NHS
Yorkshire
Ambulance Service
NHS Trust

MEETING TITLE Public Board		**MEETING DATE** 27/03/2018	
TITLE of PAPER	Significant Events & Lessons Learned – Bi-annual report Q1 & Q2 17-18.	**PAPER REF**	3.3
STRATEGIC OBJECTIVE(S)	Provide a safe and caring service which demonstrates an efficient use of resources Ensure continuous service improvement and innovation		
PURPOSE OF THE PAPER	The purpose of the paper is provide an overview to the Board of the key events and learning that have taken place during the first half of the 17-18 financial year. This will cover Q1 and Q2 (April 2017 – September 2017)		
For Approval	☐	**For Assurance**	☒
For Decision	☐	**Discussion/Information**	☒

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DISCUSSED AT / INFORMED BY –
Quality Committee – June 2017 and September 2017

PREVIOUSLY AGREED AT:	**Committee/Group:**	**Date:**
RECOMMENDATION(S)	It is recommended that the Board note the current position and take assurance from the work highlighted within the report, supporting the ongoing proposals for improvement.	

RISK ASSESSMENT	**Yes**	**No**
Corporate Risk Register and/or Board Assurance Framework amended *If 'Yes' – expand in Section 4. / attached paper*	☐	☒
Resource Implications (Financial, Workforce, other - specify) *If 'Yes' – expand in Section 2. / attached paper*	☐	☒
Legal implications/Regulatory requirements If 'Yes' – expand in Section 2. / attached paper	☐	☒
Diversity and Inclusion Implications If 'Yes' – please attach to the back of this paper	☐	☒

ASSURANCE/COMPLIANCE	
Care Quality Commission Choose a DOMAIN(s)	All
NHSI Single Oversight Framework Choose a THEME(s)	2. Quality of Care (safe, effective, caring, responsive)

1. PURPOSE/AIM

1.1 The purpose of the paper is provide an overview to the Board of the key events and learning that have taken place during the first half of the 17-18 financial year. This will cover Q1 and Q2 (April 2017 to September 2017).

2. BACKGROUND/CONTEXT

2.1 This report primarily covers the period 1 April 2017 to 30 September 2017.

2.2 Where necessary immediate action is taken to ensure patient and staff safety following an adverse event. This is followed by more formal review and analysis proportionate to the seriousness of the event, to ensure that all relevant lessons are learned. Trust timescales for these reviews are in line with national and regional guidance.

2.3 Specific sources of significant event & lessons learned within the scope of this report include:

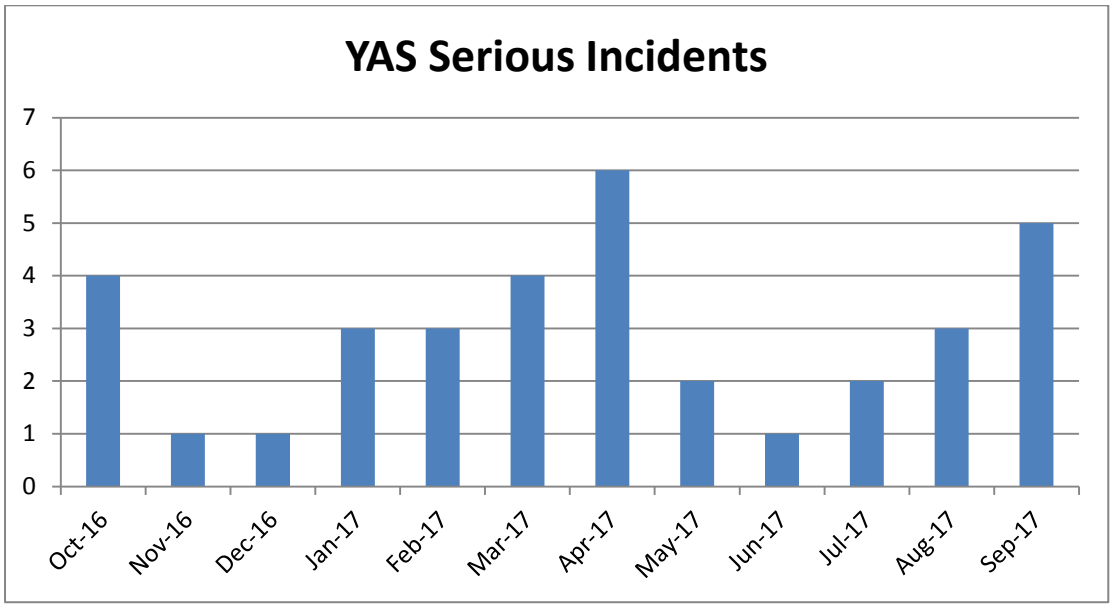
- Serious Incidents reported to the Trust's commissioners
- Incidents
- Complaints & patient experience – including requests received from other services and including the Ombudsman
- Claims
- Coroners Inquests – including Prevention of Future Death Reports (PFDs) received by the Trust.
- Safeguarding Serious Case Reviews (SCRs) and Domestic Homicide Reviews (DHRs)
- Professional Body Referrals
- Clinical Case Reviews
- Information Commissioner's Office notifications
- Health & Safety Executive notifications
- Duty of Candour (Being Open)
- Freedom to Speak Up

