NHS
Yorkshire
Ambulance Service
NHS Trust

MEETING TITLE Trust Board in Public		**MEETING DATE** 27/04/2021	
TITLE of PAPER	Significant Events & Lessons Learned – Bi-annual report Q3 – Q4 2020/21	**PAPER REF**	TB21.008
KEY PRIORITIES	Embed an ethos of continuous improvement and innovation, that has the voice of patients, communities and our people at its heart Create a safe and high performing organisation based on openess, ownership and accountability		
PURPOSE OF THE PAPER	The purpose of the paper is to provide an overview to the Board of the key events and learning that have taken place during the second half of the 2020 financial year. This will cover Q3 and Q4 (October 2020 to March 2021)		
For Approval	☐	**For Assurance**	☒
For Decision	☐	**Discussion/Information**	☒
AUTHOR / LEAD	Simon Davies, Head of Investigations and Learning	**ACCOUNTABLE DIRECTOR**	Steve Page, Executive Director of Quality, Governance & Performance Assurance/ Deputy Chief Executive
DISCUSSED AT / INFORMED BY: – Quality Committee			
PREVIOUSLY AGREED AT:	**Committee/Group:**	**Date:**	
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 *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)**	All
NHSI Single Oversight Framework **Choose a THEME(s)**	2. Quality of Care (safe, effective, caring, responsive)

1. PURPOSE/AIM

1.1 The purpose of the paper is to provide an overview to the Board of the key events and learning that have taken place during the second half of the 20-21 financial year. This will cover Q3 and Q4.

2. BACKGROUND/CONTEXT

2.1 This report primarily covers the period 01 October 2020 – 31 March 2021.

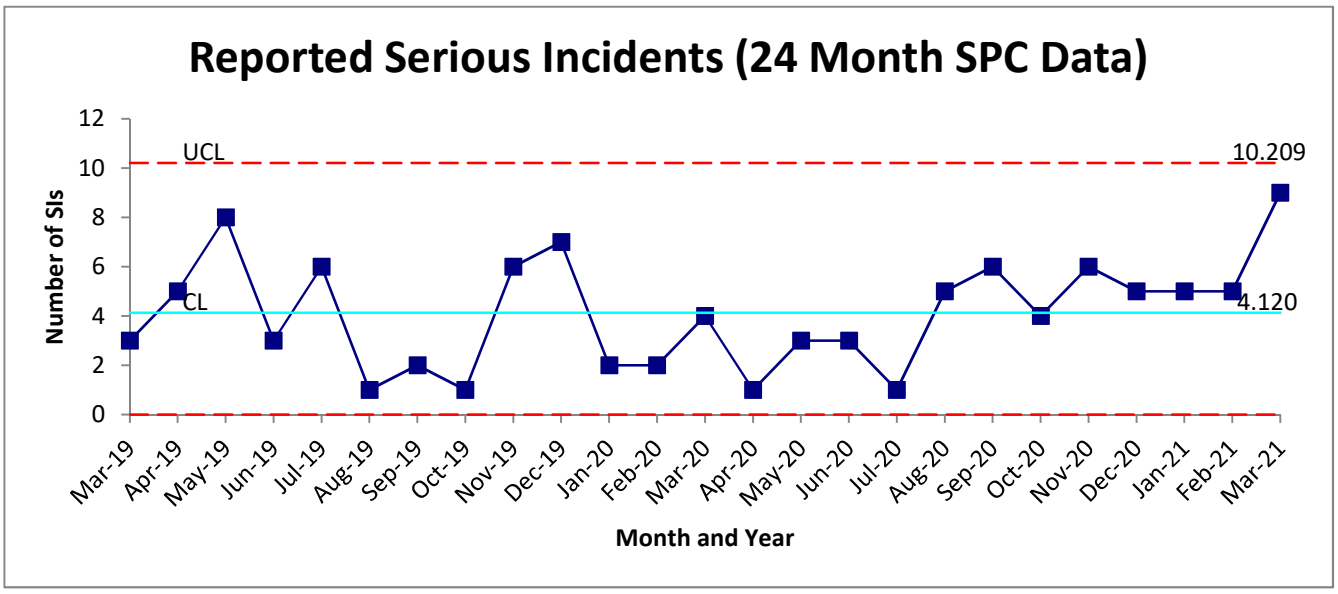
2.2 Where necessary immediate action is taken to ensure patient and staff safety following an adverse event. This is followed by more formal review and analysis proportionate to the seriousness of the event, to ensure that all relevant lessons are learned. Trust timescales for these reviews are in line 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 Engagement in External Statutory Safeguarding Processes
- Professional Body Referrals
- Clinical Case Reviews
- Information Commissioner's Office notifications
- Health & Safety Executive notifications
- Duty of Candour (Being Open)
- Freedom to Speak Up
- Other sources may be included, based on the nature of the events occurring.

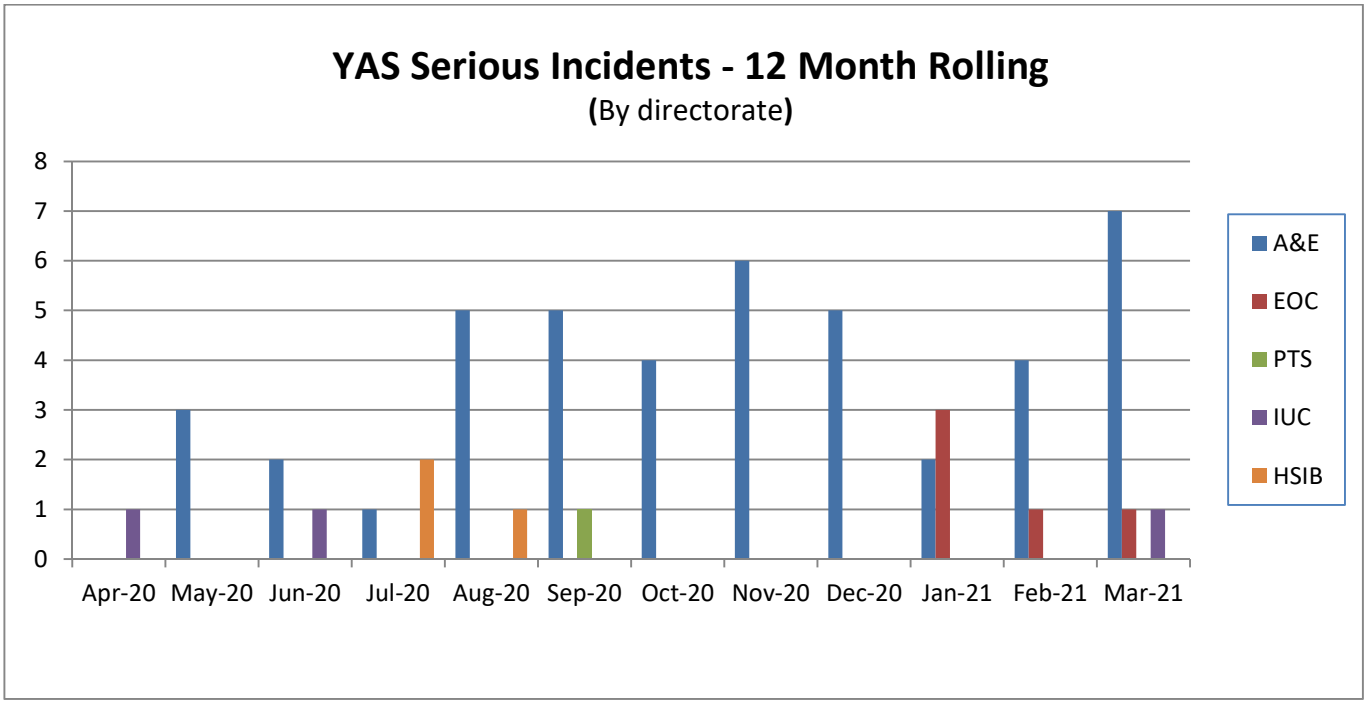
3. SERIOUS INCIDENTS (SIs)

3.1 During Q3 and Q4 2020/21 the Trust reported 34 Serious Incidents to the Strategic Executive Information System (STEIS).



3.2 The chart below shows the breakdown by service area over the last 12 months.

**HSIB entries are shown for reference however these do not appear in the YAS figures unless a separate YAS STEIS entry has been made due to significant learning.*



3.3 During Q3/4, the Trust has continued to experience an altered demand pattern relating to the emergence and continued disruption from Coronavirus disease within the general population. National lockdown measures have been in place of varying degrees across the period and a general feeling of unease was noted throughout the population along with fear of engaging with NHS services or attending NHS facilities which were perceived to have an increased risk of contracting the virus.

3.4 One of the key objectives in national urgent and emergency care plans and an important focus for ambulance services, is to enable the right care for patients in the right place, reducing unnecessary conveyance to Emergency Departments.

YAS has a number of initiatives in place to support this, including enhancing the skills of our workforce to support remote and face to face clinical assessment and intervention and extensive work with system partners to support appropriate referral into alternative pathways of care.

3.5 Whilst this work is progressing with a positive impact on patient care, a theme identified during this reporting period however, has been potential or actual harm associated with some non-conveyance decisions. Reluctance to travel due to infection risks has had an impact on patient decision making during the pandemic, and during Q3/Q4 the Trust continued to see incidents relating to non-conveyance or multiple attendances of YAS crews where refusal to travel had been a factor. In this context, key areas of practice highlighted through our incident review processes have included the need for clinicians to ensure robust discussions with the patient to support informed consent relating to the decision to discharge them from our care at home, and effective safety netting to support ongoing care where patients are not conveyed to hospital.

3.6 These issues including core skills and requirements of clinicians, avoidance of clinical and cognitive bias in decision making and promotion of shared decision-making principles have been explored in detail in the Clinical Quality and Development Forum (CQDF) sessions to inform the Trust response. Access to remote clinical advice has also been strengthened to ensure that complex clinical decisions do not need to be taken in isolation.

