NHS
Yorkshire
Ambulance Service
NHS Trust

MEETING TITLE Trust Board (held in Public)		**MEETING DATE** 01.11.2022	
TITLE of PAPER	Significant Events and Lessons Learned Q1 22/23.	**PAPER REF**	2.3
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	This report provides the Trust Board with an update on significant events highlighted through Trust reporting systems and by external regulatory bodies and provides assurance on actions taken to effectively learn from adverse events.		
For Approval	☐	**For Assurance**	☒
For Decision	☐	**Discussion/Information**	☒
AUTHOR / LEAD	Simon Davies, Head of Investigations and Learning. Dave Green, Interim Associate Director of Quality & Safety	**ACCOUNTABLE DIRECTOR**	Clare Ashby, Interim Executive Director Quality Governance & Performance Assurance
DISCUSSED AT / INFORMED BY: – Quality Committee 22.09.22; Board (held in private) 27.09.22			
PREVIOUSLY AGREED AT:	**Committee/Group:** Quality Committee Trust Board	**Date:** 22.09.22 27.09.22	
RECOMMENDATION(S)	It is recommended that the Trust Board notes the current position and is assured in regard to the effective management of, and learning from, adverse events.		

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)	1: Safe 2: Effective
NHSI Single Oversight Framework Choose a THEME(s)	2. Quality of Care (safe, effective, caring, responsive)

Board of Director Meeting
(held in Public)

1 November 2022

Significant Events and Lessons Learned Q1 22/23

Report of the Interim Executive Director Quality Governance & Performance Assurance

1. PURPOSE/AIM

1.1 This report provides the Trust Board with an update on significant events highlighted through Trust reporting systems and by external regulatory bodies and provides assurance on actions taken to effectively learn from adverse events.

2. BACKGROUND/CONTEXT

2.1 This report primarily covers the period 1 April 2022 to 30 June 2022. On occasions thematic analysis covers longer time periods as specified within the report to enable aggregation of data and identification of key themes and trends across a number of different inputs.

2.2 Specific sources of significant events and lessons learned within the scope of this report include:

- Serious Incidents reported to the Trust's commissioners
- Internal incidents reported
- Complaints – including requests received from the Ombudsman
- Claims
- Coroners Inquests – including Preventing Future Deaths received by the Trust
- Safeguarding Statutory Reviews, Safeguarding Adult Reviews (SAR) and Domestic Homicide Reviews (DHR), Child Safeguarding Practice Reviews (CSPR)
- Professional Body Referrals
- Patient Experience
- Health & Safety Executive notifications
- Duty of Candour (Being Open)
- Freedom to Speak Up

3. SERIOUS INCIDENTS (SIs)

3.1 The Trust has reported 15 SIs during this period.

3.2 Theme analysis tracked across Q1 shows the highest prevalence of SI reporting being attributable to delayed response.

3.3 Noteworthy themes for the quarter include continuation of high numbers of vehicle-related incidents and several incidents referencing clinical care

provision including challenges linked to skill fade, likely impacted by difficulties with providing update training on a regular basis during the pandemic and at periods where front line resource was prioritised over abstractions for training.

3.4 Incident reporting for Q1 totals 2,134 cases, of which SI reporting represents a percentage figure of 0.7%. This is slightly lower than Q4 and represents a very low percentage of the total, giving assurance that measures to manage and address lower-level incidents, including near-misses have a positive impact.

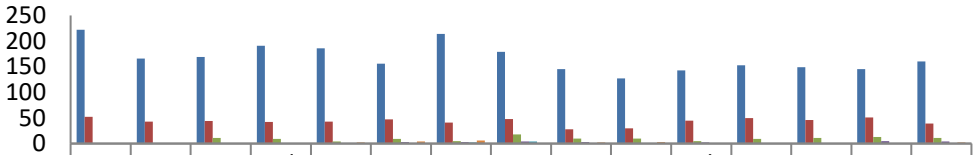
3.5 Investigations are ongoing for all cases reported during this quarter. Due to the pandemic and clinical colleagues being repositioned to support critical functions within the organisation, investigation work is taking longer than the statutory 60 days – this metric however has been suspended from the national SI Framework since May 2019 and the Trust is maintaining contact with families and relatives involved throughout any associated delays with updates where appropriate.

