NHS
Yorkshire
Ambulance Service
NHS Trust

MEETING TITLE Public Board		**MEETING DATE** 28/03/2019	
TITLE of PAPER	Significant Events & Lessons Learned – Bi-annual report Q1 & Q2 18-19.	**PAPER REF**	4.3
STRATEGIC OBJECTIVE(S)	Safe and Sustainable: Provide a safe, effective, caring and sustainable service for all patients Achieving Excellence: Transform our services to exceed national performance and quality measures		
PURPOSE OF THE PAPER	The purpose of the paper is provide an overview to the Board of the key events and learning that have taken place during the first half of the 18-19 financial year. This will cover Q1 and Q2 (April 2018 – September 2018)		
For Approval	☐	**For Assurance**	☒
For Decision	☐	**Discussion/Information**	☐
AUTHOR / LEAD	Brogan Greenhaugh, Coordinator Quality and Safety, Rebecca Mallinder (Head of Investigations & Learning)	**ACCOUNTABLE DIRECTOR**	Steve Page (Executive Director of Quality, Governance & Performance Assurance)
DISCUSSED AT / INFORMED BY Quality Committee – July 2018 and December 2018			
PREVIOUSLY AGREED AT:	Committee/Group: Quality Committee Quality Committee	Date: July 18 December 18	
RECOMMENDATION(S)	It is recommended that the Board note the current position and take assurance from the work highlighted within the report, supporting the ongoing proposals for improvement		

RISK ASSESSMENT	**Yes**	**No**
Corporate Risk Register and/or Board Assurance Framework amended *If 'Yes' – expand in Section 4. / attached paper*	☐	☒
Equality Impact Assessment - *[New]* *If 'Yes' – expand in Section 2. / 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	☐	☒
ASSURANCE/COMPLIANCE		

Care Quality Commission **Choose a DOMAIN(s)**	1: Safe 5: Well led
NHSI Single Oversight Framework **Choose a THEME(s)**	2. Quality of Care (safe, effective, caring, responsive) 6. Leadership & Improvement Capability (Well-Led)

[Significant Events & Lessons Learned Bi-Annual Report]

1. PURPOSE/AIM

1.1 The purpose of the paper is provide an overview to the Board of the key events and learning that have taken place during the first half of the 17-18 financial year. This will cover Q1 and Q2 (April 2017 to September 2017).

2. BACKGROUND/CONTEXT

2.1 This report primarily covers the period 1 April 2017 to 30 September 2017.

2.2 Where necessary immediate action is taken to ensure patient and staff safety following an adverse event. This is followed by more formal 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:

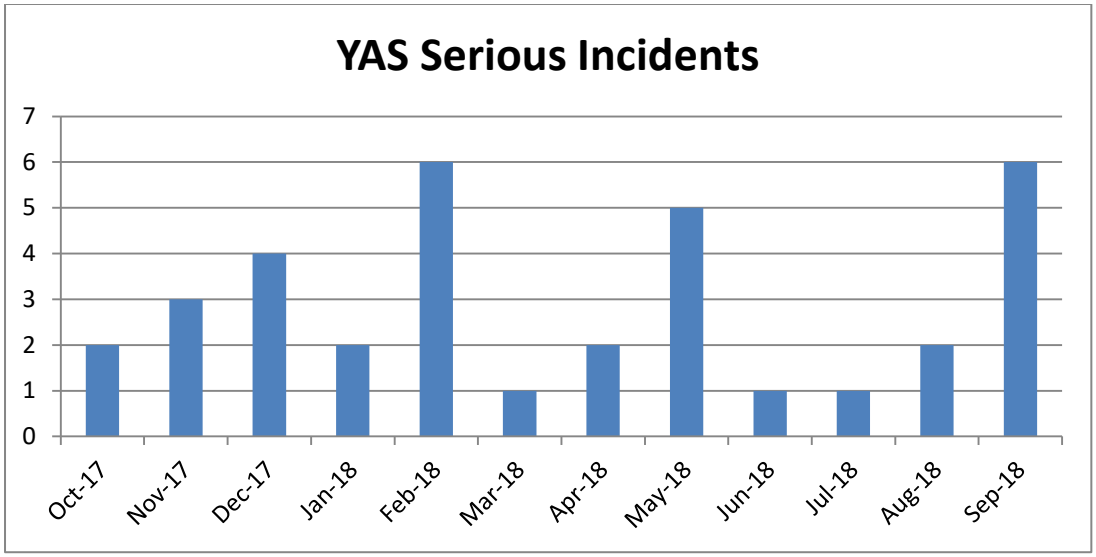
- Serious Incidents reported to the Trust's commissioners
- Incidents
- Complaints & patient experience – including requests received from other services and including the Ombudsman
- Claims
- Coroners Inquests – including Prevention of Future Death Reports (PFDs) received by the Trust.
- Safeguarding Serious Case Reviews (SCRs) and Domestic Homicide Reviews (DHRs)
- Professional Body Referrals
- Clinical Case Reviews
- Information Commissioner's Office notifications
- Health & Safety Executive notifications
- Duty of Candour (Being Open)
- Freedom to Speak Up