3.7 Other pertinent themes from Q3/Q4 of 20/21 include:

- Delayed Response
- Newly Qualified Paramedic (NQP) grade colleagues being involved in incidents.

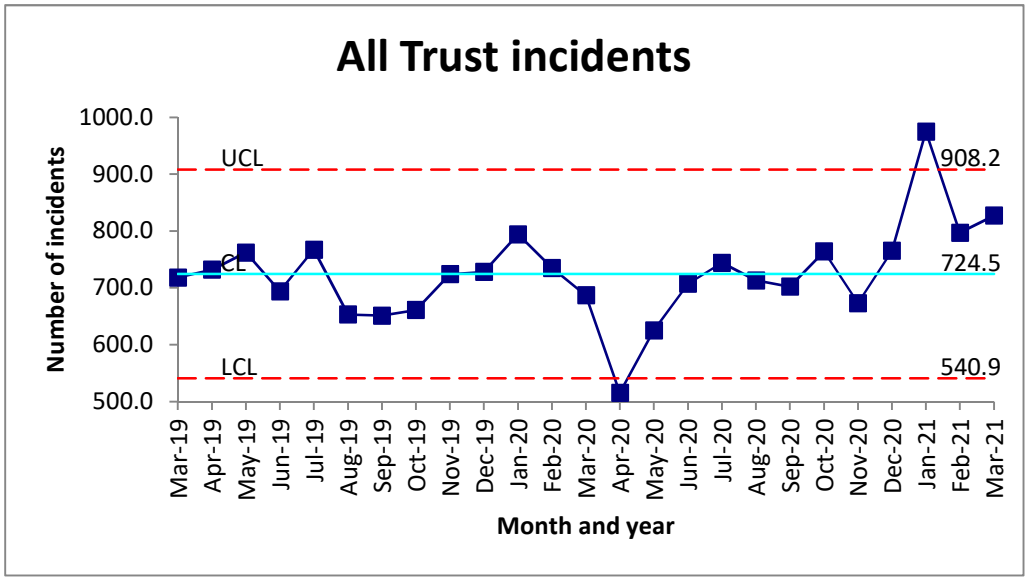
3.8 The Trust continues to review resource in line with national guidance to ensure that staffing is in place to respond to the increasing number of incidents seen during the pandemic. Increased rates of absence including shielding of vulnerable staff associated with the pandemic and careful management of social distancing has created resource challenges and as a result the Trust has experienced delays to response during busy periods. Demand management processes have been utilised throughout 2020/21 to manage the increased demand for NHS services, and processes are in place to review excessive response where this occurs.

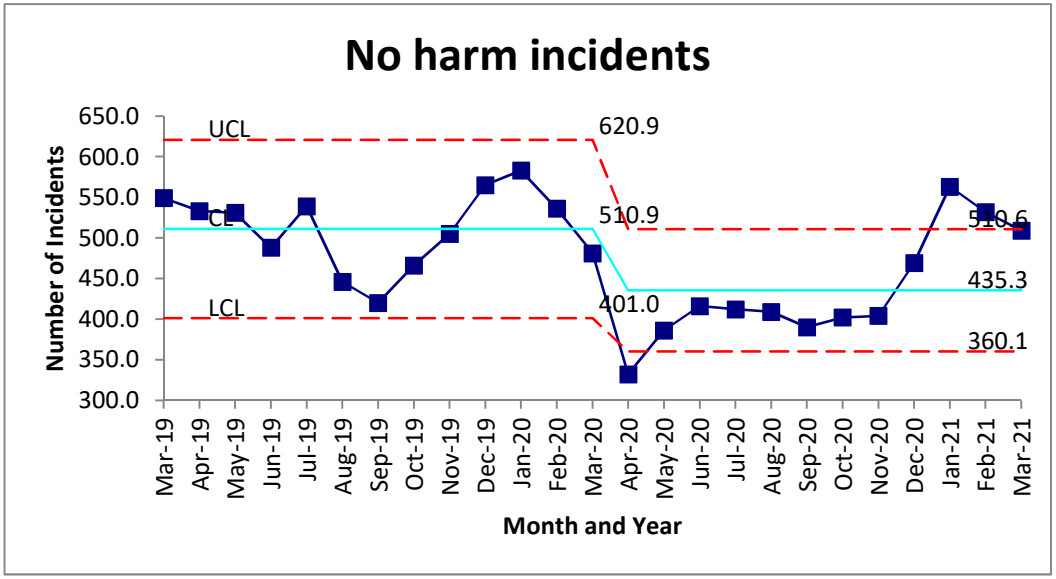
3.9 Between October 2020 and March 2021 incidents were highlighted associated with the practice of Newly Qualified Paramedics (NQP), including a number associated with the management of cardiac arrest situations. As a result plans have been put in place to further increase the support for NQPs during their transition to the service and to work with universities to consider potential enhancements to curricula in areas identified.

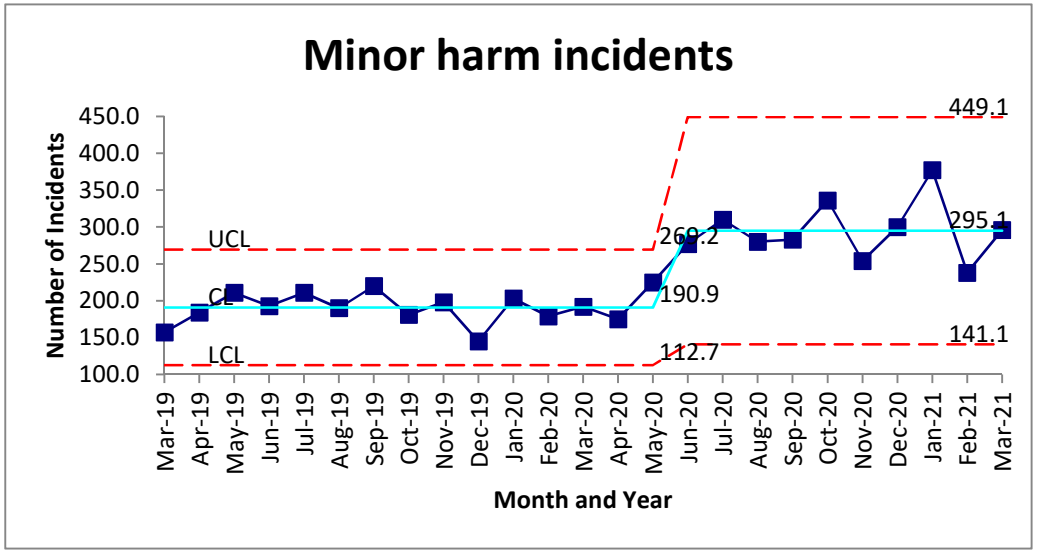
3.10 All actions arising from SI investigations continue to be tracked by the Quality & Safety team and reported to commissioners. Internally actions remain open until written evidence is provided to the Quality & Safety team to confirm completion. Implementation is then monitored by tracking incidents, near misses and issues/concerns reported on Datix.

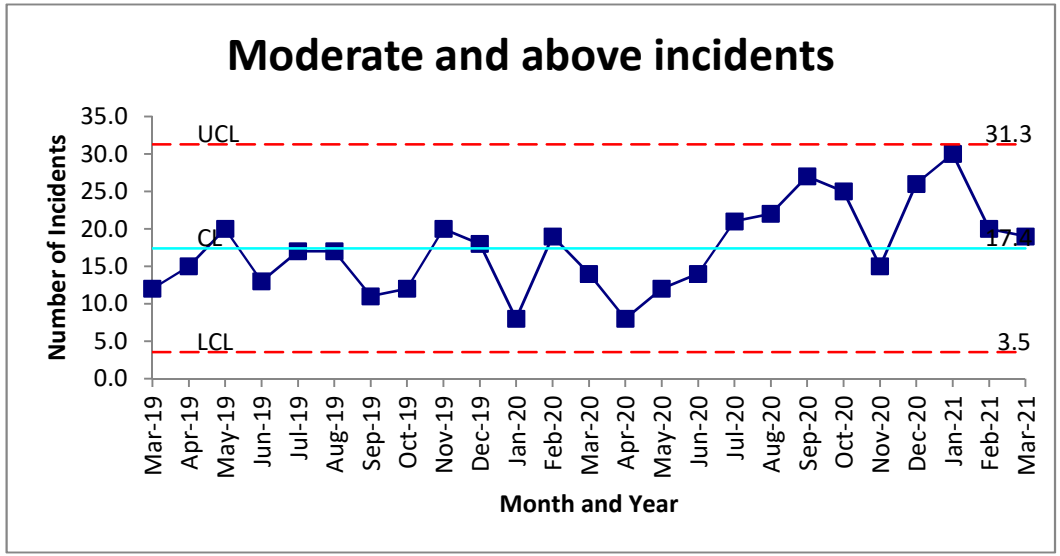
The Trust regularly meets with commissioners to review SI action plan evidence to provide assurance of delivery on an individual case basis in addition to collectively identifying common themes in quarterly contractual reports.

