Yorkshire Ambulance Service NHS
NHS Trust

MEETING TITLE Public Board		**MEETING DATE** 31/01/2017	
TITLE of PAPER	Significant Events & Lessons Learned – Bi-Annual Report	**PAPER REF**	4.6
STRATEGIC OBJECTIVE(S)	Ensure continuous service improvement and innovation		
PURPOSE OF THE PAPER	This report provides the Board with an update on significant events highlighted through Trust reporting systems and by external regulatory bodies, and provides assurance on actions taken to effectively learn from adverse events. The report covers Quarters 1 and 2 2016-17.		
For Approval	☐	**For Assurance**	☒
For Decision	☐	**Discussion/Information**	☒
AUTHOR / LEAD	Rebecca Mallinder (Head of Investigations & Learning)	**ACCOUNTABLE DIRECTOR**	Steve Page (Executive Director of Standards & Compliance)
DISCUSSED AT / INFORMED BY – Quality Committee – July 2016, September 2016 and December 2016			
PREVIOUSLY AGREED AT:	**Committee/Group:** Quality Committee	**Date:** 08/12/2016	
RECOMMENDATION(S)	It is recommended that the Board notes the current position and is assured in regard to the effective management of, and learning from, adverse events.		

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 This report provides the Board with an update on significant events highlighted through Trust reporting systems and by external regulatory bodies, and provides assurance on actions taken to effectively learn from adverse events. The report covers Quarters 1 and 2 16-17.

2. BACKGROUND/CONTEXT

2.1 This report primarily covers the period 1 April 2016 to 30 September 2016.

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:

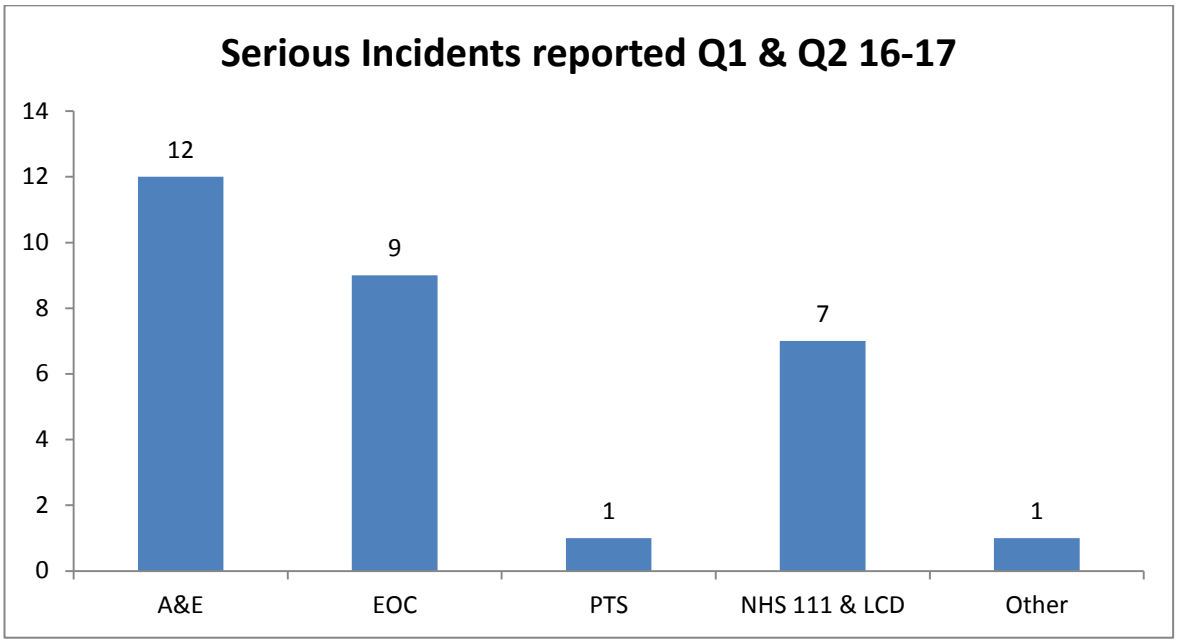
- Serious Incidents reported to the Trust's commissioners
- Incidents
- Complaints – including requests received from other services and including the Ombudsman
- Claims
- Coroners Inquests – including Prevention of Future Death Reports (PFDs) received by the Trust.
- Safeguarding Serious Case Reviews (SCRs) and Domestic Homicide Reviews (DHRs)
- Professional Body Referrals
- Clinical Case Reviews
- Patient Experience
- 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 1 and 2 16-17 the Trust reported 30 Serious Incidents.

