London Ambulance Service
NHS Trust

Patient safety incident response plan

Document Control

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Lead Director/ Manager	Tim Lightfoot, Medical Director, Clinical Quality and Governance
Author(s)	April Wrangles, Head of Quality Governance and Patient Safety
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Change History

Date	Version	Change	Approved by/ Comments
01/02/2025	V4.0	Annual review and update of priorities	Approved by QAC
07/03/2023	V3.3	Updated following Quality Assurance Committee Feedback (context)	Approved by QAC
23/02/2023	V3.2	Updated following Quality Oversight Group Feedback (amendment of priorities)	Approved by QOG
21/02/23	V3.1	Annual review and update in line with the full national role of PSIRF	DoQ/ HofQIL Approved by LAS CQRG 21/02/23
06/02/2023	V3	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 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 requests 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 patients whose conditions are less serious. Within these centres, we employ emergency call handlers, emergency response dispatchers, clinical advisors, clinical team managers, mental health nurses, and emergency operations centre managers as well as specialists within the tactical operations centre.

111/Integrated Urgent Care

Our 24-hour 111 integrated urgent care services in northeast and southeast 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 several 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 the 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 have been profiled using organisational data from patient safety incident reports, complaints, Learning from Death reviews, inquests, case note reviews, staff survey results, claims and risk assessments.

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

Stakeholder engagement supported by quality intelligence identified the following areas for consideration:

1	Incident type	Area/ Service
1	Delays	Trust wide
2	Management of multiple calls	EOC/IUC/CHUB
3	Missing/faulty equipment	Trust wide
4	Management of older patients who have sustained trauma	Trust wide
5	Mental capacity assessment and documentation	Trust wide
6	Use of decision-making tools	Ambulance Services
7	Paediatric assessment and management	Trust Wide
8	Informed consent/decision making	Trust wide
9	Seeking clinical support	Trust wide
10	Abdominal pain	Trust wide
11	Call handling chief complaint selection	EOC
12	Learning disabilities and autism	Trust wide
13	PGD breeches	Ambulance Services
14	Rhythm recognition and ECGs	Ambulance Services

These priorities were compared to local priorities outlined in previous plans from 2021/23 and 2023/25 (Appendix 1).

The previous two plans saw the commissioning of over 600 learning responses combined, which produced several system improvement plans (section 4). Some priorities did not receive a system improvement plan during 2023/25 due to the volume of cases and the lack of specificity of those priorities. This plan will, therefore, be more focused than previous plans to enable more targeted learning for specific areas of risk. The plan will also be renewed on an annual basis moving forward, acknowledging the specific nature of each priority and requirement of a system improvement plan ahead of closure.

4. Defining our patient safety improvement profile

The findings from incident reviews, learning responses 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 Lean methodology and the Quality, Service Improvement Re-design (QSIR) programme to ensure staff have the tools they need to sustain improvement.

Several strategic programmes and projects, as well as locally designed patient safety improvement plans, are underway across the Trust. These relate to full plans, rather than individual actions, designed and prescribed to address known issues with all of them incorporating previous learning responses, review, audit or risk assessment findings (e.g. national suicide prevention plan).

Below is an overview of these trusts' programmes, projects and current quality improvement plans:

	Safety incident improvement plans titles	Specialty	Monitoring Committee/Group
1	Identification of ineffective breathing	EOC	999 Operations Board
2	Medicines Management	Ambulance Services	MMG, LAG, CQOG, QAC
3	Duplication of calls	EOC	999 Operations Board
4	Dispatch to high-risk determinants	EOC	999 Operations Board, LAG
5	Shift change over	Ambulance Services, EOC	999 Operations Board, CQOG, QAC
6	Category 2 improvement	Trust wide	999 Operations Board, CQOG, QAC

Below is an overview of patient safety led improvement work commencing for areas of concern for the Trust.

	Area of concern	Specialty	Work underway
1	ECG and STEMI care	Ambulance Services	Thematic underway, national review complete, space on CSR 2025/26 approved, STEMI checklist to be launched, system improvement plan pending
2	Face-to-face paediatric assessment	Ambulance Services	Thematic underway, space on CSR 2025/26 approved, system improvement plan pending
3	Assessment and management of patients with learning disabilities and/or autism	Trust wide	Meets national criteria (LeDeR). For consideration for 2025/26 audit plan
4	Assessment and management of abdominal pain	Trust wide	For consideration for the 2025/26 audit plan, covered in 'extremes of age' priority.
5	Utilisation of decision support tools	Ambulance Services	Patient referral tool and Pathfinder updated, review underway of all trust tools.
6	Missing/faulty medical equipment	Ambulance Services	The localised delivery model is commencing, which will see a new method of equipment distribution.

