Yorkshire Ambulance Service NHS
NHS Trust

MEETING TITLE				
MEETING TITLE Trust Board Meeting in Public			**MEETING DATE** 26/01/2015	
TITLE of PAPER	Bi-Annual Significant Events & Lessons Learned paper Q1 and Q2 2014/15		**PAPER REF**	5.6
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 Q1 & Q2 2014-15. The report also focuses on actions taken and lessons learned.			
For Approval	☐	**For Assurance**	☒	
For Decision	☐	**Discussion/Information**	☒	
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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 is extracted for inclusion in this Public Board bi-annual report.

PREVIOUSLY AGREED AT:	**Committee/Group:** Quality Committee	**Date:** 04/12/2014
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 Q1 and Q2 2014-15. The report also focuses on actions taken and lessons learned.

2. BACKGROUND/CONTEXT

2.1 This report primarily covers the period April 2014 – December 2014 (Q1 and Q2 14-15). The emerging themes and trends arising so far during Q3 and Q4 in 14-15 are detailed later in this report for insight, whilst full details will be provided in the next bi-annual report.

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
- 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 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 Standards and Compliance, 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 40 SIs have been reported in Q1 and Q2 14-15, and 56 in the year to December. The table below shows the number of SIs reported across the business areas.

Serious Incidents	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Ops - A&E	3	3	7	6	3	1	2	4	5
EOC	2	1	4	0	3	0	2	0	2
PTS	0	0	0	0	1	0	0	0	0
111	0	0	1	1	0	2	0	0	0
OTHER	0	0	0	1	1	0	1	0	0
TOTALS	**5**	**4**	**12**	**8**	**8**	**3**	**5**	**4**	**7**

3.2 A key theme identified from SIs reported during Q1 and Q2 was related to delays in response to patients. The increase in delayed response SIs during this period reflected the challenges with performance and associated increase in R1 and R2 demand. Although the number of SIs was at its lightest in June to August, with monthly rates reducing to within previously seen levels in Q3 and Q4 so far. Significant challenges in relation to the Red call demand remain however, and an A&E Performance Improvement Plan is in place to address these operational challenges. There is no clear relationship between achievement of performance targets, delayed response and patient outcome but analysis of data for all response related incidents has allowed specific adjustments in workforce and resources to be made within certain locations as part of the improvement plan. The data continues to be analysed on a weekly basis and allows for real time data to influence service provision. Incidents are also being reviewed by clinicians real time within the EOC to ensure all those with associated patient harm are reviewed and reported appropriately.

3.3 Following three SIs during a 12 month period relating to lone responding, a large amount of work was also completed during Q1 and Q2 in relation to this. Updates were made to the Lone Worker Procedure (as part of the Safety & Security Policy). SI 2014.6401 was subject to a rigorous Coroner's inquest in July 2014.

Whilst the Coroner was not critical of the clinician's decision to stand off, he was critical of the acts/omissions made following the stand-off decision. The Coroner remained concerned that there may be lessons which could be learned more widely and a Preventing Future Death (PFD) report was issued to the Secretary of State for Health (copied to The Association of Ambulance Trust CEOs, NHS England, CQC, the International Academy of Emergency Medical Dispatch (IAEMD) and YAS. The report raised the following concerns for the Secretary of State to consider:

1) *Whether EMD training should include how to recognise signs of respiratory difficulty, including 'the well-known relevance of snoring in a person who cannot be roused'. The Coroner will pose the question as to whether this requires an amendment to the breathing diagnostic tool.*

2) *That where the crew make a unilateral decision to stand off a manager should be informed, especially when there is likely to be a delay in the provision if support.*

