NHS
Yorkshire
Ambulance Service
NHS Trust

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| **MEETING TITLE**<br>Trust Board in Public | | **MEETING DATE**<br>31/08/2017 | |
| **TITLE of PAPER** | Significant Events & Lessons Learned – Bi-annual report Q3 & Q4 16-17 | **PAPER REF** | 3.5 |
| **STRATEGIC OBJECTIVE(S)** | Provide a safe and caring service which demonstrates an efficient use of resources<br>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 second half of the 16-17 financial year. This will cover Q3 and Q4 (October 2016 to March 2017). | | |
| **For Approval** | ☐ | **For Assurance** | ☒ |
| **For Decision** | ☐ | **Discussion/Information** | ☒ |

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|---|---|---|---|
| **AUTHOR / LEAD** | Rebecca Mallinder (Head of Investigations & Learning) | **ACCOUNTABLE DIRECTOR** | Steve Page (Executive Director of Quality, Governance & Performance Assurance) |

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| **DISCUSSED AT / INFORMED BY –**<br>Quality Committee – March 2017 and June 2017 | | |
| **PREVIOUSLY AGREED AT:** | **Committee/Group:**<br>Quality Committee | **Date:**<br>15/06/2017 |
| **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**<br>*If 'Yes' – expand in Section 4. / attached paper* | ☐ | ☒ |
| **Resource Implications (Financial, Workforce, other - specify)**<br>*If 'Yes' – expand in Section 2. / attached paper* | ☐ | ☒ |
| **Legal implications/Regulatory requirements**<br>If 'Yes' – expand in Section 2. / attached paper | ☐ | ☒ |
| **Diversity and Inclusion Implications**<br>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 second half of the 16-17 financial year. This will cover Q3 and Q4 (October 2016 to March 2017).

## 2. BACKGROUND/CONTEXT

2.1 This report primarily covers the period 1 October 2016 to 31 March 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:

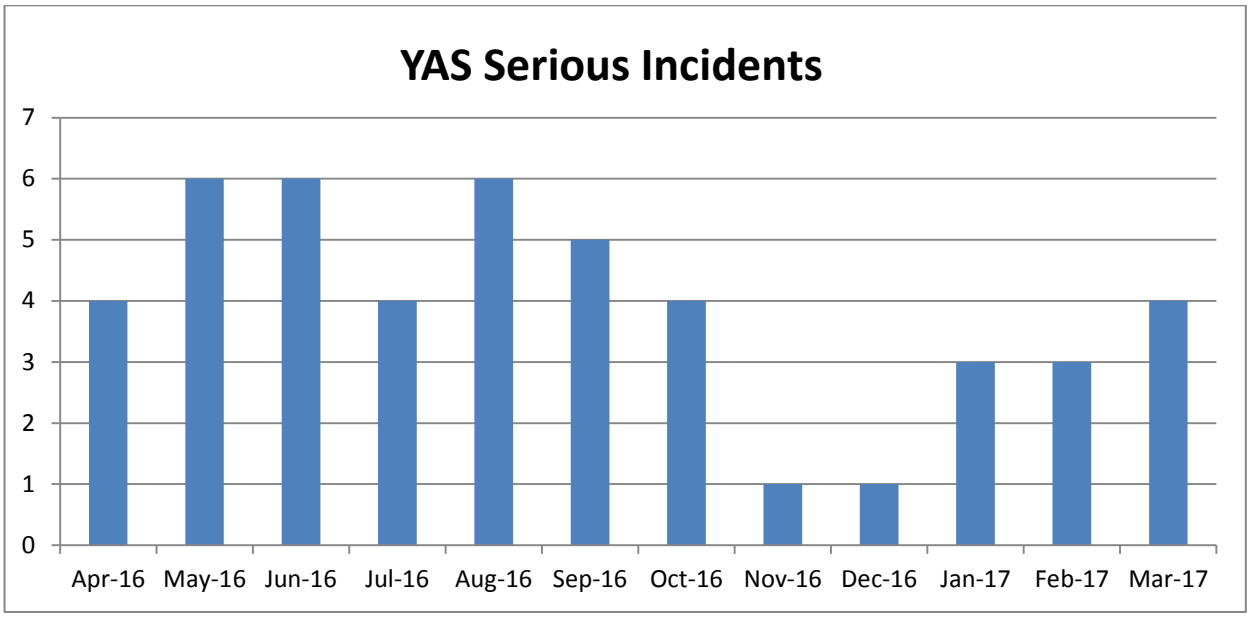
- Serious Incidents reported to the Trust's commissioners
- Incidents
- Complaints & patient experience – including requests received from other services and including the Ombudsman
- Claims
- Coroners Inquests – including Prevention of Future Death Reports (PFDs) received by the Trust.
- Safeguarding 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.

