements)

National incident types below may change considering patient safety developments reported, which in turn will change our profile. Our plan will be reviewed to the national requirements when defined and change is needed.

Patient safety incident type
Incidents meeting the Never Events criteria
Death thought more likely than not due to problems in care (incident meeting the learning from deaths criteria for patient safety incident investigations (PSIIs)) – including child deaths and those with learning disabilities
Incidents meeting 'Each Baby Counts' criteria
Mental health-related homicides by persons in receipt of mental health services or within 6 months of their discharge
Safeguarding incidents

Local profile

Following review 4 key themes have been identified, which will be included in our risk profile. The plan will then be reviewed internally, and with our lead commissioner. Further detail is in appendix one.

The subjects were identified using analysis of risk management data as well as themes identified at IRP. 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 the PSIRF Plan made.

	Theme type	Specific area for investigation
1	Pre hospital resuscitation	Decisions not to start resuscitation in the pre hospital setting Decisions to stop resuscitation in a pre hospital setting after it has been commenced
2	Effective assessment of patients with abdominal pain in a pre hospital setting	Clinicians ability to safely assess, discharge, appropriately safety net and document information for patients that present with abdominal pain.
3	Medication errors – Adrenaline 1:1000	IM adrenaline being administered via the incorrect route IM adrenaline being administered with the incorrect dose
4	PTS Injury	Patients Injured whilst in the care of PTS A comparison of any patients injured whilst in the care of frontline A&E crews

Other local incident themes

Delayed ambulance responses leading to harm have consistently been the highest reported incident category during the review period. 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 closely and investigated where appropriate.

The organisation provides various services, including patient transport services in some locations. Whilst patient transport services are not included in the local profile, the organisation will continue to monitor these incidents closely as requested by those ICSs where we provide the service.

References

2022 Patient Safety Incident Response Framework - and supporting guidance (NHSE August 2022)

- Engaging and Involving patient families and staff following a patient safety incident
- Guide to responding proportionately to patient safety incidents
- Oversight roles and responsibilities
- Patient safety incident response standards

2019 The NHS Patient Safety Strategy. Safer culture, safer systems, safer patients. (NHSE July 2019)

2021 NHS Complaints Standards (Parliamentary Health Service Ombudsman March 2021)

2021 Safety Enabling Strategy 2021-2024 (East of England Ambulance Service NHS Trust)

2015 The NHS Serious Incident Framework (NHSE 2015)

Resource links:

NHSE PSIRF page.

https://www.england.nhs.uk/patient-safety/patient-safety-insight/incident-response-framework/

Appendices

Chart one: Shows a breakdown of Patient safety incidents by level of harm versus overall activity, April 2023 - August 2024.

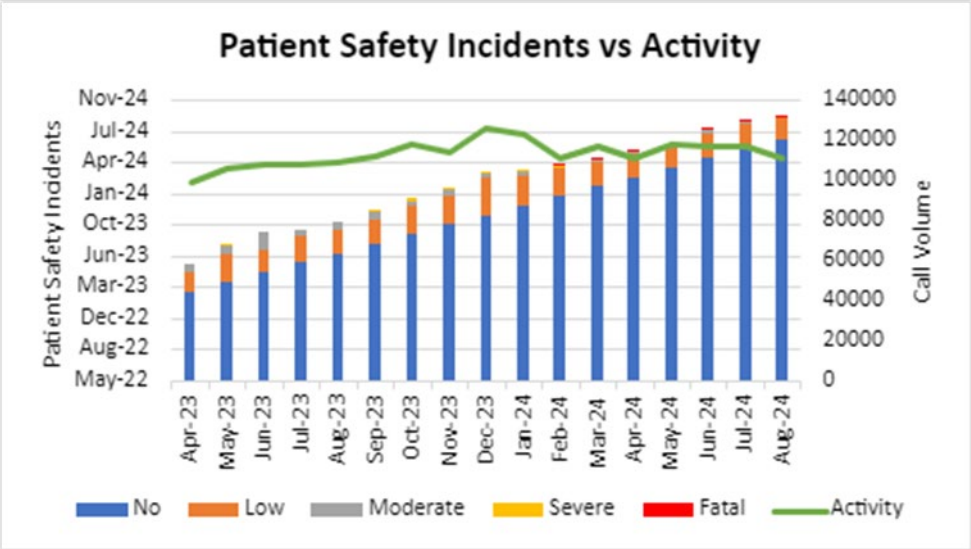


Chart two shows a breakdown of Patient Safety incidents by level of harm, October 2023 – December 2024.