2.4 Other sources may be included, based on the nature of the events occurring.

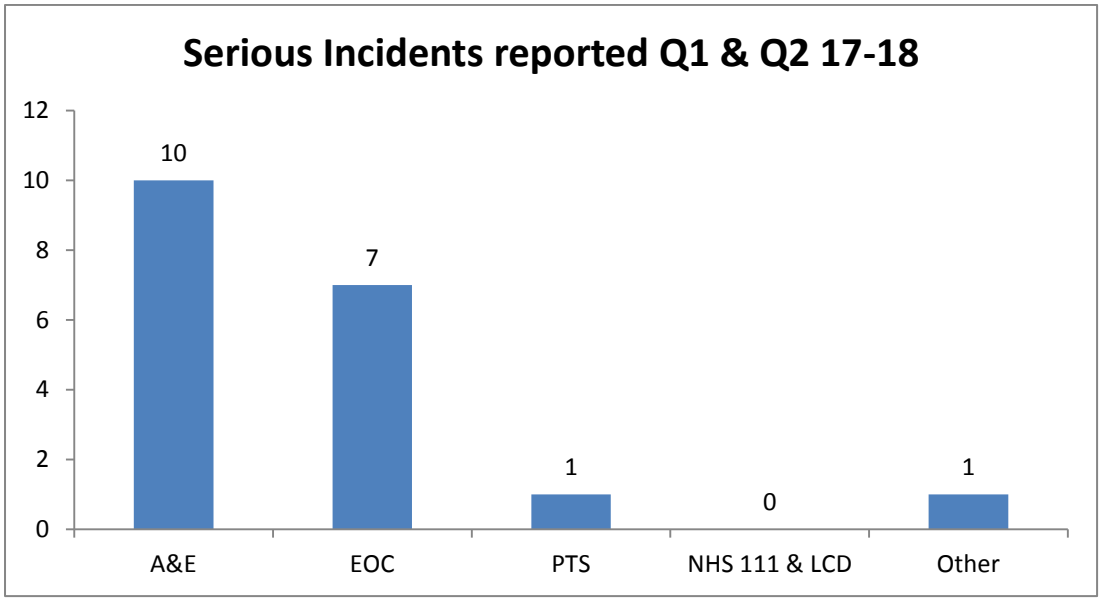
3. SERIOUS INCIDENTS (SIs)

3.1 During Q1 and Q2 17-18 the Trust reported 19 Serious Incidents. This is in comparison to 16 reported in the previous 6 months.

