Yorkshire Ambulance Service NHS
NHS Trust

An Aspirant Foundation Trust

MEETING TITLE Trust Board Meeting in Public		**MEETING DATE** 22/07/2014	
TITLE of PAPER	Bi-Annual Significant Events & Lessons Learned paper Q3 and Q4 2013/14	**PAPER REF**	5.10
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 2013-14. The report also focuses on actions taken and lessons learned.		
For Approval	☐	**For Assurance**	☒
For Decision	☐	**Discussion/Information**	☒
AUTHOR / LEAD	Clare Ashby, Head of Safety	**ACCOUNTABLE DIRECTOR**	Director of Standards & Compliance

DISCUSSED AT / INFORMED BY –
Bi-monthly Significant Events & Lessons Learned reports are submitted to the Quality Committee and the relevant information from those reports is extracted for inclusion in this Public Board bi-annual report.

PREVIOUSLY AGREED AT:	**Committee/Group:** Quality Committee Quality Committee	**Date:** 12/11/2013 06/02/2014
RECOMMENDATION	The Trust Board notes the contents and supports the actions detailed in the paper.	

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	☐	☒
Equality and Diversity Implications If 'Yes' – please attach to the back of this paper	☐	☒

ASSURANCE/COMPLIANCE	
Care Quality Commission Registration Outcome(s)	4: Care and welfare of people who use services 9: Management of medicines 17: Complaints
NHSLA Risk Management Standards for Ambulance Trusts	2: Learning from Experience 1: Governance

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 2013-14. The report also focuses on actions taken and lessons learnt.

2. BACKGROUND/CONTEXT

2.1 This report primarily covers the period October 2013 – March 2014 (Q3 and Q4 13-14). Investigations launched during Q1 14-15 are still underway and full details of lessons learned will be provided in the next bi-annual report to the Trust Board. However, the emerging themes and trends arising so far in 14-15 are detailed later in this report for insight.

2.2 Where necessary immediate action following a significant event is taken to ensure patient and staff safety following an event. 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
- 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

2.4 The Trust Incident Review Group (IRG) meets bi-weekly 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 Medical Director and includes all associate director-level clinical leads as well as managers responsible for managing the work 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.

Local Operational Management Boards receive reports on lessons learned within their governance or standards & compliance updates

2.6 At a corporate level, lessons relating to clinical care are reported monthly to Clinical Governance Group and bi-monthly to Quality Committee.

3. LEARNING FROM SERIOUS INCIDENTS

3.1 A total of 19 SIs have been reported in Q3 and Q4 13-14. The table below shows the number of SIs reported across the business areas.

Serious Incidents	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Ops - A&E	1	1	1	0	1	1	1	0	1	2	2	1
EOC	1	0	0	1	0	0	2	0	1	0	0	0
PTS	1	0	2	0	0	0	2	0	0	1	0	0
111	2	0	1	1	0	0	1	1	0	0	1	1
OTHER	0	0	0	0	0	1	0	0	0	0	0	2
TOTALS	**5**	**1**	**4**	**2**	**1**	**2**	**6**	**1**	**2**	**3**	**3**	**4**

3.2 Of the SIs reported during Q3 and Q4, 7 related to delayed responses, 3 related to clinical care & treatment, 1 related to an inadequate clinical assessment, 2 were related to patient falls and 5 were categorised as 'other'. These included system failures, equipment related incidents and a staff behavioural incident. Information is provided below in relation to the themes and trends arising from SIs reported during this period and also work underway to address previously identified learning.

Falls

3.3 During 2013/14 staff reported an increase in the number of SIs relating to falls sustained whilst in receipt of YAS care. However during Q3 and Q4 the Trust has seen a reduction in these numbers following implementation of safety initiatives. Within the PTS service a number of the falls relate to staff failing to follow correct policies and procedures and these have been addressed on an individual basis.

3.4 The Trust has developed a safety thermometer as part of the CQUIN programme with action plans in place to reduce harm caused to patients. One of the identified harms is falls and the learning from the above SIs has been used to inform the work being developed by the Safety Thermometer Steering Group. A weekly bulletin on the safety thermometer and learning from related incidents is circulated to staff.

3.5 A review of the PTS moving and handling training was conducted in August 2013. Recommendations included review of the learner outcomes. These have been updated to reflect the requirement for patients to wear a seat belt during travel; with refusal leading to non-conveyance, reference to the loading and unloading of wheelchairs and details on how competency is assessed and maintained. Tutors now place particular emphasis on the importance of securing patients correctly for all moving activities during their training sessions.