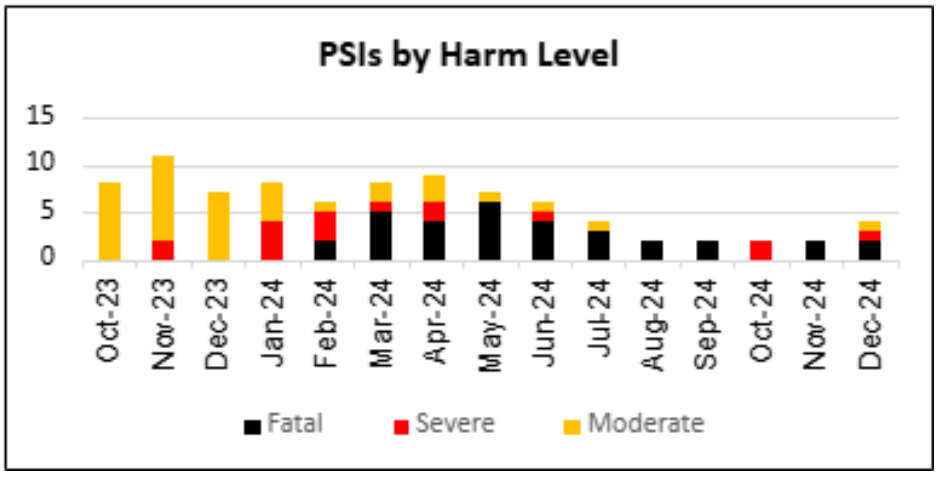


Chart three shows a breakdown of Patient Safety Incidents by incident type, October 23 – December 24.

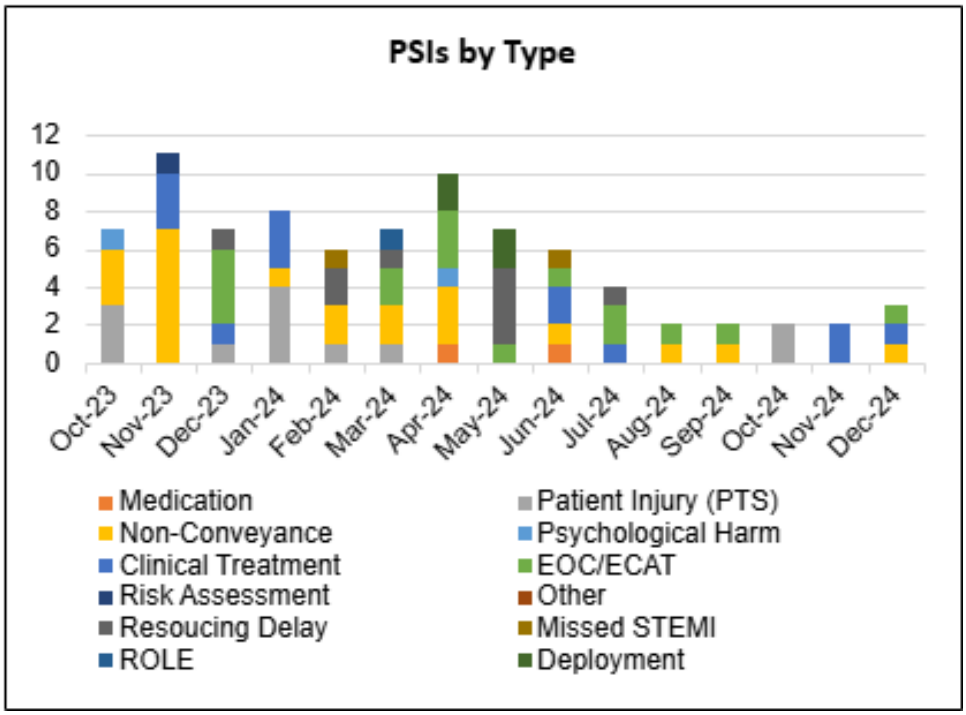


Chart four shows a breakdown of incidents by type, October 2023 – August 2024.