3.2 The graph below shows the SIs reported on a rolling 12 month period.



3.3 The chart below shows the breakdown by service area for Q1 and Q2 17-18.



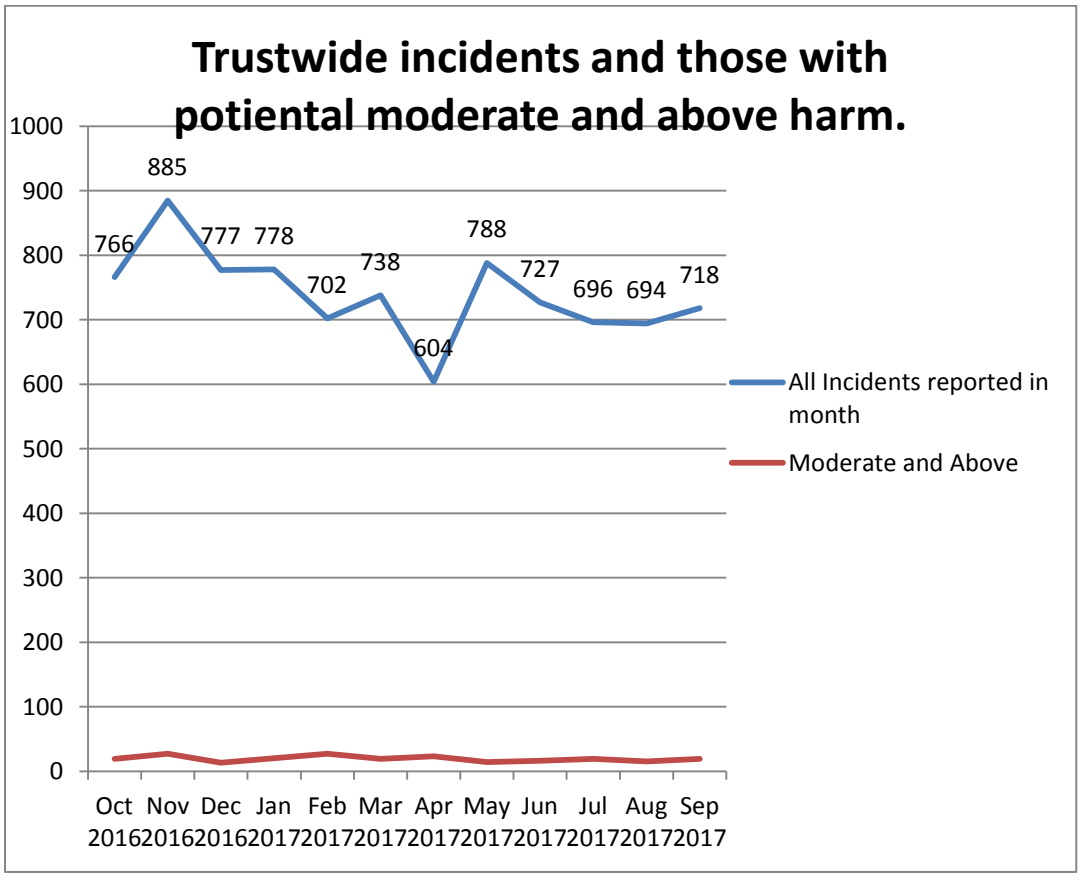
3.4 A theme identified in Q4 16-17 and going into Q1 17-18 within the EOC was in relation to Emergency Medical Dispatchers (EMDs) not recognising in a timely manner when a patient was ineffectively breathing. This was leading to incorrect coding of calls and subsequently delays in response. A quality improvement (QI) action plan was developed for delivery over summer. At the EOC away days in June further education and training was provided to all EMDs to assist with this area of work as the root cause analysis (RCA) from the investigations determined that the list of descriptors that had been provided to EMDs was being used verbatim and therefore other similar descriptive words were not being recognised. As part of the QI plan the effectiveness of the interventions has been monitored since June and seen a reduction in the number of non-compliant audits relating to ineffective breathing and no further SIs have been detected.

An external review of these calls by the International Academy of Medical Dispatch has been requested to provide additional assurance on Trust processes.

3.5 During Q2 a theme was also identified in relation to the management of cardiac arrests and timely defibrillation. Three SIs during Q2 were reported in addition to two cases that were reported in the 14 months prior. This prompted a collective review of cases as well as individual investigation and a number of actions identified. This included reviewing how the rhythm presents on the defibrillator monitor to make it clearer for clinicians view it, increased supervision and training and improved induction packages for new entrants to the service. This work continues to be monitored closely and reported on to the Clinical Governance Group (CGG).