4a All Incidents by Severity (24 Month SPC Data)









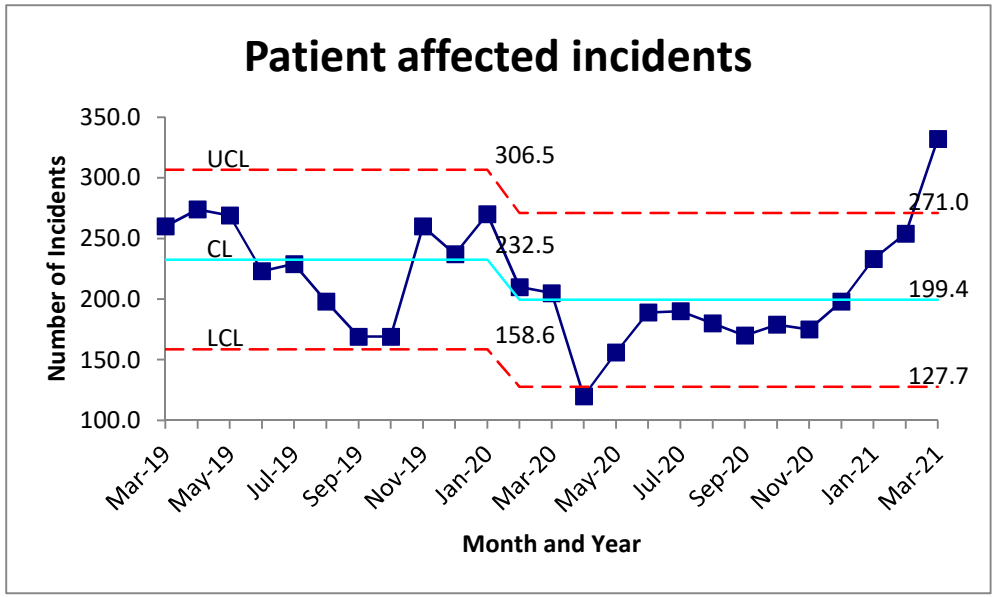
All Incidents - SPC Data Narrative

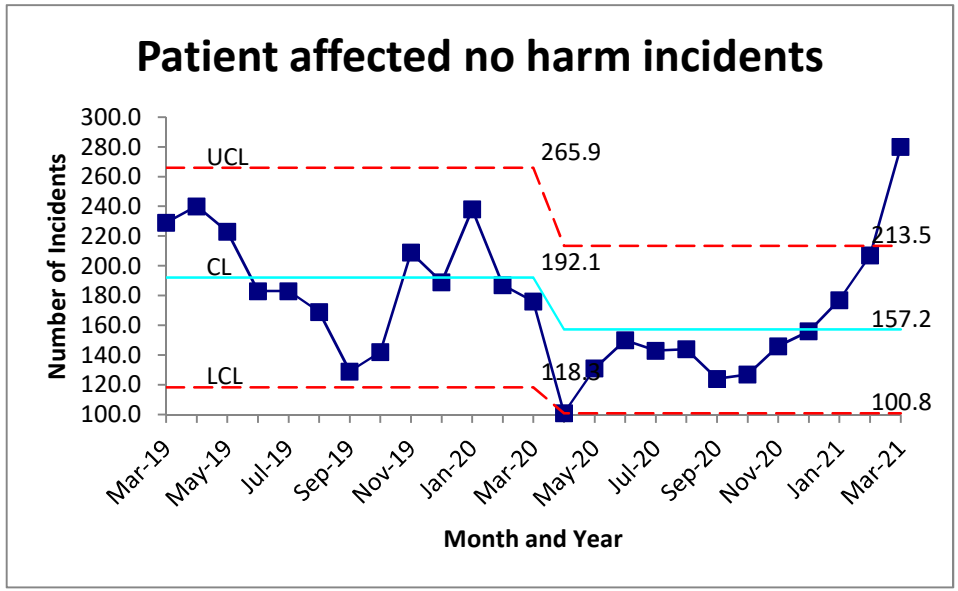
Minor harm incidents remain within normal limits throughout Q3/Q4, with an artificial rise shown in no-harm incidents which is attributable to coronavirus vaccine reaction reporting and a new process for identification of faulty staff uniform items. There has been an increase in moderate and above incidents during the reporting period reflecting the increased service pressures.

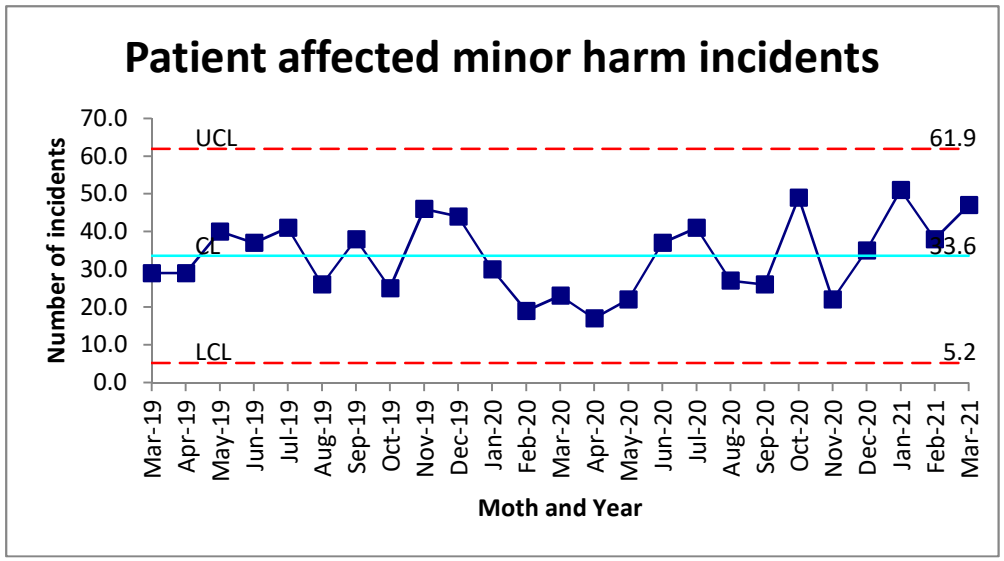
4.1 The chart below shows a breakdown of incidents and near misses reported within each service line across Q3/Q4 2020/21.

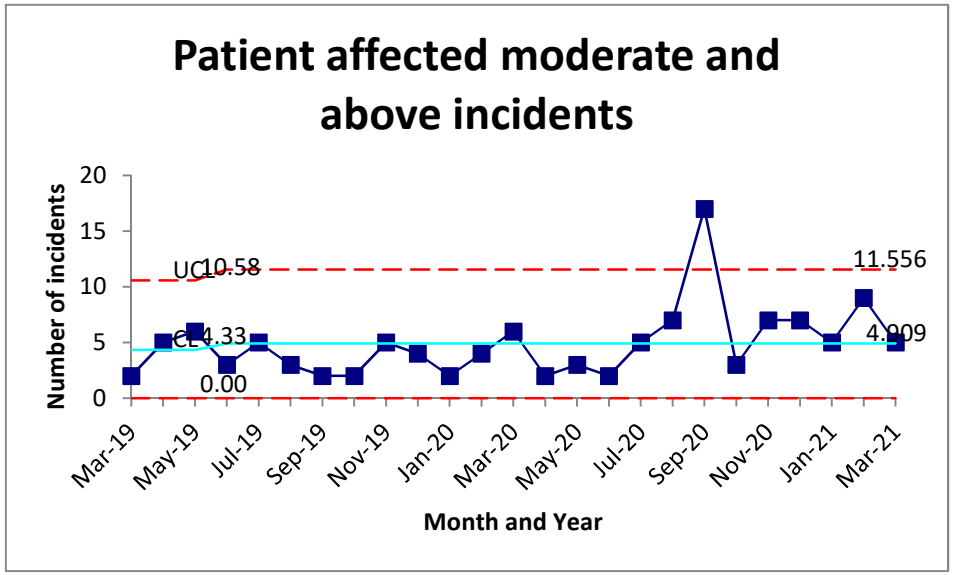
	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	**Total**
Integrated Urgent Care (IUC)	50	56	86	117	92	80	481
Patient Transport Service (PTS)	115	99	99	145	112	96	666
Performance, Assurance and Risk	1	5	4	2	4	4	20
Safeguarding	188	109	155	176	206	213	1047
Quality and Nursing	5	3	5	1	30	41	85
Business Intelligence	1	0	1	0	0	0	2
Estates and Facilities	1	1	0	0	1	3	6
Finance	5	1	2	0	0	0	8
Fleet	11	9	8	8	4	10	50
Procurement and Logistics	2	1	0	0	1	0	4
Ancillary Services	1	1	1	0	2	4	9
Resilience and Special Services	11	9	12	15	7	8	62
A&E Operations	598	508	573	616	476	548	3319
Emergency Operations Centre (EOC)	25	21	32	77	65	26	246
Education and Learning	1	1	2	3	1	2	10
Corporate Communications	0	1	0	0	0	0	1
Information Technology (ICT)	0	2	3	1	1	0	7
West Yorkshire Medic Response Team	0	1	0	1	0	0	2
Workforce and OD	0	1	1	2	2	0	6
Legal Services	0	0	2	1	1	2	6
Patient Relations and Experience	0	0	2	1	2	0	5
Total	**1015**	**829**	**988**	**1166**	**1007**	**1037**	**6042**

4b Patient Related Incidents by Severity (24 Month SPC Data)









Patient Related Incidents - SPC Data Narrative

Minor / Moderate and above incidents remain within normal expectation throughout Q3/Q4, there has been an increase in the total number of patient related incidents overall during the reporting period which are mainly categorised as no harm and reflect the increased service pressures.

4.2 Within the patient affected incidents, the highest category of incident reported is response related. Excessive response and back up continues to be monitored in real time in line with the following parameters:

Cat 1 – 15 mins+
Cat 2 – 50 mins+
In addition to:
Hot transport as recorded code following exit of scene.

4.3 During Q3, comprehensive review of excessive cases was completed, including clinical qualitative analysis of all reviewer comments and findings relating to further investigation work once any level of harm was established.

The analysis showed that the majority of potential harm for patients where there was a response time beyond the agreed threshold was effectively mitigated by the Trust's clinical prioritization and other demand management processes.

The review also identified and number of learning points, including:

- A significant proportion have involved patients who have recently been discharged from hospital probably reflecting the increased pressure on other parts of the health and social care system during the pandemic.
- An impact on patients experiencing acute stroke symptoms – these patients totalled around half of all the identified cases for potential harm where the patient *may* have been impacted because of extended delays for ambulance service response due to a narrowing of the window of opportunity to provide definitive diagnosis and immediate hospital care.
- Trauma patients were identified as waiting longer for care in a number of cases identified and these patients experienced extended periods of distress and discomfort.
- Identified patients experiencing cardiac symptoms were found to have the potential for delay to conveyance to PPCI centres or appropriate acute receiving units for ongoing assessment and care.
- Elderly or compromised patients were identified in several cases as experiencing potential for poorer outcomes due to longer waits in cases of fall or trauma.
- A larger than usual number of patients had to wait longer for either pain relief or clinical intervention.