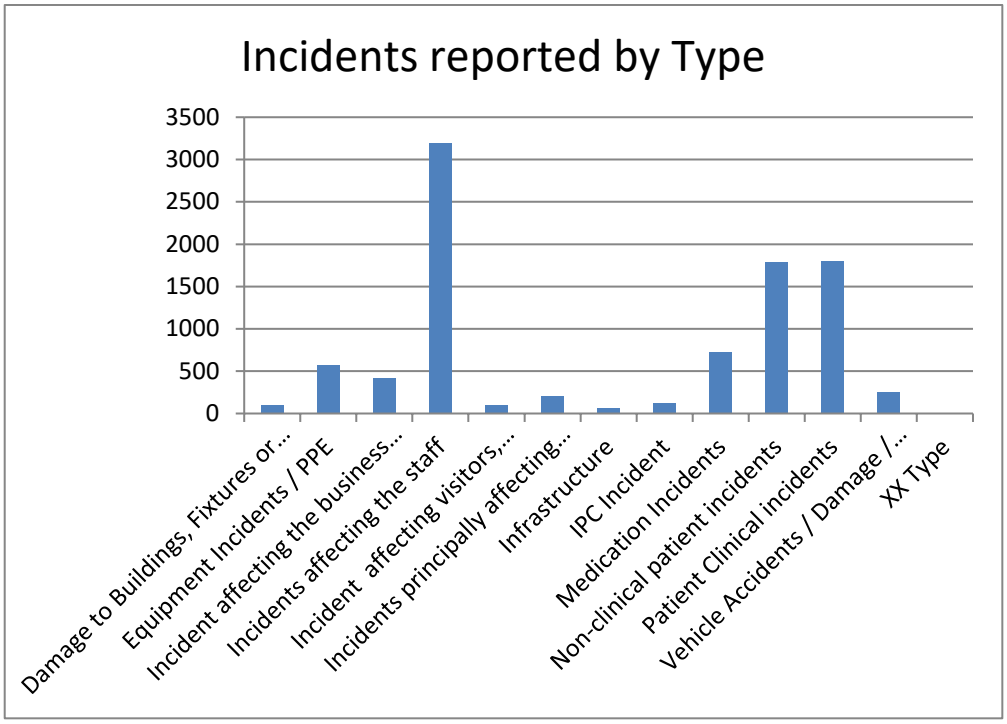
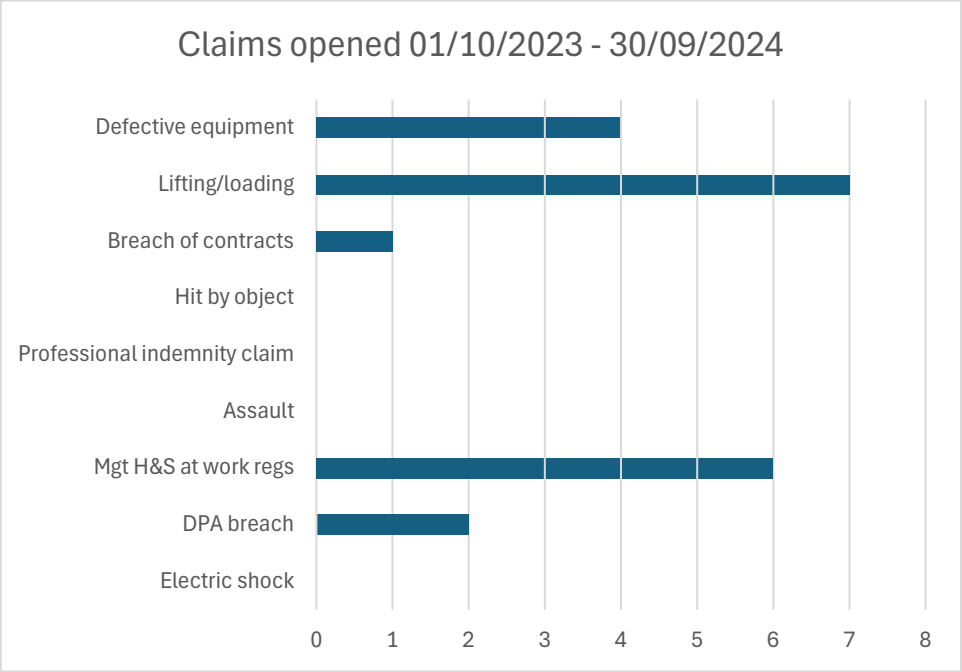
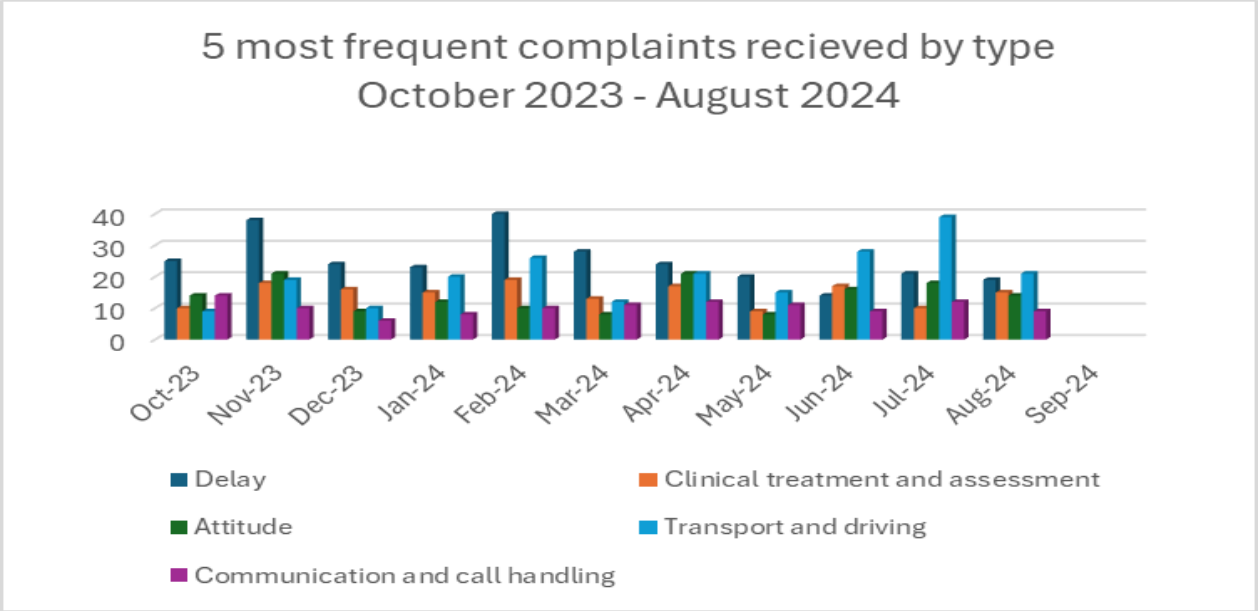