4. INCIDENTS

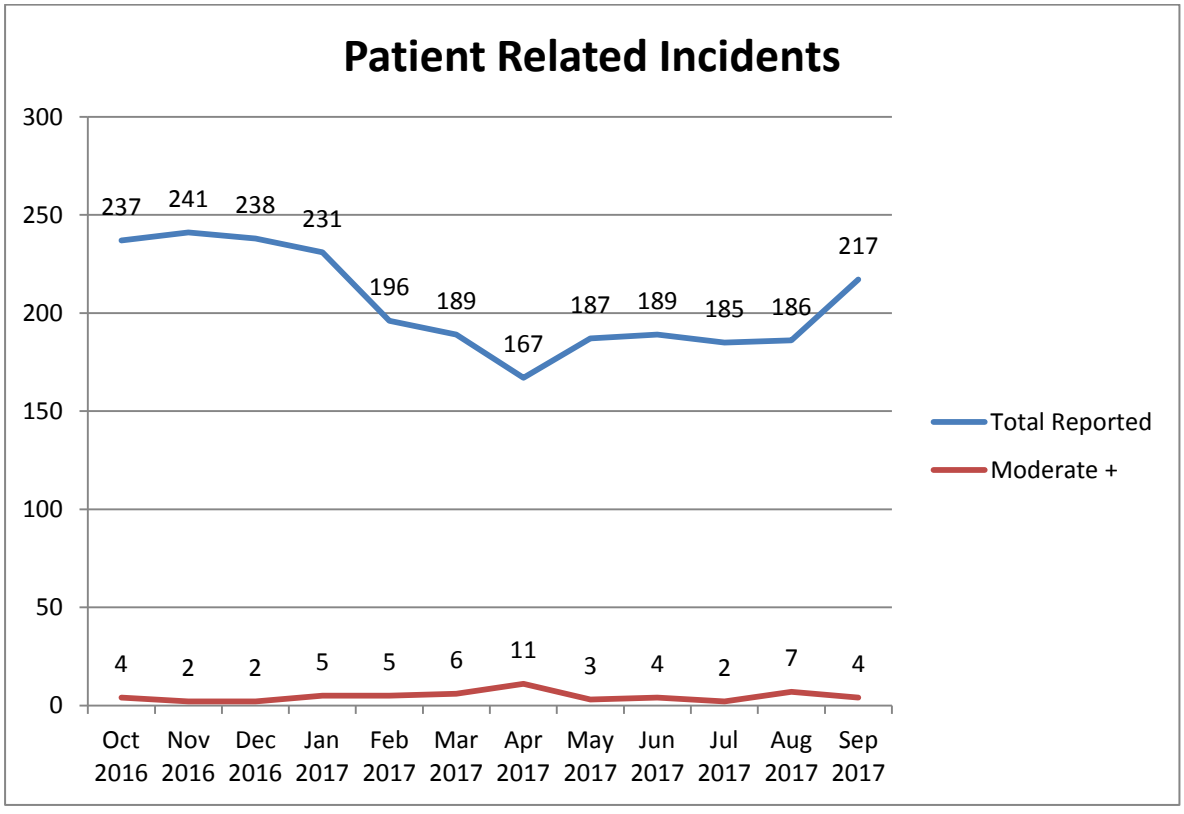
4.1 The graph below shows the number of incidents reported over the previous 12 months.



4.2 The chart below shows a breakdown of incidents reported within each service line.

	A&E Operations	EOC (Emergency Operations Centres)	NHS 111	PTS (Patient Transport Services) - Operations
Oct 2016	421	76	41	86
Nov 2016	519	77	44	113
Dec 2016	461	70	47	81
Jan 2017	438	71	34	113
Feb 2017	407	54	35	94
Mar 2017	429	57	34	86
Apr 2017	344	59	29	67
May 2017	424	77	46	80
Jun 2017	387	64	29	107
Jul 2017	383	67	38	97
Aug 2017	403	49	48	84
Sep 2017	394	45	64	106
Total	5010	766	489	1114