3.6 The Trust has commenced a targeted educational campaign to raise awareness amongst operational staff of the issues arising from failure to safely handle patients.

Delayed response

3.7 Of the seven delayed response related SIs reporting during this period, 4 were related to the A&E service and 3 were related to the NHS 111 service.

3.8 The A&E related included a number of root causes for the delays including dispatcher errors, a satellite navigations system delay and lack of resource. The number of SIs related to delayed responses within the A&E service has risen in Quarter 1 of 2014-2015 and the Trust is currently undertaking further analysis of root causes to inform the Operational Improvement Plan.

3.9 Within the NHS 111 service, 2 of the delayed responses involved an Out of Hours Provider and the other related to the 111 call failing to reach an ambulance disposition.

Clinical assessment & treatment

3.10 The SIs reported in relation to clinical assessment and treatment have been individual in nature and subject to Clinical Case Review, however, wider learning has been included within the Clinical Update day for ambulance clinicians to share the lessons learned.

Actions taken following SI investigations

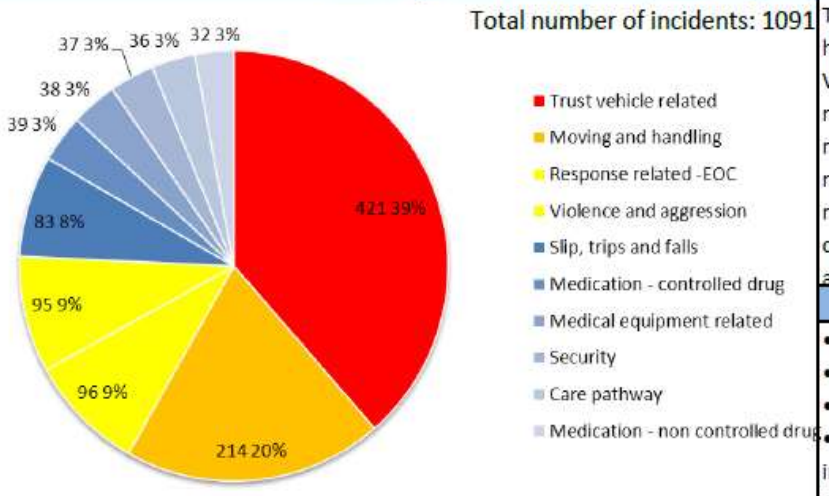
3.11 Actions arising from SI investigations continue to be tracked by the Risk & Safety team and reported to the West & South Yorkshire and Bassetlaw Commissioning Support Unit as defined in the Serious Incident Framework issued by the NHS Commissioning Board in March 2013. Internally actions remain open until written evidence is provided to the Risk & Safety team to confirm completion. Assurance reports are presented to each meeting of the Quality Committee.

4. INCIDENTS

4.1 The chart below shows comparitive data between Q3 and Q4 13-14 of the total number of incidents reported across the Trust.

Quarter 3

Datix Reported Incidents - Top 10 Categories



Trust vehicle related, Moving and handling, Response related EOC and Violence & aggression incidents remain the highest categories reported, making up 77% of all reporting. The remaining issues relate to medicines management, care pathways, slips trips and falls and security.

Risks

- Patient safety
- Patient experience
- Reputational loss
- Staff safety and absence due to injury (moving and handling)
- Financial loss mainly from RTC

Mitigating Actions

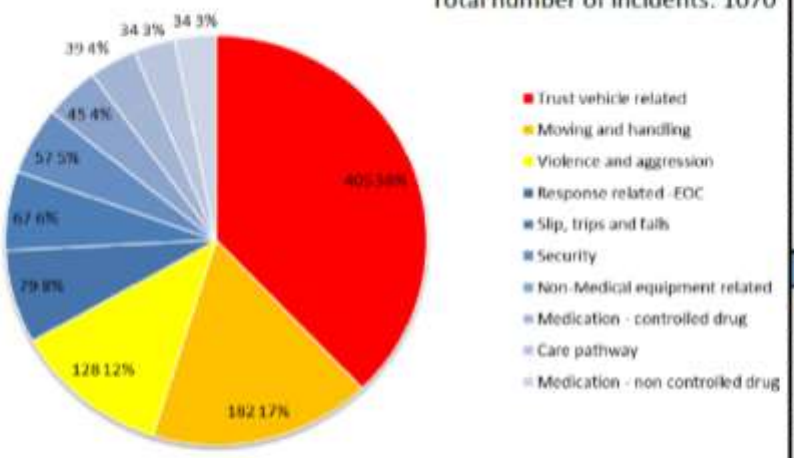
Analysis into the causes for the top five most common type of incidents - (to be found within this report). Work remains on-going for accident prevention, safer moving and handling & security issues.

