Yorkshire Ambulance Service NHS
NHS Trust

An Aspirant Foundation Trust

MEETING TITLE Trust Board Meeting in Public		**MEETING DATE** 28/07/2015	
TITLE of PAPER	Bi-Annual Significant Events & Lessons Learned paper Q3 and Q4 2014/15	**PAPER REF**	5.5
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 2014-15. The report also focuses on actions taken and lessons learned.		
For Approval	☐	**For Assurance**	☒
For Decision	☐	**Discussion/Information**	☒
AUTHOR / LEAD	Maxine M Travis, Risk Manager	**ACCOUNTABLE DIRECTOR**	Executive Director of Standards & Compliance

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:**
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 2014-15. The report also focuses on actions taken and lessons learned.

2. BACKGROUND/CONTEXT

2.1 This report primarily covers the period October 2014 – March 2015 (Q3 and Q4 2014-15).

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 30 SIs have been reported in Q3 and Q4 14-15, and 70 in the full year April 2014 to March 2015. 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	3	3	7	6	3	1	2	4	5	2	1	1
EOC	2	1	4	0	3	0	2	0	2	3	0	1
PTS	0	0	0	0	1	0	0	0	0	1	1	1
111	0	0	1	1	0	2	0	0	0	2	0	1
OTHER	0	0	0	1	1	0	1	0	0	0	0	0
TOTALS	**5**	**4**	**12**	**8**	**8**	**3**	**5**	**4**	**7**	**8**	**2**	**4**

3.2 Delayed response remains a theme of SIs during this period. Significant challenges remain in relation to demand and an A&E Performance Improvement Plan is in place to address these operational challenges. Delays in response and backup are monitored and escalated in real-time through the EOC audit process, in addition to weekly, monthly and quarterly reporting. This process highlights potential SIs for consideration.

3.3 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. At the time of reporting the underlying causes may not be clear. After the investigation was completed, a retrospective review of 27 delayed response SIs reported in 2014, was conducted by the Executive Medical Director and Executive Director of Standards and Compliance. They found that in 48% there was no causative relationship between delay and patient outcome. In 30%, delay as a contributory factor was uncertain and in 22% (6 cases) it was clear that the delay led directly to harm. Measures in place in EOC and Operations help to ensure that patient safety is maintained when there are peaks of demand.