4.3 The graph below show the breakdown of incidents by those that have affected patients.



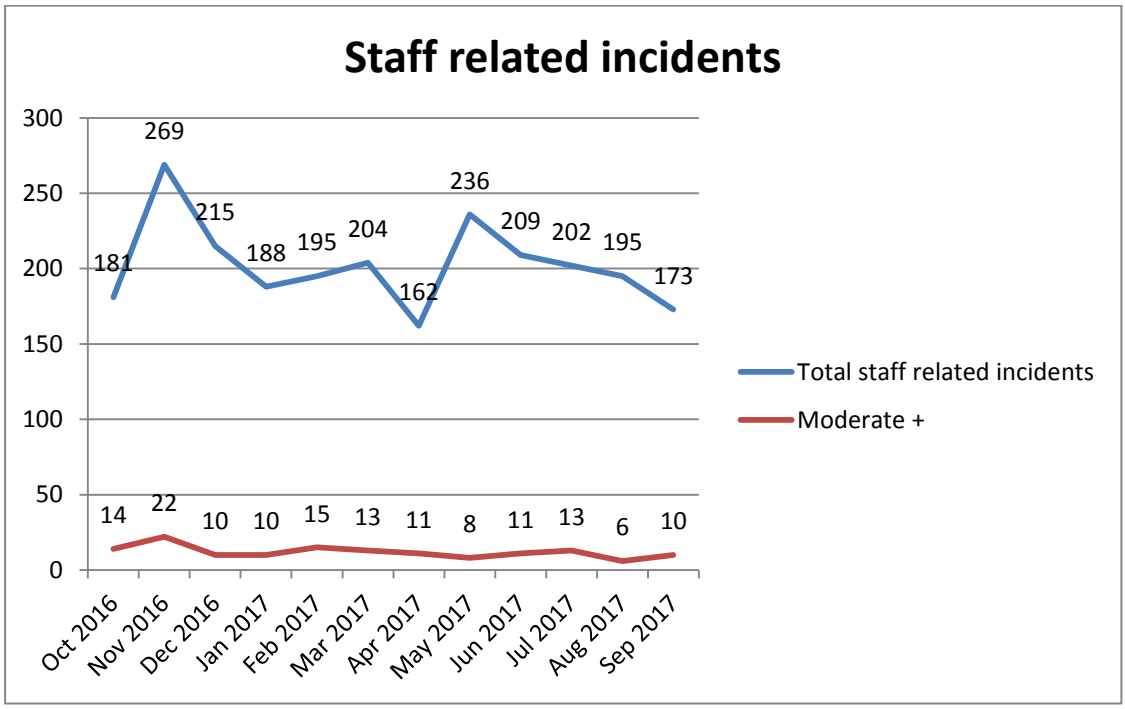
4.4 Within the patient related incidents the highest category of incidents reported is response related. The EOC has a robust process for capturing incidents where there has been an excessive response and harm may have been caused to the patient. This is positive practice by the Trust to identify these real-time and understand whether harm has been caused. YAS is the leading ambulance service within the UK in initiating such a process.

4.5 YAS continues to monitor incident rates against 3 key harms; falls whilst in receipt of YAS care, injury whilst in receipt of YAS care and medication errors whilst in receipt of YAS care. These are tracked on a daily, weekly and monthly basis using the "harm free care days" methodology utilised in the national hospital Safety Thermometer data.

4.6 Following launch of the national Sign up to Safety campaign; which has an ambition to reduce harm within the NHS by up to 50%, Yorkshire Ambulance Service has succeeded in reducing medication errors by 80% over 2 years using the Safety Thermometer data and feedback system, from 54 in 2014-15, 25 in 2015-16 and only 14 throughout 2016-17. These medicine errors are those that have the potential to cause harm to patients and do not include breakages or loss of controlled drugs.

4.7 The Trust-wide Moving Patients Safely Group, another key work-stream for the Sign up to Safety programme, is reviewing all incidents that relate to patient movement – these include relevant injuries and falls. This group leads on the development of improvement plans, based on multi-directorate working, that cover policies and procedures, risk assessment processes, education and training, communication, review of systems and process and increased learning from these incidents. In the planning process is a meeting in line with this work stream, with patients, relatives and carers from the Trust's Critical Friends Network to ensure that the patient voice is at the heart of everything we do.

4.8 The graph below show the breakdown of incidents by those that have affected staff.



4.9 One of the highest categories within staff related incidents is Violence & Aggression incidents. There was a spike in the number of these reported in November 2016 which explains the increase in overall staff related incidents as shown on the graph above. This was when the updated Violence & Aggression Policy was launched and further awareness raising took place, not related primarily to an increase in violence towards staff. There has been an increase overall in violence and aggression incidents in comparison to last year; noticeably relating to knife related incidents and sexual assaults. Whilst many of these have been near miss incidents they have risen and this is an area the Trust is actively pursuing to take further action. The EOC has recently trained a staff member to Local Security Management Specialist (LSMS) level who will focus on seeing through the process of prosecution of individuals who have assaulted staff members.

