Yorkshire Ambulance Service NHS
NHS Trust

MEETING TITLE Trust Board Meeting in Public			**MEETING DATE** 26/07/2016	
TITLE of PAPER	Bi-Annual Significant Events & Lessons Learned paper Q3 & Q4 15-16		**PAPER REF**	4.3
STRATEGIC OBJECTIVE	To develop culture, systems and processes to support continuous improvement and innovation To provide services which exceed patient and commissioner expectations			
PURPOSE OF THE PAPER	This report provides the Trust Board with a bi-annual briefing on significant events highlighted through Trust reporting systems and by external regulatory bodies during Q3 & Q4 2015-16. The report also focuses on actions taken and lessons learned.			
For Approval	☐	**For Assurance**	☒	
For Decision	☐	**Discussion/Information**	☒	
AUTHOR / LEAD	Rebecca Mallinder (Head of Investigations & Learning)	**ACCOUNTABLE DIRECTOR**	Executive Director of Quality Governance & Performance Assurance	

DISCUSSED AT / INFORMED BY – include date(s) as appropriate (*free text – i.e. please provide an audit trail of the development(s)/proposal(s) subject of this paper)*:
Bi-monthly Significant Events & Lessons Learned reports are submitted to the Quality Committee and the relevant information from those reports informs this Public Board bi-annual report.

PREVIOUSLY AGREED AT:	**Committee/Group:**	**Date:**
RECOMMENDATION	The Trust Board notes the contents and supports the actions detailed in the paper.	

RISK ASSESSMENT	**Yes**	**No**
Corporate Risk Report and/or Board Assurance Framework	☐	☒
Resource Implications (Financial, Workforce, other - specify)	☐	☒
Legal implications/Regulatory requirements	☐	☒
Quality and Diversity Implications	☐	☒

ASSURANCE/COMPLIANCE	
Care Quality Commission Registration Outcome(s)	4: Care and welfare of people who use services 7: Safeguarding people who use services from abuse 16: Assessing and monitoring the quality of service provision
Monitor Governance Framework	All

1. PURPOSE/AIM

1.1 This report provides the Trust Board with a bi-annual briefing on significant events highlighted through the Trust reporting systems and by external regulatory bodies during Q3 and Q4 2015-16. The report also focuses on actions taken and lessons learned.

2. BACKGROUND/CONTEXT

2.1 This report primarily covers the period October 2015 – March 2016 (Q3 and Q4 2015-16).

2.2 Where necessary immediate action is taken following a significant event to ensure patient and staff safety. This is followed by more formal incident 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 and near misses
- Complaints – including requests received from the Ombudsman
- Claims
- Coroners Inquests – including ‘Prevention of Future Deaths’ letters received by the Trust
- Safeguarding Serious Case Reviews
- Professional Body Referrals
- Clinical Case Reviews
- Information Commissioner's Office notifications
- Health & Safety Executive notifications
- Being Open (Duty of Candour)
- In future reports themes arising from the Freedom to Speak Up process launched in July 2016 will also be included

2.4 The Trust Incident Review Group (IRG) meets fortnightly and considers all cases rated as moderate or above via the Trust risk grading system. IRG is the key forum for ensuring that themes and trends across multiple sources are identified and that lessons learned are shared across teams and appropriate action plans are in place. This group is chaired by the Trust Executive Medical Director and includes the Executive Director of Quality, Governance & Performance Assurance, all associate director-level clinical leads as well as managers responsible for the work areas outlined above.

2.5 The nominated local investigating manager is responsible for ensuring that action plans to address the lessons learned are delivered. They are accountable for this work via their line management structure. Additional monitoring systems are in place for serious incidents and notifications from external agencies.

2.6 At a corporate level, lessons relating to clinical care are reported to Clinical Governance Group (via the Clinical Quality Development Forum) and to Quality Committee.

2.7 Feedback to staff is provided by responsible managers in relation to individual incidents and this is supplemented by thematic reports to local management groups and a new monthly highlight bulletin for all staff (Safety Update). Learning from adverse events is included in relevant training materials where appropriate.

3. LEARNING FROM SERIOUS INCIDENTS

3.1 A total of 34 SIs were reported in Q3 and Q4 15-16; the table below shows this split by business area.

Serious Incidents	Oct	Nov	Dec	Jan	Feb	Mar
A&E	0	0	1	3	1	1
EOC	2	1	2	3	2	3
PTS	0	0	0	1	0	0
NHS 111	1	2	0	1	2	2
LCD	0	0	2	0	1	1
Other	0	0	0	0	0	1
TOTALS	**3**	**3**	**6**	**8**	**6**	**8**

3.2 The Trust proactively reports as SIs, cases where a delayed response/back up is associated with severe harm or death of the patient and there is potential for the delay to have been a contributing factor. The real-time reporting of delayed responses in EOC highlights potential SIs for consideration at IRG.

