Yorkshire Ambulance Service NHS
NHS Trust

| MEETING TITLE<br>Trust Board Meeting in Public | | | MEETING DATE<br>26/01/2016 | |
|---|---|---|---|---|
| TITLE of PAPER | Bi-Annual Significant Events & Lessons Learned paper Q1 and Q2 2015/16 | | PAPER REF | 5.4 |
| STRATEGIC OBJECTIVE | To develop culture, systems and processes to support continuous improvement and innovation<br>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 2015-16. 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:<br>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<br>7: Safeguarding people who use services from abuse<br>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 2015-16. The report also focuses on actions taken and lessons learned.

## 2. BACKGROUND/CONTEXT

2.1 This report primarily covers the period April 2015 – September 2015 (Q1 and Q2 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
- 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)

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 to Clinical Governance Group 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. Learning from adverse events is included in relevant training materials where appropriate.

## 3. LEARNING FROM SERIOUS INCIDENTS

3.1 A total of 24 SIs were reported in Q1 and Q2 15-16; the table below shows this split by business area.

| Serious Incidents | Apr | May | Jun | Jul | Aug | Sep |
|---|---|---|---|---|---|---|
| **Ops - A&E** | 3 | 1 | 0 | 1 | 1 | 0 |
| **EOC** | 1 | 1 | 2 | 1 | 2 | 3 |
| **PTS** | 0 | 0 | 0 | 0 | 0 | 0 |
| **111** | 0 | 0 | 0 | 2 | 1 | 1 |
| **LCD** | 1 | 1 | 0 | 2 | 0 | 0 |
| **TOTALS** | **5** | **3** | **2** | **6** | **4** | **4** |

3.2 Delayed response, including delayed dispatch and delayed back up remains a theme of SIs in A&E Ops and EOC during this period, although the number of SIs overall and relating to delayed response was lower throughout this period than for the same period in 2014/15. The A&E Improvement Plan has delivered improvement in response performance in the year to date and this should continue over the coming year. Delays in response and backup are managed in real-time through the EOC escalation process, in addition to weekly, monthly and quarterly reporting. 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. This process highlights potential SIs for consideration at IRG.

3.3 Delayed dispatch can result from coding errors which lead to inaccurate disposition; this 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 is on human factors which might impact on such errors.

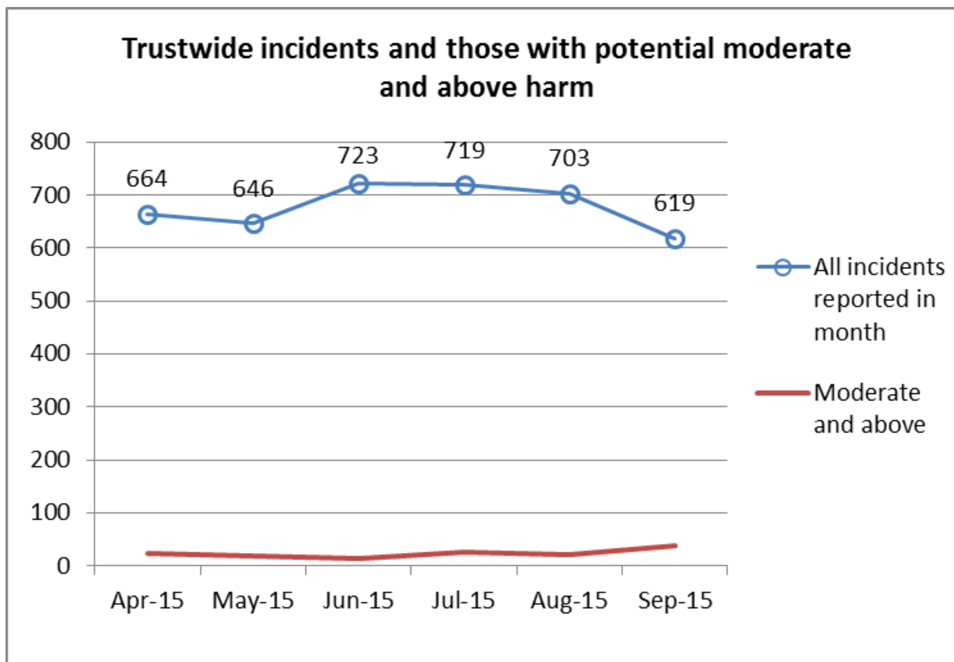
3.4 Themes and trends from serious incident investigations conducted jointly by NHS111 and Local Care Direct relate to primary assessment of headache presentation through NHS Pathways algorithm and failure of assessment to identify brain haemorrhage. This has been highlighted in training to staff within the service to raise awareness of the risks.