4.10 In Quarter 1 of 2017/18 the issuing of Data Flag warning letters to perpetrators of violence and aggression to YAS staff begun. These letters are recorded as a sanction on the Datix incident record. Reviews of incidents are conducted on an individual case-by-case basis with evidence collated by the Risk Team and Data Flag Coordinator in EOC. The decision to maintain a flag is made collectively by the DFG and a record of decision-making is maintained by the Data Flag Coordinator. The warning letter is prepared by the Risk Team on behalf of the group.

4.11 For Q1 of 2017/18, the Data Flag Group agreed to issue warning letters to 12 perpetrators of violence and aggression to our staff. For Q2 the Data Flag Group agreed to issue warning letters to 22 perpetrators of violence and aggression to our staff.

4.12 The A&E abstraction of 2 days agreed by the Trust Executive Group has allowed for face-to-face training in conflict resolution and associated topics to be strengthened. From July 2017, the new Conflict Resolution 'refresher' Training for A&E Operations front line staff was launched. This package includes management of Clinically Related Challenging Behaviour and Acute Behavioural Disturbance which are a requirement of the NHS Protect standards for relevant staff groups, and Dynamic Risk Assessment and Safer Responding procedures including Joint Decision Model. There are also sections on incident reporting, data flagging, post-incident care and staff welfare/support including contacts. Subject Matter Experts from across the Trust have contributed to development of training materials which have been amalgamated by the Training Department.

5. COMPLIMENTS, COMMENTS, CONCERNS & COMPLAINTS

5.1 The table below shows the breakdown of complaints and concerns received during this period.

	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sept 17
A&E	39	41	44	53	40	38
EOC	33	40	45	36	43	47
PTS	52	52	69	46	50	67
NHS 111 & LCD	85	79	63	68	55	45
Total	209	212	221	203	188	197

5.2 Within the EOC the largest category of complaints relates to delayed responses to Interfacility Transfer (IFT) bookings. There has been a reduction in these from Q1 to Q2 mainly as a result of the joint work taking place in Sheffield which has reduced the volume of cases being received.

5.3 Under the A&E Operations service the highest category of complaints relate to attitudes and behaviours. This has become more prevalent during Q2 particularly within the South Yorkshire area and further analysis has highlighted some instances of inappropriate attitudes and behaviours towards vulnerable patients. This has been raised at the Clinical Quality Development Forum (CQDF) and a directed piece of work has been tasked involving the A&E management team within South Yorkshire, the Head of Diversity and Inclusion and Human Resources to address these issues. The wider Trust developments relating to the Trust values and behavioural framework will also help to reinforce positive attitudes across Trust departments.

5.4 Around a quarter of all PTS complaints relate to patients being collected late from clinics. In addition to this the narrative responses from patient surveys have been reviewed in conjunction which shows that people are overwhelmingly positive or the excellent customer service demonstrated by our PTS staff. This has prompted a piece of work within the PTS service to improve communication to patients who are awaiting their transport home to try and alleviate some of these concerns. This will involve a pilot trial and will explore a number of ways we can advise patients of their likely wait time when they advise us they are ready to travel and also keeping them informed of any delays they may experience.

5.5 The highest category of complaint received for the NHS 111 service is related to the appropriateness of the call outcome, accounting for approximately one quarter of all complaints.

Ombudsman

5.6 During this period, the Ombudsman has completed one investigation into a complaint relating to the A&E service; the case was not upheld. There was one initial enquiry of a case however the Parliamentary Health Service Ombudsman (PHSO) opted to not progress this case to investigation. During Q2 one referred was received and concerns a safeguarding referral made by an A&E crew. The investigation continues into this case.