Chart five shows a breakdown of the number of claims received by the legal team.



The number of claims has declined in the last five years. The data for 2022 only includes claims up until 30 June 2022. Figures include staff and patient claims and were no clinical claims.

Chart six shows a breakdown of the most frequent complaints received by type via the Patient Experience Team.



Appendix two:

Training for PSIRF

This training plan will be reviewed annually in line with the PSIR Plan review

	Type of Training	**Attendees and information**
Complete by the Patient Safety team	**East Regional Training Modules:** Systems 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	Patient Safety Team reps Patient Experience Team reps QI Team reps General Managers Assistant General Managers Director of Nursing
Complete Autumn 2023	Oversight of learning from patient safety incidents	Board Seminar Executive and Non-Executive Directors Deputy Clinical Directors
Ongoing throughout 2024/2025 via local events and management kickstart courses	After Action Review Training to include train the trainer	Staff involved in incident review process including corporate teams and local management teams Patient Safety Specialist to roll out training
Ongoing (not currently mandated)	Level one and two patient safety training	Patient Safety Specialist to roll out training after completing regional training Training to be agreed with Learning and Development Team to include online and in person training.
Ongoing	Staff awareness sessions	Dedicated PSIRF page on staff intranet

		Posters with QR code to link to PSIRF page Page will include webinars and other tools for self-directed learning
December 2024	Patient Safety Syllabus Training	Attendance by the Patient Safety Specialists to the national training