Recommendations have been made to NHS Pathways to review the questioning within the headache pathway, particularly in relation to severity and onset, and commencement and use of anticoagulation medication as risk factors.

3.5 Previous serious incident investigations in A&E Operations had established a failure to recognise and appropriately manage potential spinal cord injury. Following launch of a new evidence-based spinal assessment and management tool along with training materials, an educational video and inserts for the Paramedic Pocket Book, YAS has seen a reduction in incidents relating to identification and management of potential spinal cord injuries in Q3 of 15/16.

## 4. INCIDENTS

4.1 Chart 1 below shows overall incident data for Q1 and Q2 of 2015-16 with those incidents intially reported as moderate and above harm. On average, incidents with potential for moderate and above harm make up 3.5% of all incidents reported.

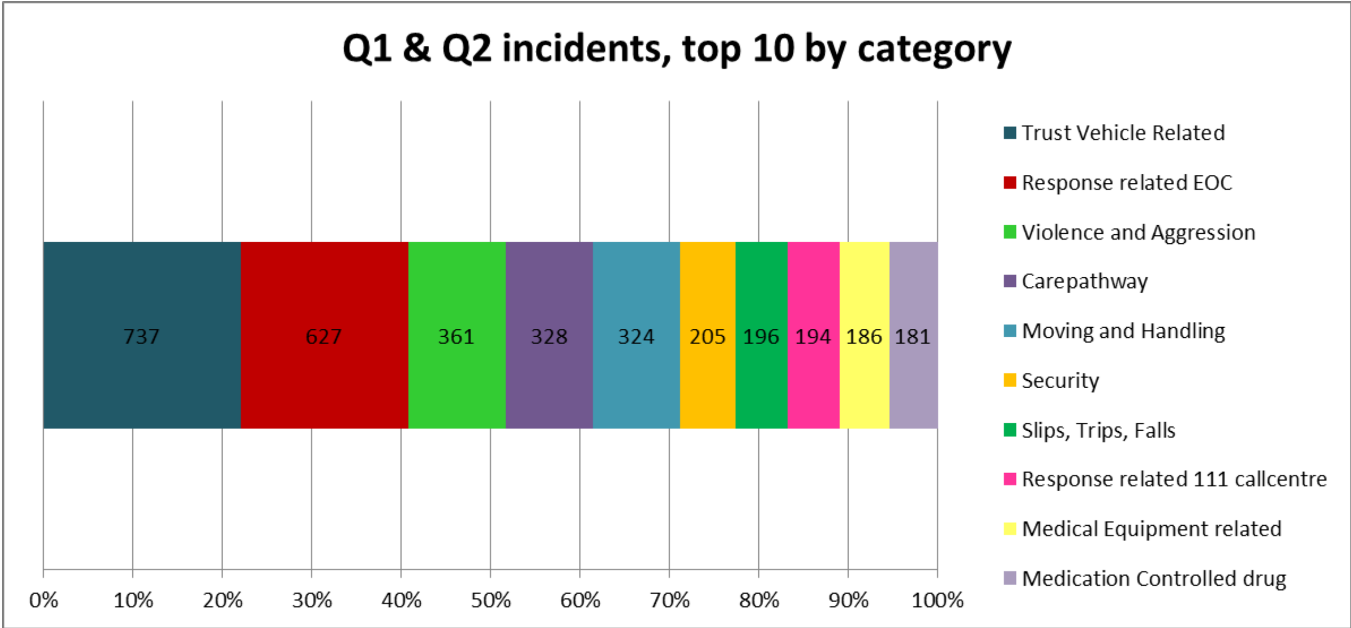



4.2 Patient-related moderate and above harm incidents are reviewed at Incident Review Group where they are considered in lilne with the Serious Incident Framework. Thematic reports are also reviewed at Clinical Governance Group. Staff-related moderate and above harm are reviewed against RIDDOR reporting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

4.3 The YAS Safety Thermometer captures moderate and above incidents related to slips trips falls, medication errors and patient injuries.