3.2 The breakdown of SIs reported during this time is shown below.



**Please also note during Q1 and Q2, four SIs were also logged but subsequently de-logged. Three were de-logged due to the investigation findings determining that no harm was caused and one was de-logged as another NHS Trust took over as lead organisation with YAS contributing to the wider investigation.*

3.3 Of the A&E reported SIs, 5 of these were delays in response where there was a lack of resource available to meet an increased demand on the service. Two of the other SIs involved vehicle accidents, three related to clinical treatment provided on scene and two involved patient falls. The Quality & Safety Team have worked closely with the Clinical Directorate to ensure the learning from these SIs has been encompassed in the clinical refresher training over the course of the next year to ensure learning is widespread across the organisation. Individual learning for all of these SIs was identified and acted upon at the time of incident identification.

3.4 The EOC reported SIs have involved errors in the call handling process either in the coding of the call, the dispatch of resources or the intervention of clinicians in the Clinical Hub. Some of these incidents have also involved wider issues including turnaround times at hospitals, incorrect bookings being made by hospitals, one had staffing issues and one related to the national Ambulance Response Programme (ARP) when this was implemented.

3.5 In April 2016 the Ambulance Response Programme (ARP) was introduced which involved a change to the coding of emergency calls. Learning from cases is being reported to a national review group. No serious incidents directly associated with the ARP have been identified to date.

3.6 A mechanism for real-time review and escalation of delayed response incidents is established in the EOC. The aim is to identify these cases in real time in order that the Clinical Duty Manager (CDM) or Duty Manager (DM) are alerted to assess resources and provide a better response or clinical input to the situation. This process has worked effectively during 16-17 to identify incidents where harm may have been caused as a result of delays in response, promptly.

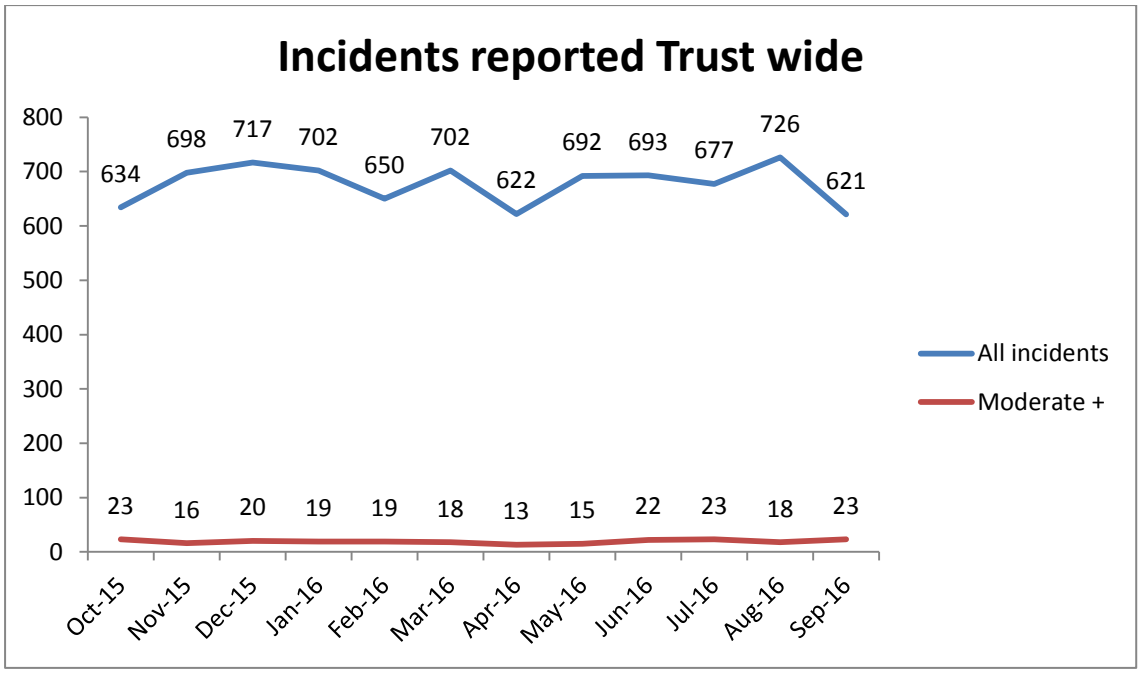
3.7 The PTS SI involved a patient falling on the vehicle and sustaining injuries. Much work has been done in recent years to ensure patient falls are prevented and this was an isolated incident with learning identified and shared in relation to understanding when patients may require more assistance than normal and ensuring the mobility bookings are appropriate to the patient's needs at that time.