Further Recommendations

Review and update of training for 14/15 to inculde key learning from incidents. Review process for equipment selection, procurement, trial and implementation. EOC reivew of their reports via within their clinical governance structure.

Quarter 4

Datix Reported Incidents - Top 10 Categories



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Further Recommendations

Review and update of training for 14/15 to inculde key learning from incidents. Review process for equipment selection, procurement, trial and implementation. EOC reivew of their reports via within their clinical governance structure.

4.2 Trust Vehicle Related incidents remained the highest incident category in both quarters, consistent with previously reported quarters also.

The Vehicle Accident Reduction Manager and operational management teams continue to address the issues arising from RTCs. Many of these are low speed, low impact collisions but are costly to the Trust.

4.3 Moving and handling related incidents feature second highest category in Q3 and Q4 and many of these are staff related. The new emergency response bag roll out across the Trust has been completed and is likely to reduce the number of reported moving and handling injuries. Also, additional training provided to staff on the use of the new track carry chair should see a reduction in these incidents.

4.4 Response related – EOC dropped from third highest category in Q3 to fourth highest in Q4. These incidents cover a range of sub-categories from delays in response to the more frequent featuring category; inappropriate booking of an ambulance.

4.5 Violence and aggression related incidents increased in numbers from Q3 to Q4 making it the third highest reported incident. The Trust's Local Security Management Specialist views all incidents of this nature and continues to work on improving safety of staff from violent perpetrators. This has included the use of CCTV on most vehicles where necessary.

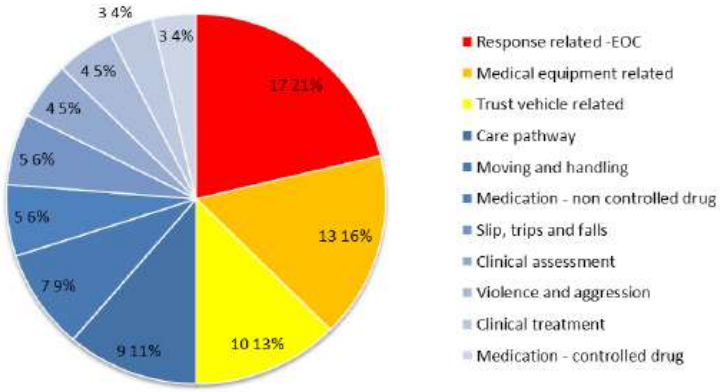
Near misses

4.6 The charts below show comparitive data for Q3 and Q4 13-14 on the reporting of near miss incidents.

Quarter 3

Datix Reported Near Misses - Top 11 Categories

Total number of near misses: 80



Number of near misses reported has reduced slightly from Q2.The highest category of near miss incidents remains EOC response related, as in Q1 & Q2 reports. Near misses related to medical equipment has increased during Q3 and this is likely to be due to a high number of reports of potential issues with the new track chair due to ad hoc training cascade.

Risks

While response related near miss reporting is high the number of actual incidents in also increasing with 96 reported in Q3 compared to 72 in Q2. Further focus on actions to reduce the near misses may also affect the actual incident rate

Mitigating Actions

• EOC have a Governance team responsible for monitoring all EOC related incidents and implementing adequate interventions to learn from these. They are undertaking a review of near miss cases in order to ensure appropriate actions.

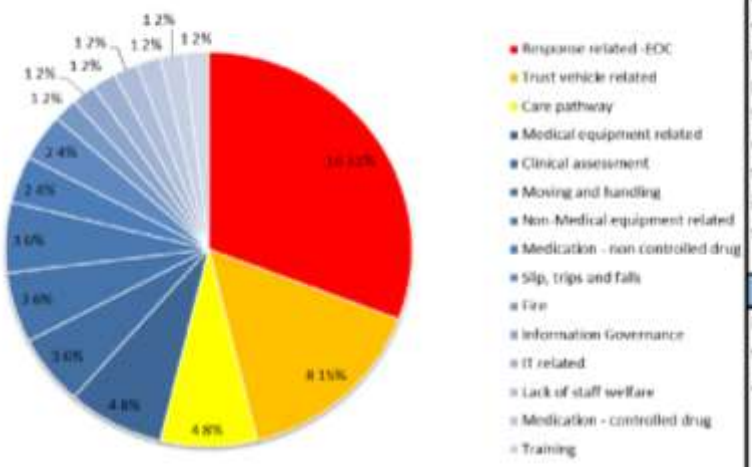
Further Recommendations

Report back on EOC near misses in order to be sure that actions mitigate further incidents.

