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# Patient Safety Incident Response Plan 2024/25

## Western Medical Services

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## Introduction

This Patient Safety Incident Response Plan (PSIRP) outlines how Western Medical Services Limited (We) intends to respond to patient safety incidents over the next 12 to 18 months. As a live document, it will adapt to specific circumstances and the needs of those affected whilst remaining flexible to the needs of the patients.

The plan aims to enhance the value of patient safety incident investigations (PSIIs) by:

- Reframing: Using a system-based approach to identify root causes.

- Focusing: Addressing systemic factors to mitigate risks.

- Transferring: Emphasising quality over quantity in investigations.

- Demonstrating: Highlighting measurable improvements in safety outcomes.

## About Us

Western Medical Services is an independent ambulance service based in the UK. While we do not currently handle 999 emergency calls, we provide critical and non-emergency patient transport services, with a focus on quality, compliance, and governance. Our services include:

- Scheduled patient transport for routine appointments.
- Specialist patient care transport with paramedics and medical staff.
- Collaborative partnerships with healthcare providers for tailored solutions.
- SafeBus/Safespace NTE Provisions
- International Repatriations
- Event Medical Services

With a dedicated team of healthcare professionals, we prioritise safety, compliance, and excellence in patient care.

## Our Stakeholders

We collaborate with a range of stakeholders to ensure safe and effective patient care, including:

- Healthcare providers (e.g., NHS Trusts, private clinics, and community care organizations).

- Regulatory bodies (e.g., Care Quality Commission).

- Patients and their families.

- Local authorities and integrated care boards.

We aspire to become a trusted partner in our region and across the UK, whilst raising expected standards within the independent ambulance sector. We will continue this ethos and philosophy as we develop our patient safety incident response plan.

Within our role in the independent ambulance sector, we are committed to identifying and supporting cross-provider, or cross-system patient safety incidents to make healthcare safer for everyone.

## Defining Our Patient Safety Incident Profile

Western Medical Service is a relatively new organisation, only providing regulated activities since 10th October 2023. Since this time due to limited exposure, we have not experienced any patient safety incidents and so currently are unable to build a full safety incident profile.

Our plan was consulted internally via our senior leadership team meetings, clinical governance review meetings and shared externally to NHS Devon Integrated Care Board as our main NHS commissioner.

Our safety profile will be future informed by:

- Incident reports and complaints.
- Staff feedback and Freedom to Speak Up reports.
- Clinical audits and risk assessments.
- Annual review of electronic patient report forms (e-PRFs).

Through internal steering groups we have identified the following priority areas which include:

1. Harm identified during patient transport.
2. Delays in scheduled inter-facility transfers.
3. Risks associated with manual handling during patient movement.
4. Equipment reliability and readiness.
5. Delays in accessing definitive care

## Improving Our Patient Safety Culture

Extensive research into organisational safety has consistently demonstrated that creating an open and transparent culture is a cornerstone for improving safety standards. In such an environment, colleagues feel confident and secure in reporting incidents or raising concerns without the fear of blame or punitive actions. This sense of psychological safety is essential for fostering honest communication and facilitating continuous learning, ultimately leading to a safer and more effective organisation.

At Western Medical Services, we place significant emphasis on encouraging and supporting all staff members to report any incidents or situations they believe have occurred, or may occur, that could potentially cause harm to patients or colleagues. This

proactive approach ensures that issues are identified and addressed early, reducing risks and enhancing the overall quality of care. We also recognise the critical role of our managers and leaders in this process. They are empowered to take direct action in response to reports, driving localised improvements and implementing changes that align with our organisational goals.

At the same time, we prioritise sharing insights and learning outcomes across all levels of the organization, ensuring that knowledge gained from one area benefits the entire team.

Our commitment to fostering a “just culture” is at the heart of these efforts. This means we focus on understanding the underlying systems and processes that contribute to incidents rather than placing blame on individuals. By promoting fairness, accountability, and a dedication to improvement, we aim to create a supportive environment where staff are motivated to contribute to the shared goal of enhancing patient safety and organisational excellence.

## Defining Our Patient Safety Improvement Profile

We understand that the insights gained from learning responses, including Patient Safety Incident Investigations (PSIIs) and related activities, must be transformed into actionable and sustainable measures that effectively mitigate risks and enhance the safety of our patients. Translating learning into meaningful change is central to our commitment to continuous improvement in patient safety.