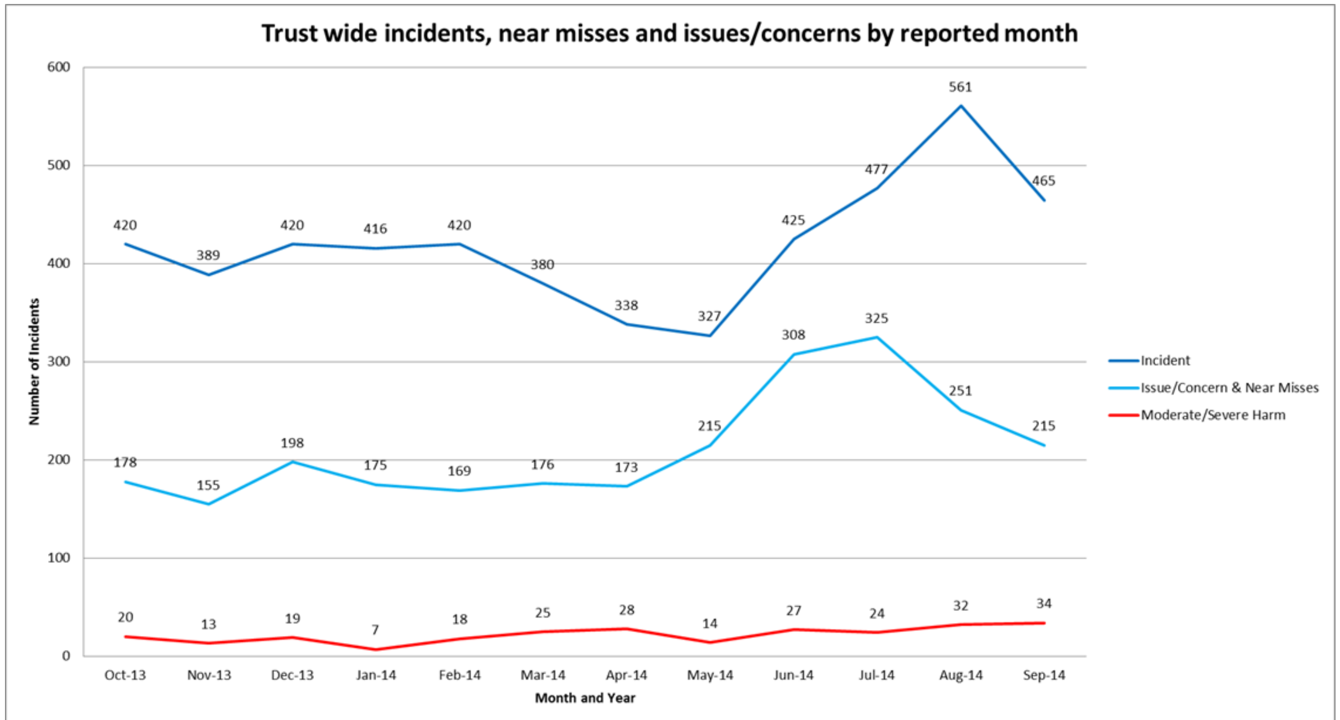
3) *That where a stand-off occurs, all alternative methods of support are automatically considered, not simply a double crewed ambulance.*

YAS have also provided a response following the PFD and implemented local solutions in regard to actions 2 and 3 highlighted above. These include robust escalation processes within the EOC and new guidance for staff to follow when managing stand-off incidents. This includes gathering specific information from the clinician in relation to the reasons for stand-off, the type of back-up required and the guidance also stresses the importance of considering all alternative resources that could be sent to back-up not just a Double Crewed Ambulance (DCA) as was the issue in this case.