Quarter 4

Datix Reported Near Misses

Total number of near misses: 52



Number of near misses reported has reduced slightly from Q3.The highest category of near miss incidents remains EOC response related, as in previous reports. Near misses related to medical equipment has increased during Q4 and this is likely to be due to a number of reports of potential issues with the new track chair due to ad hoc training cascade.

Risks

Further focus on actions is required to reduce the near misses. This may also affect the actual incident rate.

Mitigating Actions

• EOC have a Governance team responsible for monitoring all EOC related incidents and implementing adequate interventions to learn from these. They are undertaking a review of near miss cases in order to ensure appropriate actions.

Further Recommendations

Report back on EOC near misses in order to be sure that actions mitigate further incidents.

4.7 The number of near miss incidents reported reduced from Q3 to Q4 13-14. The Trust would expect to see higher numbers of near miss incidents being reported by staff members to enable further learning. Awareness has been raised during Q1 14-15 to remind staff about the importance of reporting such incidents, and reporting rates have risen in Quarter 1, supported by the extension to the 24 hour operation of the telephone reporting line.

4.8 Response related – EOC near misses remains the highest incident category during both quarters and similar to the incident analysis above, the sub-categories within this remain similar. Care pathway related near misses has featured fourth and third respectively and incidents have been reviewed by the Trust's Lead Nurse for Urgent Care to identify any themes or trends requiring action. A number of these near misses involved other providers and joint working arrangements to ensure the appropriate care pathways are in place.

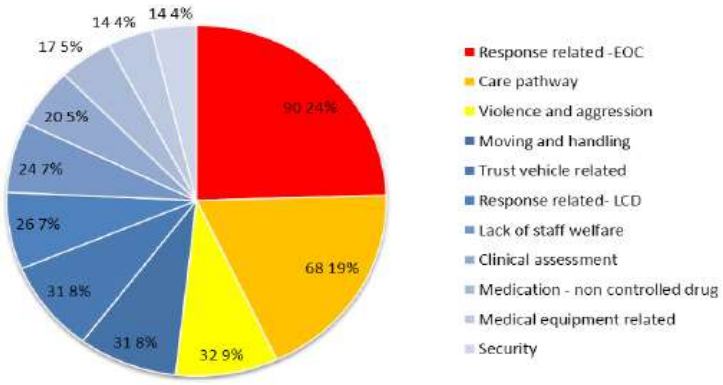
Issues and concerns

4.9 The chart below shows the comparative data from Q3 to Q4 13-14 for the issues and concerns reported by staff across the Trust.

Quarter 3

Datix Reported Issue and Concern's - Top 10 Categories

Total number of issue and concern's: 367



We have seen a further increase in reporting of issues and concerns has increased within Q3. Response related EOC issues & concerns remian a quarter of those reported across the Trust. Care pathways (within 111) issues remain static from Q2, but much improved from Q1 which confirms some embedding of the 111 service. Most issues and concerns reported are in the same areas as incidents and near misses with the exception of *lack of staff welfare*. The Risk and Safety team are to review this area further.

Risks

Issues and concerns have potential to turn into incidents if not managed correctly. Analysis of them can help highlight areas for further action.

Mitigating Actions

• Response related issues and concerns are being reviewed by the clinical governance team within EOC to understand the key issues. Other issues have actions from specific leads in place.