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 National learning response

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 Maternity and Newboarn Safety Investigations (MNSI) team for investigation (https://www.mnsi.org.uk/)
- 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

- All unexpected child deaths are reported via our safeguarding processes for investigation.

Deaths of persons with learning disabilities:

- All learning disability deaths should be notified to the Learning Disability & Vulnerabilities Specialist who liaises with the Learning Disabilities Mortality Review (LeDeR) programme.

Safeguarding incidents:

- Safeguarding concerns and referrals must be reported via the LAS safeguarding process. See Safeguarding Children and Safeguarding Adult at Risk policies. Safeguarding allegations against staff are managed via the Safeguarding Allegations against staff policy.

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 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 events for investigation have been identified through analysis of local data and intelligence and have been agreed as being a local priority for the Trust for the next 12 months.

These local priorities will be reviewed on an ongoing basis via the Learning and Assurance Group with a formal review of the PSIRP no later than 12 months from the date of issue.

	Local Priority	Descriptor	Anticipated improvement route
1	Informed consent	Patients not receiving a face-to-face response or non-conveyed, where learning related to informed consent and/or decision-making has been identified.	Inform ongoing improvements linked with safe discharge of patients.
2	Management of patients under the influence of alcohol and/or drugs	Patients under the influence of drugs and/or alcohol, where learning related to their assessment and management has been identified	Local safety actions to feed into wider piece to work linked to mental capacity assessment and human factors

3	Remote assessment and management of patients at extremes of age.	Patients at the extremes of age where learning has been identified in the assessment and management by the IUC or EOC contact centres, including Clinical Hub	Local safety actions to feed into a wider piece of work.
4	Incorrect MPDS protocol or fast-track selection	Patients triaged by 999 EOC with incorrect MPDS protocol or fast-track selection, where organisational learning has been identified.	Local safety actions to feed into a wider piece of work.

The learning response for incidents meeting the plan will be agreed on by specialists within the Trust using the following pre-planned responses:

Method	Descriptor
Patient Safety Incident Investigation (PSII)	A PSII offers an in-depth review of a single patient safety incident or cluster of incidents to understand what happened and how
Multidisciplinary team (MDT) review	An MDT review supports health and social care teams to learn from patient safety incidents that occurred in the significant past and/or where it is more difficult to collect staff recollections of events either because of the passage of time or staff availability. The aim is, through open discussion (and other approaches such as observations and walk-throughs undertaken in advance of the review meeting(s)), to agree on the key contributory factors and system gaps that impact safe patient care.
Swarm Huddle	The swarm huddle is designed to be initiated as soon as possible after an event and involves an MDT discussion. Staff 'swarm' to the site to gather information about what happened and why it happened as quickly as possible and (together with insight gathered from other sources wherever possible) decide what needs to be done to reduce the risk of the same thing happening in future.
After action review (AAR)	AAR is a structured, facilitated discussion of an event, the outcome of which gives individuals involved in the event an 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 and can be used to discuss both positive outcomes and incidents. It is based around four questions: What was the expected outcome/expected to happen? What was the actual outcome/what actually happened? What was the difference between the expected outcome and the event? What is the learning?

The choice of learning response will be appropriate and proportionate and will consider:

- The **views** of those affected, including patients and families
- The **capacity** to undertake a learning response

- What is **known** about the factors that led to the incident
- Whether **improvement** is already underway, which addresses contributory factors
- Is there evidence that improvement work is having the intended **benefit**?
- Are the Trust and its ICB satisfied that **risks** are being managed appropriately?

It is acknowledged that not all safety events will meet the Trust's plan. Those that are outside of the plan will continue to receive an investigation which is appropriate, proportionate and in line with the framework and the Trusts incident reporting policy.

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 resulted in the conveyance to the hospital but not to definitive care, where there was a 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 probable 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		

Appendix 2 – 2023/25 PSIRP

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 resulted in the conveyance to the hospital but not to definitive care, where there was a 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 probable 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	