2.4 Other sources may be included, based on the nature of the events occurring.

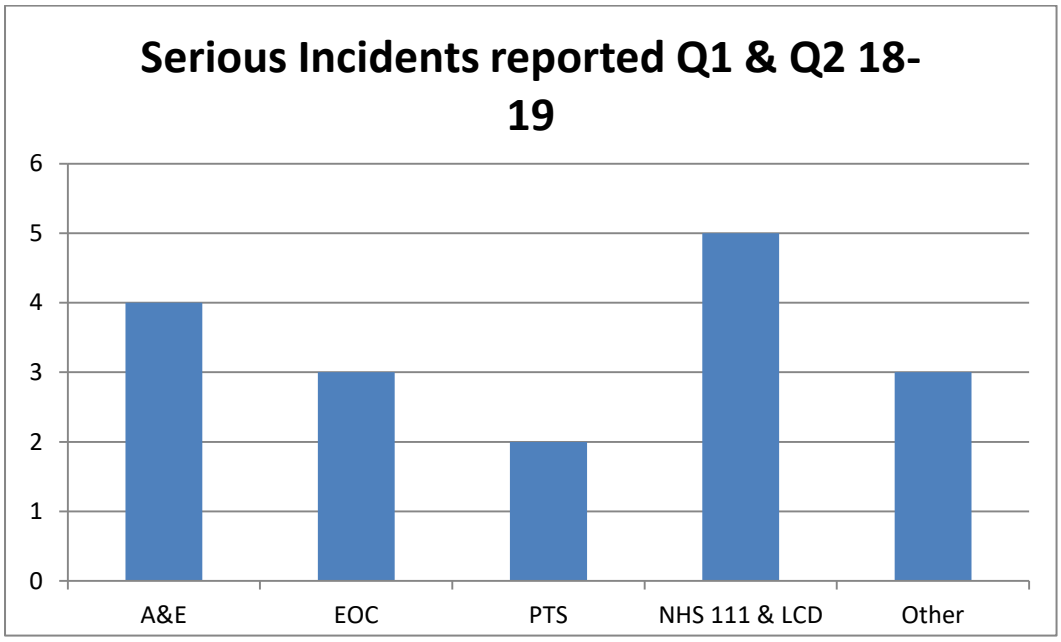
3. SERIOUS INCIDENTS (SIs)

3.1 During Q1 and Q2 18-19 the Trust reported 17 Serious Incidents. This is in comparison to 18 reported in the previous 6 months.