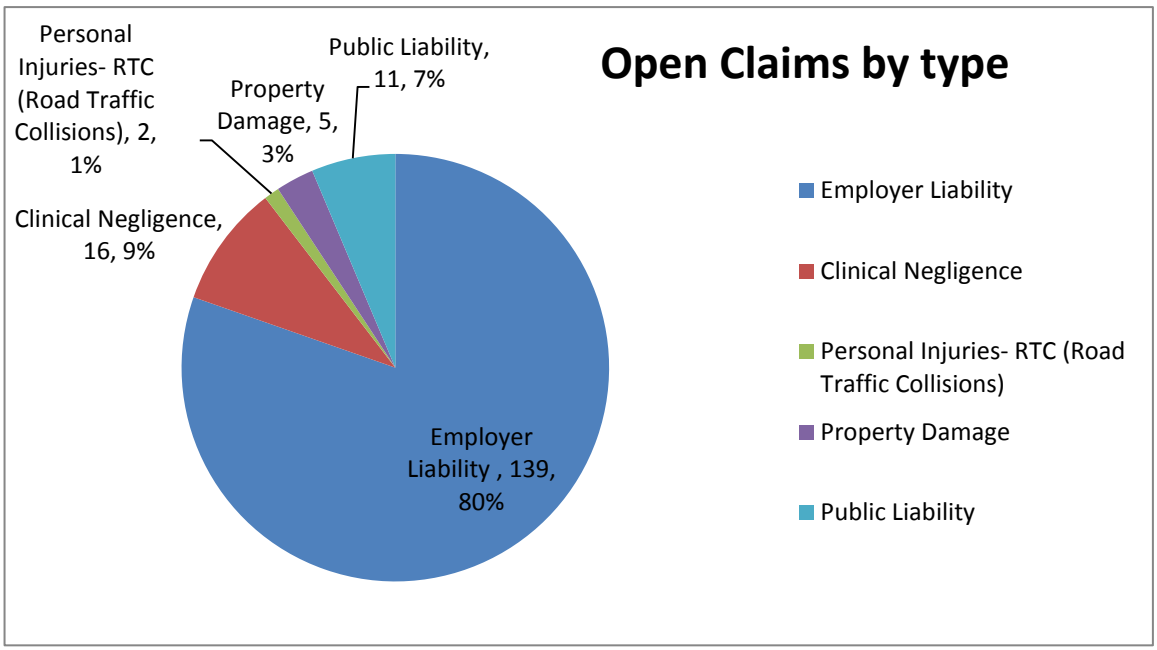
Compliments

5.7 The table below shows the number of compliments received for each service line during Q1 and Q2.

	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sept 17
A&E	50	85	69	67	34	40
EOC	1	3	1	0	0	1
PTS	2	11	2	5	7	3
NHS 111 & LCD	17	12	9	12	13	20
Total	70	111	81	84	54	64

6. CLAIMS

6.1 At the end of Q2 there are currently 173 open claims against the Trust that come under the NHS Resolution Insurance Scheme for Trusts with employer liability claims being the highest volume (80%).



6.2 The main focus of the employer liability claims is moving and handling related with injuries arising from the carry chair, stretchers and wheelchairs and from moving patients. The second highest category is injuries sustained from Trust vehicles primarily the tail lift and ramp.

6.3 Clinical negligence claims are reported in low numbers. Two CNST claims were made during Q1 and Q2 in relation to undiagnosed brain haemorrhage and an undiagnosed seizure and subarachnoid haemorrhage.

6.4 During this period there have been three public liability claims reported. One relates to a fall from a tail lift, one relates to a tripping hazard on a YAS trolley which was in a hospital ED and one relates to a patient being collected by a taxi driver sub-contracted by the Trust and the patient was almost tipped from the wheelchair sustaining injuries to the arm.

6.5 Overall numbers of new claims and the caseload of live claims has continued to fall year on year.

7. CORONERS INQUESTS INCLUDING PFDs

7.1 The Trust's involvement in inquests continues to remain high in relation to attendance of staff as witnesses and currently there are 314 open inquest cases.

Prevention of Future Death (PFD) reports

7.2 During this period one PFD report was issued to the Trust. This was from an inquest held in South Yorkshire involving a 999 call made for a 69 year old male on 23 August 2016. There was a delay in response to this patient and the Coroner was concerned that YAS protocols were not adhered to in relation to a review and allocation of resources; there was a lack of knowledge and training around understanding of protocols for resource allocation and lack of escalation to a senior manager when an incident remains without resource allocated over the prescribed time limit. A response was issued to the Coroner and satisfactory reassurance provided that the process has been improved and staff members are adequately trained and supported.

