London Ambulance Service
NHS Trust

Patient safety incident response plan

Document Control

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07/03/2023	V2.11	Updated following Quality Assurance Committee Feedback (context)	Approved by QAC
23/02/2023	V2.10	Updated following Quality Oversight Group Feedback (amendment of priorities)	Approved by QOG
21/0220/23	V2.9	Annual review and update in line with full national role of PSIRF	DoQ/ HofQIL Approved by LAS CQRG 21/02/23
06/02/2023	V2.8	Local priority review	DoQ/ HofQIL
March 2022	V2.7	Annual review (early PSIRF adopter framework)	Trust Board
February 2021	V2.6	Live document (early PSIRF adopter framework)	Trust Board
October 2020	V0.1-V2.5	Document Development	Quality Improvement and Learning Team

Contents

1. Introduction

This patient safety incident response plan sets out how the London Ambulance Service NHS Trust intends to respond to patient safety incidents over a period of 12 to 18 months. The plan is not a permanent 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 document should be read in conjunction with the Trust's Patient Safety Incident Response Policy.

2. Our services

Emergency and urgent healthcare access

Our main service is to answer request for help of an emergency or urgent medical nature, including 999 calls and calls transferred by a dedicated computer link from the Metropolitan Police Service, collectively known as "calls".

We run two emergency call centres which are split between two sites, HQ (Waterloo) and Newham known as our emergency operations centres (EOC) which deal predominately with patients who are seriously ill or life-threatened, as well as dealing with patients whose conditions are less serious. Within these centres, we employ emergency call handlers, emergency response dispatchers, clinical advisors, clinical team navigators and emergency operations centre managers.

111/Integrated Urgent Care

Our 24-hour 111 integrated urgent care services in north east and south east London answer around 2.2 million calls a year. This deals predominantly with patients needing advice or access to urgent care services. We employ non-clinical service and health advisors to perform an assessment and a multi-disciplinary team of General Practitioners, Advanced Clinical Practitioners, Nurses and Paramedics to assess and manage patients using their specialist clinical knowledge and skills such as prescribing.

Emergency and Urgent Health care response

We have a number of ways to respond to the clinical needs of callers to our 999 service. The options include:

Hear and treat: the patient is given clinical advice over the telephone, which may include referring to an alternative care pathway.

See and treat: frontline response sent to treat the patient at the scene and either discharge them or refer them for follow up at an appropriate care pathway.

See, treat and convey: frontline sent to treat patients at the scene and transport them to the most appropriate setting of care, which may be an emergency department, specialist centre or an appropriate care pathway.

Our front line response staff include: paramedics, advanced paramedic practitioners, registered mental health nurses, emergency medical technicians, assistant ambulance practitioners and non-emergency transport staff. Some of our response vehicles are staffed in collaboration with other providers and may be staffed by a combination of our paramedics and registered general nurses or therapists employed by community providers.

Specialist operational response

We provide an emergency clinical response to incidents of a chemical, biological, radioactive and nuclear (CBRN) or other exceptionally hazardous nature within London and surrounding area deploying staff with specialist training and equipment.

Health professionals' information provision and case management

We manage the Emergency Bed Service (EBS), a 24-hour referral support team which provides a range of services to health care professionals within and external to the Trust.

Non-Emergency Transport Service (NETS)

NETS are deployed as a frontline resource to some Cat 3, Cat 4, HCP 3&4 and IFT 3&4 calls, where the call has been deemed suitable for their skill set by the clinical hub or following a see and treat assessment by a clinician.

3. Defining our patient safety incident profile

The patient safety incident risks for the Trust has been profiled using organisational data from patient safety incident reports, complaints, freedom to speak up reports, mortality reviews, case note reviews, staff survey results, claims and risk assessments.

Consultation on the Trust's prioritisation plan has been undertaken internally via the Trusts Safety Investigation Assurance and Learning Group, the Quality Oversight Group, the Quality Assurance Committee, Trust Board and externally with Trust's Commissioners.

The following local priorities have been identified by review of the data:

	Incident type	Area/ Service
1	Delays	Trust wide
2	Call handling and dispatch	EOC/IUC
3	Civility (behaviour and attitude)	Trust wide
4	Clinical assessment	Trust wide
5	Medicines management	Trust wide
6	Cardiac arrest management, including delayed defibrillation	Ambulance Services
7	IT Infrastructure	Trust Wide
8	Medical equipment	Ambulance Services/Logistics
9	Management of patients 65 years old and older who have fallen	Trust wide
10	Discharge of care	Trust wide

These priorities were compared to local priorities outlined in the 2021/23 Trust PSIRP (appendix 1).