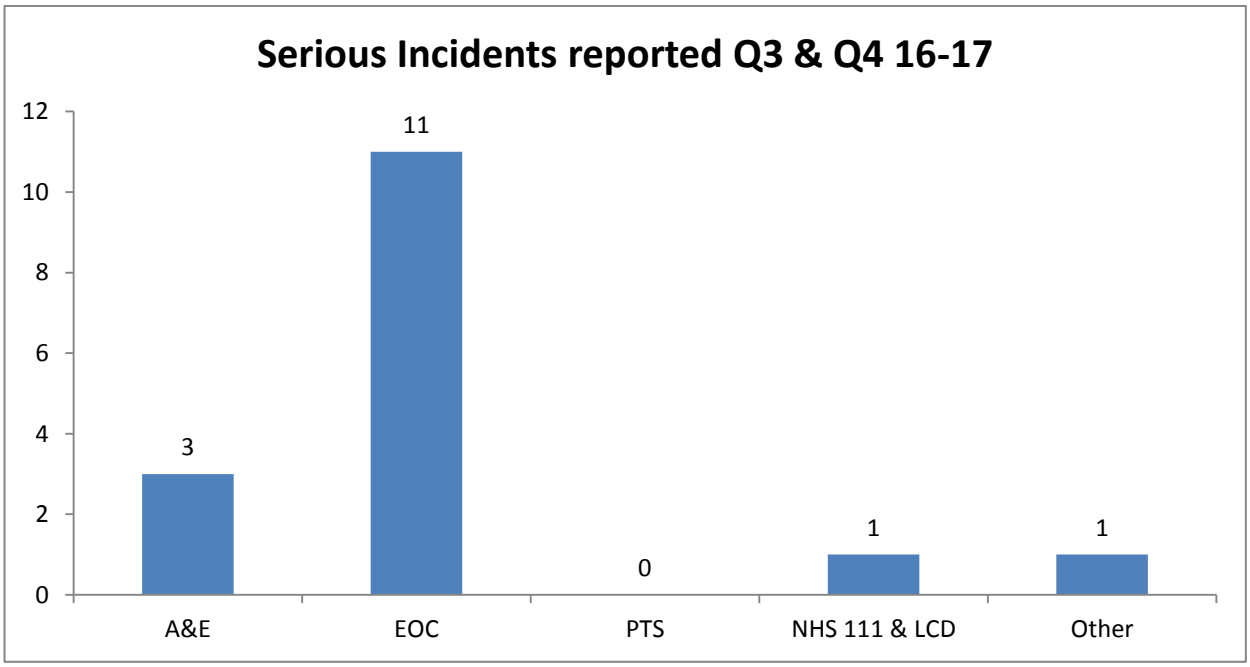
## 3. SERIOUS INCIDENTS (SIs)

3.1 During Quarters 3 and 4 16-17 the Trust reported 16 Serious Incidents.

3.2 The graph below shows the SIs reported throughout 16-17.




3.3 The chart below shows the breakdown by service area for Q3 and Q4 16-17.




3.4 Of the EOC reported SIs, 4 of these were reported in Q3 and 7 were reported in Q4 and these related to excessive responses. From January 2017 the process for reporting of excessive responses changed with a more critical view of potential SIs to understand any failures in care or service delivery. This has allowed more effective use of senior clinical time to truly understand the lessons to be learned and a more efficient and effective way or implementing actions to help prevent recurrence.

3.5 A theme identified during Q4 was in relation to Emergency Medical Dispatchers (EMDs) within the EOC not recognising when a patient was ineffectively breathing on a 999 call.