3.2 The graph below shows the SIs reported on a rolling 12 month period.



3.3 The chart below shows the breakdown by service area for Q1 and Q2 18-19.

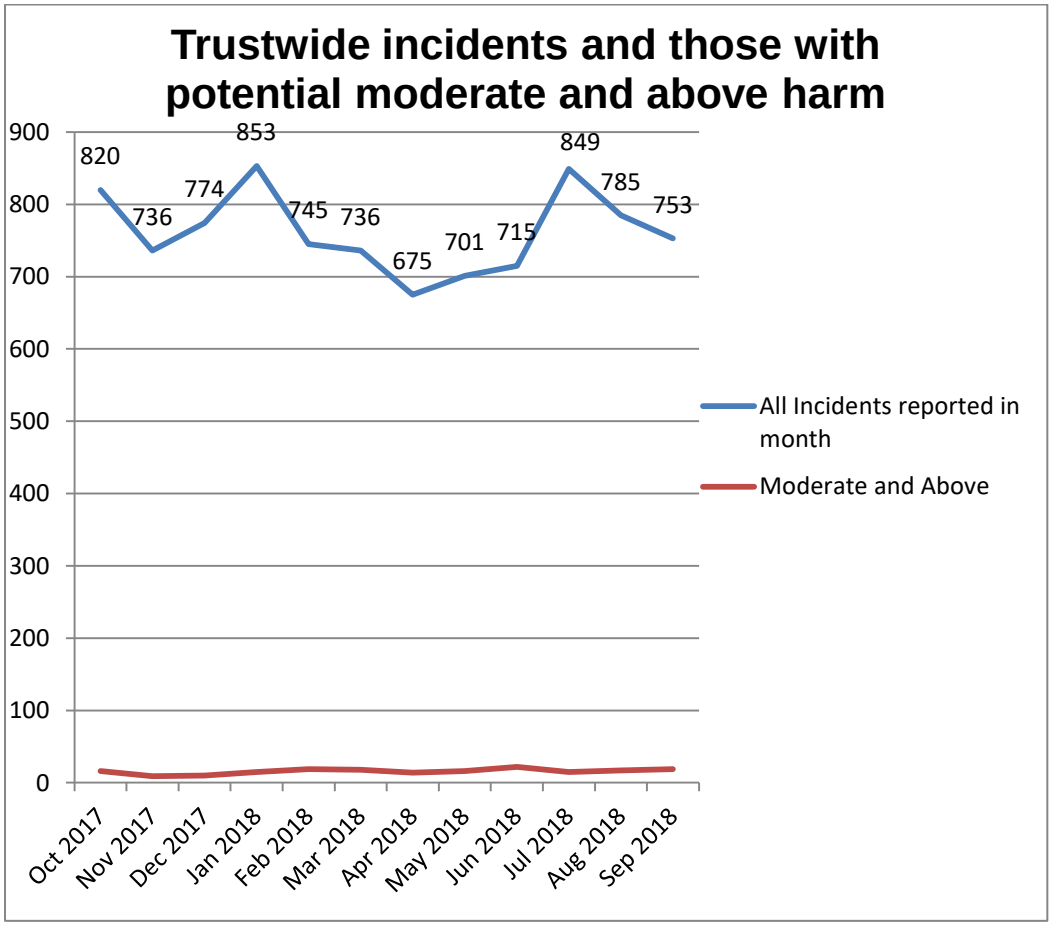


3.4 A theme identified in Quarter 2 was a number of inquests and Serious Incidents relating to the response to patients who have taken an overdose, in particular propranolol. The Trust highlighted this issue to the Healthcare Safety Investigation Branch (HSIB) primarily due to concerns over high prescribing amounts in primary care. HSIB visited the Trust as part of their investigation to consider the need for a national review.

3.5 The Health Service Investigation Branch are undertaking two maternity case investigations that involved our service currently. HSIB has been asked to undertake investigations of the most serious maternity cases using its independent, impartial and standardised process that does not apportion blame or liability. From April 2018, HSIB will conduct independent safety investigations for all relevant cases, working to the protocols and systems that characterise its investigative approach and extracting learning from all these investigations leading to a national view of safety issues in maternity. HSIB considers this the vanguard for future HSIB safety investigations in all clinical areas.