4.4 It should be noted that whilst there has been a clear impact on the experience of patients, our analysis at this stage does not identify a commensurate rise in Serious Incidents resulting in serious harm or death in the same period specifically involving excessive response.

The excessive response process is ongoing as part of the Trust's routine monitoring process. From Q4 the threshold for review was changed to 2 x the 90th Centile target based on the previous analysis of potential harm.

Safety Thermometer

4.5 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.

4.6 The safety thermometer ensures that frontline staff members are informed of the level of incurred harm in their patient group during care delivery for these 3 indicators. It supports the open and honest 'Just Culture' reporting for incidents and informs staff of the actions to take in order to prevent further incidents. There has always been an acknowledgement that as we raise awareness of these incidents the number of cases reported may increase; however having now run the Patient Safety Thermometer for nearly ten years it is likely that we have reached an average baseline from which we can work to reduce these incidents, thereby reducing harm to our patients.

4.7 YAS is aligned to the National Patient Safety Strategy (2019) and Patient Safety Specialists have been identified as patient safety experts, providing dynamic, senior leadership, visibility and support. In addition, they will support the development of a patient safety culture, safety systems and improvement activity external training is still ongoing.

4.8 Falls, injuries and medication errors make up a small proportion of reported patient related safety incidents, with rates being consistently below 0.05% harm. There is however patient harm that Yorkshire Ambulance Service has zero tolerance for. This has been aligned to the Clinical strategy and the zero avoidable harm work plan has been established spanning 2018-2023.

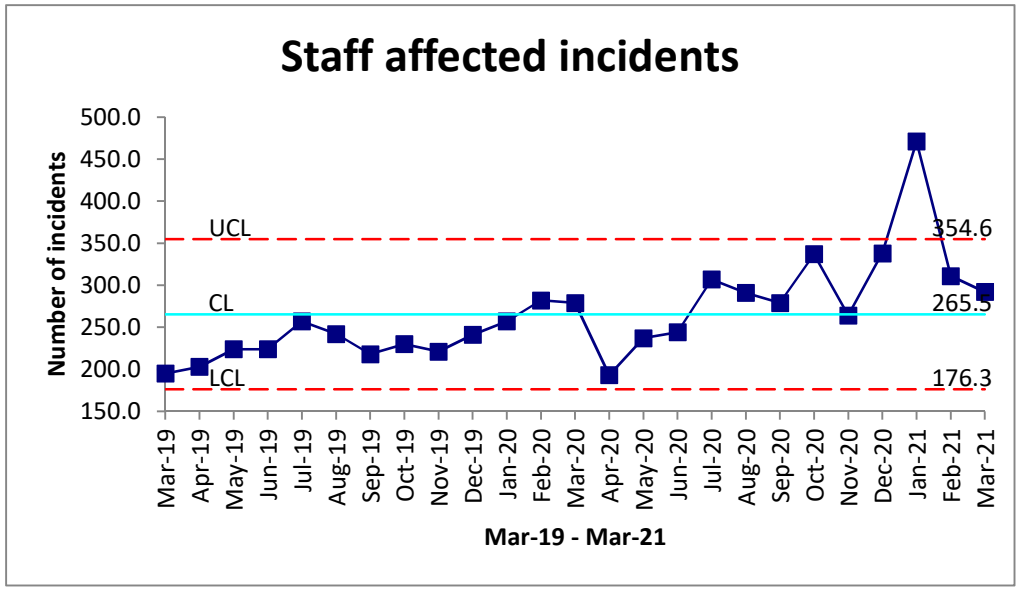
Table 1: Current Safety Thermometer data A&E Service: **YTD 2020-21 Q4** and annual comparison of identical quarters previously.

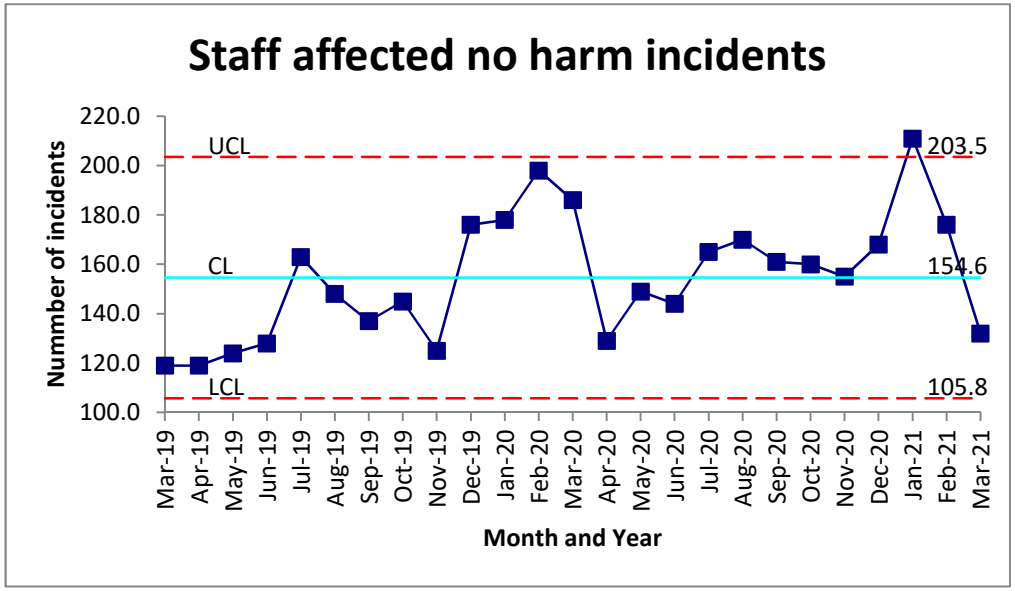
Incident Category	A+E Incidents 2017-18 Q4	A+E Incidents 2018-19 Q4	A+E Incidents 2019-20 Q4	A+E Incidents 2020-21 Q4
Falls	2	2	1	9
Injuries	14	14	12	59
Medicine	5	5	7	39
Total	21	21	20	107

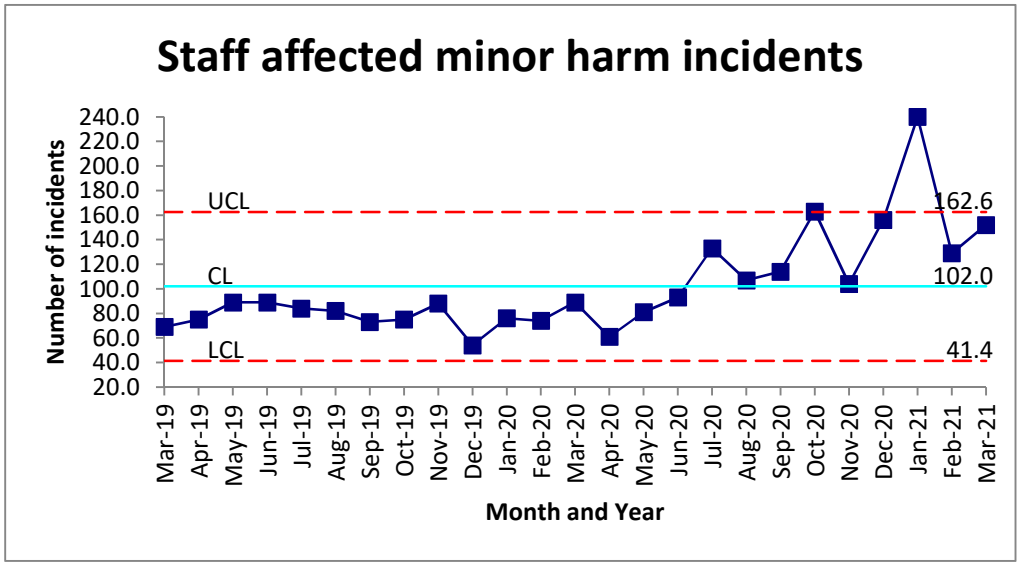
4.9 The increase of incidents reported in Q4 directly correlates to the number of incidents and issues related to the pandemic which was on an upward trajectory in Q4 2633 19-20 and 2937 in Q4 20-21.

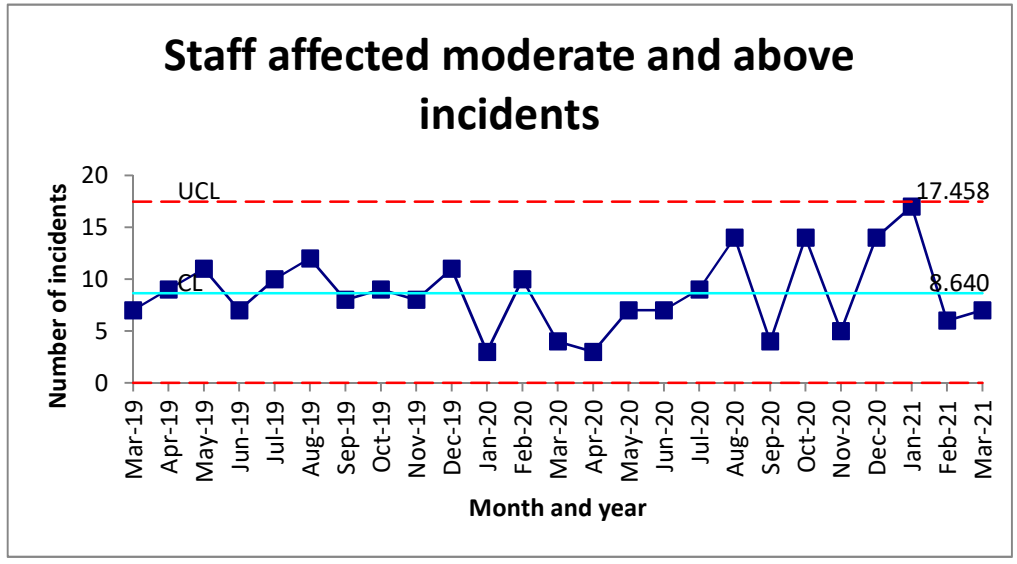
4.10 In addition to this the Quality & Safety Team increased their DATIX call taking capacity and times to provide an enhanced service which may have helped to increase reporting rates.