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

The top 10 categories of incidents represent over 80% of incidents in Q1 and Q2 (3339/4089). Nine of the top 10 categories remain consistent from Q3 and 4 of 14/15 report, with only 'Medication – non controlled drug' dropping out of the top 10 into 11th place, and being replaced by Medical Equipment-related incidents due to the change to a smaller model of defibrillator in RRVs.

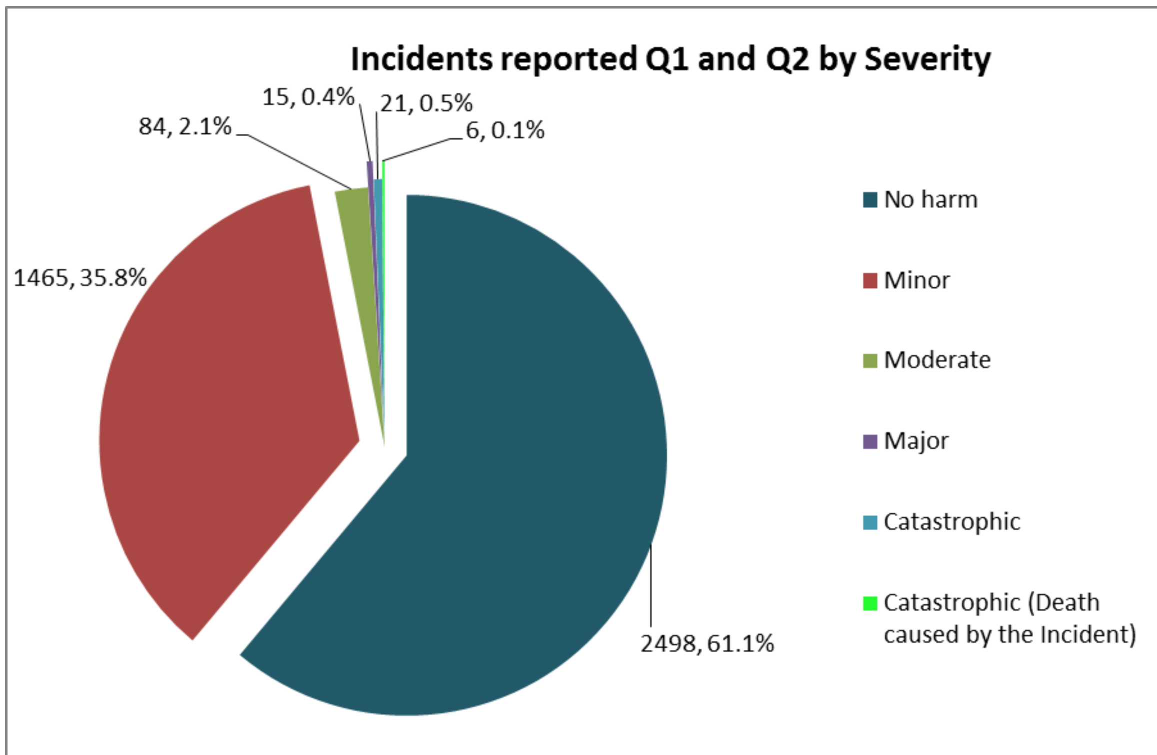



4.5 The most significant change in position in the top 10 reported incidents is in the category of carepathway-related, which moved from 8th place with 221 incidents in Q3 and Q4 of 2014/15 to 4th place with 328 incidents in the first half of 2015/16.