3.8 NHS 111 and Local Care Direct (LCD) reported SIs include five reported for the NHS 111 service and two reported for the LCD service. One of the LCD SIs related to significant pressures on the service over the Easter weekend. Many of the actions identified as a result of this SI related to wider system issues and the need for partnership working between commissioners and other stakeholders. YAS and LCD to address the issue. The most common theme arising from the NHS 111 reported SIs is a failure of clinical assessment, in the majority of cases the call handler selected the incorrect NHS Pathway or incorrectly selected the wrong/inaccurate answer. This is an ongoing risk with any assessment either undertaken by a clinical or non-clinical member of staff. Ongoing audits, staff training and updates on lessons learnt in the Practice Developer newsletter are used to reduce this risk. NHS Pathways twice yearly updates also help refresh staff knowledge regarding the correct NHS Pathways selection.

3.9 One other SI was declared within the Trust during this period and this related to a data protection breach. This related to accidental sharing of employee information. All affected employees were advised and concerns addressed. Immediate improvements to systems and processes have been made internally to reduce the risk of recurrence.

4. INCIDENTS

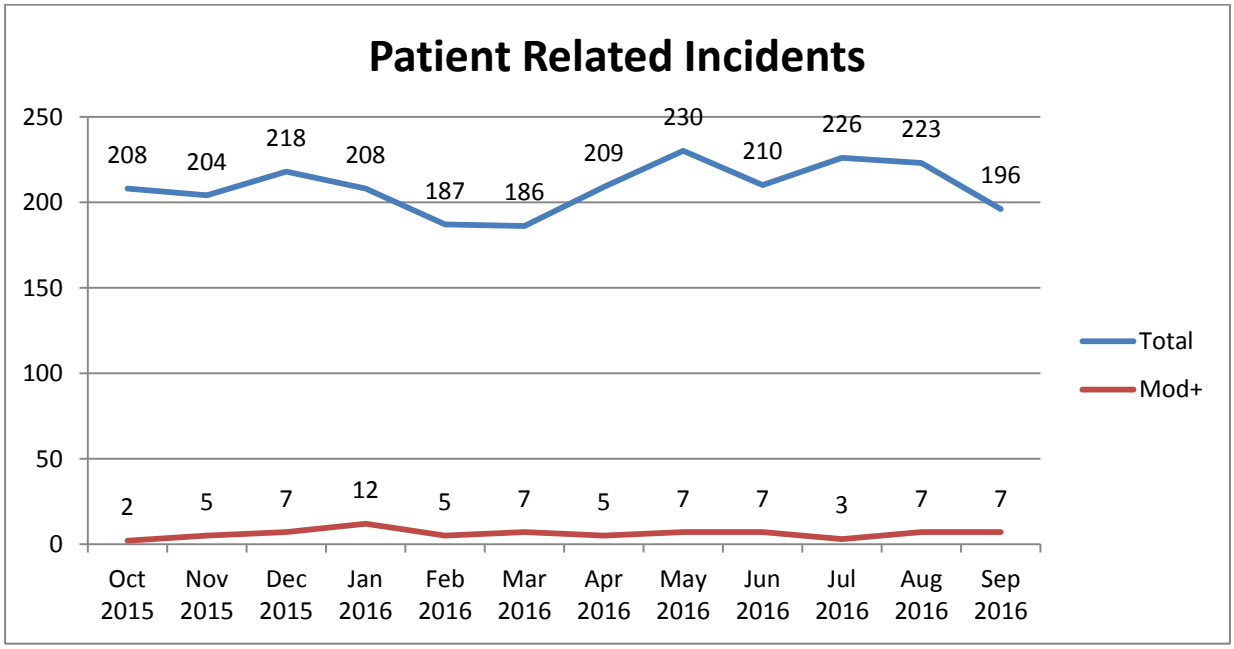
4.1 The graph below shows the number of incidents reported over the previous 12 months.



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

	A&E Operations	EOC	NHS 111	PTS
Oct 15	426	48	50	77
Nov 15	456	64	58	77
Dec 15	501	86	53	51
Jan 16	448	78	48	88
Feb 16	456	38	35	96
Mar 16	469	74	30	105
Apr 16	371	78	42	85
May 16	436	90	39	99
Jun 16	423	86	28	129
Jul 16	386	99	46	106
Aug 16	438	86	44	123
Sep 16	434	50	30	76
Total	5244	877	503	1112

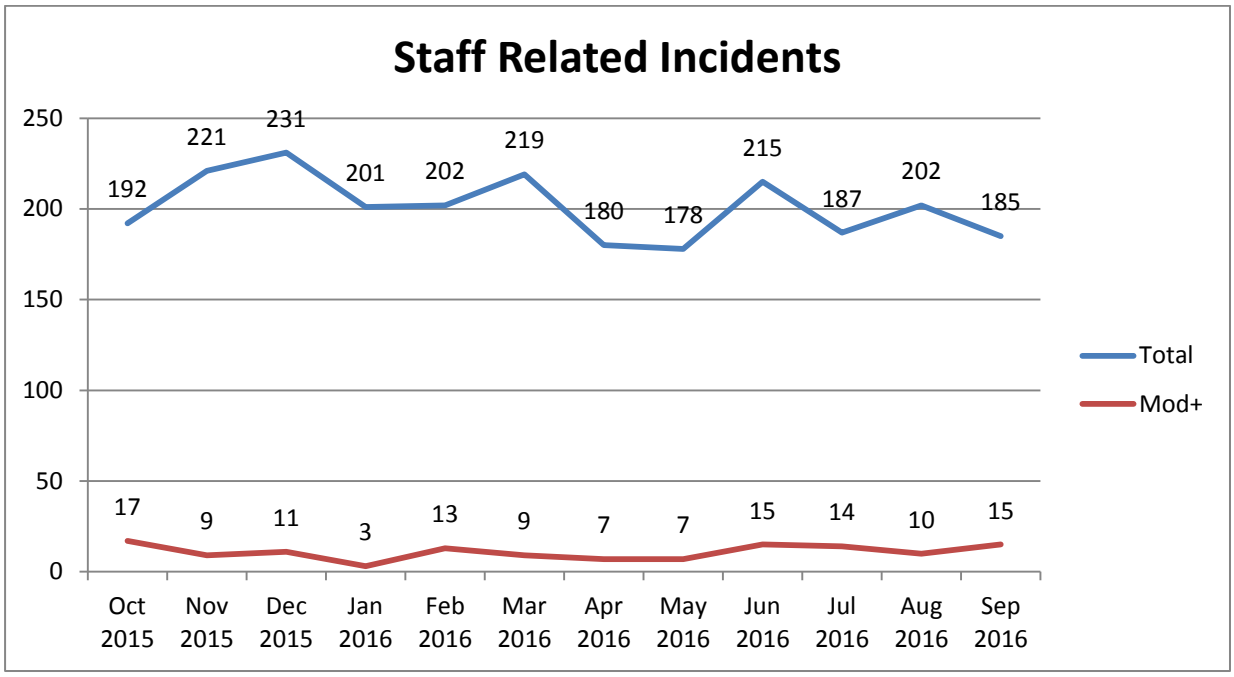
4.3 The graph below show the breakdown of incidents by those that have affected patients.