4c Staff Affected Incidents by Severity (24 Month SPC Data)







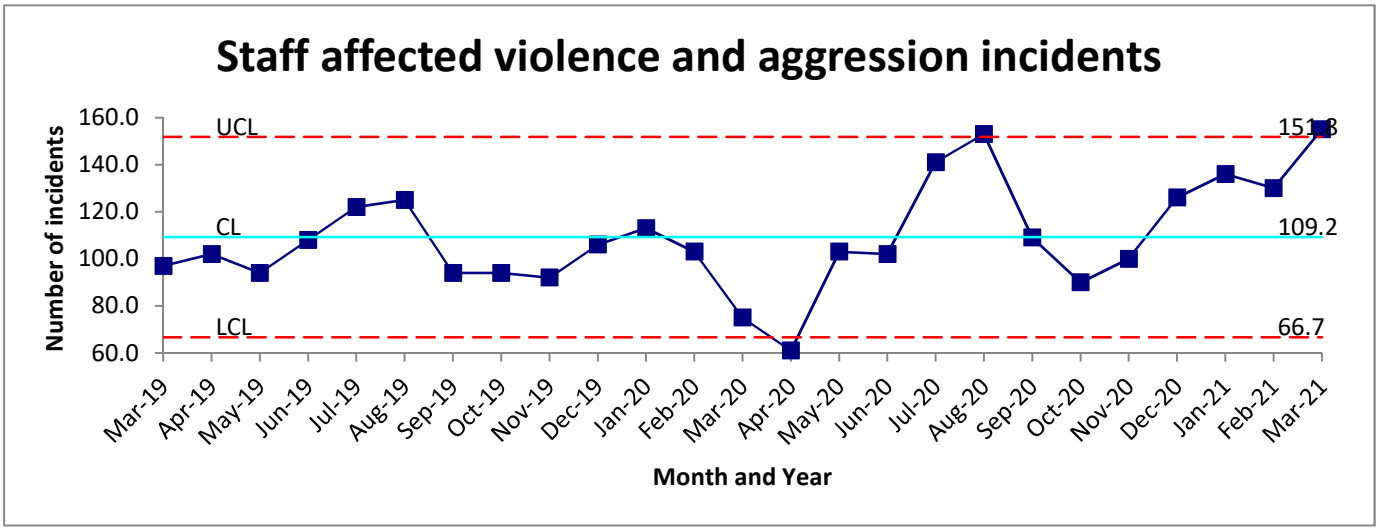


Staff Affected Incidents - SPC Data Narrative

Minor harm incidents remain within normal limits throughout Q3/Q4, as previous charting - an artificial rise shown in no-harm/minor incidents is attributable to coronavirus vaccine reaction reporting and a new process for identification of faulty staff uniform items. Moderate harm and above incidents relating to staff remain within expected tolerance however increases in staff reporting incidents involving violence and aggression has seen some rise during this quarter and is discussed below.

Staff Affected Incident Themes

4.11 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.

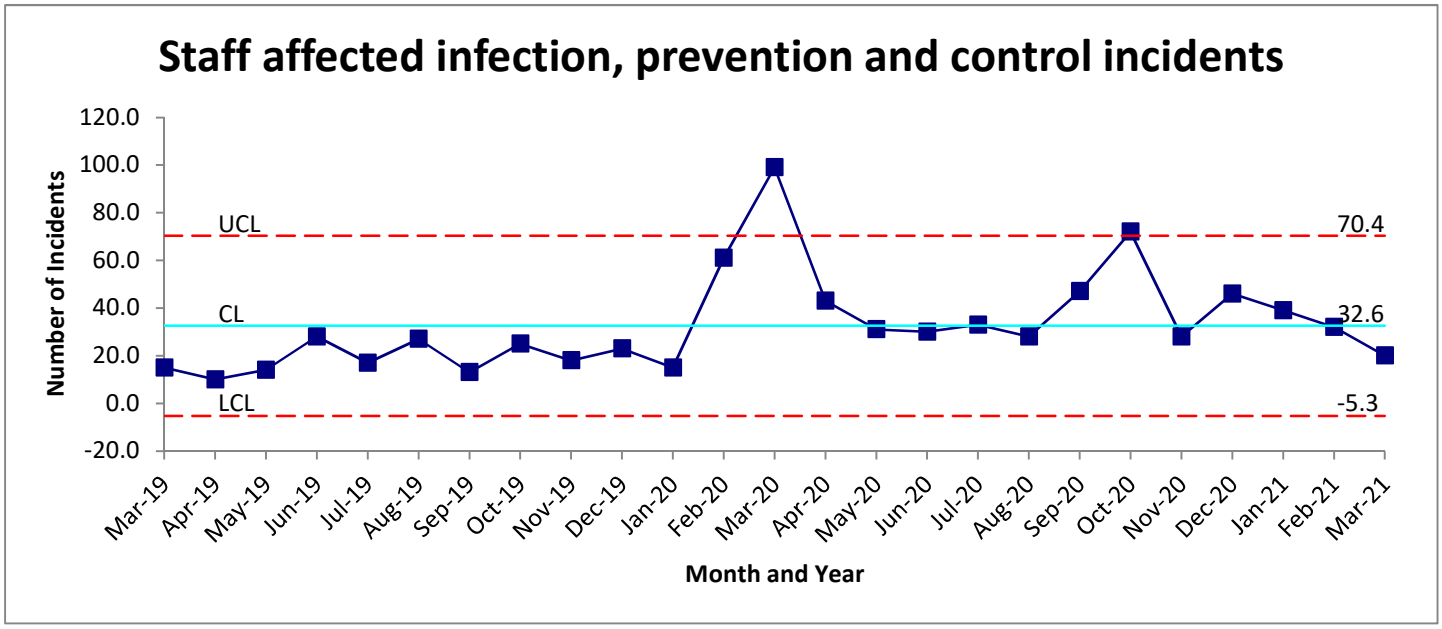


4.12 Unlike the first half of the year where cases were noted as affecting call handling staff in all settings, the majority of concerns during Q3/Q4 related to violence and aggression following or during interactions with patients or relative on scene, both by A&E and PTS colleagues. The Trust has recently announced that we are taking part in a national pilot of body worn video cameras in A&E Operations to assess the impact these have and has strengthened processes to support staff if they are a victim of violence and aggression whilst at work.

4.13 The Trust safer responding group meets regularly to discuss areas of concern and learn from staff reporting. A concise review of incidents reporting during Q3/Q4 involving unplanned restraint of patients during a challenging scenario is underway and expected to be completed during Q1 21/22.

4.14 YAS continues to work collaboratively via the National Ambulance Security Group, and regionally at the Yorkshire and Humber Region Security Managers group, to share good practice and lessons learned and to understand the future direction of security management in the NHS, however the regular meetings have been adversely affected by the demands of the COVID-19 Pandemic.