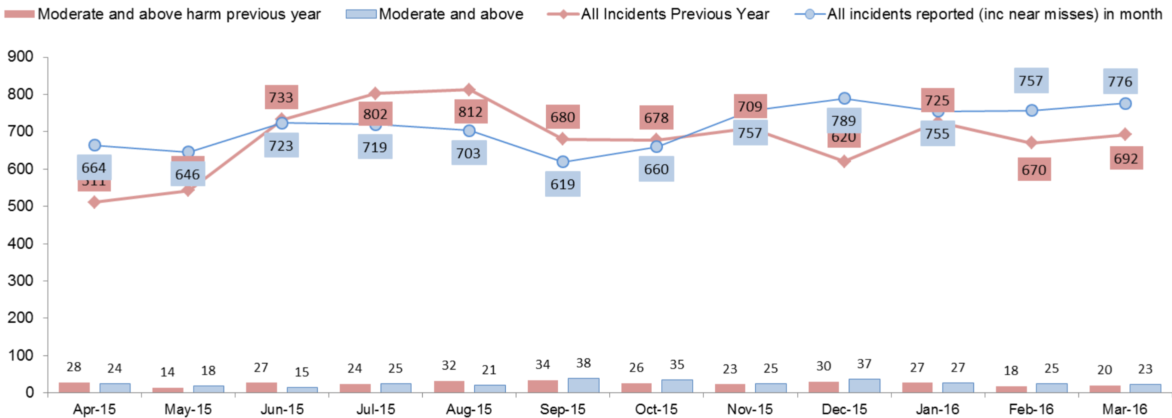
3.3 In comparison to Q1 & Q2 15-16 the number of SIs increased during the final two quarters of the year. It is likely that the rise in Q3 and Q4 has been influenced by improved awareness following the introduction of the real time reporting of delayed response incidents and significant focus on human factors as a cause of adverse events in the EOC.

3.4 A key theme arising from serious incident investigations conducted within the NHS 111 service relates to re-assessment following call backs. In some cases when patients have re-contacted the service to follow up on progress with an agreed treatment plan, the call handler has not conducted a further full assessment. This has on occasion resulted in worsening symptoms being missed. This learning has been highlighted across the whole NHS 111 service reminding staff the importance of re-assessment on all cases where there is multiple contact made.

3.5 A joint investigation by LCD and NHS 111 recognised weaknesses in the NHS Pathways system in relation to the management of sepsis in children. This case in particular was raised nationally to feed into the wider sepsis review taking place across the NHS. Additional learning for LCD also included strengthening clinical practice audit processes of clinical practice to support improved learning from clinical practice.

4. INCIDENTS AND NEAR MISSES

4.1 The chart below shows the incidents and near misses reported throughout 15-16 and the number of cases where moderate or above harm has been sustained to patients and/or staff. 15-16 saw a 4% increase overall in the number of incidents reported which is a positive indicator of staff engagement with the reporting process. The number of moderate and above incidents remained as 3.7% of all incidents reported.



4.2 During 15-16 a lot of awareness raising has been carried out across the organisation to encourage incident and near miss reporting. From Q1-Q2 to Q3-Q4 there has been an overall 10% increase in the number of incidents and near misses reported.