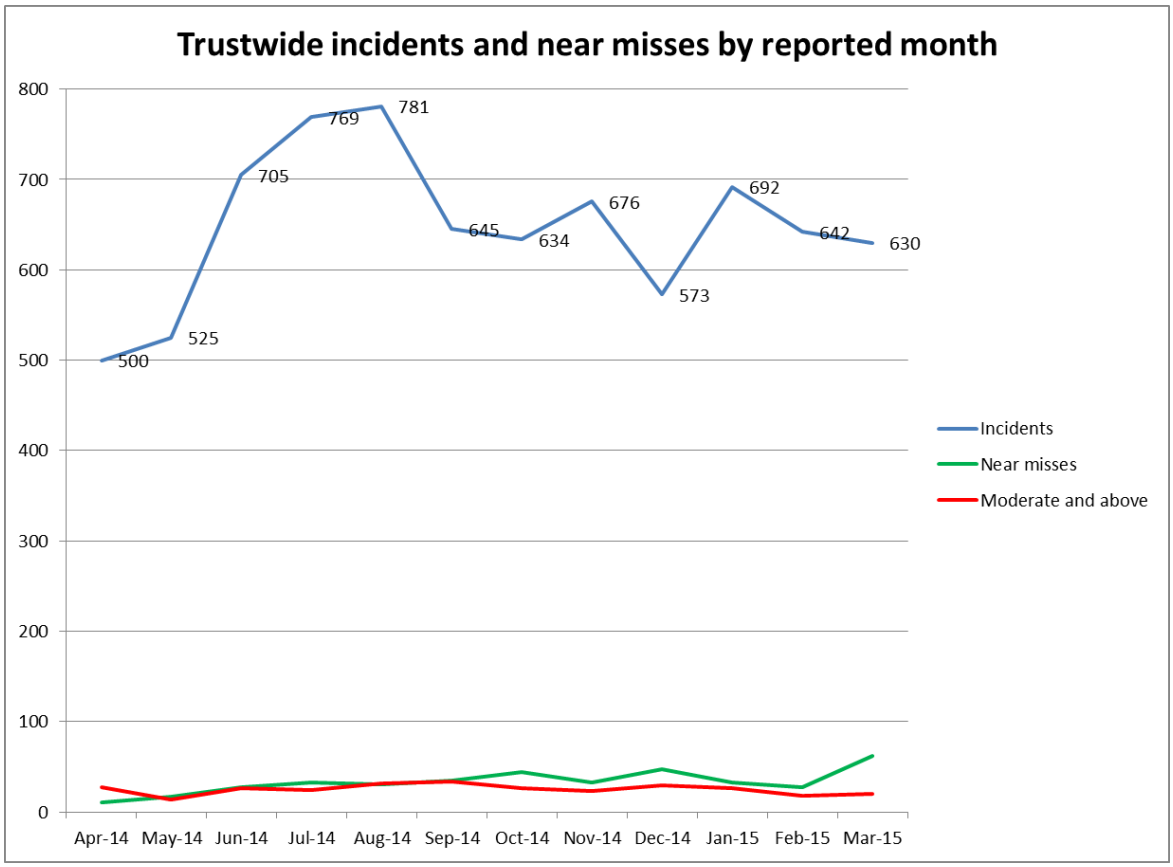
3.4 Coding errors resulting in inaccurate disposition has been highlighted from thematic analysis of SIs and incidents. This intelligence has been used to inform safety improvement goals which form part of the Sign Up To Safety campaign. Within the EOC the focus will be on human factors.

3.5 Identification and management of the deteriorating patient has been identified as a theme in SI investigations. YAS is taking part in the national Sign up to Safety campaign with an aim to increase awareness around management of the deteriorating patient, and specifically recognition of sepsis.

This involves working with Emergency Departments on pre-alerts and implementation of the National Early Warning Score NEWS to ensure patients who rapidly deteriorate are identified and potential sepsis as a cause is considered and managed effectively. Sepsis is also an agreed CQuIN for 2015/16.