4. INCIDENTS

4.1 The graph below shows the number of incidents reported over the previous 12 months.

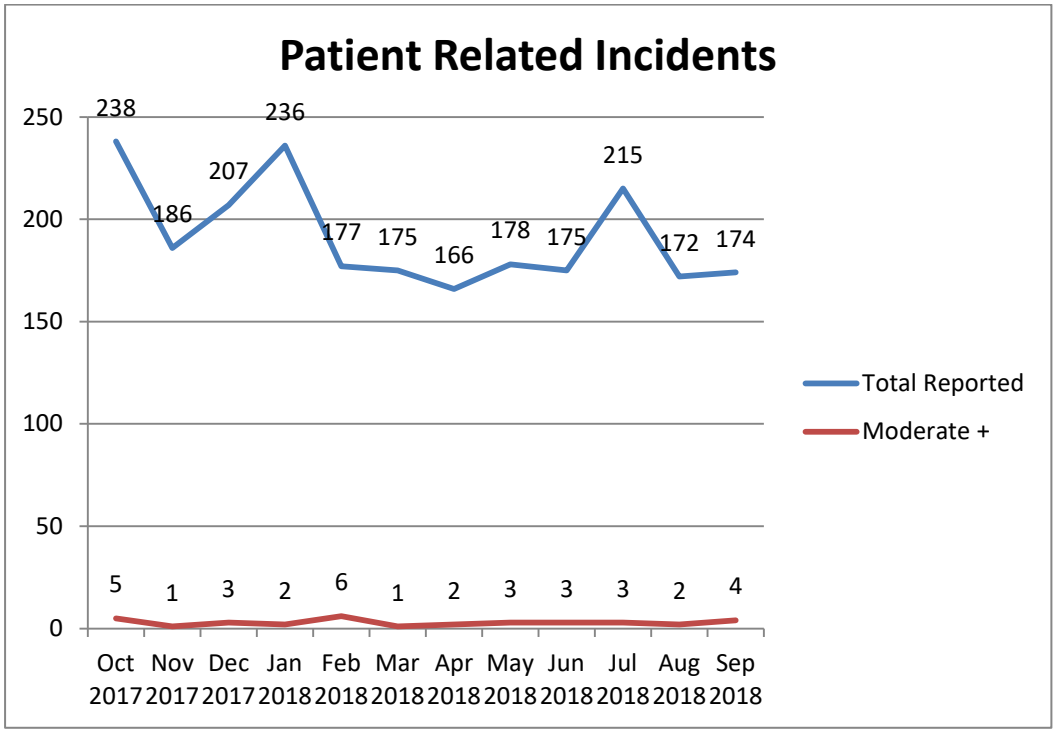


4.2 The chart below shows a breakdown of incidents and near misses reported within each service line.

	A&E Operations	EOC (Emergency Operations Centres)	NHS 111	PTS (Patient Transport Services) -Operations
Oct 2017	408	56	70	110

Nov 2017	430	43	33	97
Dec 2017	460	51	46	78
Jan 2018	478	53	40	104
Feb 2018	425	54	47	74
Mar 2018	446	38	38	72
Apr 2018	360	57	39	69
May 2018	400	46	45	81
Jun 2018	383	43	45	110
Jul 2018	480	40	47	107
Aug 2018	448	42	48	84
Sep 2018	412	43	40	81
Total	5130	566	538	1067

4.3 The graph below show the breakdown of incidents by those that have affected patients.



4.4 Rates of incidents in relation to the level of activity are reported in the Integrated Performance Report (IPR). During this period the overall rate of incidents associated with harm in each service has remained low.