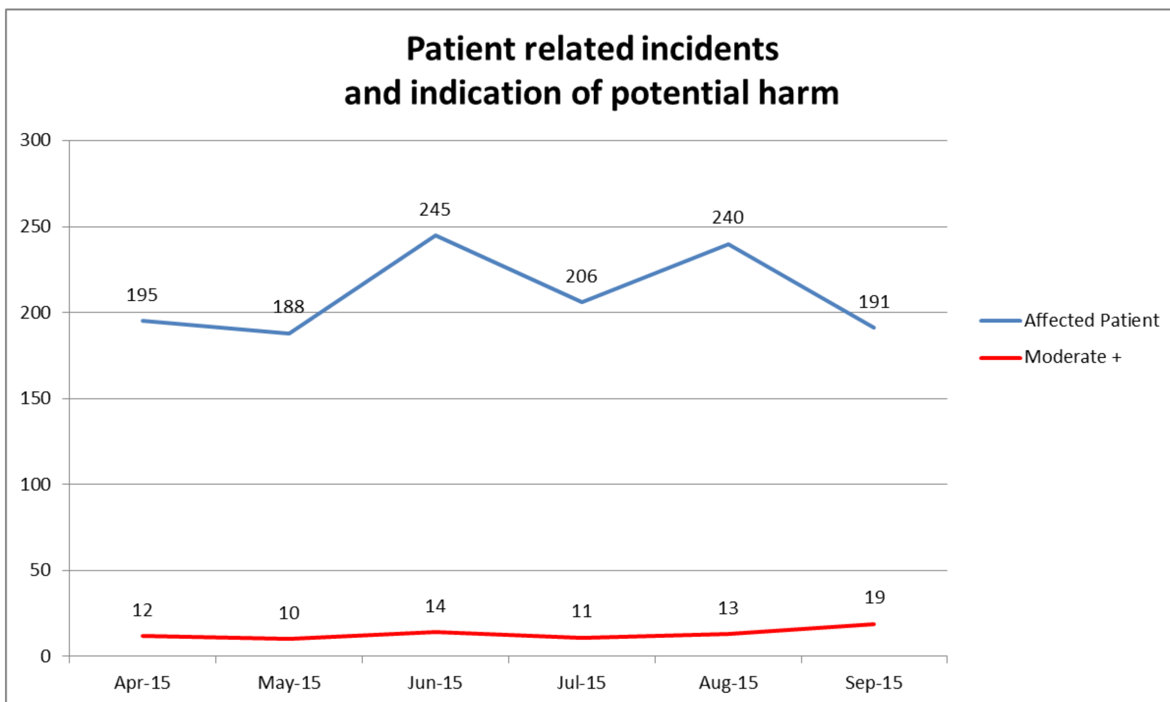
Further analysis has identified that 101 of these 328 carepathway incidents have been categorised as 'service outbound' meaning that they were reported by YAS staff about concerns accessing carepathways of other providers; the majority being acute trusts. YAS has notified other healthcare providers of these incidents and we are contributing to serious incident investigations declared by them relating to pPCI (Primary Percutaneous Coronary Intervention) for STeMi (ST Elevation Myocardial Infarction) where refusal of admission to a 'cath lab' by the acute trust for pPCI has had potential to lead to adverse patient outcome.

4.6 Over the first 6 months of 2015/16 YAS has categorised 270 (6.6%) incidents as 'service outbound' and notified other healthcare providers of these. In addition to carepathway, the next largest group are represented by 'inappropriate booking of ambulance by healthcare professional'.

4.7 The piechart below is a representation of harm level reported for all incidents in Q1 and Q2. It shows that over half of all incidents reported resulted in no harm, and 96.9% were no or minor harm.