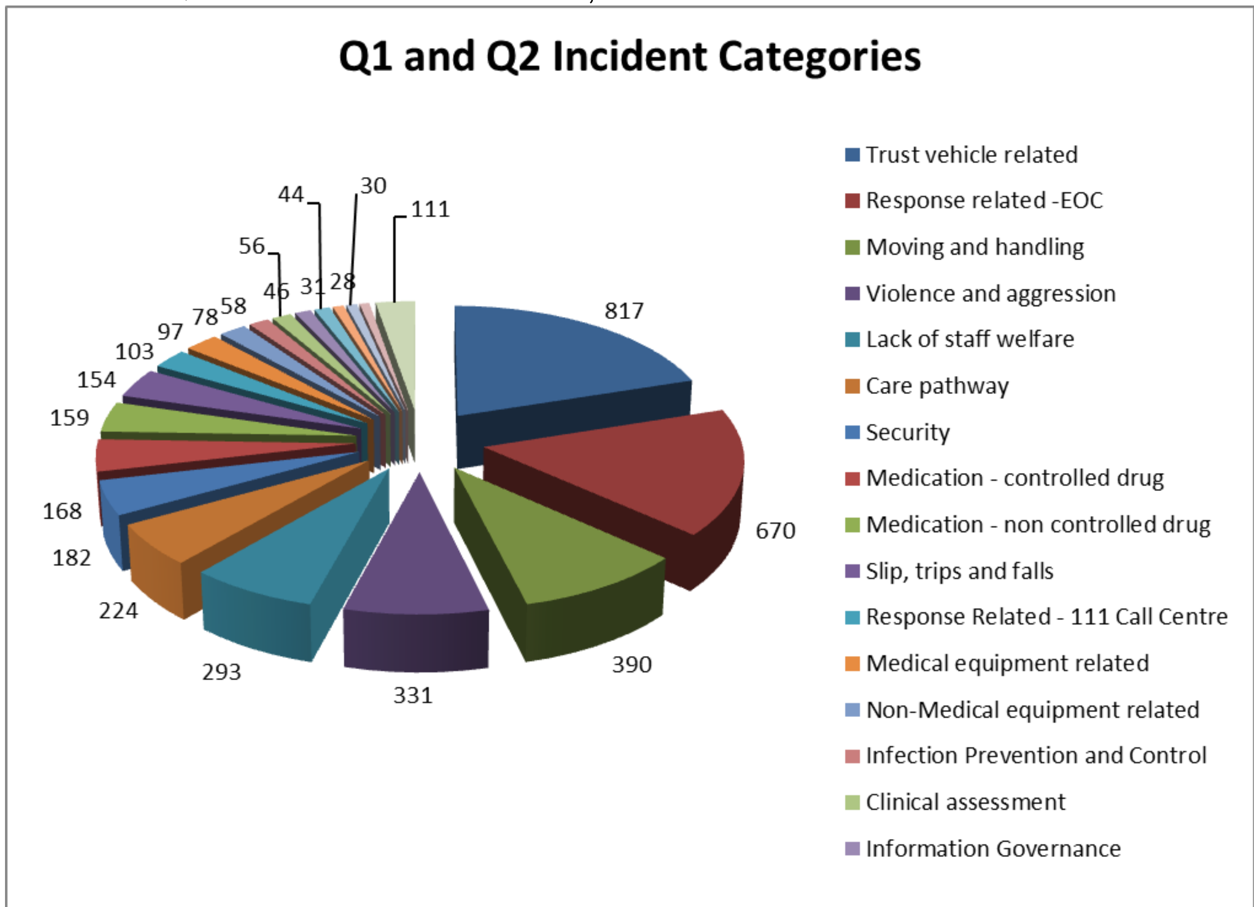
3.4 Learning identified through a number of SIs related to dispatchers within the EOC conducting regular resource allocation checks. Whilst dispatchers were aware of the resource they had available these checks were not being conducted frequently on the CAD and therefore could not be evidenced. A reminder was issued to staff in highlighting the importance of conducting these resource checks and there has been subsequent improvement in this area. A developmental project in relation to human factors in the EOC is planned for 2015/16, and it is anticipated that this will be built into the annual CQUIN programme.