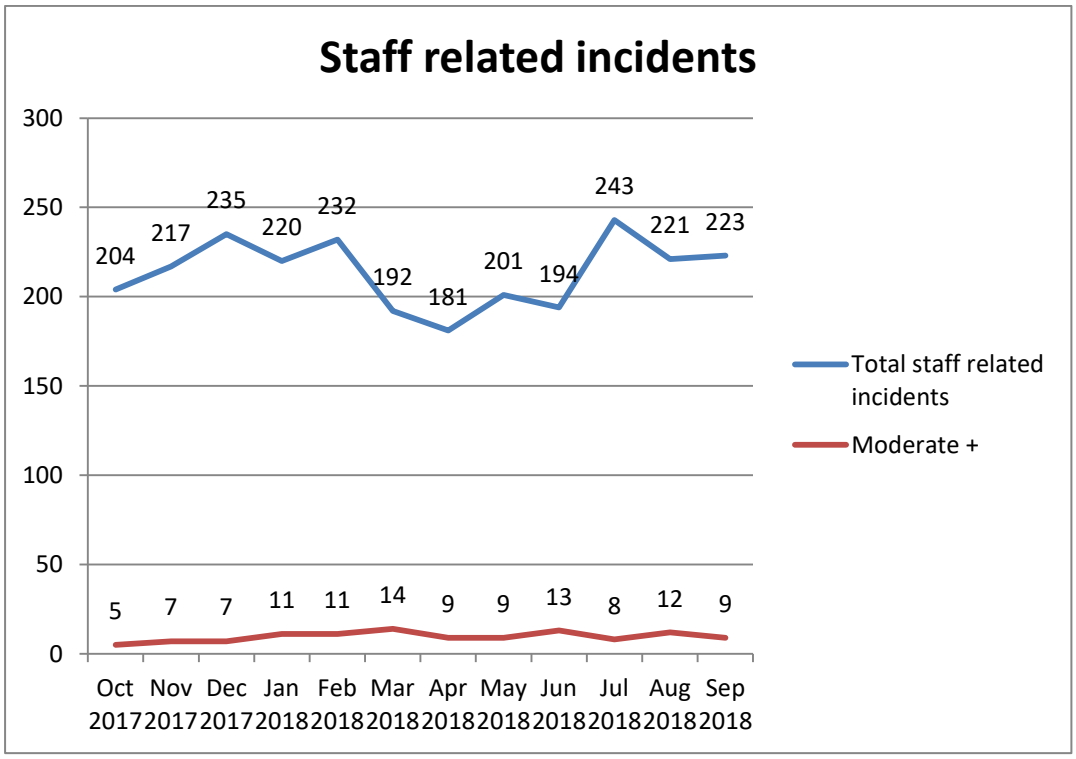
4.5 Within the patient related incidents the highest category of incidents reported is response related. The EOC has a robust process for capturing incidents where there has been an excessive response and harm may have been caused to the patient. This is positive practice by the Trust to identify these real-time and understand whether harm has been caused. YAS is the leading ambulance service within the UK in initiating such a process.

4.6 YAS continues to monitor incident rates against 3 key harms; falls whilst in receipt of YAS care, injury whilst in receipt of YAS care and medication errors whilst in receipt of YAS care. These are tracked on a daily, weekly and monthly basis using the “harm free care days” methodology utilised in the national hospital Safety Thermometer data.

4.7 Following launch of the national Sign up to Safety campaign; which has an ambition to reduce harm within the NHS by up to 50%, Yorkshire Ambulance Service has succeeded in reducing medication errors by 80% over 2 years using the Safety Thermometer data and feedback system, from 54 in 2014-15, 25 in 2015-16 and only 14 throughout 2016-17. These medicine errors are those that have the potential to cause harm to patients and do not include breakages or loss of controlled drugs.

4.8 The level of harm remains low for patient related incidents and all moderate and above patient related incidents are reviewed in line with the Duty of Candour criteria.