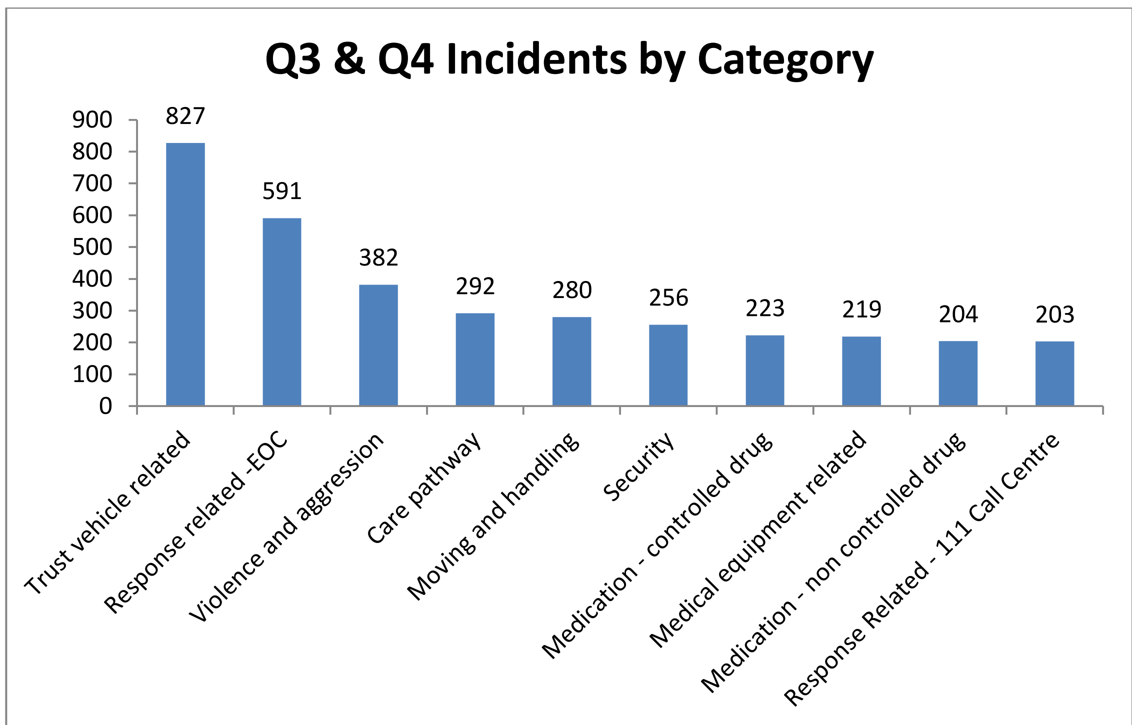
Patient Related Incidents

4.3 Patient-related moderate and above harm incidents are reviewed at Incident Review Group where they are considered in line with the Serious Incident Framework. Thematic reports are also reviewed at the Clinical Quality Development Forum. Staff-related moderate and above harm are reviewed against RIDDOR reporting requirements and reported to Health and Safety Committee, along with Estates and Security incidents.

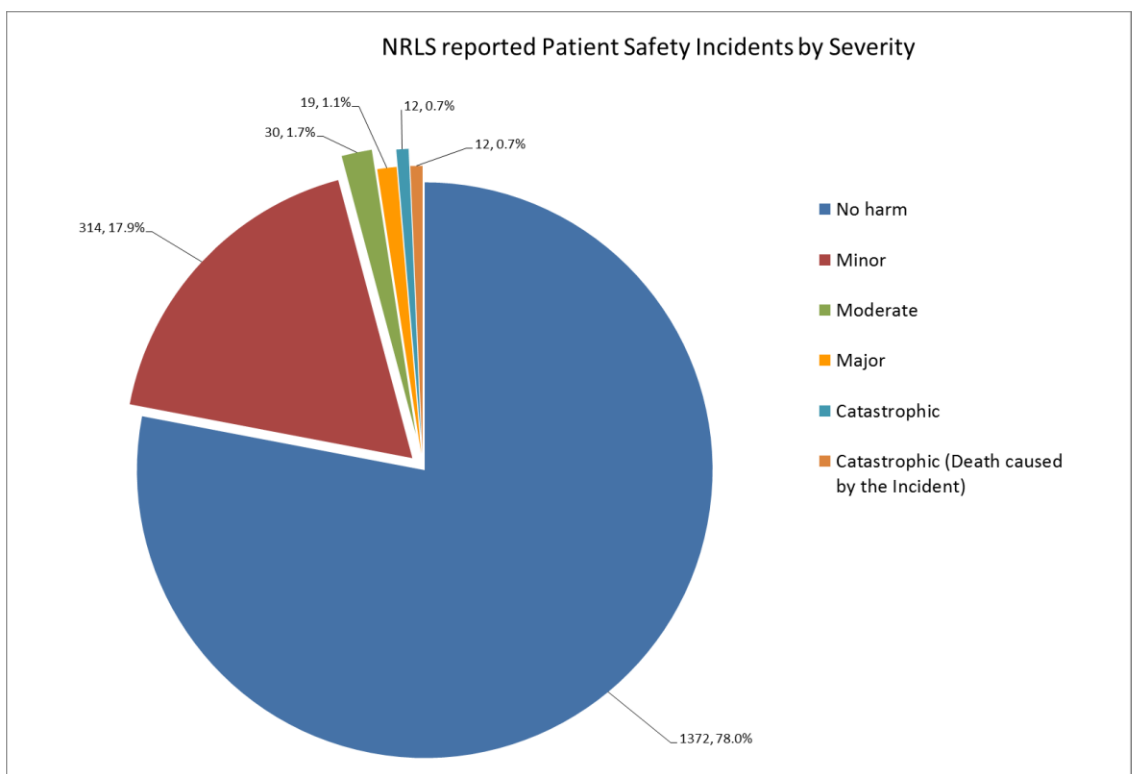
4.4 Chart 2 below shows the top 10 categories of patient incidents reported during Q1 and Q2.