4. INCIDENT OVERVIEW

4.1 Pressure on patient-facing roles has continued in Q1 & Q2. Staff and patient incident reporting remains consistent with expectations and for the last two quarters, all patient-related incidents have remined below the median line.

4.2 The number of incidents reported on the Trust incident reporting system (RLDatix) that have affected patients in all categories by severity is shown below. The proportion of incidents coded moderate or above remains in line with previous quarters and gives assurance that YAS are acting on low level incidents to reduce the amount of higher severity incidents.

Patient Related Incidents by Severity April 2021 - June 2022



	Apr 2021	May 2021	Jun 2021	Jul 2021	Aug 2021	Sep 2021	Oct 2021	Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022	Apr 2022	May 2022	Jun 2022
No harm	222	166	169	191	186	156	214	179	145	127	143	153	149	145	160
Minor	52	43	44	42	43	47	41	48	28	30	45	50	46	51	39
Moderate	1	1	11	9	4	9	5	18	10	10	5	9	11	13	11
Major	0	0	0	1	1	3	3	4	3	0	2	0	0	5	4
Catastrophic	1	1	0	1	0	1	2	4	0	1	1	1	0	0	0
Catastrophic (Death caused by the Incident)	1	0	0	1	2	4	6	0	2	3	1	0	1	0	2

4.3 The highest reporting category for patient related incidents during reporting period was response related within EOC, IUC/111 and PTS.

4.4 The proportion of staff-related incidents coded moderate or above remains low and in line with previous quarters with higher numbers reported during the pandemic period as a result of peaks and troughs in increased demand on the service.

4.5 Violence and Aggression has remained in the top reported category of incident at YAS and continues to be the highest category of 'Affected Staff' incident overall.

Unfortunately, significant increases in reporting of cases of this type have been seen throughout the pandemic, however data suggests that levels are now stabilising. Work on conflict resolution training and the body worn camera pilot is likely to have a continued positive impact on reducing violence and aggression.

Quality Alerts (Service to Service - Outgoing Incidents)

4.6 In Q1 the Quality Alerts, following process review, are now sent within seven days of the incident being reported.

4.7 As part of this review we are also monitoring the number of responses received back to YAS from these alerts to measure if the change to approach to these means people are more likely to respond. If the alerts are issued closer to the incident, they may also be more likely to respond. For Q1 we have had a response of 37.2% from Quality Alerts sent out.

4.8 The number of Quality Alerts by service area for Q4 are as follows:

- IUC – 59
- PTS – 51
- A&E Operations – 204
- EOC – 20
- Support Services – 2

5. COMPLAINTS, CONCERNS, COMPLIMENTS AND COMMENTS (4Cs) and PATIENT EXPERIENCE

5.1 Tables A and B highlight the spread of 4Cs across the Trust for Quarter 1.

Table A

Complaints and Concerns received (Includes Service to Service issues raised)			
	April 2022	**May 2022**	**June 2022**
Call Handling & Dispatch	68	28	51
A&E Ops	46	59	70
PTS	30	48	56
IUC (111)	27	38	35
TOTAL	171	173	212

Table B

Compliments received			
	April 2022	**May 2022**	**June 2022**
Call Handling & Dispatch	0	1	1
A&E Ops	81	118	84
PTS	4	6	5
IUC (111)	4	3	3
TOTAL	89	128	93

5.2 Table C is an analysis to demonstrate the key issues associated with complaints and concerns (including service to service issues) raised in respect of excessive responses to emergency calls. This analysis is not reportable on cases received during the period as the outcome is unknown until the investigation has completed. Therefore, the data is displayed in relation to those cases closed during the quarter. A delayed response may be due to a number of reasons and therefore the number of reasons reported is greater than the number of cases upheld and partly upheld.

The higher than usual proportion of cases upheld due to EMD error and dispatcher error this quarter.

5.3 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%.

Current response rate performance is at 52% for the whole of the Trust. Performance in A&E services was 37% in March and PTS was 67%. IUC achieved 90%. This is an improvement on last quarter.

A&E Call Handling and Dispatch

5.4 The number of cases received for 999 call handling and dispatch has increased by 14% from last quarter but remain 27% lower than Q1 2020/21. There has been an increase in cases related to delayed responses and call handling of Category 4 calls.