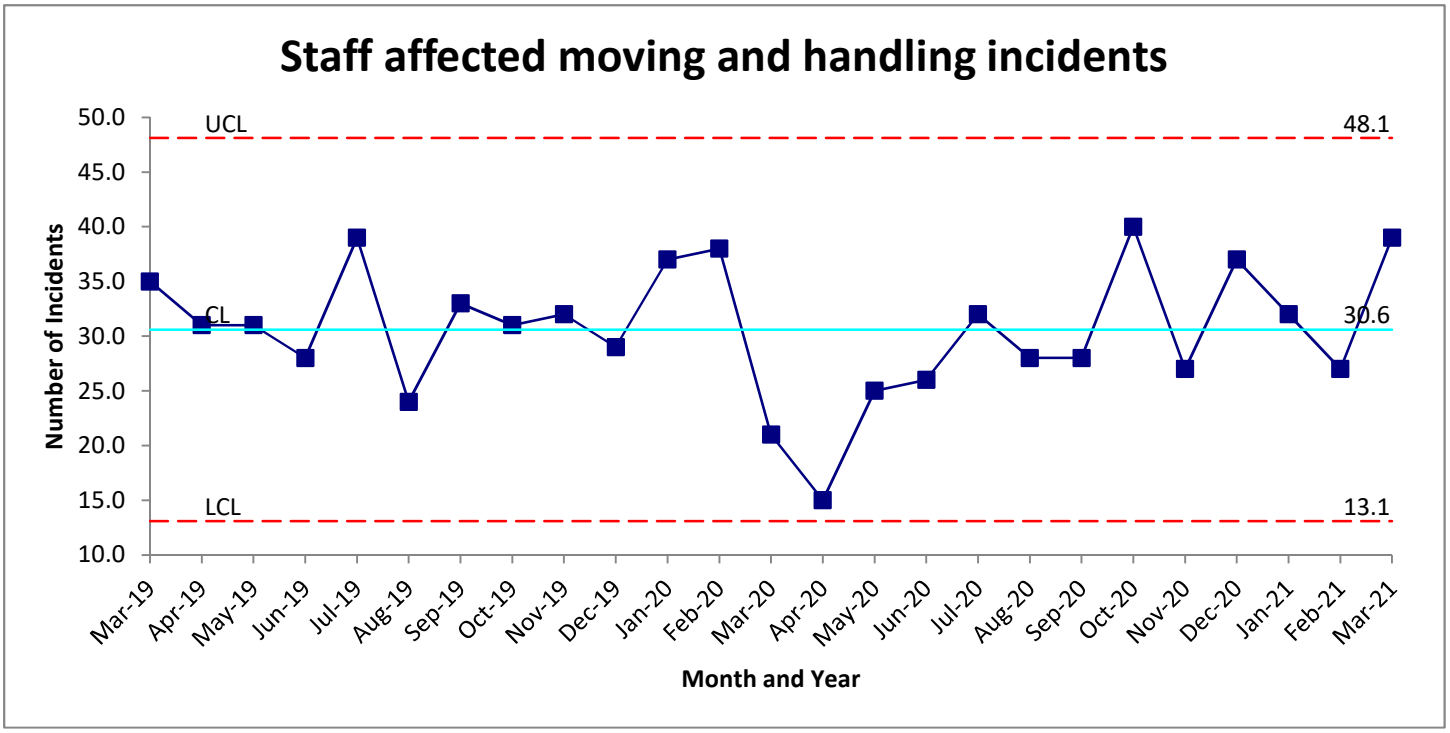
Infection Prevention and Control



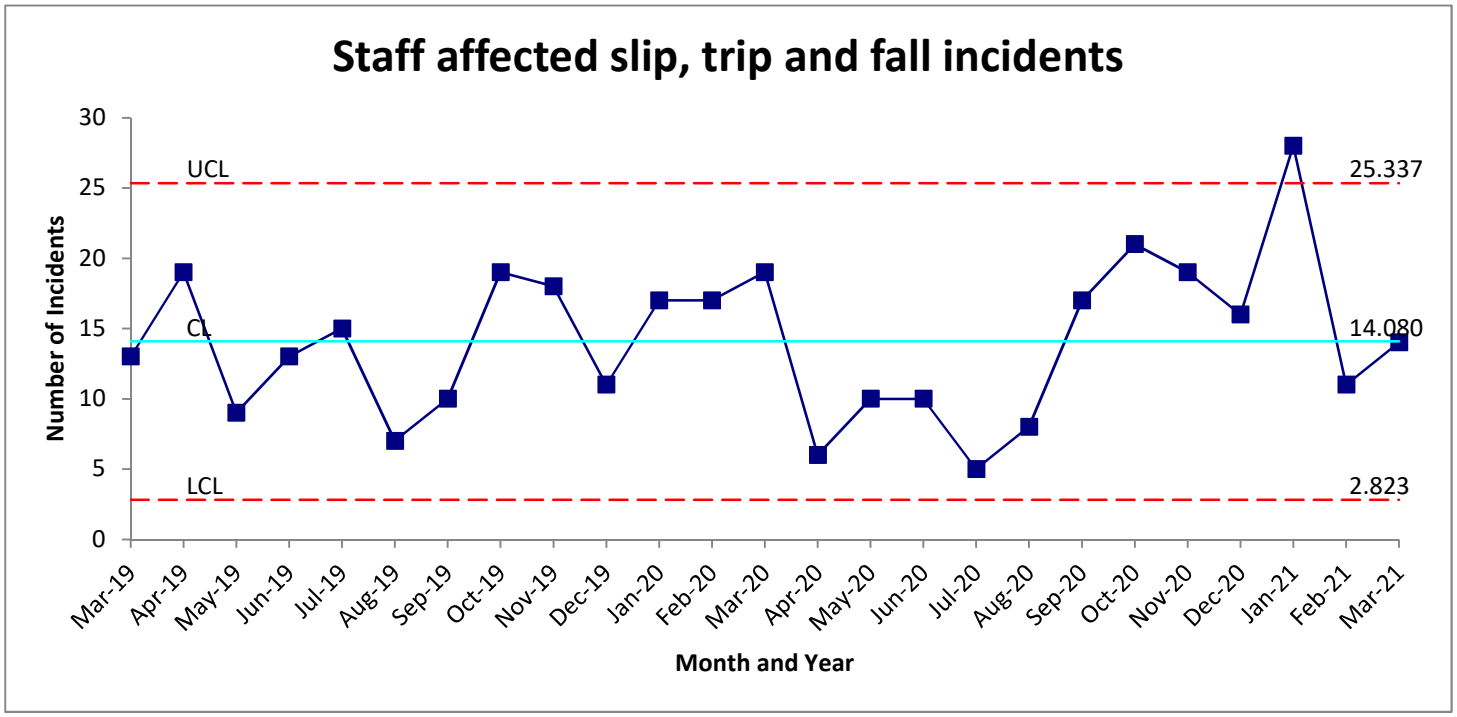
4.15 Following a steep increase in incidents at the start of the coronavirus pandemic and a similar peak during the second lockdown period, levels of reporting have returned to expected normal with an encouraging downward trend noted throughout Q4.

4.16 Infection prevention and control remains a key process in the Trusts response to the challenges of managing the novel coronavirus pandemic and colleagues involved in these processes are witnessing a welcome overall reduction in the resource required to manage new and emerging IP&C challenges across the Trust.

Moving and Handling



4.17 Staff affected moving and handling incidents remain within expected levels throughout Q3 & Q4, with slip, trip and fall data showing a slight increase towards the start of the new year and falling to expected levels during the quarter.



5. COMPLIMENTS, COMMENTS, CONCERNS & COMPLAINTS

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

	Oct-20	Nov-20	Dec-20	Jan21	Feb-21	Mar-21
A&E	72	61	59	69	50	80
EOC	55	40	35	19	18	29
PTS	47	44	40	35	39	58
IUC	38	64	54	38	25	54
Total	**212**	**209**	**188**	**161**	**132**	**221**

5.2 The most prominent theme in patient complaints relates to delays in care. Another key theme relates to communication and behaviours with patients. Analysis of these complaints highlights a number of factors and a deeper analysis is being prepared to inform future support and development.

Complaint and concern response timescales are monitored and reported against achievement of the timescales which have been agreed with the Complainants. The target is 85%. Performance as measured at the beginning of Q3 was at 94% for the whole of the Trust. Performance in A&E services was 94% in November and PTS was 93%. IUC achieved 73%

Ombudsman Concerns

5.3 During Quarters 3 & 4 there has been no contact from the Parliamentary and Health service Ombudsman (PHSO).

Compliments

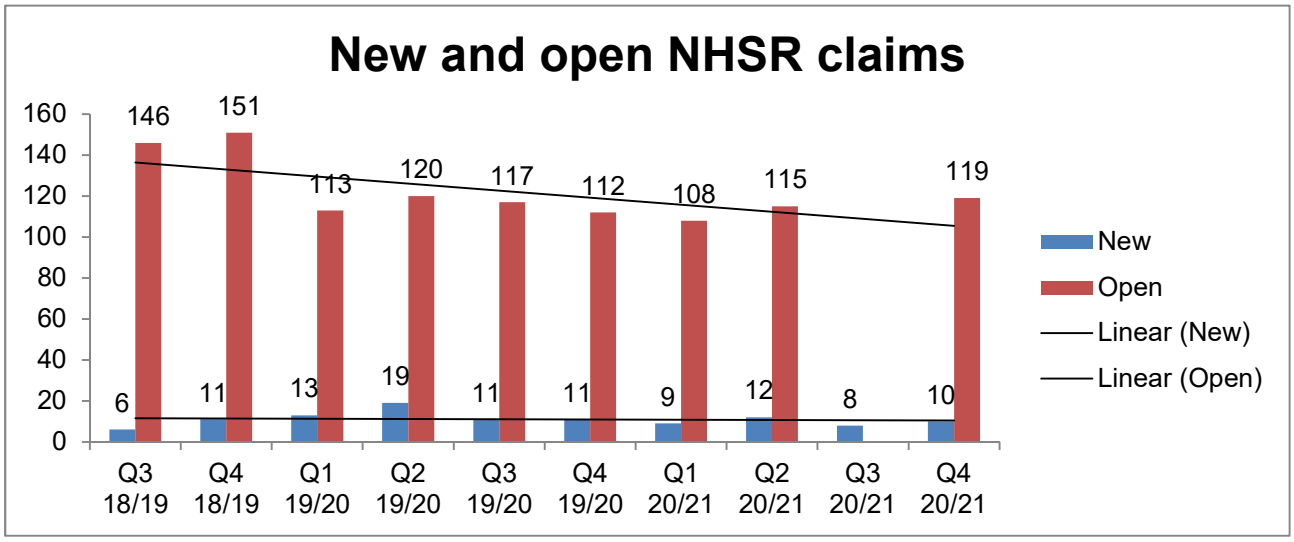
5.4 The table below shows the number of compliments received for each service line during Q1 and Q2.

	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
A&E	85	82	113	111	107	95
EOC	1	0	2	0	2	3
PTS	2	2	6	1	5	4
IUC	3	9	7	5	4	5
Total	**91**	**93**	**128**	**117**	**118**	**107**

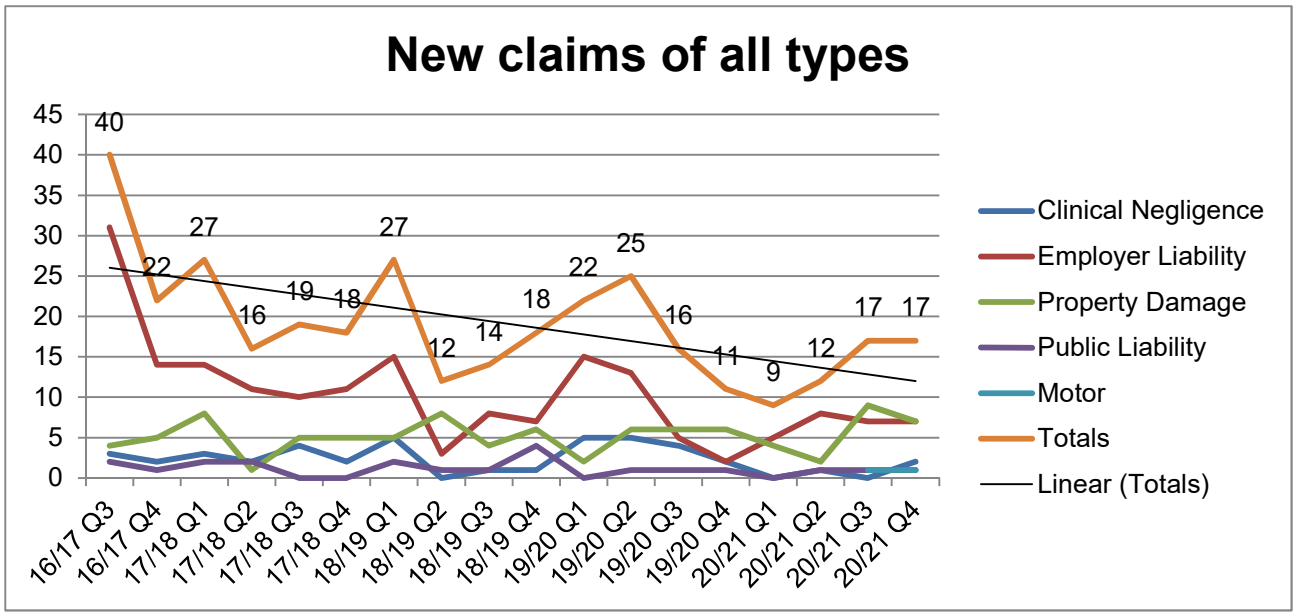
6. LEGAL SERVICES

Claims

6.1 There are currently 119 open claims against YAS that have been reported under the NHS Resolution Insurance Schemes. During Q3 and Q4, 8 and 10 new claims were reported, respectively. The graph below shows the total amount of claims for Q3 and Q4 which demonstrates a slight increase from the previous recorded quarter which was Q2. Unfortunately, due to the way the data is recorded, it is not possible to note the open claims at the end of Q3.