To achieve this, we are leveraging evidence-based knowledge in patient safety science and improvement methodologies to create a comprehensive and robust patient safety improvement plan. A key component of this strategy is our Quality Improvement training program, which is being implemented using the Define, Measure, Analyse, Improve, and Control (DMAIC) methodology. This structured approach equips staff with the tools and skills necessary to drive sustainable improvements at every level of the organisation, aligning with our broader Quality Improvement strategic objectives.

We have initiated several strategic programs and locally tailored patient safety improvement plans across the organisation. These initiatives represent comprehensive, system-focused approaches rather than isolated actions, addressing identified issues with input from prior incident investigations, reviews, audits, and risk assessments. Each

program is designed to systematically address safety risks and drive measurable enhancements in care quality.

The Improvement Journey for our current priorities is underway and is being closely monitored by dedicated oversight groups. Progress is reported to the Management and Steering Group. Additionally, this group is tasked with evaluating the effectiveness of improvement workstreams derived from new learning, ensuring that our efforts translate into tangible benefits for patient safety and organisational performance.

## Our Patient Safety Incident Response Plan: National Requirements

Western Medical Services will be putting forward a dedicated group of staff to achieve compliance with the standards outlined in the Patient Safety Syllabus, supporting a transition to enhanced patient safety practices. Western Medical Services will collaborate with NHS Devon, being our local integrated care board and main commissioner. Western Medical Services commits to having a group of management staff compliant with this training by Q2 2025 using approved NHSE training courses and content

In the first year of implementation, training compliance will be closely monitored by the Incident Reporting and Management Steering Group. Following this initial phase, responsibility for overseeing training will transition to the System Governance Group, where it will become an integral part of our routine processes.

**Core Modules of the Patient Safety Syllabus:**

- **Patient Safety Syllabus Level 1:** Essentials for patient safety.
- **Patient Safety Syllabus Level 2:** Access to practice.
- **Involving Those Affected:** Engaging patients, families, and staff in the learning process.
- **System Approach:** Adopting a system-wide perspective to learning from patient safety incidents.
- **Oversight of Learning:** Ensuring effective evaluation and integration of lessons learned.

Western Medical Services fully acknowledges the importance of the Patient Safety Syllabus.

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 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 attendance . | 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 Resolutions 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 Review 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) |

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## Our Patient Safety Incident Response Plan: Local Focus

Locally identified priorities over the next 12 to 18 months include:

1. Harm identified during patient transport.
2. Delays in scheduled inter-facility transfers.
3. Risks associated with manual handling during patient movement.
4. Equipment reliability and readiness.
5. Delays in accessing definitive care

We commit to completing at least one PSII for each priority area, reviewed by the internal management and steering groups.

Additional Local Responses:

- Conducting After Action Reviews (AARs) for critical incidents.
- Leveraging SWARM huddles for rapid learning.
- Engaging staff and patients in collaborative improvement efforts.

| Patient Safety Incident Type | Planned Response | Anticipated Improvement Route |
|---|---|---|
| Harm identified during patient transport | PSII where patients are at risk of, or suffer harm during conveyance | Feed into organisational improvement plan utilising quality improvement methodology |
| Delays in scheduled inter-facility transfers | PSII where the patient suffers harm, or delay/cancellation of planned treatment | Feed into organisational improvement plan utilising quality improvement methodology |
| Risks associated with manual handling during patient movement | PSII where the patient suffers or is put at risk of actual harm during a patient movement. | Feed into organisational improvement plan utilising quality improvement methodology |
| Equipment reliability or readiness | PSII where an equipment failure or missing equipment causes actual adverse patient harm | Feed into organisational improvement plan utilising quality improvement methodology |
| Delays in accessing definitive/extended care | PSII where a patient suffers actual or serious potential for harm due to delay in accessing definitive/extended care | Feed into organisational improvement plan utilising quality improvement methodology |

## Locally defined emergency patient safety incidents requiring PSII

The Incident Review Group is tasked with the responsibility of monitoring and addressing emerging themes in patient safety. A Patient Safety Incident Investigation (PSII) should be initiated when an unforeseen patient safety incident occurs that poses a significant risk to patients, their families, carers, staff, or partner organisations. This decision is guided by the potential for uncovering new insights and opportunities for meaningful improvement.