4.9 The graph below show the breakdown of incidents by those that have affected staff.



4.10 Violence and Aggression remains in the top 3 reported categories of incident at YAS and the highest category of ‘Affected Staff’ incident. The category V&A includes physical assault; spitting, biting, punching and kicking, sexual assault, and verbal abuse; swearing, threats, racial and homophobic.

4.11 During Quarter 1 and Quarter 2 of 2018/19 Conflict Resolution Training was delivered to frontline operational A&E Ops and PTS staff. This focused on de-escalation techniques, the Joint Decision Model as part of the Safer Responding procedure, dynamic risk assessment and breakaway techniques

as well as relevant legislation. The Risk Team continue to work with the YAS Academy to develop training packages for other staff groups, including communication centres in 111, PTS and EOC.

4.12 A Task and Finish Group was convened in Quarter 1, led by the Risk Team, to formalise processes to support staff who are victims of violence and aggression during the course of their duties in order to apply a full range of sanctions and to pursue redress for damage to Trust assets. The Task and Finish Group includes representation from A&E Operations, Staff Side, our Freedom to Speak Up Guardian, Legal Services, Fleet Department, Frequent Caller Team, and Health and Wellbeing, the LSMS and is coordinated by the Risk Team. A staff support booklet and managers checklist has been developed during Quarter 2 of 2018/19 and has now been launched. The group also agreed processes between corporate support functions who work in the pursuance of redress for damage to Trust assets; usually vehicles and equipment and the prosecution process

5. COMPLIMENTS, COMMENTS, CONCERNS & COMPLAINTS

5.1 The table below shows the breakdown of complaints and concerns received during this period.

	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sept 18
A&E	49	46	36	51	42	36
EOC	40	41	42	58	38	27
PTS	47	57	74	76	79	67
NHS 111 & LCD	85	80	80	73	67	55
Total	221	224	232	268	226	185

5.2 Within the EOC the largest category of complaints relates to excessive responses to Category 3 calls followed by excessive responses to health care professional admission calls. Overall the volume of complaints received for the EOC increased by 10% from Quarter 1 to Quarter 2. There was also an increase in the volume of cases about the *handling* of Category 3 and 4 calls (as opposed to excessive responses).

5.3 Under the A&E Operations service the highest category of complaints relate to attitudes and communication skills. This increased by 20% from Quarter 4 of 2017/18 into Quarter 1 of 2018/19. During Quarter 2 the number of cases relating to Clinical Assessment increased by 56%. All cases received for A&E Operational services increased by 10% across Quarter 1 and Quarter 2 of 2018/19. Work is continuing internally and with Commissioners to refine our processes to ensure that the application of eligibility criteria reflects individual patient needs whilst also meeting the commissioners contract requirements.

5.4 Around a quarter of all PTS complaints relate to patients being collected late from clinics. There was a significant reduction in cases regarding call handling during Quarter 1 – down from 14 to 6, whilst Eligibility was added as a new category and 5 cases were logged to this subject during Quarter 1. Patient

Transport Services and Patient Relations are working together to attempt to resolve issues and signpost patients informally to keep the number of formal cases to a minimum.

5.5 The highest category of complaint received for the NHS 111 service is related to the appropriateness of the call outcome, accounting for approximately one third of all complaints each month.

Ombudsman

5.6 During this period, the Ombudsman has completed one investigation into a complaint relating to the EOC service; the case was not upheld.