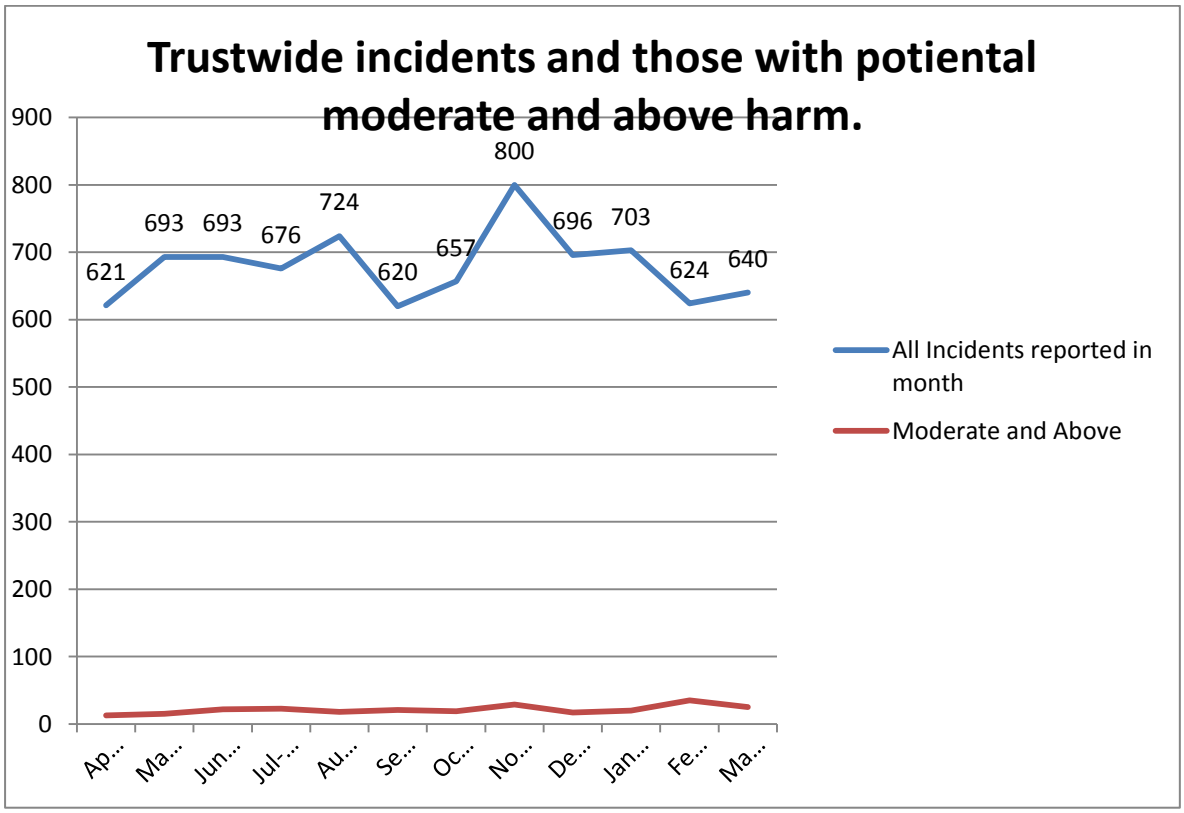
As a result, further education and training was delivered to all EMDs during June through the EOC away days, additional material has been provided for EMDs to take away with them and a quality improvement plan is now in place monitoring this on a monthly basis. The QI plan tracks numbers of SIs identified in relation to ineffective breathing and also quality audit results conducted within the EOC. This will help the management teams to understand if the actions taken have been effective. This concern has also been recorded on the EOC risk register and Corporate Risk Register.

3.6 The three A&E SIs took place within North (2) and East (1) Yorkshire. One of the North A&E SIs related to resource availability and one related to the clinical treatment delivered on scene. The Hull A&E SI also related to clinical care. Organisational learning has been shared as a result of the SIs as well as a programme of individual learning.

3.7 The NHS 111 SI related to an incorrect disposition being reached by the call handler which delayed help arriving with the patient and the corporate SI related to an information governance breach.