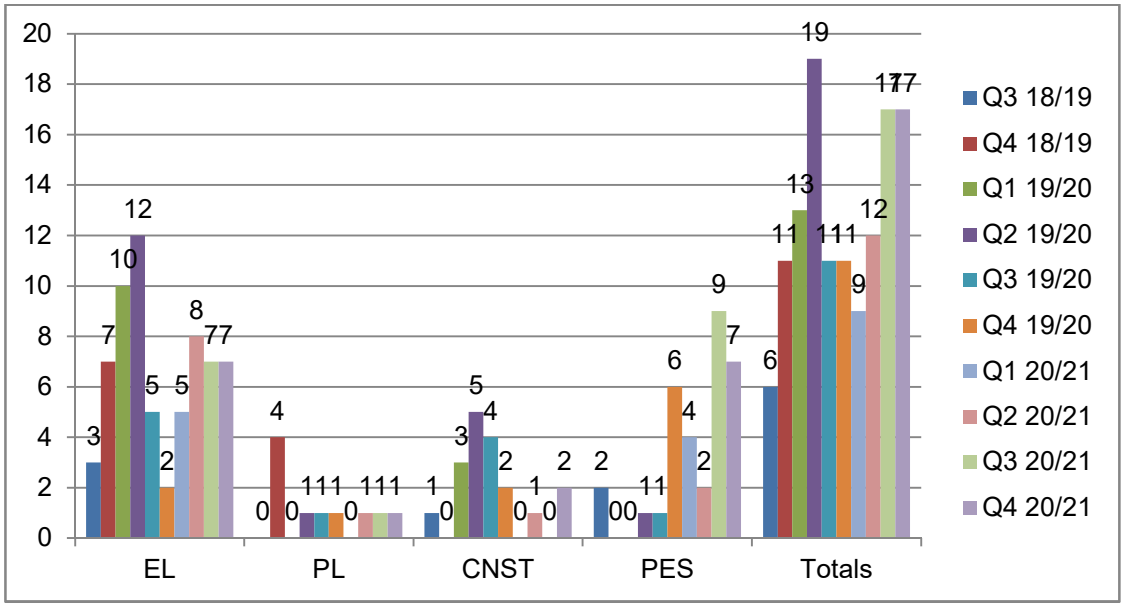
6.2 The graph below shows the number of claims received by the Trust from Q3 2016/17 to date – please note that the figures below include non-NHSR policy claims (such as property claims and motor insurance claims).



6.3 As can be seen, the number of claims received has dropped significantly from the highest amount received, which was in Q3 2016/17 (n=40). The small dip and then increase/maintain from Q2 to date is believed to be an effect of the ongoing COVID-19 pandemic.

New Claims

6.4 The below graph details the new claims that have been received from Q3 2018/19 to date by type.



Employer Liability (EL) Claims

6.5 14 employer liability claims were received in the last two quarters (seven in both), a decrease from the previous reported quarters. The highest three categories within employer's liability claims remain within the same triumvirate however Trust vehicle related is now the largest (n=24), followed by moving and handling (n=21) and then slips, trips and falls (n=18). This quarter has seen a slight increase in this triumvirate, which was seen in previously reported quarters.

6.6. The Trust has received two employers' liability claims relating to COVID-19 in the two quarters covered by this report. Both claims are pursuant to the disease and illness pre-action protocol and are currently being investigated.

Clinical Negligence (CN) Claims

6.7. Two clinical negligence claims were received in the last quarter, and once again these continue to be in a low number compared to the employer liability claims. There are currently 28 open claims with the highest proportion of these being related to clinical care (n=24), with a very small proportion relating particularly to the response of the organisation (n=4) and a sole moving and handling category. The largest sub-category of clinical care is incorrect / inappropriate treatment (n=11) followed by inadequate / incorrect clinical assessment (n=4) and the other sub-categories having single to double claims therein.

Public Liability (PL) Claims

6.8. There was one new public liability claim received in Q3 and one received in Q4. These claims continue to remain low in volume and there are currently 13 open claims. The categories contained within this profile are similar to employer liability claims; namely moving and handling (n=6) followed by slips, trips and falls (n=4) and others.

The categories have remained the same from previously reported quarters.

Risks

6.9. The turnaround of obtaining documents and evidence of investigations back to the insurers (NHSR) within the allocated timescale as outlined within the policy remains as previously reported, the biggest challenge for Legal Services departmental staff. However, the increased use of the Claim Strategy Meetings are providing effective and have shown a reduction in the e-mail traffic and better coordination at source. This new process is reflected in the Claims Management Policy which is being reviewed and ratified at the time of writing.

6.10. Monthly meetings continue to take place between the Health and Safety & Legal Services Managers, and this provides additional support to non-clinical claims by way of advice which continues to prove useful in terms of identifying both current and future risks which need managing and actions agreed. The Legal Services Manager is now attending Divisional Management Group ("DMGs") for all CBUs to report on claims, inquests, police requests and fines. Appearances at the DMGs has assisted in being a vital link between A&E Operations and the Legal Services Department.

6.11. Action on risks pertaining to working practices surrounding the familiarisation training pertaining to vehicles and equipment is continuing with pace, with the Legal Services Manager taking the lead on this approach. The filming for the bite-size videos has been completed and they are currently in post-production. The Legal Services Manager will be attending the non-clinical training meeting in due course to present the change form to take this project further.

Coroner's Inquests

6.12. The ongoing COVID-19 pandemic affected the coronial services within England and Wales considerably with nearly all inquests being postponed during the early stages of the pandemic. As the pandemic continues and as restrictions ease, the department has seen a dramatic increase in the number of listed inquests. These have culminated in a grouping of large scale and long-running inquests being listed at the very end of Q4. Although expected, this has placed the department under increased pressure to arrange representation at inquests with either the Trust Solicitor, Legal Services Manager or Legal Services Coordinator (Coroners) attending in person or remotely.

6.13 During the pandemic, the Trust set up dedicated hearing rooms at both Ambulance Headquarters (Springhill) and Beverley Ambulance Station. These two locations have allowed witnesses to attend to give their oral evidence remotely. The technology at both locations has been perfect to meet the needs of the court and to the satisfaction of HM Coroner along with reducing the anxiety and apprehension for staff members giving evidence at inquests. Although it is not possible to quantify how the coroners service shall operate in a post-COVID world, it is hoped that remote evidence giving will become routine and not by exception.

6.14. At the end of Q2, there were 267 open inquest cases (on DATIX, notwithstanding any legacy cases which are spreadsheet based) which is a dramatic reduction as to the amount of open inquest cases at the end of Q2 (n=932).

This was due to proactive enquiries made with HM Coroners offices to see whether cases were still ongoing and a change in internal processes by keeping open cases where statements have been provided and closing at source any 'standard' requests for documents only. The highest number of open cases originated from HM Coroner for Hull & East Riding of Yorkshire (n=111) followed by HM Coroner for West Yorkshire Western District (n=46) and HM Coroner for South Yorkshire Eastern (n=34). There are a number (n=2) of cases outside of Yorkshire and the Humber.

6.15. During Q3 the Trust has received 295 new requests, which was around the same as the previous quarter. The largest amount received was from the Coroner for West Yorkshire Eastern District (n=78) followed by the Coroner for North Yorkshire (excluding City of York) (n=72). During Q4, the Trust received 297 requests. The largest amount received was from the Coroner for North Yorkshire (excluding City of York) (n=97), followed by Coroner for West Yorkshire Eastern (n=65). The Trust and provided evidence (written and/or oral) at 53 inquests in Q3 and 52 in Q4, which is a considerable increase than previous 'pandemic' quarters.

6.16. Out of the 53 inquests heard in Q3 where oral or written evidence was adduced, three were rated amber and two were rated as red (due to being serious incidents). The amber cases included a patient who was at 'end of life' and who called both NHS 111 and 999 due to worsening symptoms after being advised by a local acute Trust to do so, a patient who had been reported missing to the local police and a patient in a care home where different questions should have been asked during telephone triage. The red cases included a young child with complex health needs who called NHS 111 before becoming unresponsive and a patient with an allergy who was given medication before allergies had been confirmed. Out of the 52 inquests heard in Q4 where oral or written evidence was adduced, five were rated amber and another five were rated as red (due to being serious incidents). The amber cases included concerns regarding the destination of a patient once they had died, a patient who refused treatment after a significant overdose and a perceived delay to a GP urgent call for transport. The red cases included a patient who was discharged at scene with COVID-19 symptoms, a patient who was not immobilised and a pedestrian knock-down involving a Trust vehicle.

6.17. Each request is risk rated and those rated amber and above are reviewed through the Trust's Incident Review Group. Lessons and actions are identified and actioned through this group and disseminated as required.