4.4 Within the patient related incidents the highest category of incidents reported is response related. As outlined in section three of this report, 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. The second highest category reported is 'care pathway'. Further work is underway to capture these appropriately as currently these include a number of incidents relating to other NHS providers where the pathways they have in place have not been appropriate for the patient.

These are highlighted to the relevant organisation via the outbound service to service process. Response related incidents within NHS 111 and LCD feature as the third highest category of incident reported.

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



4.6 Within Quarter 2 the highest categories of incidents reported that have affected staff include moving and handling incidents, slips, trips & falls incidents and violence and aggression incidents. Work is underway led by the Trust's Local Security Management Specialist to address the violence and aggression incidents and to look at improvements to our management and prevention. This includes working with partner organisations to ensure appropriate action is taken against individuals who have carried out these acts towards staff.

5. COMPLAINTS

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

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
A&E	53	39	33	31	45	42
EOC	42	33	38	54	45	54
PTS	66	51	142	167	100	67
NHS 111 & LCD	88	112	128	64	63	41
Total	249	235	341	316	253	204

5.2 There was a large increase in PTS complaints over the summer months and this was due to some changes made with the renal service.

As part of the PTS modernisation project these changes involved combining two separate renal rotas and core PTS rotas into one rota to provide a greater pool of staff and vehicles to improve responsiveness. The focus was within the West Yorkshire area. This led to a number of issues for PTS renal patients with longer wait times impacting on their treatment and subsequently their overall health. A number of actions were taken as a result of this to resolve the operational issues. Engagement with the renal patient representative groups, renal units and commissioners was also increased to support the affected patients and increase feedback on the impact. These issues are now resolved and the service is running smoothly with the planned improvements in place. Going forward further engagement work is planned to ensure any changes to services are carried out factoring in feedback and potential issues from service users.

5.3 Within the A&E service a proportion of complaints raised relate to attitudes and behaviours. In November 2016 a group was reinstated to look at some of the detail underpinning this and a number of actions were identified including building in learning from specific examples into the Trust Customer Care Course.

5.4 The table below shows the numbers of compliments received across the Trust during this period.

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
A&E & EOC	75	92	106	78	82	89
PTS	5	1	4	6	6	3
NHS 111 & LCD	13	14	13	6	12	5
Total	93	107	123	90	100	97

6. CLAIMS

6.1 Moving and handling claims continue to be the highest category of calims reported. Claims arising from the emergency response bag and carry chairs are still reported, however, the numbers are significantly lower and there was only 1 claim of this nature reported during Q1. During Q2 claims arising from slips, trips and falls reduced from Q1.

6.2 Clinical negligence claims are reported in small numbers. During this period there were 6 new clinical negligence claims reported. Three of these related to the clinical assessment on scene, one related to the NHS 111 call handling process, one related to a delay in response and one related to failure to carry out an electrocardiogram (ECG) when it was clinically indicated. Remedial actions were taken in terms of further training with the individual clinician.