## 4. INCIDENTS

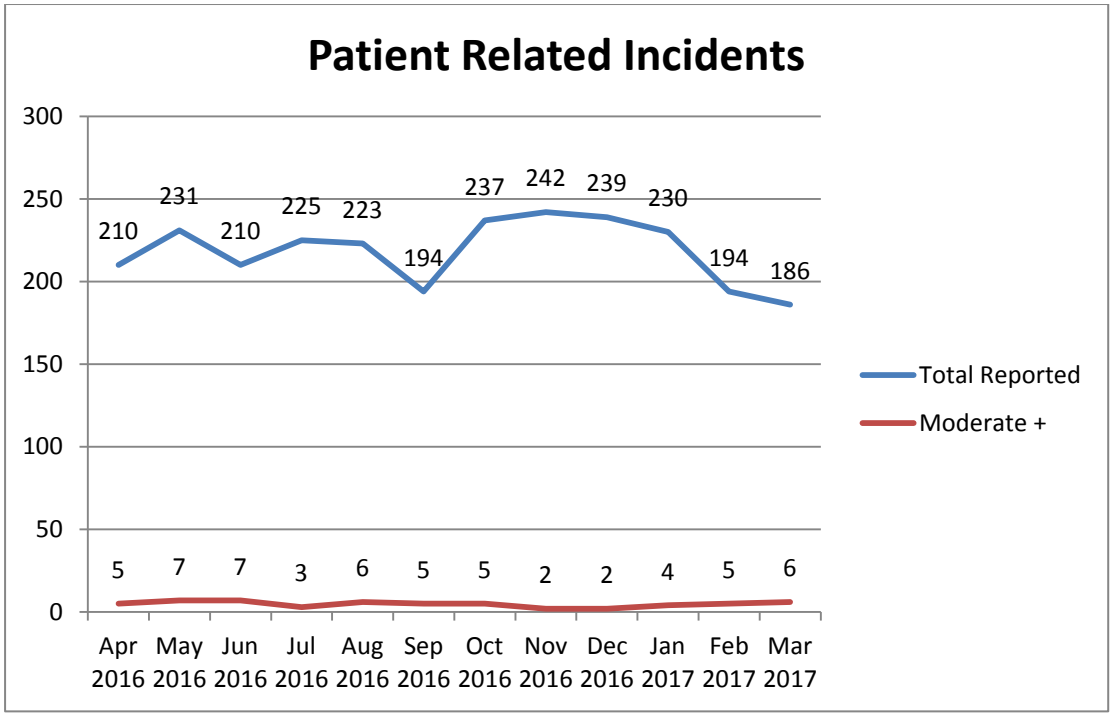
4.1 The graph below shows the number of incidents reported over the previous 12 months.




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 |
|---|---|---|---|---|
| Apr 2016 | 371 | 78 | 42 | 84 |
| May 2016 | 436 | 90 | 39 | 99 |
| Jun 2016 | 423 | 86 | 29 | 129 |
| Jul 2016 | 386 | 99 | 46 | 106 |
| Aug 2016 | 435 | 86 | 44 | 123 |
| Sep 2016 | 434 | 51 | 30 | 76 |
| Oct 2016 | 412 | 85 | 41 | 86 |
| Nov 2016 | 506 | 89 | 44 | 113 |
| Dec 2016 | 453 | 79 | 47 | 81 |
| Jan 2017 | 429 | 85 | 33 | 114 |
| Feb 2017 | 396 | 64 | 36 | 94 |
| March 2017 | 412 | 72 | 34 | 87 |
| Total | 5093 | 964 | 465 | 1192 |