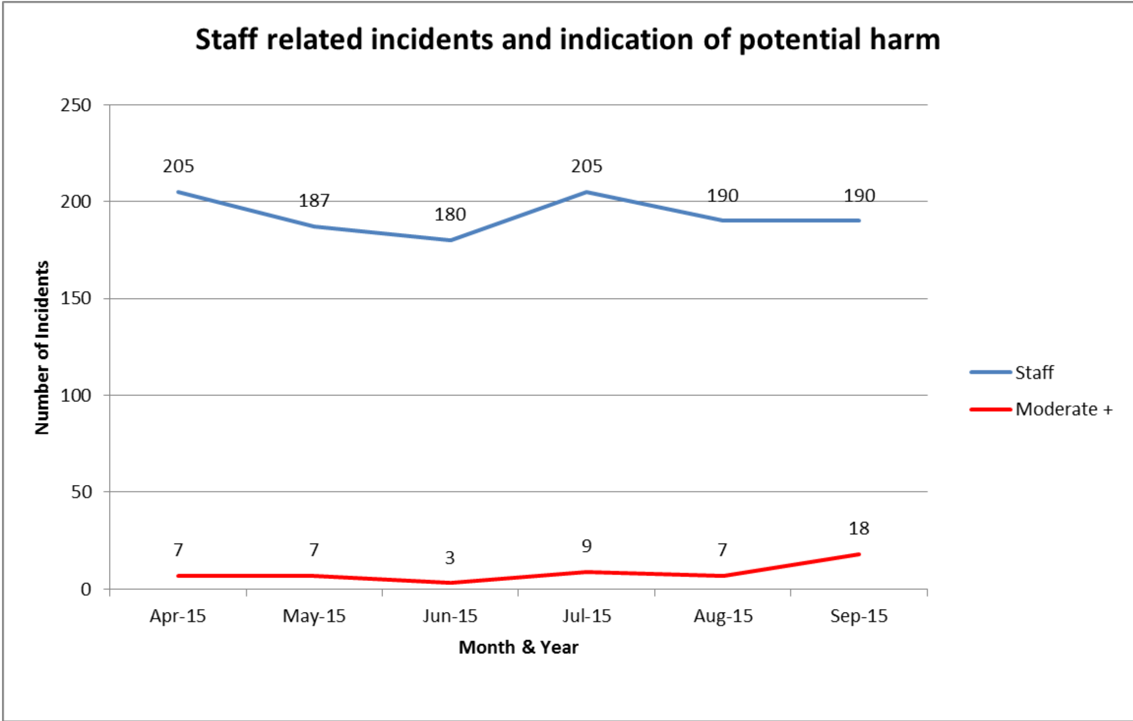

4.8 All patient–related incidents and those with a severity of moderate and above are illustrated in the chart below.




4.9 Patient related incidents make up 31% of incidents reported in this period (n=1275), consistent with previous reports. The proportion of moderate and above graded incidents remains constant and equates to 6.3% of all incidents in the 6 months April to September 2015.

4.10 The top categories of patient-related incidents are response-related, carepathway, medical equipment and slips trips, falls. These make up 71.6% of patient related incidents, with no harm and minor harm in these categories representing (862/913) 94.4%.

4.11 The chart below shows staff-related incidents and those graded as moderate and above harm. Staff related incidents make up 28.8% of all incidents reported in Q1 and Q2, with 4.4% of these graded moderate and above.




4.12 'Violence and aggression' and 'Moving and handling' incidents make up 51.9% of staff-related incidents.

4.13 Data from incidents and claims related to moving and handling is analysed and themes identified resulting changes in practice. Implementation of replacement equipment bags and modification of the Mercedes ambulance to improve storage and reduce the likelihood of musculosketal problems has been instigated as a result of this process. A decision has been made by the Trust to move to a new vehicle in 2016/17. The new specification has been designed with significant staff input and the additional space within the vehicle should signficantly reduce the risk of musculoskeletal injury. Moving safely is part of YAS Sign Up To Safety campaign to reduce staff injury and risk to patients.

4.14 Violence and aggression incidents are monitored at Health and Safety Committee. The majority are experienced within A&E Operations and relate to the attitude or behaviour perpetrated by the patient and/or relative.

4.15 In the six month period April to September 2015, 336 incidents of violence and aggression to staff were reported, and of these, one was graded as moderate harm, the remainder minor or no harm.

Themes and trends from incidents have been used to inform development of a Safer Responding procedure which includes the Joint Decision Model of intelligence gathering, scene safety and risk assessment.

## 5. COMPLAINTS INCLUDING OMBUDSMAN REQUESTS & PATIENT EXPERIENCE

5.1 Dissatisfaction from patients regarding response times to Green calls remains the largest proportion of all EOC complaints; representing 49% in Q1. During Q2 there was an increase in complaints from Healthcare Professionals relating to Inter-facility transfers.