4. INCIDENTS

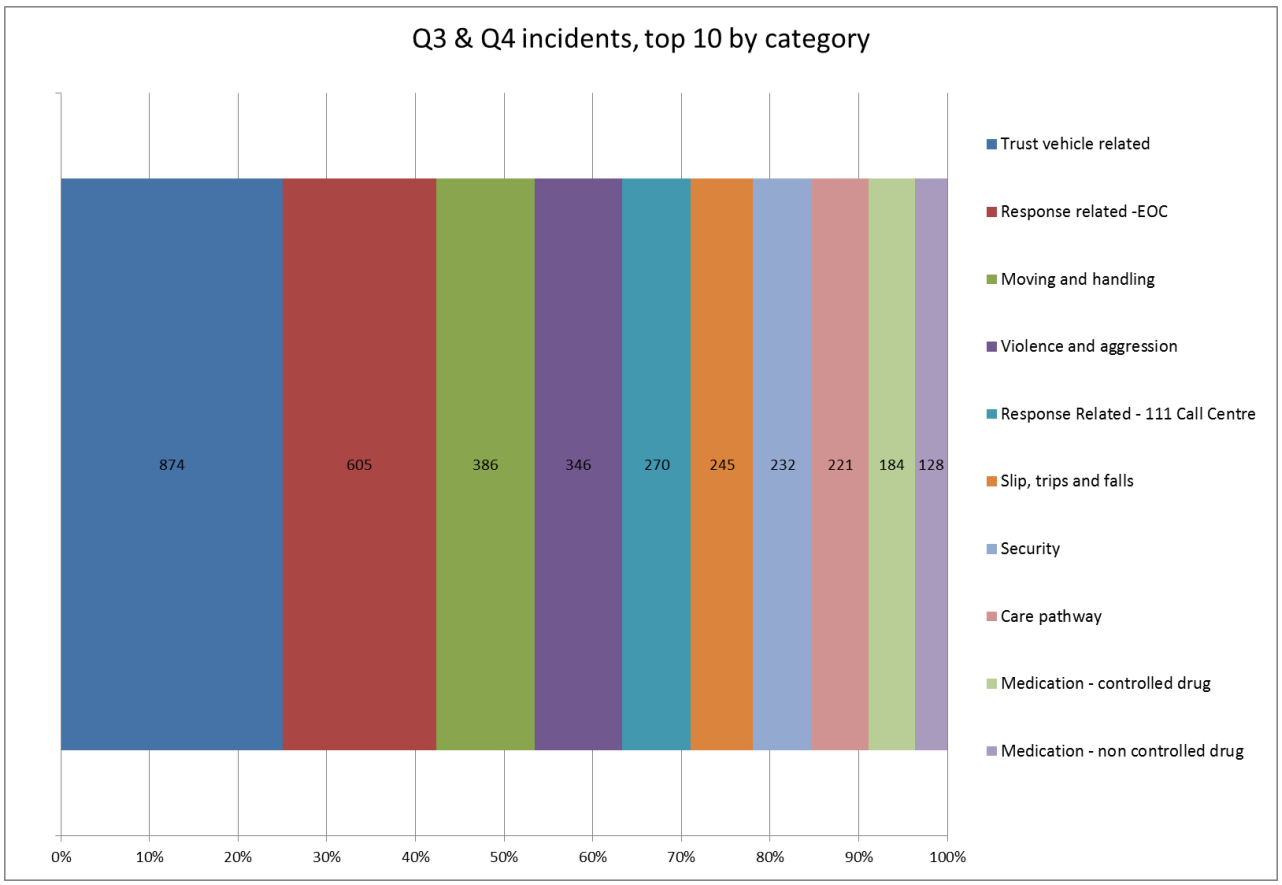
4.1 Chart 1 below shows overall incident data for the year 2014-15



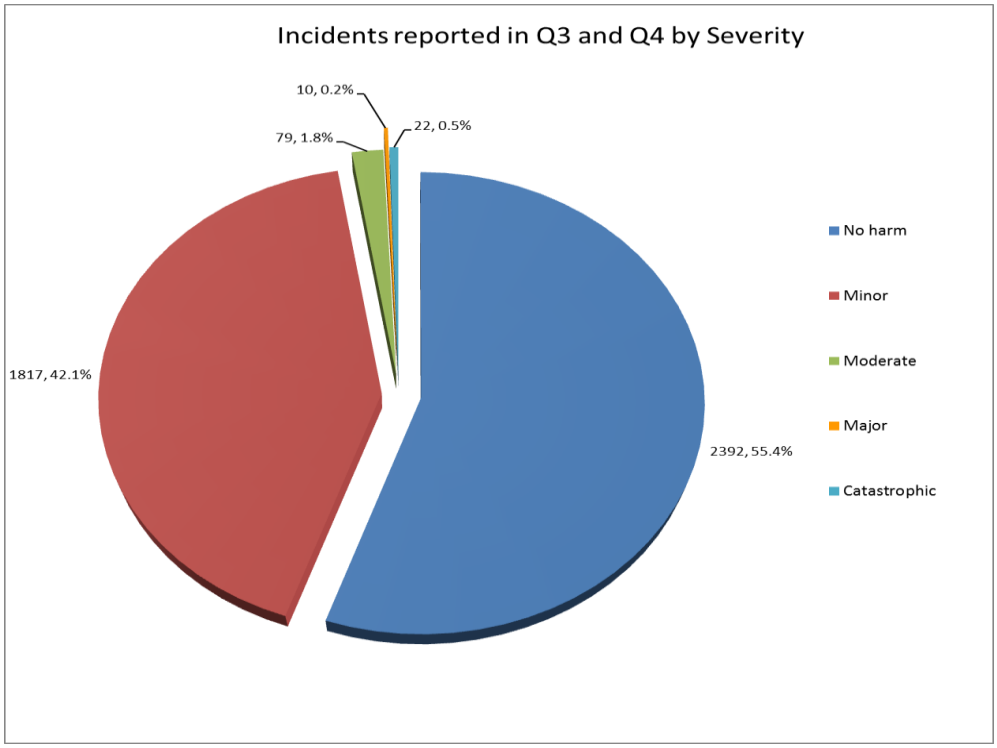
The increase in incident reporting in June 2014 correlates with implementation of the 24 hour Datix incident reporting phoneline. Awareness around identification and reporting of near-miss incidents has increased, resulting in a significant increase in quarter 3 and 4. This positive trend will enable identification of themes in near-misses and allow for preventative measures to be put in place to reduce the likelihood of actual incidents occuring.