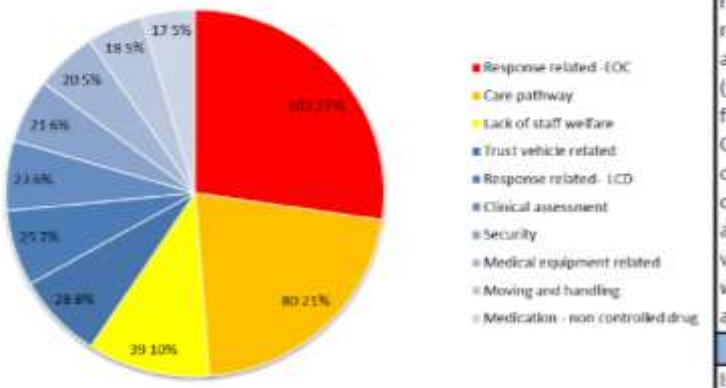
Further Recommendations

• Further analysis of issues and concerns related to lack of staff welfare required to establish real root cause of issues and recommendations identified where appropriate to address these.

Quarter 4

Datix Reported Issue and Concern's - Top 10 Categories

Total number of issue and concern's: 373



We have seen a further increase in reporting of issues and concerns has increased within Q4. Response related EOC issues & concerns remian a quarter of those reported across the Trust. Care pathways (within 111) issues remain static from Q2, but much improved from Q1 which confirms some embedding of the 111 service. Most issues and concerns reported are in the same areas as incidents and near misses with the exception of *lack of staff welfare*. The Risk and Safety team are to review this area further.

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Issues and concerns have potential to turn into incidents if not managed correctly. Analysis of them can help highlight areas for further action.

Mitigating Actions

• Response related issues and concerns are being reviewed by the clinical governance team within EOC to understand the key issues. Other issues have actions from specific leads in place.

Further Recommendations

• Further analysis of issues and concerns related to lack of staff welfare required to establish real root cause of issues and recommendations identified where appropriate to address these.

4.10 The issues and concerns reported by staff remained consistent in the two highest categories. There was an increase in Q4 of the number of issues and concerns relating to staff welfare. This may have been related to the introduction of new rotas in February 2014 which staff reported as having concerns around.

Incident severity

4.11 During both quarters, approximately 50% of incidents reported involved no harm. Approximately 43% of incidents involved minor harm with a very small percentage of incidents incurring moderate or above harm. For all patient related incidents that caused moderate or above levels of harm, the Trust considers these for being open with the patient and/or family under the Duty of Candour. All of these incidents are reviewed at the fortnightly Incident Review Group.

5. COMPLAINTS INCLUDING OMBUDSMAN REQUESTS & PATIENT EXPERIENCE

Ombudsman referrals

5.1 A number of complaints have been referred to the Ombudsman during this period. Specific details can be found in the supporting Private Trust Board papers.

Emergency Operations Centre (EOC)

5.2 Complaints for the EOC primarily relate to dissatisfaction with passing calls for triage and a mis-match between service provision and patient expectations. As a result of two complaints received from a hospital consultant regarding ambulance delays for inter-facility transfers, the Head of EOC Governance has instigated a quality auditing process for monitoring dispatchers.

Accident and Emergency services

5.3 Overall patients report high satisfaction levels across the Trust. This is evidenced by 95% of respondents agreeing with the statement ‘Overall I was happy with the service received from Yorkshire Ambulance Service’.

5.4 The most frequently occurring source of attitude complaints/concerns relates to the way in which patients are moved. A proportion relate to occasions where patients/families/carers felt that the clinicians did not listen to the wishes/needs of the patient.

5.5 A number of complaints/concerns relate to patients/families/carers reporting that the clinicians attending them suggested in some way that their call wasn’t an emergency after they called NHS111. The highest number of complaints/concerns about clinical care related to dissatisfaction with non-conveyance decisions made by YAS clinicians

5.6 The patient experience team use the learning from complaints and concerns around attitude, as well as the positive feedback received through compliments, to inform corporate induction and the YAS Dignity Campaign.

Patient Transport Service

5.7 Overall patient satisfaction with the PTS service, as measured by the Friends and Family test, is 70.7%. This compares favourably with 64.0% as the national average score for A&E and in-patient NHS services.

5.8 The survey results show significant improvements over the last three months with seven of the eleven questions receiving a higher percentage of positive responses each month. The quantitative data shows that dissatisfaction is mainly around communication - information regarding the length of wait for transport home and information about pick up times at home. The latest survey results show:

- 52.6% of people responding to the survey feel they are kept informed about the length of wait for transport home.
- 62.1% of people responding to the survey say they were contacted on the day of their appointment to be told when to be ready.

5.9 The highest numbers of complaints relate to non-attendance or late attendance of PTS to collect patients from clinics and about staff attitudes.