4.5 The top 10 categories reported during Q3 and Q4 15-16 remain consistent with those reported during Q1 and Q2. A 12% increase can be seen in the Trust vehicle related incidents; some of this is due to the seasonal variations in driving conditions. During Q4 work has been undertaken to strengthen the reporting requirements on Datix in relation to care pathways. The additional

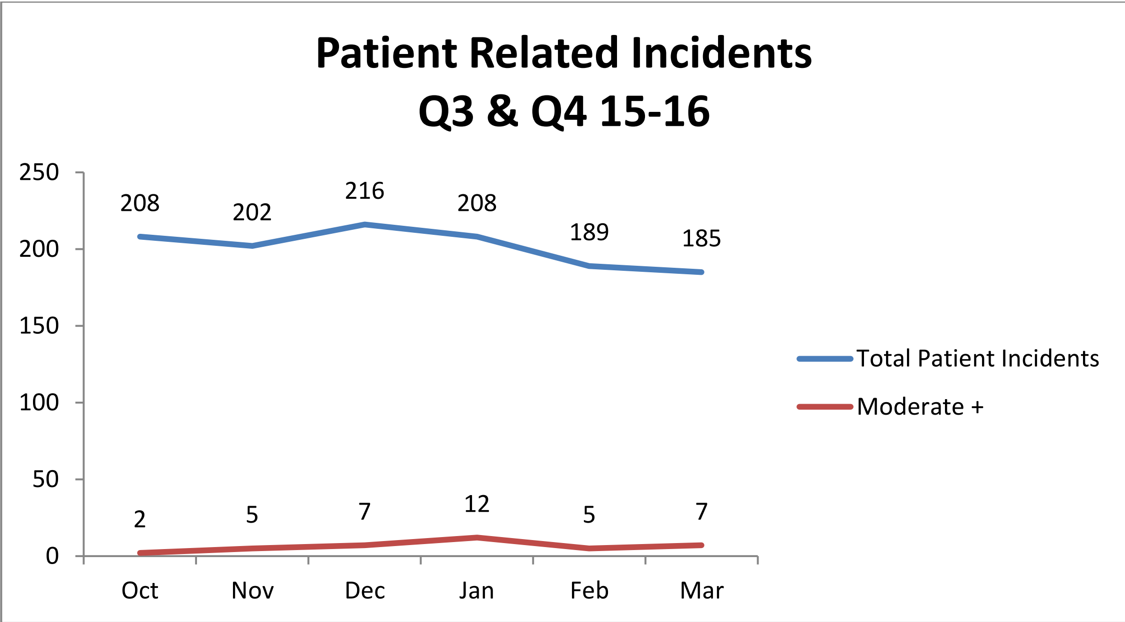
categories will allow for further reporting to assess whether the pathways relate to internal YAS pathways or or multi-agency pathways requiring action across the wider health and social care system.



4.6 The Trust reports patient safety incidents to the National Reporting & Learning System (NRLS) each month. The chart below shows the breakdown of severity from 15-16 of all patient related incidents. As would be expected the majority (96% approx.) are graded as no harm or low harm.