New priorities were discussed and have been included in this plan based on quality intelligence. This was specifically reviewing patient safety incidents in 2022 and identifying the opportunity to being more specific when articulating priority criteria. This includes a specific focus on the care of people aged 65 years or older who have fallen as well as other incidents relating to patients at the extremes of age, and a focus on cardiac arrest management to include unrecognised oesophageal intubation and recognition of cardiac arrest, alongside our existing priority of delayed defibrillation.

Harm in relation to delays in call-answering and ambulance attendance were recognized as part of this review to continue to represent an area of concern, with between 14 and 190 incidents per quarter being subject to a 50 criterion delays structured judgement review (SJR) which has formed part of incident investigation since early in the COVID-19 pandemic. The delays SJR process is no longer yielding new learning and in line with the Patient Safety Incident Response Framework our future focus will be on improvement in this area as part of our Quality Priorities for 2023/24.

One of the priorities which were present in the 2021/23 plan were identified for removal from the PSIRP. Clinical assessment which led to a patient being managed down an incorrect pathway was removed having had no PSIIs commissioned during 2022.

4. Defining our patient safety improvement profile

The findings from incident reviews, PSIIs or other related activities must be translated into effective and sustainable action that reduces the risk to patients. For this to happen, organisations must be able to apply knowledge of the science of patient safety and improvement to identify:

- Where improvements are needed
- What changes need to be made
- How changes will be implemented
- How to determine if those changes have the desired impact (and if they do not, how they could be adapted).

The Trust uses the standardised approach to improvement via the Quality, Service Improvement Re-design (QSIR) programme to ensure staff have the tools they need to sustain improvement.

A number of 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 PSIIs, review, audit or risk assessment findings (e.g. national suicide prevention plan).

The below is an overview of these Trust's programmes, projects and current quality improvement plans:

	Strategic Programmes and Projects improvement plan	Specialty	Monitoring Committee/Group
1	IT Infrastructure	Integrated Patient Care Services/IM&T/Ambulance Services	IMT Delivery Board
2	Category 2 Improvement Plan	Ambulance Services/ Emergency Operations Centre	Executive Committee
3	Emergency Operations Centre Transformation Programme	Emergency Operations Centre	Executive Committee
4	Estates Modernisation Programme	Emergency Operations Centre/ /Integrated Patient Care Services/Ambulance Services	Executive Committee

5	Right care, right place	Integrated Patient Care Services/Ambulance Services	Executive Committee

	***Local* patient safety incident improvement plans titles**	**Specialty**	**Monitoring Committee/Group**
1	Patients who have fallen	Ambulance Services	SIALG/QOG/QAC
2	Timely Defibrillation	Ambulance Services	SIALG/QOG/QAC
3	Cleric Implementation	EOC/IUC	SIALG/QOG/QAC
4	Medicines Management	Ambulance Services	SIALG/QOG/QAC

5. Our patient safety incident response plan: national requirements

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 2018	PSII	Create local organisational actions and feed these into quality planning.
Incidents that meet the 'Learning from Deaths' criteria; that is, deaths clinically assessed as more likely than not due to problems in care.	PSII	Create local organisational actions and feed these into quality planning.

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

Maternity and neonatal incidents:

- incidents which meet the 'Each Baby Counts' and maternal deaths criteria detailed in Appendix 4 of the PSIRF must be referred to the Healthcare Safety Investigation Branch (HSIB) for investigation (https://www.hsib.org.uk/maternity/)
- all cases of severe brain injury (in line with the criteria used by the Each Baby Counts programme) must also be referred to NHS Resolution's Early Notification Scheme

- all perinatal and maternal deaths must be referred to MBRRACE

Mental health related homicides by persons in receipt of mental health services or within 6 months of their discharge

- Cases must be discussed with the relevant NHS England and NHS Improvement regional independent investigation team (RIIT)

Child deaths

- Incidents must be referred to child death panels for investigation

Deaths of persons with learning disabilities:

- Incidents must be reported and reviewed in line with the Learning Disabilities Mortality Review (LeDeR) programme

Safeguarding incidents:

- Incidents must be reported to the local organisation's named professional/safeguarding lead manager and director of nursing for review/multi-professional investigation.

Incidents in screening programmes:

- Incidents must be reported to Public Health England (PHE) in the first instance for advice on reporting and investigation (PHE's regional Screening Quality Assurance Service (SQAS) and commissioners of the service)

Deaths of patients in custody, in prison or on probation where healthcare is/was NHS funded and delivered through an NHS contract:

- Incidents must be reported to the Prison and Probation Ombudsman (PPO), and services required to be registered by the Care Quality Commission (CQC) must also notify CQC of the death. Organisations should contribute to PPO investigations when approached.