NHS 111

5.10 The NHS 111 quality team are establishing a positive record of learning and acting on complaints and concerns. The majority of learning from complaints and concerns relate to individuals' practice and personal development around correct use of pathways, communication skills and appropriate identification of when to refer for clinical advice.

5.11 In the last few months there have been a number of instances where improved care and attention to detail needs to be taken and this has been shared with staff as appropriate.

6. CLAIMS

6.1 Personal injury claims relating to the use of response bags continued to be the main focus of claims handled by the Legal Services Team during this reporting period.

6.2 A small number of 'slips and trips' claims have been received by the Trust during these months. The Estates Department was advised by the NHSLA to produce a procedural document in relation to gritting premises to ensure all adequate processes were in place to prevent further injury.

7. CORONERS INQUESTS INCLUDING 'PREVENTION OF FUTURE DEATHS' LETTERS

7.1 No 'Prevention of Future Deaths' letters have been received by the Trust during this period.

7.2 YAS involvement in inquests continues to rise in frequency of attendance of staff as witnesses. There have been no adverse verdicts for the Trust to consider during Q3 and Q4.

7.3 Reforms of the law governing Coroners and inquests came into force in July 2013. These reforms include changes to timescales, deadlines and associated penalties, disclosure, and the introduction of new offences for non-compliance.

Hillsborough Inquests

7.4 Work was underway during Q3 and Q4 to prepare for the re-opening of the 96 Hillsborough Inquests. The inquests commenced on 31 March 2014 and are expected to last between 6 and 9 months.

7.5 The Trust, as one of the successor organisations for South Yorkshire Metropolitan Ambulance Service (SYMAS) was made an interested person for the purpose of the inquests.

8. SAFEGUARDING

8.1 Primarily, the SCRs that took place during Q3 and Q4 were individual in nature and appropriate actions were taken as necessary to address the actions required.

8.2 An organisational lesson learned from an Individual Management Review (IMR) into a Domestic Homicide Review (DHR) was for YAS to remind staff the importance of considering children and vulnerable adults who may be living in homes or houses where domestic violence is evident or suspected. A feature was placed in the Operational Update bulletin in September to remind crews and a domestic violence campaign is planned for August 2014.

9. PROFESSIONAL BODY REFERRALS

9.1 No organisational lessons learned were identified from Professional Body Referrals during this period.

10. CLINICAL CASE REVIEWS (CCRs)

10.1. Of the CCRs carried out in this period some organisational lessons learned have been identified. These include increasing staff awareness on the end of life care pathway, a review of trauma training, awareness about treatment of sepsis and potential enhancements to education relating to stoma care in emergency situations. The Clinical Update day has incorporated organisational learning and will act as a reminder to staff on important clinical procedures and other information.

11. INFORMATION COMMISSIONERS OFFICE (ICO) NOTIFICATIONS

11.1 Further correspondence has been received by the ICO in January 2014 relating to meeting of timescales for FOI requests.

This follows an initial correspondence from the ICO in October 2013. A full review of the FOI process has been completed.

12. HEALTH & SAFETY EXECUTIVE (HSE) NOTIFICATIONS

12.1 An inspector from East Riding of Yorkshire Council visited the Trust on 25th October 2013 on behalf of the Health & Safety Executive (HSE) following an SI (ref 2013.30380). The purpose of the visit was to view the ambulance involved in the incident. No further action was taken by the HSE following the visit however actions were identified by the Trust following the incident investigation which primarily related to improving risk assessment across the Trust and updates to procedural documents.

13. BEING OPEN

13.1 The Trust continues to be committed to being open with patients and/or families involved in adverse events.

13.2 The Trust has exercised the being open policy in relation to a number of Serious Incidents in recent months under the Duty of Candour.

14. 2014-15 EMERGING THEMES AND TRENDS

14.1 This report focuses on Q3 and Q4 13-14 however Q1 14-15 has highlighted an emerging theme in relation to the timeliness of response to patients who dial 999 for assistance.

14.2 This has been evident in the increased number of incident reports, SIs, complaints and Coroners' inquests. To ensure closer monitoring of potential harm during the period of lower response performance seen in quarter 1, an additional weekly response report has been generated and a case review process initiated. To-date this has not identified additional actual patient harm, although the Trust recognises the potential for harm and is using the initial phase of data collection to inform the development of an ongoing case review process.

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.

16. RECOMMENDATION

16.1 The Trust Board notes the contents and supports the actions detailed in the paper.