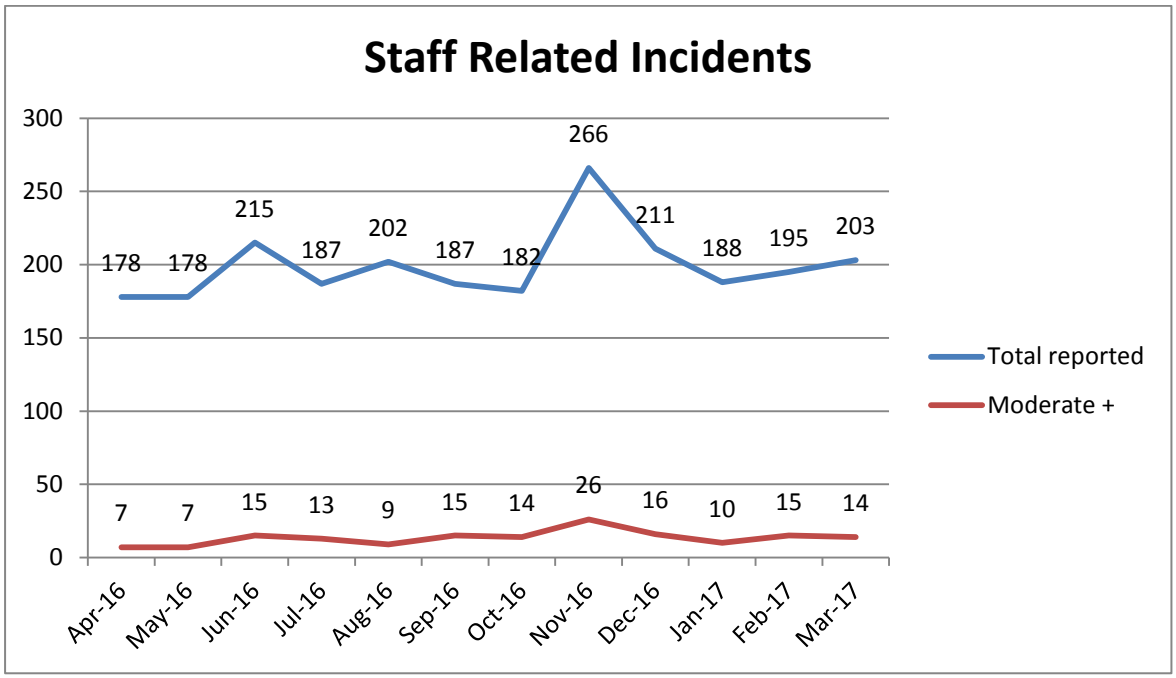
4.3 The graph below shows incidents that have affected patients.




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 The second highest category reported is 'care pathway'. The largest proportion of these relate to a care plan not being in place for a patient or an inappropriate referral being made. Any learning identified through these incidents is shared where appropriate with other providers.

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




4.7 There was a spike in incidents reported in November 2016 and this was around the time of the relaunch of the Violence & Aggression Policy. Staff are continued to encourage to report violence related incidents so that appropriate action can be taken against perpetrators. There has been an increase in the number of staff related incidents involving knife attacks and sexual assault. Whilst the majority of these have been near miss incidents, work continues with assistance from other agencies to address concerns in these areas.

## 5. COMPLAINTS

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

| | Oct 16 | Nov 16 | Dec 16 | Jan 17 | Feb 17 | Mar 17 |
|---|---|---|---|---|---|---|
| A&E | 53 | 45 | 56 | 67 | 42 | 68 |
| EOC | 54 | 46 | 58 | 47 | 38 | 34 |
| PTS | 76 | 49 | 55 | 52 | 39 | 74 |
| NHS 111 & LCD | 75 | 66 | 171 | 194 | 121 | 164 |
| Total | 258 | 206 | 340 | 360 | 240 | 340 |

5.2 The significant increase in NHS 111 complaints and concerns is due to the process of logging within the service. From December, Post Event Messages (PEMs) were logged using the 4Cs module on Datix. This includes feedback on changes to demographies in response to PEM messages and therefore does not accurately reflect the actual incoming complaints and concerns. Actual figures remain consistent with previous reported months and the highest category is in relation to complainants not being satisfied with the clinical call outcome. Future reports will separate the specific feedback types.

5.3 Within the EOC high numbers of complaints were being received during Q3 in relation to HCP bookings and Inter/Intra Facility Transfers (IFTs). This number has decreased during Q4. There was an overall reduction in EOC complaints during Q4 by 21% in comparison to previous quarters and this has continued into 17-18. Positive discussions have recently taken place with Sheffield Teaching Hospitals to develop a joint plan to improve management of IFTs.

5.4 Within the A&E service complaints are in the main related to attitude and behaviours of staff. A wider piece of work is underway across the Trust in developing a behavioural framework and input from complaints and concerns is being fed into this work programme. There has been a slight increase during Q3 and Q4 for A&E complaints however further analysis of these has not identified any specific themes or trends.