4.2 Chart 2 below shows the top 10 categories of incidents reported during Q3 and Q4. This includes all incidents and near misses.

The top 10 categories of incident represent over 80% of incidents in Q3 and Q4 (3491/4321). Nine of the top 10 categories of incidents remain consistent from Q1 and 2 report, with only 'Lack of Staff Welfare' dropping out of the top 10 into 13th place, this is due to the reduction in the number of incidents being reported related to meal breaks.



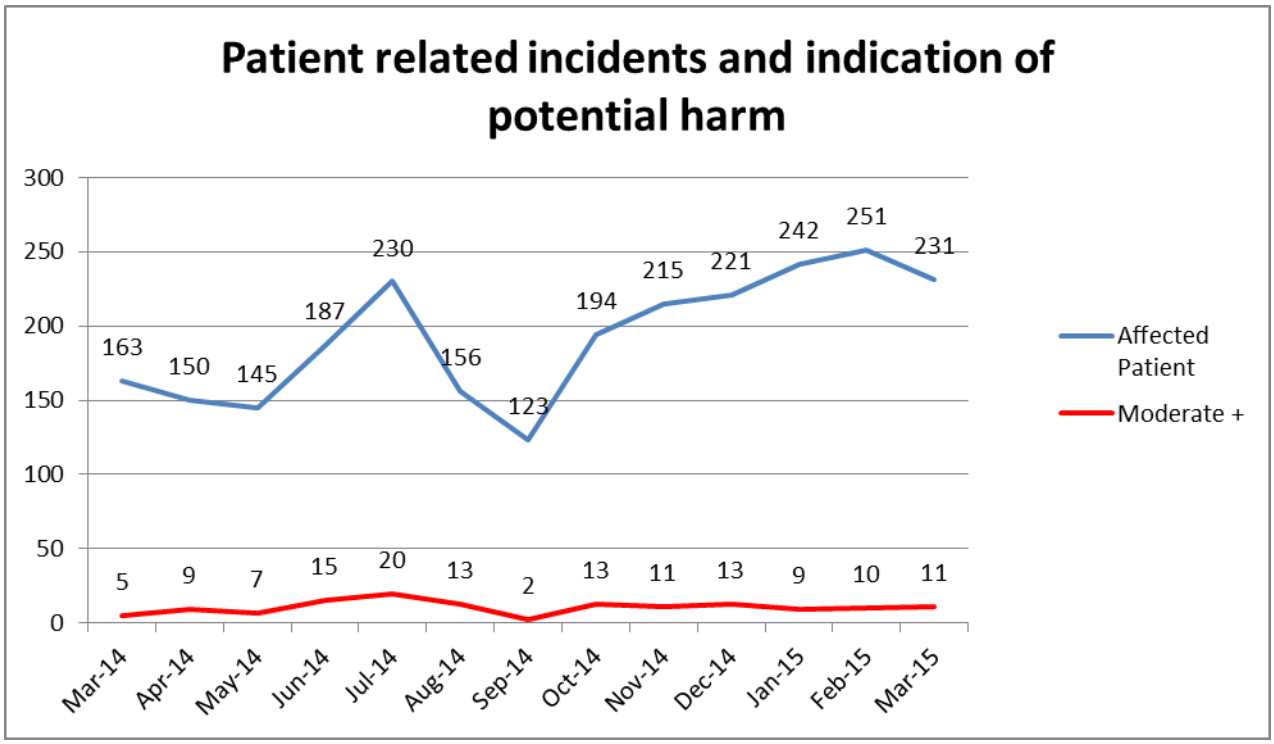
4.3 Chart to show incident severity reported during this period.