7. CORONERS INQUESTS INCLUDING PFDs

7.1 The Trust's involvement in inquests continues to require significant input in relation to attendance of staff as witnesses. During this period 203 new requests for information were received and evidence was provided (written and/or oral) at 135 inquests.

7.2 Inquests relating to delayed response times within the A&E service continue to be reported but in much smaller numbers and are concerned with delays to lower acuity calls in which time the patient has deteriorated. These reported have consisted of a combination of demand/resource issues and human factors within the EOC. Lessons and actions have been taken on an individual case basis and are also fed back into wider Trust workstreams.

7.3 There has been an increase in the number of Coroner's requests involving NHS 111 and GP Out of Hours (OOH) services. The main focus of these relate to human factors within the call hanlding processes. As a result from a recent case which went through both the inquest and claim routes, a change in process for those calls within NHS 111 that reach an outcome of a R2 ambulance (pre-ARP) response was implemented.

Prevention of Future Death (PFD) reports

7.4 During this period one PFD report was received in relation to an inquest that was held in Bradford in August 2016 which concerned a bariatric patient who had fallen and been unable to move all night before being found by a friend who contacted 999. The call was given a Green 4 coding which was found to be compliant and the overall response time was 2 hours and 2 minutes. The Coroner felt that a further review of the protocols in place were required in relation to incorporating more enquiries with respect to long lays, particularly in the case of obese patients, and issued a PFD on this basis. The case is currently being discussed with the International Academy of Emergency Dispatch as to whether they feel that any changes to the AMPDS system are appropriate.

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

8.1 Within Q1 and Q2 there were no significant events or Lessons Learned from the Safeguarding Adult, Safeguarding Children Reviews and Domestic Homicide Reviews.

8.2 The safeguarding team are now using Datix to capture information regarding the amount and type of information requests that are generated by Adult and Children Social Care teams, the NSPCC and from various Safer Working partnerships across Yorkshire.

8.3 In the period between April and June 2016 the team received 72 requests relating to Adults this included; 3 scoping exercises for Domestic Homicide Reviews and 1 information request for a Safeguarding Adult Review. There were 69 requests relating to children of which 19 were reports submitted to Child Death Overview Panels and 1 Serious Case Review. The wider learning from the Safeguarding Adult Review and Serious Case Reviews is being used to inform training materials for use by all staff. i.e. the challenges of self-neglect, within Adult Safeguarding cases.Training, including face to face delivery and the new Safeguarding Adults and Children Level 2 work book; are being planned to be ready for launch in the autumn.

8.4 Within Q2, the safeguarding team received requests for information from Adult and Children Social Care teams investigating the concerns and referrals raised by staff. Information requests also from NSPCC/ChildLine and from various Safer Working Partnerships across Yorkshire. In Q2 the team received 55 requests from Adult Social Care and 34 requests from Children Social Care. There were 23 reports submitted to Child Death Overview Panels. Within the CDOP process Yorkshire Ambulance information assists to identify the factors which may have contributed to the death of the child and which, by means of locally or nationally achievable interventions, could be modified to reduce the risk of future child deaths.

8.5 The team have recruited a new experienced safeguarding practitioner. One of the key roles will be to assist the Safeguarding Team to produce an updated Safeguarding Training strategy; that delivers training to all services lines within YAS in line with National Guidance and Contract, Management, Reporting and Information Requirements.

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 The CCRs conducted during this period have primarily highlighted learning for the individuals involved. The key themes are around clinical decision making and documentation. Work is ongoing within Clinical Audit to address common errors made on the Patient Care Record (PCR) and to look at ways to improve how we document information.

11. PATIENT EXPERIENCE

11.1 Involving our employees, patients and members of the public is vital when we are looking to develop and improve the care and services we offer.One of the key workstreams for 16-17 within Patient Experience is the establishment of a Critical Friends Network (CFN).