4. INCIDENTS

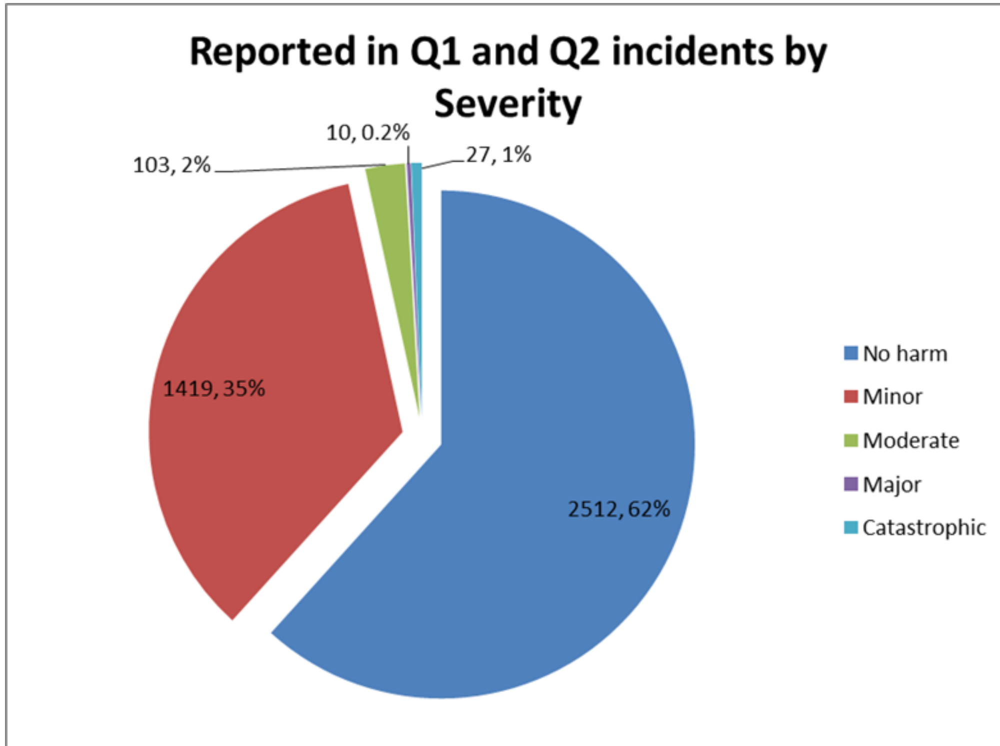
4.1 Chart 1 below shows overall incident data from Q1 and Q2 2014/15



4.2 Chart 2 below shows the top 20 categories of incidents reported during Q1 and Q2. This includes all incidents, near misses and issues/concerns.