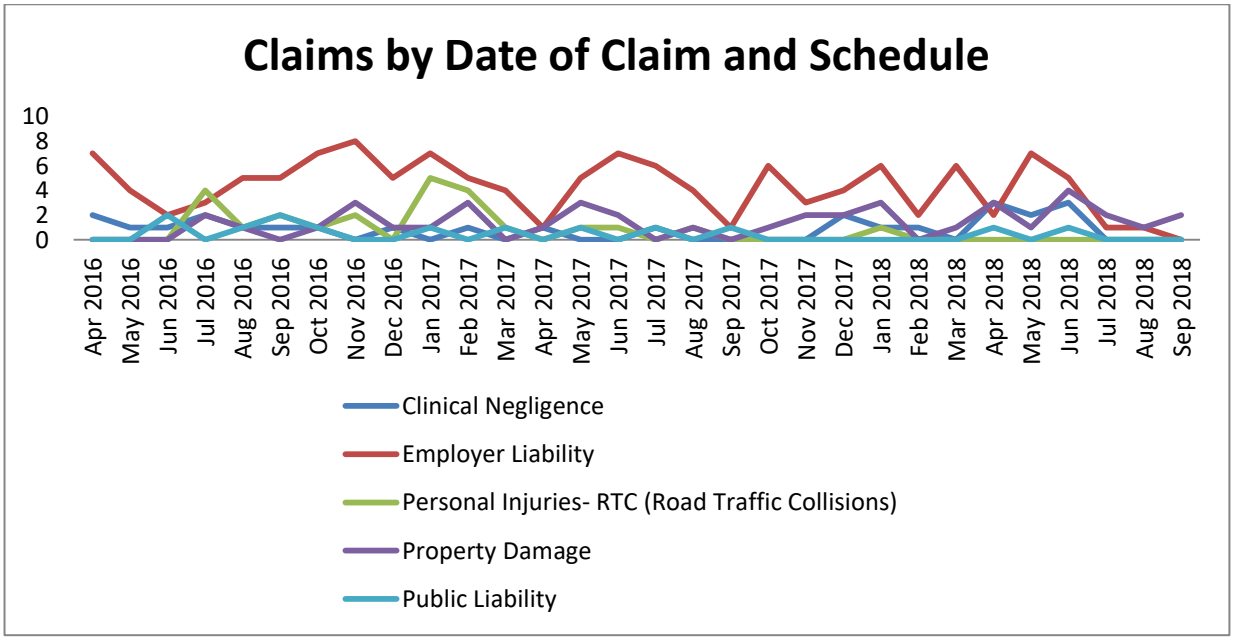
Compliments

5.7 The table below shows the number of compliments received for each service line during Q1 and Q2.

	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sept 18
A&E	79	77	85	81	68	59
EOC	2	1	2	1	0	0
PTS	1	6	3	7	2	4
NHS 111 & LCD	10	12	16	7	9	7
Total	92	96	106	96	79	70

6. CLAIMS

6.1 At the end of Q2 there are currently 161 open claims against the Trust that come under the NHS Resolution Insurance Scheme for Trusts with employer liability claims being the highest volume (80%).



6.2 The main focus of the employer liability claims has shifted from moving and handling claims to injuries sustained from Trust vehicles (53), in particular injuries arising from tail lifts, ramps, doors and seats. One theme that keeps arising is the familiarisation training provided to staff in relation to the vehicles and whether this is robust enough. This has been identified and is currently being reviewed.

6.3 Clinical negligence claims are reported in low numbers. Five CNST claims were made during Q1 and Q2 in relation to non-conveyance of a patient, clinical care provided on scene and response times.

6.4 During this period there have been eight public liability claims reported all of which relate to damage to property.

7. CORONERS INQUESTS INCLUDING PFDs

7.1 The Trust's frequency of involvement in inquests continues to remain high. There were 324 open inquest cases at the end of Q2, and during this period the Trust has received 255 new requests and provided evidence (written and/or oral) at 125 inquests.

Prevention of Future Death (PFD) reports

7.2 There has been one PFD report received during this period in relation to an inquest that was heard in November 17 involving the NHS 111 service where a number of errors were identified within the call handling process. The Coroner issued a PFD report due to their being multiple errors made by a number of call takers and felt this may require a review of systems/training as opposed to individual action. A number of actions have since been implemented which included the development of additional guidance for call handlers and a review of the 'Managing Call Backs' standard operating procedure within 111. A full response has been provided to the Coroner to provide assurance that the concerns have been addressed.