4.7 All patient–related incidents and those with a severity of moderate and above are illustrated in the chart below.

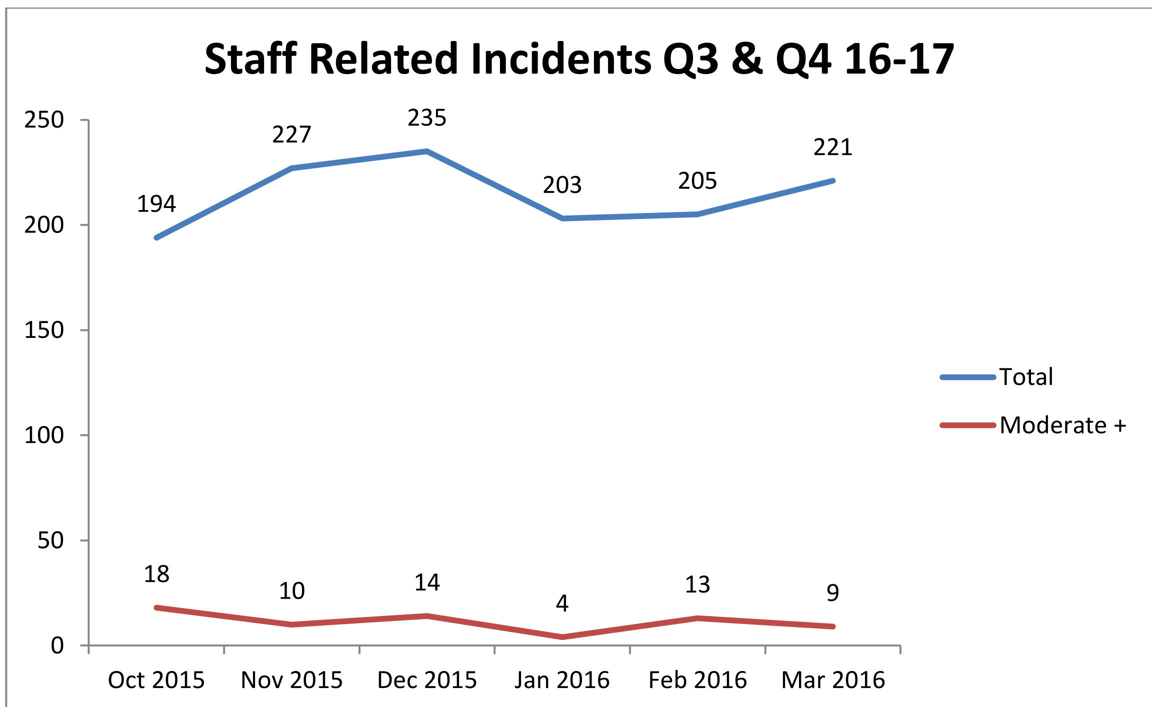


4.8 Overall, moderate and above patient incidents reported 3.15% of the total patient related incidents in this period which is a 3% decrease compared to the previous 6 months. There was a rise in moderate and above incidents in January 2016. These included four cases of slips, trips & falls and/or moving and handling related incidents where patients had fallen and sustained injuries whilst in receipt of YAS care. Three were within the A&E service and 1 was within PTS. Learning was identified in relation to securing patients properly and the key issues have been fed into the wider Sign up to Safety Programme within the work stream of 'moving patients safely' to ensure that key messages are retiterated to staff regarding effective and appropriate securing of patients. 5 delayed responses were reported in this period reflecting the increased service pressure over the festive period.

4.9 The Trust has two Key Performance Indicators (KPIs) in relation to incident reporting during 16-17. One KPI is to increase incident and near miss reporting by 5% and the other is to reduce the proportionality of patient related incidents where moderate or above harm has been sustained to 3% or less of overall incidents reported.

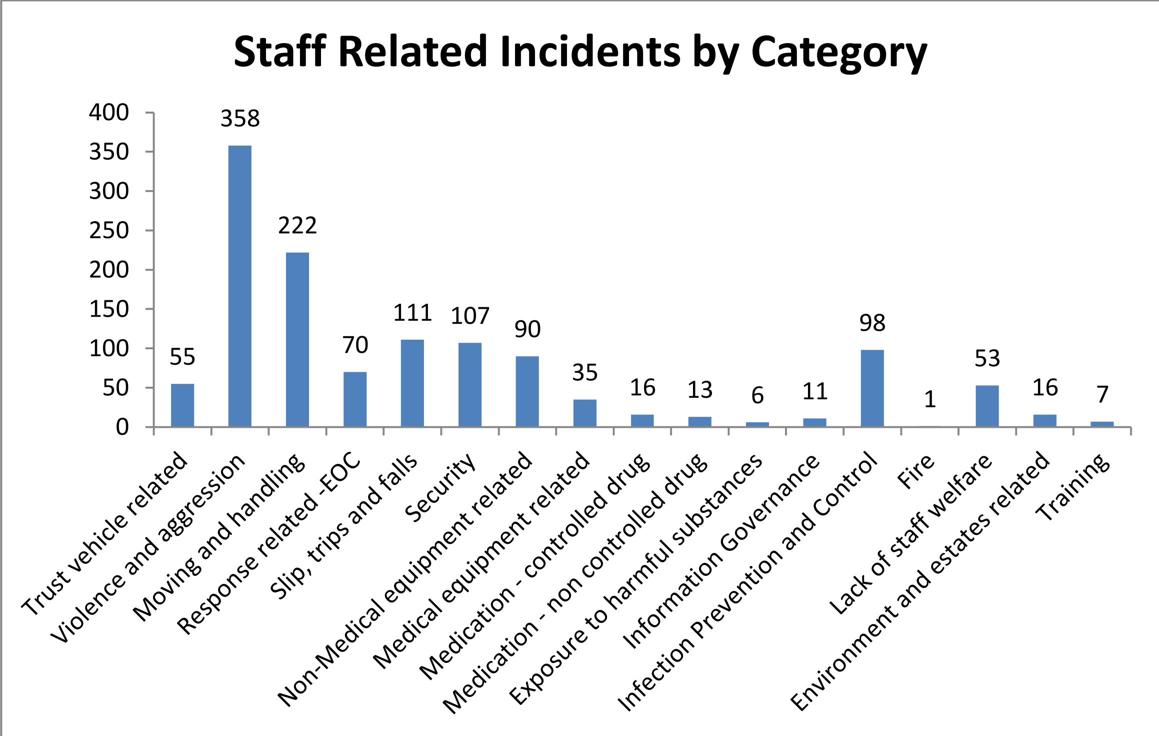
Staff Related Incidents

4.10 The line graph below shows the staff related incidents reported during this period.



The overall numbers have remained consistent with an overall increase over the 6 month period. In comparison to the previous 6 months there has been a 10% increase in the number of staff related incidents. Throughout this period 5.3% of these incidents have resulted in moderate or above harm to staff. This is a 1% increase from the previous reporting period.