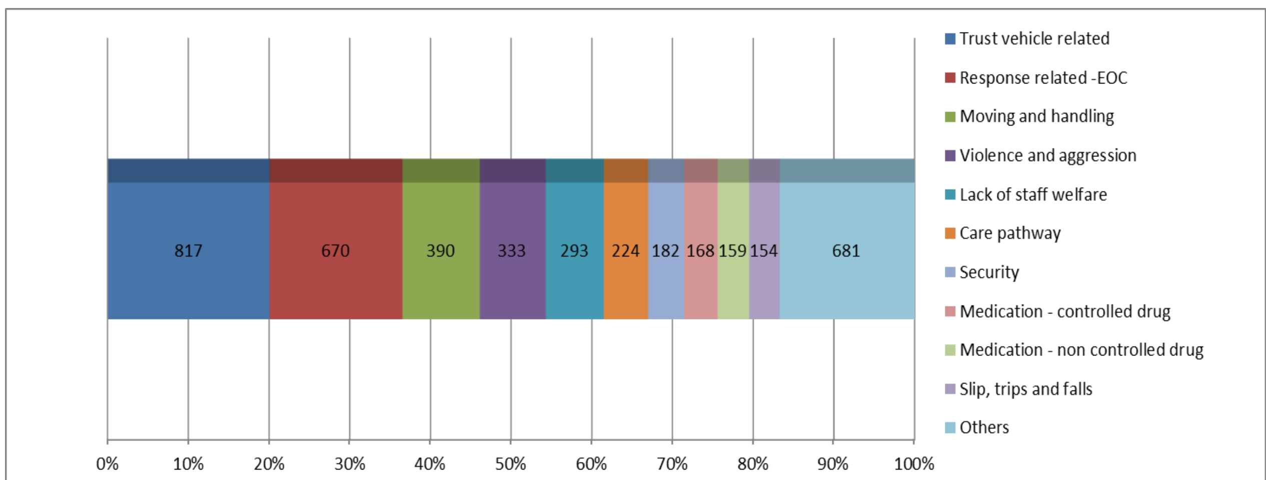


4.3 Chart 3 below identifies the incident severity reported during this period.



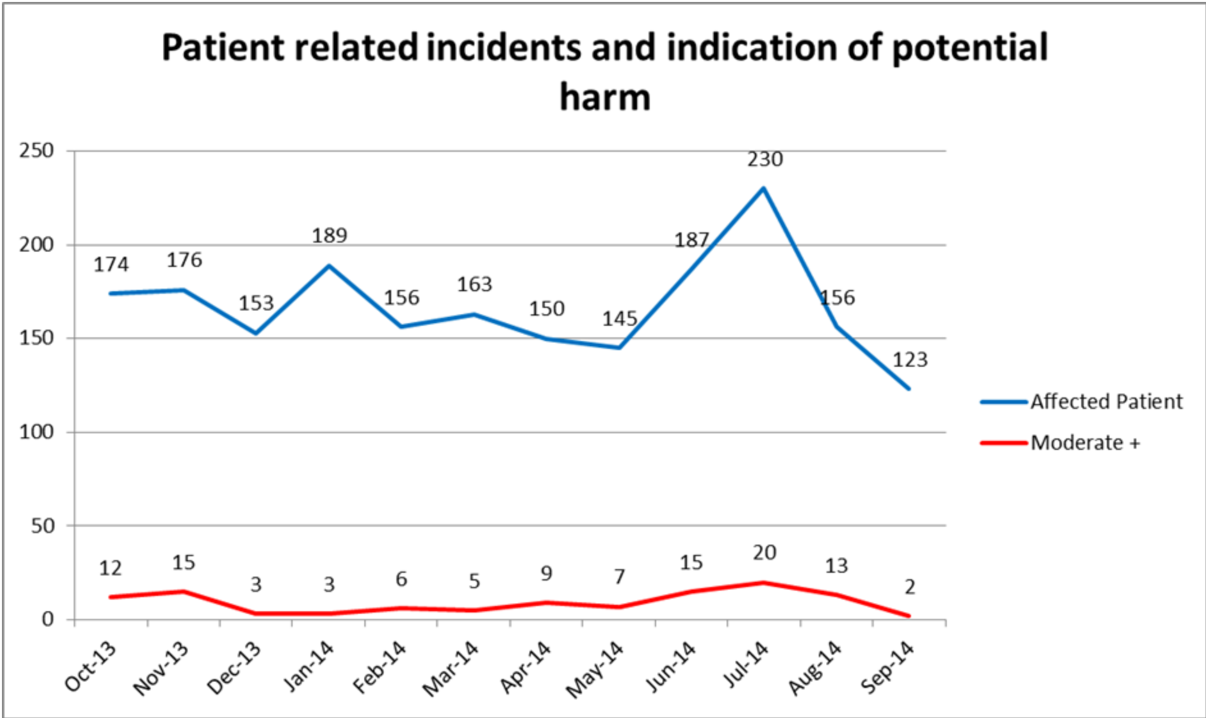
During both quarters, over 50% of incidents reported involved no harm, and over the two-quarters, 97% incidents were no or minor harm. A very small percentage of incidents involved harm recorded as moderate or above. The figures above include all affected staff, affected patient and affected Trust incidents.

4.4 Chart 4: Top 10 reported incident categories in Q1 and Q2



YAS top 10 categories of incidents make up over 80% of all incidents.