5.5 PTS complaints are currently at the lowest in 12 months. The highest category of complaint is relating to patients being collected late from clinics. There had been an increase during Q2 and Q3 in attitude complaints however this has halved in Q4 and now remains consistent with previous months.

**Ombudsman**

5.6 During this period, 7 cases were investigated by the Parliamentary Health Service Ombudsman (PHSO) and two of these were partly upheld. These were for the NHS 111 and LCD services. One resulted in a recommendation for YAS to make an apology for poor complaint handling and the other received a recommendation for an apology and £300 financial remedy due to call handling error delaying treatment.

## 6. CLAIMS

6.1 At the end of Q4 there are currently 211 open claims against the Trust primarily Employer Liability claims (71%). Moving and handling claims continue to be the highest category of claims reported. Injuries arising from equipment, for example the carry chair, stretchers and wheelchairs and from assisting patient movements remain the highest in this category. A ‘moving patients safely’ working group has been established and will look to improve both patient and staff safety. Patient representatives will also be part of this group. So far this group has overseen development of an SOP for patients with complex mobility needs. Upcoming areas for development include staff training, with a focus on handling bariatric patients.

6.2 Clinical negligence claims are reported in small numbers. During this period there were 3 new clinical negligence claims reported.

## 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. During this period 210 new requests for information were received and evidence was provided (written and/or oral) at 139 inquests.

7.2 Inquests relating to delayed response times within the A&E service continue to be reported and investigations have highlighted a number of contributory factors including an increased demand on the service and human factors when handling the calls.

### Prevention of Future Death (PFD) reports

7.3 During this period two PFD reports were received. One concerned a patient with suicidal ideation who had been conveyed to an emergency department, later discharged and died later the same day. YAS was not invited to inquest nor were they aware the inquest was taking place. YAS has considered the report and recommendations but feels that all appropriate systems and processes were in place.

7.4 The second PFD related to a maternity patient who had suffered a cardiac arrest and had been conveyed to ED. During the inquest it was identified that the crew on scene had requested a pre-alert to be made by the EOC but this had not been actioned and as a result the hospital were not expecting the patient upon arrival of the crew. The Coroner had concerns in relation to the robust processes for pre-alerts. Enhanced processes have since been put in place.

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

8.1 Within this period 3 SCRs have been commissioned and information has been provided to the Local Safeguarding Children Boards. A key theme identified is in relation to interagency communication between the emergency services.

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.

## 9. PROFESSIONAL BODY REFERRALS (PBRs)

9.1 There have not been any cases identified during this period that have highlighted organisational learning.

## 10. CLINICAL CASE REVIEWS (CCRs)

10.1 Of the CCRs conducted during this period many of the lessons learned have been individual based however a recurring theme identified is in relation to documentation. Regular reminders are issued to staff regarding the importance of thorough documentation.

## 11. INFORMATION COMMISSIONER'S OFFICE (ICO) NOTIFICATIONS

11.1 During this period YAS did not receive any notifications from the ICO however did report an SI on 19 January 2017 as a result of the wrongful addressing of a letter to a member of staff regarding a disciplinary matter. The ICO reviewed the case and was assured that the Trust had a checking process in place but this failed on this occasion. They also noted that the Trust has reported one previous data protection incident to the ICO in the last 2 years but that this was of a different nature. After considering the available information the ICO determined that the incident does not meet the criteria for formal enforcement action and have closed their file on the incident.

## 12. HEALTH & SAFETY EXECUTIVE (HSE) NOTIFICATIONS

12.1 The Trust did not receive any formal notifications from the HSE during this period.

## 13. DUTY OF CANDOUR (BEING OPEN)

13.1 The Trust continues to communicate proactively 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 Q3 and Q4 16-17 the Trust has applied the being open process to 30 cases. Overall, very 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 30 concerns were raised via this process. The common theme arising, and this is consistent across the NHS, is in relation to staff issues for example cases of bullying and harassment as opposed to direct patient safety related concerns.

14.3 The Trust was invited to present at the National Conference in March 2017 to demonstrate good practice in relation to sharing the message of Freedom to Speak Up across a varied service and a challenging geographical area. The Trust's Guardian has also played a pivotal role in developing the National Ambulance Network for FTSU Guardians and have so far hosted one event at YAS HQ. The network will be pivotal for sharing learning.

## 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.