The chart above is a representation of harm level reported for all incidents in Q3 and Q4. It shows that over half of all incidents reported resulted in no harm, and over 97% incidents were no or minor harm.

4.4 Overall numbers of patient–related incidents and those with a severity of moderate and above are illustrated in the chart below.

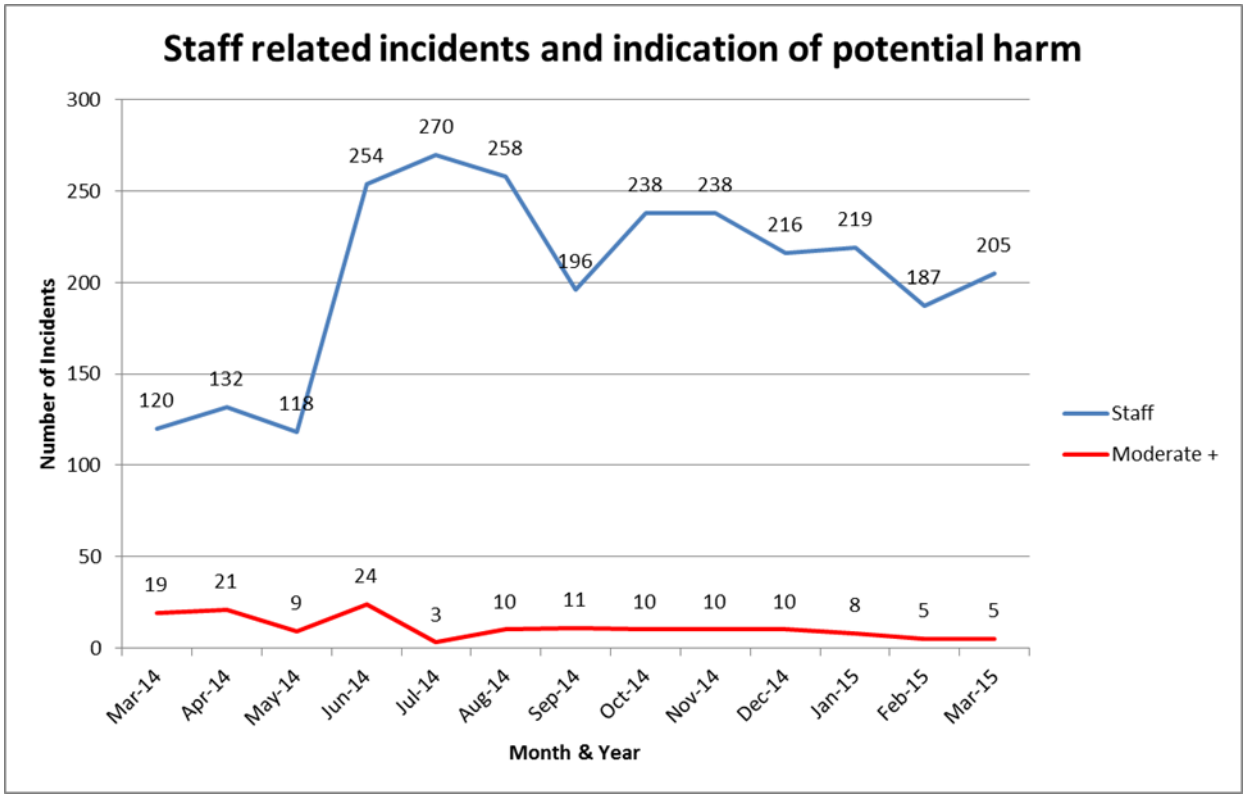
The chart shows a steady increase in reported incidents in quarters 3 and 4, demonstrating a positive reporting culture, with moderate and above graded incidents remaining constant and equating for 5% of all incidents in the 6 months October 14-March 15 (range by month 3.7%-6.7%)



4.5 The key themes under patient-related incidents are primarily related to delayed response and care pathways. No harm and minor harm in these categories represent 94% and 98% of incidents respectively.