4.5 Chart 5 below shows patient–related incidents

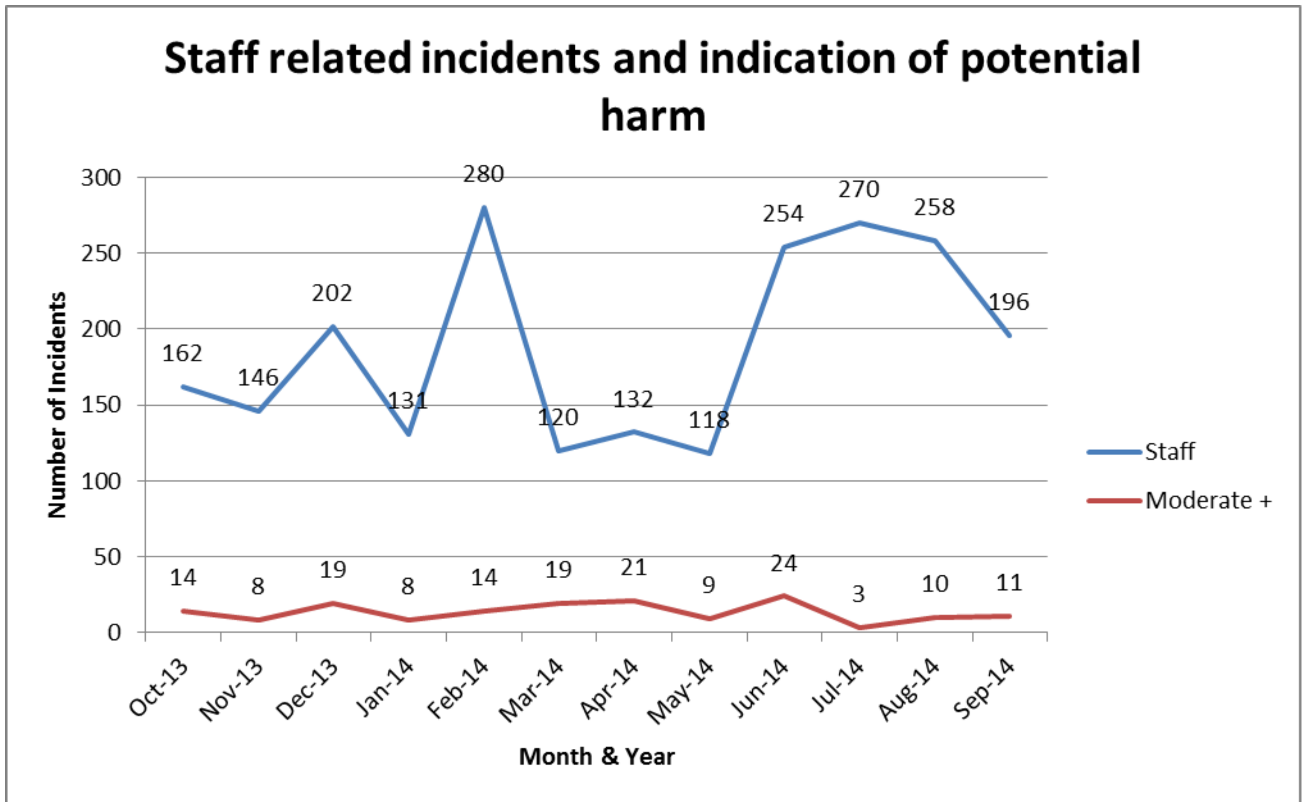


4.6 The key themes under patient-related incidents are primarily related to delays in response and availability of care pathways and appropriateness of referrals.

4.7 In relation to the pathways/referral theme, the issues are addressed through liaison with commissioners and other providers and are part of the wider urgent care development plan. Internally a number of issues relate to NHS111 referral and this is an ongoing element of NHS111 service development.

4.8 The Clinical Safety & Improvement Group launched in October 2014 and one of the key workstreams explored was care pathway incidents; identifying the themes and trends and introducing initiatives to help reduce these incidents, whilst working with other providers. This has seen a reduction in these incidents in recent months

4.9 Chart 6 below shows staff-related incidents



4.10 Q1 and Q2, 293 incidents related to staff welfare; two-thirds of these being missed or delayed meal breaks. Of the 136 response-related EOC incidents, one-third were considered an inappropriate grading of call by the responder and one-third related to lack of a warning message being communicated to the crew. Where a warning message was not conveyed, 90% resulted in no harm, and the remainder were categorised as minor.

4.11 Earlier in the year there were a number of moving and handling incidents mainly involving staff and the use of the emergency response bag and the new track carry chair. The new response bag has now been fully rolled out across the Trust and there has been a subsequent reduction in the number of associated incidents. Carry chair training is underway across the Trust with continued progress on staff training in the last quarter.

4.12 All violence and aggression incidents are been reviewed by the Head of Safety and the Local Security Manager (LSMS). Incidents resulting in no harm represent 74% of the data, a further 24% were minor harm, this includes abrasions and laceration, the remaining 2% were categorised as moderate harm. Staff are trained in conflict resolution as part of their annual training programme and incidents where CCTV footage has been captured in the back of the ambulance may lead to court proceedings against the perpetrator.

4.13 Trust Vehicle Related incidents remained the highest incident category consistent with previously reported quarters also. Many of these are low speed, low impact collisions but are costly to the Trust. A poster campaign has been launched across the Trust to raise awareness with staff and with key messages to help reduce the number of collisions.

YAS is also working jointly with the other ambulance trusts on a national awareness raising campaign including the production of a staff training and education video.

5. COMPLAINTS INCLUDING OMBUDSMAN REQUESTS & PATIENT EXPERIENCE

5.1 Key themes arising from complaints during these quarters include dissatisfaction from patients in relation to EOC response to Green calls.