## Local patient safety incidents requiring investigation

It is essential to recognise that incidents not classified as priorities within this Patient Safety Incident Response Plan (PSIRP) will still be investigated using methods that are appropriate and proportionate to their significance. The specific investigation techniques for these cases will be determined by the internal management and steering groups. Examples of such planned responses include, but are not limited to:

- Patient Safety Incident Investigations (PSIIs)
- After Action Reviews (AARs)
- Multi-Disciplinary Team (MDT) reviews

A comprehensive explanation of the learning methodologies available to us can be found in Appendix B. The internal management and steering groups will validate cases where leaders proactively implement immediate safety measures or learning responses following a Patient Safety Incident (PSI).

Additionally, there are other proportionate responses, not explicitly detailed within this PSIRP, that can support individuals affected by patient safety incidents while also helping the organization gain valuable insights. These responses, outlined in Appendix C, include:

- End-to-end reviews
- Debriefs
- Clinical audits

In situations where a Structured Judgment Review (SJR) concludes that a PSII is not necessary, the organization will prepare a factual report upon the coroner’s request. This report will focus on the incident’s chronology, analysis, and its connection to the

organisation's Trust-Wide Improvement Plan. Learning opportunities will be identified and acted upon using the proportionate response framework established by the internal management and steering groups.

## Locally defined emergent patient safety incidents requiring cross-system response

Western Medical Services is dedicated to addressing cross-system Patient Safety Incidents (PSIs) by taking a leading role or collaborating with partners to conduct comprehensive learning responses. We recognise the significant value of a multi-disciplinary team approach in these efforts, ensuring that insights and solutions are informed by diverse expertise.

Lessons learned from cross-system PSIs will be shared within relevant Patient Safety Networks across the region to foster collective improvement. Outcomes from these learning responses will also be presented to the internal management and steering groups including input from commissioning colleagues, to ensure transparency and accountability.

A key focus of our approach is to identify and address health inequalities during the review of cross-system PSIs, ensuring that all patients receive equitable and high-quality care. This commitment underscores our dedication to improving outcomes for all stakeholders involved.

## Additional Learning Responses

Western Medical Services acknowledges the importance of conducting learning responses in cases where care has been identified as positive or exemplary. Understanding the factors that contribute to successful outcomes is essential, as it enables us to reinforce these practices and maintain a consistently high standard of care across the organisation.

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## 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. |
| 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. |
| 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. |

| Term/Acronym | Definition |
|---|---|
| Just Culture Approach | The treating of staff involved in a patient safety incident in a consistent, constructive, and fair way. |
| 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. |
| PSIRF | Patient Safety Incident Response Framework |
| PSIRP | Patient Safety Incident Response Plan |
| RIDDOR | Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 |
| 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. |