Coronial Inquest Risks

6.18. The greatest risk at present is addressing the backlog of inquests which are held by the respective coroner districts within the Trust's geographical footprint. The end of Q4 and beginning of Q1 2021/22 has been particularly difficult with dates for inquest clashing with others. All suitable members of Legal Services Department staff are being utilised appropriately and external legal advice options are being explored (when required).

Prevention of Future Death (PFD) reports

6.19. One Prevention of Future Death report was issued to the Trust in Q3 following a long-standing coronial investigation, involving a death of a young patient with complex medical needs in January 2015.

In January 2015 YAS responded to a 999 call for the patient, a resident in a supported living facility, and following assessment the decision was made for this patient to remain at home as ongoing healthcare was already in place. Following an independent, multi-agency investigation into the events commissioned by NHS England, it was identified that although the decision was deemed appropriate, better safety netting could have taken place including a referral to the GP for a home visit the following day. Four days later, a further 999 call was received and the patient was transported to hospital but unfortunately passed away shortly afterwards.

6.20 The following recommendations were agreed upon and were implemented prior to the inquest taking place in November 2020:

- audit the quality of safety netting across the service to ensure onward referrals are being made where appropriate; and
- audit the referral of patients/quality of information sent to Primary Care for patient in residential homes following a non-conveyance.

6.21 Subsequent to the patient's death and prior to the inquest taking place, the Trust also implemented its Electronic Patient Record ("ePR") system which enables clinicians to record the rationale for their decisions and information provided to patients. The Trust also implemented a new method of providing tailored information and advice for patients, rather than generic leaflets.

6.22 Following the inquest, HM Coroner raised a new matter of concern relating to the potential for a mismatch between information recorded on the EPR and that given to patients when a PFD was issued to the Trust. The Trust is not aware of any specific evidence to indicate that this is a problem in practice, but it recognises the value of proactively auditing practice to ensure that it is consistent with the desired standards. The Trust will therefore be acting on the Coroner's recommendation and will schedule a programme of spot audits as part of its 2021/22 Clinical Audit Programme. These audits will be reported via the Clinical Governance Group and assurance provided to the Board through regular clinical governance and quality reports to the Quality Committee.

7. SAFEGUARDING ENGAGEMENT IN EXTERNAL STATUTORY SAFEGUARDING PROCESSES

7.1 During Q3 &Q4, YAS contributed to 9 Rapid reviews as an initial scope to determine threshold for a full Child Safeguarding Practice Review (CSPR). Two progressed to full CSPR, 19 Safeguarding Adult Reviews (SAR) and 11 Domestic Homicide Reviews (DHR). There has been a significant increase in the workload of the safeguarding team during the last two quarters.

7.2 Learning has been identified from the review processes undertaken for both children and adults has highlighted that work is needed to:

- Improve the identification of safeguarding and submission of safeguarding referrals in a robust and timely manner.
- Improve recognition of ineffective breathing in infants.
- Risk assessment and sign posting for support for Domestic Abuse victims.

7.3 No specific Covid-19 related learning has yet been identified from the reviews undertaken although an increase in Domestic Abuse nationally would corroborate the spike in case discussions locally where Domestic Abuse is a factor.

7.4 Safeguarding level 2 training was specifically focused during Q3 &Q4 to increase compliance. This spotlight approach has raised awareness with managers not only for staff that need to complete training now but considering the trajectory over the coming six months of staff who will become non-compliant.

7.5 Considering additional pressures placed on Yorkshire Ambulance Service from both Covid19 and Q3 representing the start of winter pressures and increased demands on frontline services, the compliance rates are a testimony to both staff and managers commitment to training.

7.6 Electronic referrals became live in A&E operations (children, adults and social care assessments) and 111 (children only at present) during Q3, with some clear evidence of time efficiency for both the production of referrals at source directly by the clinician and the length of time taken for these to reach social care.

8. PROFESSIONAL BODY REFERRALS (PBRs)

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

8.2 There are currently four ongoing cases logged on the professional registration log. Two cases have been referred by the Trust to the referring body in 2018/2019, one case in 2020 and one case in 2021 and all are awaiting a final decision by the referring body.

9. CLINICAL CASE REVIEWS (CCRs)

9.1 The predominant theme from CCRs this year is lack of shared decision making, inadequate safety-netting, lack of understanding of and adherence to the Montgomery ruling principles and documentation.

9.2 A number of actions are being taken:

- Patient Care Record completion guidance document being updated
- Montgomery principles to be included in the clinical refresher for 2021/2022.
- Safer Right Care, Right Place project initiated with workstreams including:
    - Structured Assessment
    - Decision Making
    - Training and Education
    - Clinical Supervision and Leadership
    - Urgent Care Pathways
    - Technology
    - Critical and Emergency Care
- Options are being explored to provide all frontline clinicians with approved educational texts pertinent to history taking, physical examination and systems-based assessment.

10. INFORMATION COMMISSIONER'S OFFICE (ICO) NOTIFICATIONS BC?

10.1 During this period YAS did not receive any notifications from the ICO in relation to Freedom of Information or subject access requests under the Data Protection Act 2018.

11. HEALTH & SAFETY EXECUTIVE (HSE) NOTIFICATIONS

11.1 On 20 November 2020 the Trust received a query from the HSE regarding the management of clinical waste at Bradford Ambulance Station. An allegation had been made to the HSE as follows:

"We are experiencing long delays in the collection and disposal of clinical waste from Bradford Ambulance Station. Bags are often not tagged and sealed by staff. Bins are full and therefore bags are left on the floor. Bins are not emptied or collected in a timely manner."

The Trust was asked to respond to the allegation and information was therefore gathered from the Estates department regarding the situation at Bradford.

A response to the HSE was submitted on the 30th November which detailed the Trust's sudden increase in clinical waste generation due to the pandemic and the steps that were being taken to manage that including the provision of additional waste bins and more frequent collections.

Details were also provided of a quality improvement project, on trial at Bradford ambulance station at the time, which included the use of an app for staff to report clinical waste issues.

The HSE were satisfied with the response and no further action was taken.

11.2 On the 19th January 2021 the Trust received a query from the HSE regarding the deep cleaning of ambulances at Bradford Ambulance Station. A concern had been raised with the HSE as follows:

"Staff are cleaning ambulances that have been carrying known and suspected COVID cases, wearing full PPE including hazmat suits and BA adjacent to people working in the workshop with no protection at all. Someone in the workshop has raised this, but nothing has been done to allay his concerns or reduce the risk"

The Trust was asked to look into the concern and information was therefore gathered from the Ambulance Vehicle Preparation (AVP) Manager and IPC Lead.

A response to the HSE was submitted on 28th January 2021 which detailed the findings of an investigation into this concern. It was apparent that the Trust was already aware of the individual's concerns regarding the cleaning of the ambulances and had addressed these on several occasions with the individual. Responses had been supplied through a number of channels including the Trust's Freedom to speak up process as well as via the Trust's Chief Executive.

In terms of the risk from the process identified by the individual, the Trust's AVP Manager carried out a full review of the vehicle cleaning and spoke with both the IPC team and also the supervisors for the cleaners. Following the review, it was noted that vehicles requiring the deep clean were not always being moved to the designated area before cleaning commenced. This was therefore addressed by the AVP Manager.

The HSE were satisfied with the response and no further action was taken.

12. DUTY OF CANDOUR (BEING OPEN)

12.1 The Trust communicates openly 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.

12.2 During Q3 and Q4 2020-21 the Trust has applied a being open process to 42 cases. Overall, positive feedback has been received in relation to the processes in place across the Trust with families thankful of the transparent approach.

12.3 Families have been able to identify the best way to engage during times of social distancing and most have opted for video conferencing however during Q4 it was possible in collaboration with GP Surgeries to meet families once again in person with social distancing in place and to discuss findings with them. This has been very well received and the Trust plans post May 2021 and relaxation of further restrictions, to encourage families to meet with colleagues involved in investigation face to face rather than via digital methods as this brings the greatest opportunity for questions to be answered in a supportive environment.

13. FREEDOM TO SPEAK UP

13.1 "*Freedom to Speak Up: An independent review into creating an open and honest reporting culture in the NHS*" (Francis) was published in February 2015. The aim of the review was to provide advice and recommendations to ensure that NHS staff feel it is safe to raise concerns, confident that they will be listened to and the concerns will be acted upon. FTSU promotes and encourages the raising of concerns from NHS workers, sub-contractors and volunteers. This is to ensure that patients and staff safety is maintained at all times and to make the health service a better place to work.

13.2 The Trust continues to receive concerns reported through the Freedom to Speak Up process via the Trust's Guardian and Advocates. The FTSU Guardian is supported by 12 FTSU Advocates spread geographically across the Trust and all service lines.

13.3 During Q3 and Q4 2020/21, 50 concerns were raised via this process. The largest proportion of these were from A&E operations, with smaller numbers reported from other operational areas, support services and corporate functions.

13.4 On reviewing the subject matter of all concerns raised during this reporting period, there is a new theme relating to concerns relating to processes around management of Covid-19 within the Trust and these issues were addressed contemporaneously with support from the Infection Prevention and Control team.

13.5 The subjects of other concerns raised are detailed in the Freedom to Speak Up report. A general theme relating to issues of leadership and team culture is evident across a number of concerns and in addition to action in response to the specific concerns raised, the Trust is taking forward more generalised learning and action in this area.

13.6 The progress of all concerns raised through the FTSU process is discussed at a fortnightly FTSU review meeting attended by the Chief Executive, the Executive Director for Quality, Governance & Performance Assurance, the Head of Employee Relations, the Head of Investigations and Learning and the FTSU Guardian. It is felt that this approach ensures that any barriers or issues experienced by the FTSU Guardian when progressing concerns can be addressed quickly and appropriately. Moreover, this approach ensures senior leaders have greater visibility and understanding of the concerns being raised through FTSU.

14. PROPOSALS/NEXT STEPS

14.1 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.

15. RISK ASSESSMENT

15.1 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.

16. RECOMMENDATIONS

16.1 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.