8. SAFEGUARDING SERIOUS CASE REVIEWS (SCRs) AND DOMESTIC HOMICIDE REVIEWS (DHRs)

8.1 Within this period YAS provided information towards three SCRs within the region and three DHRs. Information was also submitted to six Safeguarding Adult Reviews and four Lessons Learned Reviews.

8.2 Work is ongoing within the Safeguarding team to set up a referral pathway in partnership with Victim Support and Independent Domestic Abuse Services and a Trust wide patient information leaflet is now in circulation to ensure potential victims of domestic abuse have access to relevant contact numbers for advice and support.

9. PROFESSIONAL BODY REFERRALS (PBRs)

9.1 There have not been any cases identified during this period that have highlighted organisational learning.

10. CLINICAL CASE REVIEWS (CCRs)

10.1 Of the CCRs conducted during this period the recurrent themes relate to poor clinical decision making and poor adherence to Trust policy. These are addressed through individual feedback and support and are used to inform on-going training plans.

11. INFORMATION COMMISSIONER'S OFFICE (ICO) NOTIFICATIONS

11.1 During this period YAS did not receive any notifications from the ICO.

12. HEALTH & SAFETY EXECUTIVE (HSE) NOTIFICATIONS

12.1 The Trust received one query from the HSE during this period (Q2). This related to two members of staff who had been exposed to a patient with tuberculosis (TB). The staff members were unaware of the exposure at the time and the Trust were alerted to the issue by Public Health England who contacted the Trust's IPC Nurse. Two RIDDOR reports for the staff members were submitted as a result of the exposure. The HSE's main query was in relation to the Trust's processes. They requested a number of documentation to be submitted and are satisfied with the response provided by the Trust.

13. DUTY OF CANDOUR (BEING OPEN)

13.1 The Trust communicates directly with patients and/or their families when an adverse event has occurred resulting in moderate or above harm to a patient. The Trust also applies the being open process to other incidents when they are identified on a case by case basis that there would be benefit to the patient and/or their family to be aware of the case.

13.2 During Q1 and Q2 18-19 the Trust has applied the being open process to 24 cases. Overall, positive feedback has been received in relation to the processes in place across the Trust with families thankful of the honesty and transparency offered by the service.

14. FREEDOM TO SPEAK UP

14.1 The Trust continues to receive concerns reported through the Freedom to Speak Up process via the Trust's Guardian and Advocates.

14.2 During this period 13 concerns were raised via this process. The common theme arising, and this is consistent across the NHS, is in relation to staff

issues as opposed to direct patient safety concerns. Many of these have root causes of inappropriate and/or inadequate management styles and skills leading to a perception of bullying or harassing behaviour by staff members.

14.3 All issues raised are reviewed by the FTSU Guardian and senior Trust personnel, with appropriate safeguards for confidentiality where required, and actions are agreed and tracked.

14.3 In July 18 the Trust hosted a visit from the National Guardian Office with Dr Henrietta Hughes joining the National Ambulance Network held at YAS and then meeting with members of the senior management team to understand the challenges and opportunities of Freedom to Speak Up within the organisation. Positive feedback was received following the visit.

14.4 During the period the FTSU strategy was developed and is aligned to the Trust's overarching strategy and is influencial in embedding a positive and open learning culture.

15. PROPOSALS/NEXT STEPS

15.1 The Trust will continue to investigate, analyse and learn from adverse events when things go wrong and will continue to report through the internal committees and groups to provide assurance in relation to the key findings and lessons learned. Next steps and actions to be taken have been highlighted in the above sections within this report.

16. RISK ASSESSMENT

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

- Risk 2c) Failure to learn from patients and staff experience and adverse events within the Trust or externally.

17. RECOMMENDATIONS

17.1 It is recommended that the Board note the current position and take assurance from the work highlighted within the report, supporting the ongoing proposals for improvement.