5.5 The largest category of complaint across the Trust relating to 999 call handling and dispatch this quarter is delayed responses to Category 2 calls followed by delayed responses to Category 3 and IHT calls.

A&E Operations

5.6 Cases received for A&E Operational Services are at the same level as Q4 and are less than levels received in Q1 2020/21 (by19%). There has been a slight decrease in Attitude cases from last quarter whilst Operational cases have increased (by 25%) and Clinical cases have remained the same.

5.7 The largest category of complaint across the Trust for A&E Services continues to be Attitude and Communication Skills but very closely followed by Clinical Assessment.

Patient Transport Services (PTS)

5.8 Numbers of complaints received about the PTS Service in Quarter 1 are 14% greater than Quarter 4. There have been significant increases in cases about operational staff attitude, collected late from clinic, did not arrive at clinic, failed discharge and transport unsuitable.

5.9 There has been a significant decrease in cases about patient care and the highest category this quarter is 'Collected Late from Clinic'.

Integrated Urgent Care

5.10 The total number of cases received this quarter for IUC has decreased by 15% from last quarter. There has been a significant decrease in Attitude of Call Handlers, from 12 to 6. The highest category of complaint this quarter is Clinical - Call Outcome followed by Appropriateness of Referral.

Service Improvements implemented from individual complaints

5.11 The following Trust-level and team-level improvements have been made from complaints and concerns (including health care professional concerns) which have been investigated and responded to during the quarter. In addition, many individual-level improvements have been made in the form of feedback to individual staff members on errors made which are not listed below.

5.12 A&E Call Handling and Dispatch

- EOC not using NDM discussed in IRG and awareness raised of importance
- Awareness of the mutual aid process for Cat 1 calls.
- Trend relating to not picking up on ineffective breathing has been identified and material to be distributed around this to all EMDs

5.13 A&E Operations

- Issue of equipment for the measurement of ketones to be taken to CQDF for discussion.
- Trust Learning Group will be looking this case to further explore and review methods for ensuring that refreshers on clinical practice can be escalated more effectively to frontline staff as the current methods do not appear to be effective.
- To reiterate the use of spinal assessment tools, thorough patient assessment and documentation to cover those decisions made and reasons for not using a tool or immobilising for example.
- Awareness of deployed ramp being a trip hazard.
- Wording of the maternity pathway is too ambiguous.