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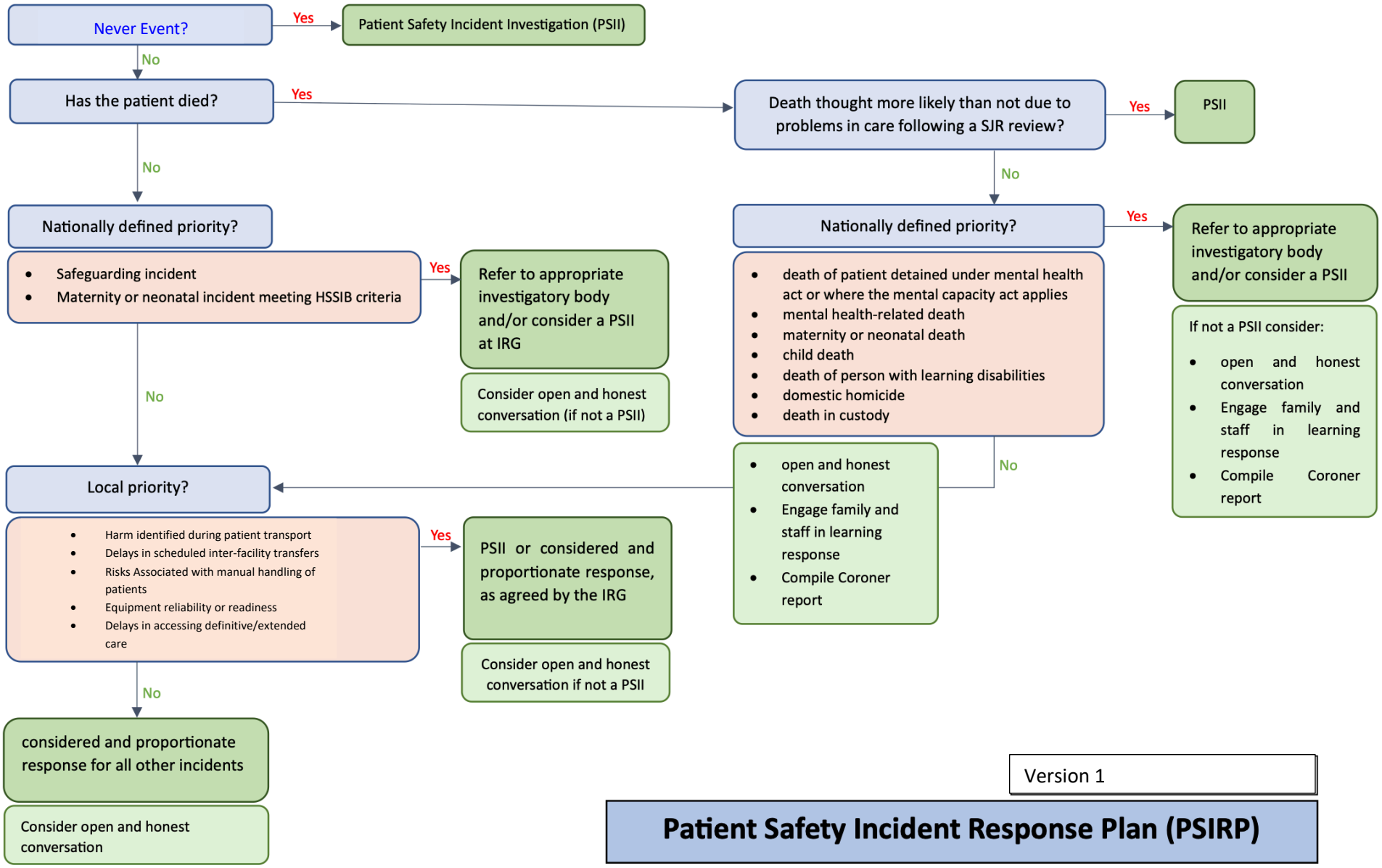
## Appendix A




Version 1

# Patient Safety Incident Response Plan (PSIRP)

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# Appendix B

| 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.<br>• 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.<br>• Whilst participants will contribute and learn, it is not the specific purpose of the activity.<br>• It is a planned event, and it may take many weeks to set up and ensure full MDT representation is available.<br>• Resource intensive to undertake. | | |

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| 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.<br>• Learning during the AAR is the main focus, not the report, with those participating positioned as the agents of change and improvement.<br>• 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.<br>• It is highly adaptable, suitable for a wide range of events.<br>• Psychological safety is actively created and maintained throughout.<br>• 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.<br>• There are limited ways to track if individuals have changed their behaviour or completed actions as a result of the AAR.<br>• 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. |

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| 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.<br>• Connecting immediately after event may reduce social isolation/ ruminating/stress for staff.<br>• Evidence shows it can increase the reporting of incidents.<br>• Quick and responsive.<br>• Prompt and easy to undertake so increases likelihood of being done.<br>• Reduces key information being lost by its immediacy. | • Scope of learning narrowed by limits on who is participating.<br>• Learning is focused on a single event rather than the interactions in the system that come with wider participation.<br>• Psychological safety is assumed to be present so full participation may not be achieved.<br>• It seeks learning to reduce the risk of a single event reoccurring and not wider learning about behaviours, team interactions and system weaknesses.<br>• Weak governance arrangements for tracking actions and collating learning through many SWARM Huddles. |

## Appendix C

| 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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## Contact Us

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Western Medical Services is committed to continuous learning and improvement, ensuring the highest standards of patient safety and care.