4.6 Clarification of vascular pathways have resulted from a SI investigations with trauma desk playing a key role in communication and coordination. The Clinical Pathways Advisor is notified of SIs and incidents where pathways issues are identified and is made aware of findings and supports development of the action plan.

4.7 The chart below shows staff-related incidents and those graded as moderate and above harm.



The increase in reported incidents in June 14, as stated earlier, is reflective of implementation of the 24 hour incident reporting line, along with staff training and greater organisational awareness.

4.8 Moving and handling incidents make up 24% of reported staff-related incidents. In 2014, in response to these incidents, training was delivered for the new track carry chair and a new response bag was rolled out across the Trust. Data from incidents and claims related to moving and handling is analysed and themes identified. Indications from claims data are that these actions are beginning to have a positive impact on levels of harm

4.9 Moving and handling is part of YAS Sign Up To Safety campaign with monitoring of incidents, claims and complaints forming the evidence-base.

4.10 Violence and aggression incidents account for a 25% staff-related incidents and are monitored at Health and Safety Committee. Of these incidents, the majority are experienced within A&E Operations and relate to the attitude or behaviour perpetrated by the patient and/or relative. Incidents resulting in no harm equate to 48% and a further 49% were recorded as minor harm.

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, this reduced from 58% in Q3 to 49% in Q4.

5.2 Within the A&E Operations service an ongoing theme from complaints relates to staff attitudes and behaviours, this too has seen a reduction from 34% in Q3 to 31% in Q4. The Training Team in conjunction with Patient Relations is working to take forward the use of real case studies in communication skills training for front line staff.

5.3 For the National See and Treat Friends and Family Test initiative, Q3 gained a 94% positive result and in Q4 feedback was 100% positive.

5.4 Within PTS, themes from complaints remain consistent with previous reports. Delays in taking the patient home from hospital appointments accounted for 31% PTS complaints in October to December 2014, this figure reduces to 21% in the quarter January to March 2015. Dissatisfaction associated with late pick-ups for hospital appointments accounted for 22% in Q3 and 20% in Q4.

5.5 Responses from the National PTS Friends and Family Test provided positive responses in 77% cases in Q3 and 88% in Q4, with negative comments reflecting the themes identified in complaints.

5.6 Complaints within NHS111 relate to clinical and operational call handling and clinical responses from the GP Out-of-Hours Service. Issues are reviewed at NHS111 and West Yorkshire Urgent Care Governance meeting.

5.7 YAS received six notifications from the Parliamentary and Health Service Ombudsman during the months October 2014 to March 2015 inclusive; two for A&E Operations and four for EOC. One outcome has been received during this period, regarding an A&E Operations complaint relating to lack of recognition of sub-arachnoid haemorrhage which was partially upheld. An action plan has been agreed with the PHSO and has been implemented, this included measures to increase awareness of the 'red flags' around headaches and the need to transport without delay. Two of the EOC complaints were not upheld and we await outcomes on the remainder.

6. CLAIMS

6.1 Claims arising as a result of staff musculoskeletal injuries from equipment and moving and handling incidents continue to be the main focus of claims handled by the Legal Team although the overall number of employee liability claims has reduced in 2014/15 compared to the previous year.

6.2 Monitoring of incidents, claims and complaints is providing a baseline and lessons learned from investigation is informing work being progressed by Clinical Managers in training of selection and use of appropriate equipment for safely mobilising the patient following a traumatic fall whilst preventing staff injury.