6. 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:

Locally-defined emergent patient safety incidents requiring PSII.

An unexpected patient safety incident which signifies an extreme level of risk for patients, families and carers, staff or organisations, and where the potential for new learning and improvement is so great (within or across a healthcare service/pathway) that it warrants the use of extra resources to mount a comprehensive PSII response.

Locally-predefined patient safety incidents requiring investigation.

Key patient safety incidents for PSII have been identified through analysis of local data and intelligence from the past three years, and agreed as a local priority. This is noting that incidents which do not meet the Trusts PSIRP will be investigated using appropriate and proportionate techniques. The investigation methods for this category of investigation will be agreed by the Patient Safety Investigation Panel using the following planned responses:

- Patient safety incident investigation
- Swarm huddle
- After action review
- MDT review

Theme	Patient safety incident type or issue	Anticipated improvement route
Medicine management	Medication error	Local safety actions to feed into a wider piece of work.
	Errors occurring during the preparation or administration of medicines with or without the presence of patient harm	
Call handling	Errors in 999 call handling which has led to a patient receiving a delayed response attributed to probable harm	Local safety actions to feed into a wider piece of work.
	Errors in 111/IUC call handling which has led to a patient receiving a delayed response attributed to probable harm	Local safety actions to feed into a wider piece of work.

Face to face clinical assessment	Clinical assessment and management of patients at the extremes of age.	Inform ongoing improvement efforts linking with fallers thematic review and Quality Priorities.
	Clinical assessment which led to a patient not receiving immobilisation where it was clinically indicated	Local safety actions to feed into a wider piece of work.
	Face to face assessment which resulted in the conveyance to hospital but not to definitive care; where there was clear indication for the patient to have been conveyed to a specialist centre.	Inform ongoing improvement efforts ascertained from findings from previously completed thematics.
Discharge of care	Enhanced telephone clinical assessment (999/111) incorrectly resulting in home management advice. The management of the patient down this pathway resulted in probably harm.	Local safety actions to feed into a wider piece of work.
	Face to face assessment which resulted in an incorrect decision to not convey the patient. The non-conveyance is attributed to probable harm.	Local safety actions to feed into a wider piece of work in collaboration with CARU.
Cardiac arrest management	Airway management including unrecognised oesophageal intubation	Inform ongoing improvement efforts linking with thematic review and Quality Priorities.
	Timely Defibrillation	
	Recognition of Cardiac Arrest	

These local priorities will be reviewed on an ongoing basis via the Safety Investigation Assurance and Learning Group with a formal review of the PSIRP no later than 18 months from the date of issue.

Appendix 1 – 2021/23 PSIRP

(Acknowledging that numbers of pre planned PSIIs were removed in spring 2022)

	Incident type Specific risk (or incident subtype) identified through risk assessment process and described with the support of patient safety teams, executive team, patient groups and clinical commissioning groups		Number of PSIIs	Planned response for specific incident type - selected based on risk assessment and particularly on potential for new learning or insight
1	Call handling	Errors in 999 call handling which has led to a patient receiving a delayed response attributed to probable harm	**6**	3 PSIIs will be undertaken into each specific incident type to identify key common interlined causal factors
		Errors in 111/IUC call handling which has led to a patient receiving a delayed response attributed to probable harm		
2	Face to Face Clinical Assessment	Clinical assessment which led to a patient being managed down an incorrect pathway	**9**	3 PSIIs will be undertaken into each specific incident type to identify key common interlinked causal factors.
		Face to face assessment which resulted in an incorrect decision to not convey the patient. The non-conveyance is attributed to probable harm.		
		Face to face assessment which resulted in the conveyance to hospital but not to definitive care; where there was clear indication for the patient to have been conveyed to a specialist centre.		
3	Enhanced Telephone Clinical Assessment	Enhanced telephone clinical assessment incorrectly resulting in home management advice. The management of the patient down this pathway resulted in probably harm.	**3**	3 PSIIs will be undertaken to identify key common interlinked causal factors.
4	Clinical Assessment of Spinal Injuries	Clinical assessment which led to a patient not receiving immobilisation where it was clinically indicated	**3**	3 PSIIs will be undertaken to identify key common interlinked causal factors.
5	Medicine management	Medication error	**4**	4 PSIIs will be undertaken to identify key common interlinked causal factors.
		Errors occurring during the preparation or administration of medicines with or without the presence of patient harm		