5.2 Within the A&E Operations service an ongoing theme from complaints relates to staff attitudes and behaviours, monitoring of this trend is ongoing with the proportion of complaints standing at 33% at the end of Q2.

5.3 The National See and Treat Friends and Family Test initiative continues to provide positive feedback although uptake is low. A plan has been made to improve response rates in Q3 and Q4.

5.4 Within PTS, themes from complaints remain consistent with previous reports. Delays in taking the patient to and from hospital appointments represent three quarters of complaints into PTS at the end of Q2.

5.5 Response to the National PTS Friends and Family Test continues to provide positive responses although the response rate is low. Any negative comments reflect 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 the NHS111 and West Yorkshire Urgent Care Clinical Governance meeting.

5.7 YAS received eleven notifications from the Parliamentary and Health Service Ombudsman to October 2015; six for A&E Operations, three for EOC, one for PTS and one for NHS111. Ten cases have been decided by the PHSO with nine not being upheld whilst one was partially upheld.

## 6. CLAIMS

6.1 Employer Liability Claims continue to be the main focus within the Legal Team, consisting mainly of musculoskeletal injuries from moving and handling incidents (both patient and equipment related). 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.

6.2 A number of ambulance vehicle related injury claims have been reported which relate to problems with tail-lifts and vehicle doors. 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.

6.3 Four clinical negligence claims have been reported in 2015/16, one in relation to management of a potential spinal injury and three relating to clinical assessment and non-conveyance. Work within Clinical Directorate to develop an evidenced based spinal assessment tool (see point 3.5 of this report) has seen a reduction in incidents of this nature.

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

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

7.2 The number of inquests opened by the Coroner as a result of delayed responses has decreased, in South area the focus of some inquests has been around communication between EOC and front line. In these cases YAS provides the SI report and representation from the Trust is made. The verdict, including lessons and recommendations is added to the report to ensure that this is captured and further informs analysis of themes and trends. Coroner recommendations have triggered a review of communication channels between EOC and front line, with particular focus on the information passed by radio.

### Hillsborough Inquests

7.3 Work continued during Q1 and Q2 to contribute towards Hillsborough Inquests. 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 Domestic Homicide Review was declared and scoped during Q2, and the investigation is ongoing. There were no immediate recommendations or lessons.

## 9. PROFESSIONAL BODY REFERRALS

9.1 No significant organisational lessons learned were identified from Professional Body Referrals during Q1 and Q2 of 15/16.

## 10. CLINICAL CASE REVIEWS (CCRs)

10.1. A CCR was conducted during this period into conveyance of a patient with a back injury to a general hospital rather than a trauma centre which necessitated secondary transfer. Learning for the crew was in relation to utilisation of Trauma desk and effective communication by pre-alert.

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

## 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.

## 13. BEING OPEN

13.1 The Trust is committed to being open with patients and/or families where an adverse event occurs. Cases are reviewed in the Incident Review Group to determine the appropriate approach to communicating with patients and their families.

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. 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 Q1 and Q2 of 2015-16.

14.2 Incidents, complaints and claims data are used to monitor the impact of delayed response, including dispatch and back up on patient safety and patient experience. Alongside real-time management and escalation in EOC, weekly and monthly monitoring continues to identify operational improvements which will assist the Trust in projecting and managing increases in demand. Processes are in place to prioritise clinical care and ensure patient safety during periods of increased demand.

14.3 Lack of clarity in requests for back up to RRVs has led to the development of a back-up request procedure to ensure that both EOC and the responder have a clear framework for request and dispatch of back up.

14.4 Development of a procedure for managing unanswered triage calls by the Clinical Hub has resulted from recognising the potential for patient harm. The procedure, which includes risk assessment of reported condition, and clinical review of the original 999 call, will support clinicians in safe management of unanswered triage call-backs.

14.5 A number of Serious Incident investigations and complaints have focussed on the management of headache where a subsequent diagnosis of cerebral bleed was made. Where appropriate, the SI report has been shared with the coroner to support inquest. Findings have also been shared with the patients GP where the patient was commenced on anticoagulant therapy, and a recommendation has been made to NHS Pathways where NHS111 assessment has not identified risk factors associated with brain bleeds.

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