5.14 PTS

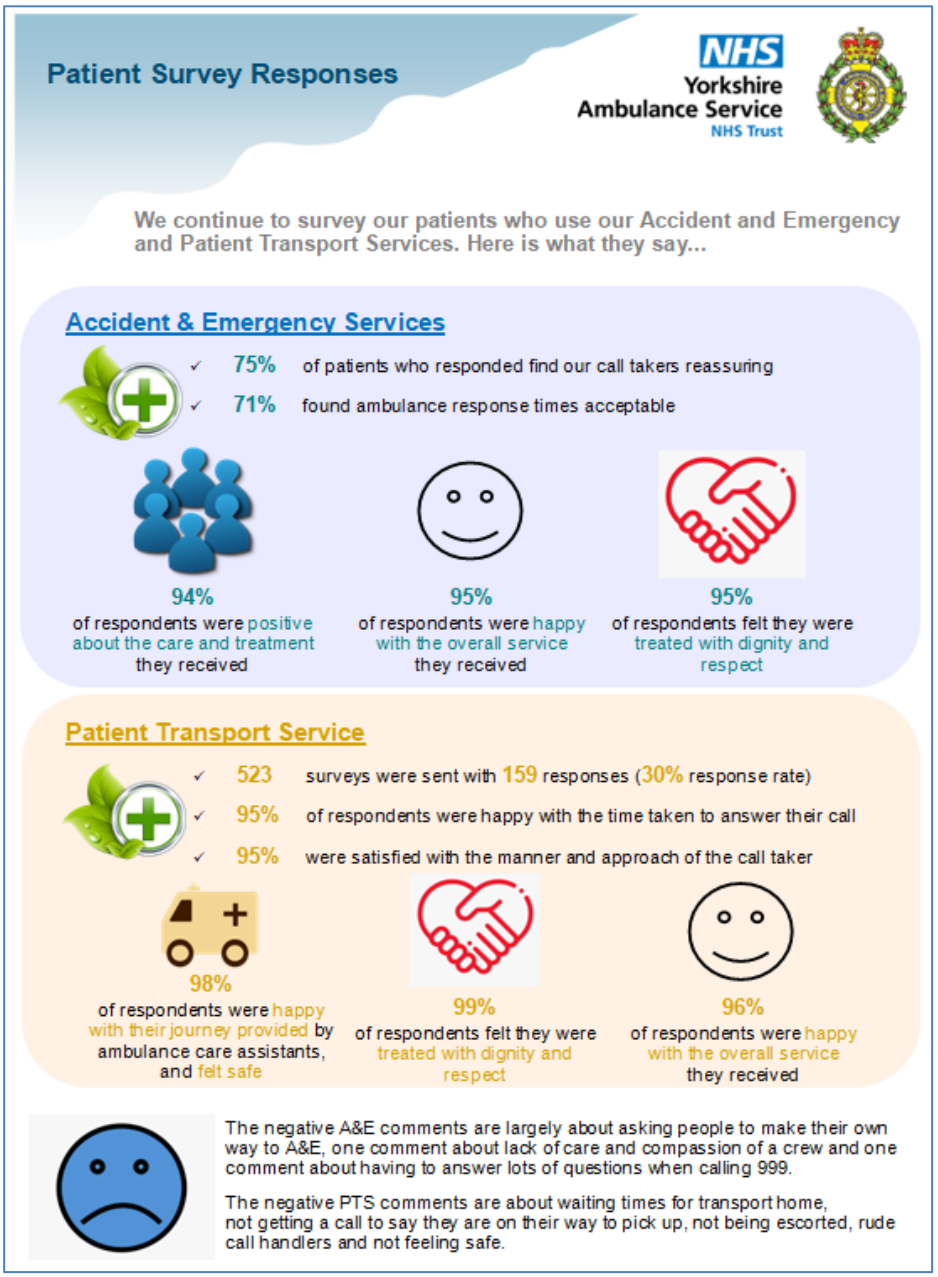
- Scheduling staff must adhere to and follow the 'no trace procedure' when a patient cannot be found by the crew on the return journey.
- New providers implemented.
- Reservations Team Leader has sent out a reminder re new patients to PTS
- PTS Reservations now aware of procedure for patient slings.

Ombudsman requests

5.15 During Q1 there were no new ombudsman cases commenced and no cases concluded.

Patient Survey responses

5.16 We continue to survey A&E and PTS patients on a quarterly basis and receive positive feedback.



6. LEGAL SERVICES

Claims

6.1 There are currently 125 open claims against YAS that have been reported under the NHS Resolution Insurance Schemes, the Trust's motor policy scheme, and property claims: an increase from the previous two quarters which had remained static. During Q1, 11 new claims were reported, which is a decrease from the previous quarter and more in keeping with previous quarters.

Claim related risks and learning

6.2 The timeliness of submission of documents and evidence of thorough investigations back to the insurers (NHSR) as required by policy remains the biggest challenge for Legal Services departmental staff. Claims Strategy meetings for complex matters and the ever embedding of Microsoft Teams as business as usual is continuing to assist with the submission of documents and evidence, along with the assigning of actions to Trust staff.

6.3 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. Appearances at the Divisional Management Group ("DMGs") by the Legal Services Manager has assisted in being a vital link between A&E Operations and the Legal Services Department and the department's presence at these meetings are now commonplace and established. Information pertaining to claims and themes/trends are then fed back to the senior leadership team within the CBUs.