6.3 Work also continues in relation to manual handling risk assessments for vehicles and equipment

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

7.1 The Trusts involvement in inquests continues to remain high in relation to attendance of staff as witnesses. .

7.2 Key areas in relation to Inquests opened by the Coroner are around delayed responses and the management of potential spinal injuries. In these cases YAS provides the SI report and representation from the Trust is made. The verdict is added to the report to ensure that learning is captured where relevant.

7.3 An inquest was held in March in the Durham area which involved a cross border incident. The Coroner had concerns in relation to communication between Emergency Services in the different regions and the systems used by YAS to locate the out of area incident. A Prevention of Future Death Report was issued and a review of the national cross border memorandum has taken place between the ambulance trusts.

Hillsborough Inquests

7.4 Work continued during Q3 and Q4 to contribute towards the 96 re-opened Hillsborough Inquests. The inquests are ongoing and are anticipated to continue until December 2015.

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

8. SAFEGUARDING

8.1 One lesson from an adult domestic homicide review was to appreciate the impact on children when parents and/or carers have mental health problems, particularly focusing on suicide/para-suicide. An Operational Update was circulated in February 2015 which advises that YAS staff must consider the impact that mental health issues may have on parenting capacity and family functioning, and respond appropriately seeking guidance and support from appropriate professional agencies.

8.2 A Child Serious Case Review in Q4 utilised a reflective methodology to review services from agencies and professionals. This proved very challenging for YAS as the 8 staff involved who could not be extracted to attend the two learning days and face to face interviews were therefore conducted by YAS Head of Safeguarding. This change of methodology, initiated by the national Munro review of child protection in 2012, determines a less prescriptive process for Safeguarding Boards to conduct SCRs. YAS needs to consider the impact this methodology may have if other safeguarding boards utilise this reflective process.

9. PROFESSIONAL BODY REFERRALS

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

10. CLINICAL CASE REVIEWS (CCRs)

10.1. Clinical Case Reviews during this period relate to utilising spinal immobilisation equipment following a traumatic fall until diagnosis of spinal injury is excluded, along with consideration of environmental factors that can contribute to determine the most appropriate management of a patient with a life-threatening condition. Education and training of staff in spinal assessment and immobilisation remains a key focus. This is also part of the Trust Sign Up To Safety campaign.

10.2 Improvements in documentation of clinical decision making continue to be a theme identified in CCR, particularly in relation to non-conveyance and DNACPR and ROLE.

11. INFORMATION COMMISSIONERS OFFICE (ICO) NOTIFICATIONS

11.1 No Information Governance notifications were received in Q3 and 4.

11.2 The Information Commissioners Office (ICO) have met with members of the National Ambulance IG Group to examine initiatives to further raise awareness of IG amongst all staff groups with specific support for Information Asset Owners.

11.3 As reported in the previous 6-monthly report, one FOI request was referred to the ICO. This was a request for details of correspondence between YAS and unions. A decision notice was received in November 2014 regarding YAS' application for exemption under 'prejudicial to conduct of public affairs' to this request. This decision was upheld by the ICO.

12. HEALTH & SAFETY EXECUTIVE (HSE) NOTIFICATIONS

12.1 The Trust has received one contact following statutory inspection of vehicle lifts. A fault was identified during the inspection which could have potentially breached the Lifting Operations and Lifting Equipment Regulations (LOLER). The Trust took immediate action to address the fault and information was provided to the HSE.

12.2 The Trust has received a notification relation to late reporting of a RIDDOR incident. The Trust has improved monitoring of RIDDOR reportable incidents with a SOP and dashboard for tracking potential RIDDORs and the Risk and Safety Team identify RIDDOR incidents as part of the initial incident quality checking process. Assurance has been provided to the HSE on robustness of processes.

13. BEING OPEN

13.1 The Trust is committed to being open with patients and/or families involved in adverse events. Cases are reviewed in the Incident Review Group to determine when and how 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 Q3 and Q4 with themes and trends remaining largely unchanged from the first six months of 2014-15.

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

14.3 Themes from incidents, complaints and claims are influencing the choice of, and driving the progress of organisational safety improvement initiatives, and will also be used as measures of realisation of safety goals determined within YAS Sign Up To Safety Campaign.

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.