8. SAFEGUARDING SERIOUS CASE REVIEWS (SCRs) AND DOMESTIC HOMICIDE REVIEWS (DHRs)

8.1 Within this period YAS provided information towards five SCRs within the region and three DHRs. Information was also submitted to five Safeguarding Adult Reviews and three Lessons Learned Reviews. Excessive responses continue to remain a theme with regard to safeguarding adult concerns from Adult Social Care teams across Yorkshire.

8.2 Work is ongoing within the Safeguarding team to set up a referral pathway in partnership with Victim Support and Independent Domestic Abuse Services and a Trust wide patient information leaflet is in production to ensure potential victims of domestic abuse have access to relevant contact numbers for advice and support.

8.3 Learning is ongoing with YAS regarding the assessment and application of the Mental Capacity Act (MCA) 2005. Within Q3 bespoke mental capacity training is to be delivered to Clinical Supervisors by Capsticks Solicitors LLP; over four dates across the region to further strengthen their knowledge on this area.

9. PROFESSIONAL BODY REFERRALS (PBRs)

9.1 There have been no cases identified during this period that have highlighted organisational learning.

10. CLINICAL CASE REVIEWS (CCRs)

10.1 Of the CCRs conducted during this period the recurrent themes relate to poor documentation and poor communication. The implementation of the Electronic Patient Record (EPR) will support an improvement in documentation.

Issues are also being highlighted in education and training programmes abd thorugh audit feedback.

10.2 Another theme also identified was in relation to inappropriate transport decisions with a small number of examples of clinicians not following divert instructions, the non-transport of deteriorating patients and not following the YAS trauma tool and transporting to the correct unit. These issues are addressed through individual feedback and reinforcement/refresh of the often complex guidance for staff.

11. INFORMATION COMMISSIONER'S OFFICE (ICO) NOTIFICATIONS

11.1 During this period YAS did not receive any notifications from the ICO.

12. HEALTH & SAFETY EXECUTIVE (HSE) NOTIFICATIONS

12.1 The Trust received one query from the HSE during this period (Q2). This related to two members of staff who had been exposed to a patient with tuberculosis (TB). The staff members were unaware of the exposure at the time and the Trust were alerted to the issue by Public Health England who contacted the Trust's IPC Nurse. Two RIDDOR reports for the staff members were submitted as a result of the exposure. The HSE's main query was in relation to the Trust's processes. They requested a number of documentation to be submitted and are satisfied with the response provided by the Trust.

13. DUTY OF CANDOUR (BEING OPEN)

13.1 The Trust continues to be open with patients and/or their families when an adverse event has occurred resulting in moderate or above harm to a patient. The Trust also applies the being open process to other incidents when they are identified on a case by case basis that there would be benefit to the patient and/or their family to be aware of the case.

13.2 During Q1 and Q2 17-18 the Trust has applied the being open process to 33 cases. Overall, positive feedback has been received in relation to the processes in place across the Trust with families thankful of the honesty and transparency offered by the service.

14. FREEDOM TO SPEAK UP

14.1 The Trust continues to receive concerns reported through the Freedom to Speak Up process via the Trust's Guardian and Advocates.

14.2 During this period 48 concerns were raised via this process. The common theme arising, and this is consistent across the NHS, is in relation to staff issues as opposed to direct patient safety concerns. Many of these have root causes of inappropriate and/or inadequate management styles and skills leading to a perception of bullying or harassing behaviour by staff members.

14.3 In August the Trust held the annual review of Freedom to Speak Up following its launch in July 2016, reflecting on a very positive first year in operation with national recognition for the good visibility and reach demonstrated by the service, relationships developed with local universities and many staff members reporting positive experiences of being involved in the Freedom to Speak Up process.

15. PROPOSALS/NEXT STEPS

15.1 The Trust will continue to investigate, analyse and learn from adverse events when things go wrong and will continue to report through the internal committees and groups to provide assurance in relation to the key findings and lessons learned. Next steps and actions to be taken have been highlighted in the above sections within this report.

16. RISK ASSESSMENT

16.1 This paper provides assurance in relation to the following principle risk on the Board Assurance Framework:-

- Risk 2c) Failure to learn from patients and staff experience and adverse events within the Trust or externally.

17. RECOMMENDATIONS

17.1 It is recommended that the Board note the current position and take assurance from the work highlighted within the report, supporting the ongoing proposals for improvement.