4.11 The chart below shows the breakdown of staff related incidents by category.



Violence & aggression incidents continued to be the highest category of reported incidents during this period. Although there has been an increase in the number of Violence & Aggression incidents being reported, the 2015 Staff Survey showed that YAS compares least favourably in this area with other Ambulance Trusts in England.

YAS compares less favourably in terms of the percentage of staff, experiencing physical violence in the last 12 months, reporting their most recent experience of violence.

Development of the Management of Violence & Aggression Policy should help to raise awareness of the need to report incidents and it is hoped that by improving the support given to staff when they are assaulted, it will encourage better reporting and improve the rate of successful prosecutions.

In an attempt to increase the number of sanctions taken against individuals who assault YAS staff and to improve the recording of those sanctions that are awarded, the LSMS is working towards developing a designated Police Point of Contact. Hopefully, this will enable the LSMS to receive regular reports in respect of YAS staff who have reported an assault; the actions that are being taken to pursue a prosecution; details of court appearances; and details of all successful prosecutions.

Moving and handling incidents are the second highest reported incident category for staff incidents. A lot of work has been undertaken as part of the Sign up to Safety programme to reduce these incidents with projects focusing on moving patients safely which also assists staff in avoiding injury.

5. COMPLAINTS INCLUDING OMBUDSMAN REQUESTS & PATIENT EXPERIENCE

5.1 Dissatisfaction from patients regarding response times remains the largest proportion of all EOC complaints; representing 73% at the year end.

5.2 Within the A&E Operations service the highest category of complaint is operational procedures at 38%. In the previous period staff attitudes and behaviours was the most frequently reported category. More detailed analysis does not reveal any specific themes underlying. Going into 16-17 further work is being planned via Clinical Quality Development Forum to understand some of the attitude and behaviour complaints further and to develop an appropriate action plan to address these concerns.

5.3 The National See and Treat and the PTS Friends and Family Test initiatives continue to provide positive feedback although uptake is low, which is comparable with other Ambulance Services.

5.4 Within PTS, themes from complaints remain consistent with previous reports. Delays in taking the patient to and from hospital appointments represents 64% of complaints into PTS at year end.

5.5 The highest category of complaints within NHS111 and WYUC relate to clinical and patient care. These relate to the patients not receiving the call outcome they desired and how appropriate they feel the referral was. Issues are reviewed at the NHS111 and West Yorkshire Urgent Care Clinical Governance meeting.

5.6 During the year 36 cases were referred by complainants to the Ombudsman. Of these only 16 were investigated and the table below summarises the outcomes.

	Referred	Upheld	Partially upheld	Not upheld
A&E	7	0	2	5
EOC	7	0	0	7
PTS	1	0	0	1
111/WYUC	1	0	0	1

The complaints which were partially upheld brought learning opportunities for record-keeping around non-transport of patients and for complaint handling. An action plan has been developed and is currently being implemented. There was also learning in relation to pathways for vascular surgery in Bradford and Calderdale.

6. CLAIMS

6.1 During 2015-16 there have been 91 new claims reported. There are currently 178 claims open. The breakdown is detailed in the table below:

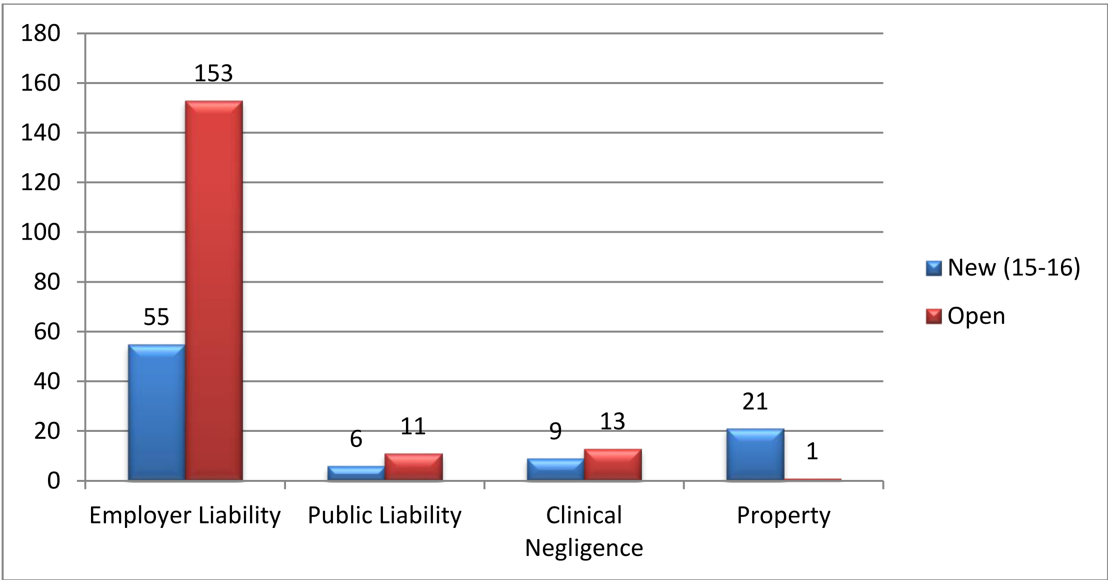


Figure 1: Total number of new and open claims

6.2 Employer Liability Claims continue to be the main focus of claims within the Legal Team, 55 new claims were reported in 15-16, with 153 open. The highest volume of these claims relate to musculoskeletal injuries from moving and handling incidents (both patient and equipment related). At the time of reporting, going into 16-17 the number of new claims has reduced. Claims arising as a result of the previously used blue response bags and carry chairs continue to be reported but in much smaller numbers following the changes in equipment provision.

6.3 The number of ambulance vehicle related injury claims has increased this past year relating to problems with tail-lifts, stairs and vehicle doors. There is currently 41 open claims of this nature. A recall of A&E vehicles to refit a modified tail-lift has been completed. Work also continues in relation to manual handling risk assessments for vehicles and equipment. The new specification vehicle which will be introduced in 2016/17 will reduce the risk of future claims relating to tail lifts.

6.4 Clinical negligence claims remain low but those that are reported are of high value. There have been 9 reported in 2015/16, with the majority relating to a d relating to clinical assessment and deterioration following a non-conveyance.

6.5 In November 2015, a stroke pathways claim from 2009 which was valued at £1 million proceeded to trial. The development and implementation of the pathways was scrutinised in detail at this trial and the judge found no fault or criticism in any of the Trusts actions which gave additional assurance around the policies and procedures in place for our management of stroke patients.

7. CORONERS INQUESTS INCLUDING PREVENTION OF FUTURE DEATHS (PFD) REPORTS

7.1 The Trust's involvement in inquests continues to remain high in relation to attendance of staff as witnesses, particularly within the Hull and East area with involvement in 200 inquests. This year the Trust has been involved in 440 inquest cases and has provided both written and oral evidence.

7.2 The number of inquests opened by the Coroner as a result of delayed response continue to be reported, however this number has decreased. Inquests relating to patients who have suffered a spinal injury also continue to be reported. The Clinical Directorate continue to re-inforce the assessment and treatment of a potential spinal injury through clinical practice and training, and a new spinal injury assessment tool was recently introduced which aims to further assist clinicians in these circumstances. Since these interventions were introduced, in 16-17 the number of claims relating to spinal management has decreased.

7.3 In all cases where a concern is raised YAS provides an investigation report and representation from the Trust is made. The conclusions, including lessons and recommendations are added to the report to ensure that this is captured and further informs analysis of themes and trends.

7.4 Coroner recommendations this past year have triggered a significant amount of work within EOC and the wider Trust on how standoff situations are managed and the communication around these. At a recent inquest the Coroner commended YAS on the work that had been undertaken in this area.

Prevention of Future Death Reports

7.5 YAS was involved in a complex inquest which was heard in October 2015 which concerned the death of a patient who had a history of mental health issues and was a frequent caller of the Trust. The patient called the 999 service on the day she died and unfortunately there was a delay in the response and she was found deceased on arrival. The Coroner felt that there should be provisions within the 999 AMPDS system to identify those patients who are alone and vulnerable and that these calls should then be managed differently. A PFD report was issued as a result of this. The recommendations from this case have triggered a review of the processes within EOC for the management of overdose cases and the mental health nurse role. The Executive Director of Operations has written to the International Academy of Emergency Medical Dispatch (IAEMD) and NHS England to share the learning from this case in order to inform future developments.

7.6 During 2015-16 there has been a small number of cases involving NHS 111 including a historical NHSD case heard in the last quarter. In these cases the Coroner raised concerns about the processes for sharing information between services (111/999/GP services) in that previous contacts/assessments are not all available to each service. Whilst YAS has provided assurance on the processes locally, the Coroner for the Bradford area is planning to make a PFD report to NHS England to look at whether any lessons can be learned and implemented across NHS 111 services nationally.

YAS will review the recommendations within the report and apply any learning to the services. The Vanguard work streams will also support this issue with the planned development of a single patient care record.

Hillsborough Inquests

7.7 Work continued during 2015/16 to contribute towards Hillsborough Inquests. The Trust, as one of the successor organisations for South Yorkshire Metropolitan Ambulance Service (SYMAS) was an 'interested person' for the purpose of the inquests. The inquest concluded in April 2016 and YAS continue to contribute to the processes arising from this as requested.