5.2 Within the A&E service an ongoing theme from complaints relates to staff attitudes and behaviours. A task and finish group of Heads of A&E Operations, Lead Paramedic, Organisational Effectiveness and Education colleagues and representatives from Patient Relations and Experience met during this time and identified a number of actions to reduce the level of complaints about attitude and communication skills in A&E services.

5.3 From the PTS service themes from complaints remain consistent with previous months with dissatisfaction associated with late pick-ups for hospital appointments and lengthy waits to return home. Results from the friends and family test found that 99% of respondents feel they are treated with dignity and respect.

5.4 The highest category of complaints raised about the NHS 111 service relate to clinical and operational handling by 111 and clinical responses from the GP Out-of-Hours Service.

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 There has been a reduction overall in incidents relating to the emergency response bag, a number of which progressed to be claims, in recent months following the introduction of an improved item of equipment.

7. CORONERS INQUESTS INCLUDING ‘PREVENTION OF FUTURE DEATHS’ LETTERS

7.1 Details of the PFD received by the Trust is included within the SI section of this report.

7.2 YAS involvement in inquests continues to rise in frequency of attendance of staff as witnesses.

7.3 In more recent months, an emerging theme has arisen. A number of cases have been identified where there has been a particular focus on mental capacity. As a result of these cases an internal review and benchmarking exercise on the Trust’s mental capacity policies, procedures and training is currently underway.

Hillsborough Inquests

7.4 Work continued during Q1 and Q2 to contribute towards the 96 re-opened Hillsborough Inquests. The inquests are ongoing and are anticipated to continue well into 2015.

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 No significant issues have been identified across the organisation from Domestic Homicide Reviews or Serious Case Reviews. Educational and training updates have been issued to staff throughout the year to continue to raise awareness regarding the importance of safeguarding and making referrals appropriately.

9. PROFESSIONAL BODY REFERRALS

9.1 No significant organisational lessons learned were identified from Professional Body Referrals during Q1 and Q2.

10. CLINICAL CASE REVIEWS (CCRs)

10.1. During this period, a key organisational theme that has been identified relates to inadequate documentation of clinical decision making and observations recorded on the PRF. A clinical audit process was conducted to actively manage these issues and a number of reminders have also been issued to staff via Operational Update.

11. INFORMATION COMMISSIONERS OFFICE (ICO) NOTIFICATIONS

11.1 The Trust has alerted the ICO of two incidents during this time. Both were data breaches and were reported as Information Governance (IG) Serious Incidents Requiring Investigation (SIRI).

11.2 Additionally, the Trust also had one complaint about the handling of a Freedom of Information (FOI) request accepted by the ICO for formal consideration under Section 50 of the FOI Act. The FOI requested information in relation to finance of the NHS 111 service. YAS responded stating the Trust believed releasing the information would be prejudicial to YAS' commercial interests and therefore exempt under Section 43 of the FOI Act. The ICO will be examining whether the exemption was appropriately applied.

12. HEALTH & SAFETY EXECUTIVE (HSE) NOTIFICATIONS

12.1 Further correspondence has been received from the HSE in relation to RIDDOR reporting timescales.

12.2 Meeting the 15 day reporting requirement poses a challenge for the Trust as there is a reliance on managers providing up to date information on staff members' injuries in a timely manner which is not always possible. The Risk & Safety Team are further developing the Datix form to assist managers in reporting these incidents promptly and with all the necessary information required in order to inform the HSE.

13. BEING OPEN

13.1 The Trust continues to be committed to being open with patients and/or families involved in adverse events. Cases are reviewed in the Incident Review Group to determine when patients and their families should be contacted.

13.2 The Trust maintains a log of all correspondence and meetings with patients and their families in accordance with the Duty of Candour and Being Open policy.

14. 2014-15 EMERGING THEMES AND TRENDS

14.1 This report focuses on Q1 and Q2 14-15 however during Q3 and Q4 the broad themes are largely unchanged with delayed responses remaining a key focus.

14.2 Weekly and monthly monitoring continues in relation to this to identify operational improvements which will assist the Trust in managing these increases in demand.

14.3 There is no clear relationship between achievement of performance targets, delayed responses and patient outcomes and processes are in place to prioritise clinical care and ensure patient safety during periods of intense demand.

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.