11.2 The CFN will comprise patients and members of the public who will be involved in service planning, developments and quality improvement. The CFN will be consulted on during the planning phase of key initiatives to ensure the patient voice is at the heart of everything we do.

11.3 The CFN will consist of approximately 30 people from a range of different backgrounds and with a range of different experiences. Applications have been taken from people who wish to be involved in the network and the selection process will take place during February 2017. Applicants will ideally have experience of using one our services during the previous 3 years, and the Trust's Diversity & Inclusion Lead is actively involved in ensuring the group is representative of the diverse population that we serve.

11.4 The first consultation event took place in July 2016 with a number of people invited to attend via the Trust's Expert Patient and this allowed ideas for the CFN to be discussed and a plan to be established. This has been built upon over the last 6 months and in December 2016 the first full CFN event took place at Cedar Court, Wakefield. The event was a great success with approximately 20 people attending who had previously expressed an interest to be involved in the network. A pilot project was conducted at this event to gain the valuable insight of patients and members of the public and this was regarding how we use people's information. Wider discussions were also had to gain feedback on the Trust's Quality Account, patient safety initiatives, communications and engagement and the upcoming Patient Research Ambassador role.

11.5 During the remainder of 16-17 the recruitment process will conclude to ensure going into 17-18 there is a fully established network of people available Trust wide to consult with on a range of projects. Applications will continue to be accepted from people to ensure the network is continuously refreshed with new experience and expertise. The CFN will compliment other existing approaches to patient involvement and the community engagement activity of the YAS Forum.

12. INFORMATION COMMISSIONER'S OFFICE (ICO) NOTIFICATIONS

12.1 During this period YAS did not receive any correspondence from the ICO in relation to Freedom of Information or subject access requests under the Data Protection Act 1998.

12.2 The Trust reported a serious incident through the Information Governance Toolkit on 5 September 2016, as required under thresholds set by the Department of Health. The Information Commissioner's Office was automatically notified.

12.3 On 16 October 2016, the Information Commissioner's Office contacted the Trust. It stated that it would be taking no action because the incident was unlikely to have caused the affected data subjects significant detriment and the incident was a result of an employee not following established procedure.

13. HEALTH & SAFETY EXECUTIVE (HSE) NOTIFICATIONS

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

14. DUTY OF CANDOUR (BEING OPEN)

14.1 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.

14.2 During Q1 and Q2 16-17 the Trust has applied the being open process to 40 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.

15. FREEDOM TO SPEAK UP

15.1 “Freedom to Speak Up: An independent review into creating an open and honest reporting culture in the NHS” (Francis) was published in February 2015. The aim of the review was to provide advice and recommnedations to ensure that NHS staff feel it is safe to raise concerns, confident that they will be listended to and the concerns wil be acted upon.

15.2 Yorkshire Ambulance Service developed a full implementation plan following the national report that was published and this involved a full review of the recommendations, development of a policy and Standard Operating Procedure (SOP), an awareness raising campaign and recruitment of a Freedom to Speak Up Guardian and a number of supporting Advocates. Training has been provided to the Guardian and Advocates and the Trust continues to represented at a national level and has received excellent feedback for the implementation process.

15.3 The Trust launched Freedom to Speak Up in July 2016 and the process has been utilised effectively for staff to raise concerns regarding quality, safety or matters of public interest. During Q2, 16 concerns were raised via the Freedom to Speak Up process. A number of these were from the EOC and related to staffing levels. Regular meetings have been held between the Freedom to Speak Up Guardian and the senior management team in the EOC to explore the issues surrounding this. Analysis continues to monitor staffing levels in line with demand on the service to ensure that there is sufficient staff to cope with the volume of work received into the EOC.

16. PROPOSALS/NEXT STEPS

16.1 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.

17. RISK ASSESSMENT

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

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

18. RECOMMENDATIONS

18.1 It is recommended that the Board notes the current position and is assured in regard to the effective management of, and learning from, adverse events.