8. SAFEGUARDING

8.1 YAS contributed to a number of reviews during Q3 and Q4 including lessons learned reviews, domestic homicide reviews (DHRs) and adult safeguarding reviews during this period. The involvement related to approaches to managing dementia patients and the Mental Capacity Act 2005 in the main. The cases found YAS' management of these contacts were appropriate and therefore no organisational learning was identified through these.

9. PROFESSIONAL BODY REFERRALS

9.1 No significant organisational lessons learned were identified from Professional Body Referrals during Q3 and Q4 of 15/16.

10. CLINICAL CASE REVIEWS (CCRs)

10.1 Improvements in documentation of clinical decision-making continue to be a theme identified in Clinical Case Reviews. Reminders have been issued to staff highlighting the importance of full and accurate completion of all documentation.

11. INFORMATION COMMISSIONERS OFFICE (ICO) NOTIFICATIONS

11.1 During the period in question YAS did not receive any correspondence from the ICO in relation to the Freedom of Information Act legislation.

12. HEALTH & SAFETY EXECUTIVE (HSE) NOTIFICATIONS

12.1 The Trust has not received any notifications from the HSE for this period.

12.2 The Trust did report one case directly to the HSE. This related to a collapsed tail lift which resulted in minor patient and staff injury. The HSE did not request any further information in relation to this incident however YAS reported this as an SI and conducted a full investigation. The investigation concluded no faults with the equipment in use and this was verified by an independent specialist. There was some learning identified for the individual that was involved. The processes for checking and servicing of tail lifts were reviewed as part of the investigation process to provide additional assurance on equipment safety.

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13. BEING OPEN (DUTY OF CANDOUR)

13.1 The Trust continues to comply with the statutory and contractual Duty of Candour ensuring we are open and honest with patients when moderate or above harm has occurred whilst in receipt of YAS care. Since January 2016 the Duty of Candour cases have been recorded on Datix and this has enabled more accurate monitoring and application of the process. In conjunction a review also took place in December prior to the transfer to the Datix system to strengthen aspects of the process. This included an amendment to how we approach patients and/or family members in these cases and this has seen improvements in engagement. An audit process has also been developed that reviews moderate and above harm cases on a monthly, quarterly, bi-annual and annual basis to ensure all relevant cases have been captured.

13.2 KPIs have been strengthened and are reported in the Quality, Governance & Performance Assurance Directorate dashboard on a monthly basis. As reported previously on average 5-10 new cases are opened on a monthly basis including SIs and non-SIs and there has been an improvement in the number of cases being closed monthly. This has been as a result of a more streamlined process.

13.3 The Trust still faces challenges with access to correct Next of Kin details when required. This is due to reliance on external providers such as hospitals and GP Practices to provide this information if YAS do not hold this. An improved process has been developed with the Legal Services Department where this information is requested immediately following declaration of a Serious Incident. This is assisting but has not eradicated the problem. The Trust seeks support from commissioners when necessary if access to information is proving difficult.

13.4 Adaptations and improvements made to the process from January 2016 have seen an increase in engagement from patients and their families and whilst the cases are often distressing for those involved a number of families have commended YAS for the pro-active approach to being open and honest when things have gone wrong.

14. 2015-16 EMERGING THEMES AND TRENDS

14.1 This report brings together sources of significant events and investigations conducted to learn lessons and to identify themes and trends within Q3 and Q4 of 2015-16.

14.2 Delayed responses continue to be a theme running throughout 15-16 and processes are in place Trust wide to monitor these real-time and on a weekly basis. Introduction of the Ambulance Response Programme (APR) in April 2016 is designed to assist in providing the most timely and appropriate resources to all emergencies and this continues to be monitored throughout 16-17.

15. CONCLUSION

15.1 Learning lessons and taking action to improve for the future is a core part of YAS's integrated governance structure.

15.2 The Trust continues to use information generated from all reporting mechanisms to continuously improve the quality and safety of the care delivered to patients across the region.

15.3 Going into 16-17 there is a key focus for the Trust on improving how lessons are learned and shared Trust wide as a result of thematic analysis from all inputs reported throughout the organisation. The Trust recognises improvement is required in disseminating learning and a number of work streams are planned for the forthcoming year to focus on this.

15.4 This year will also see the launch of the nationally mandated Freedom to Speak Up process. During Q3 and Q4 15-16 YAS has been working hard to set up systems and processes to underpin this principle. Freedom to Speak Up is all about providing further opportunity for staff to raise concerns relating to quality, safety and matters of public interest. Learning from any concerns raised via this process will be reported within the Significant Events & Lessons Learned report going forward.

16. RISK ASSESSMENT

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

5b: Failure to learn from patient and staff experience and adverse events within the trust or externally

17. RECOMMENDATION

17.1 It is recommended the Trust Board notes the contents and supports the actions detailed in the paper.