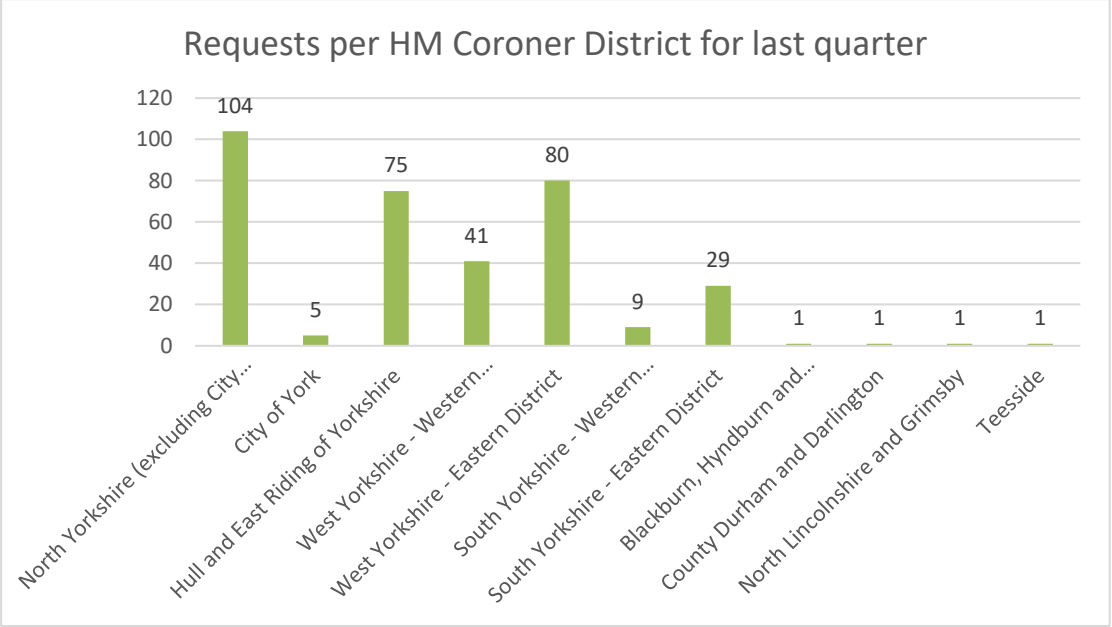
6.4 Risks pertaining to working practices surrounding the familiarisation training pertaining to vehicles and equipment remain significant as one of the largest triumvirates of claim types relate to vehicles. As referenced in previous reports, the Vehicle and Equipment Familiarisation working group (led by the Legal Services Manager) has produced an e-learning package which shows four bitesize videos as how to safely use the following:

- A&E Corpuls defibrillator
- A&E Winch
- A&E/PTS Wedge ramp
- PTS Tail lift

The uptake of this e-learning will be closely monitored to determine its effectiveness as a non-mandatory e-learning requirement.

Coroner's requests

6.5 During Q1 the Trust received 348 new requests, which is again an increase from the previous quarter. The graph below shows the HM Coroner Districts concerned:



6.6 At the end of Q1, there were 483 open inquest cases (on DATIX, notwithstanding any legacy cases which are spreadsheet based) which is a considerable increase from the previous quarter. Of the 483 cases which are open, 11 cases are confirmed as amber (medium risk), and 54 cases are confirmed as red (high risk). All inquests relating to serious incidents are automatically graded as red and the significant (if not total) proportion of the red cases are linked to serious incidents.

6.7 The Trust has provided evidence (written and/or oral) at 29 inquests in Q1 which is slightly lower than the previous quarter. Out of the 29 inquests heard in Q1 where oral or written evidence was adduced, three cases were amber and five were red.

6.8 The amber cases included the following:

- A frequent caller to both ambulance and police who suffered from self-neglect which required overview statements produced regarding the voluminous contact had with the patient along with any care plans in place.
- A patient who presented with headaches for a number of months but who had been advised to call 999 if the pain became unbearable. Patient was not conveyed on this occasion and six days later, a further call was made to 999 where the patient was conveyed to hospital. The patient passed away in hospital and the cause of death were intercranial haemorrhages.

6.9 The red cases included the following:

- A patient who had called 999 but stated that they were a bystander who was observing a third party trying to take their own life. The call was not processed in accordance with policy, and it was later discovered that the patient was calling about themself and not a third party.
- A patient who was suffering from extreme salmonella food poisoning was not conveyed by an attending A&E resource and red flag sepsis symptoms were not addressed. The same attending A&E resource was called back a couple of days later and the patient was conveyed however later passed away in hospital due to the extent of the food poisoning.

- Patient suffering from breathing problems and was coded as a Category 2 response however the response time was in excess of three hours where the patient was found to be in cardiac arrest upon arrival.
- A patient who had fallen had called 999 however was coded as a Category 5 call and received a clinical call-back where the incident was upgraded to Category 2. This was later downgraded to Category 3 and resulted in an overall response time in excess of six hours. A family member called 999 on eight occasions regarding the patient and the patient was conveyed to hospital but later passed away.

Prevention of Future Death (PFD) reports

6.10 No Prevention of Future Death reports were issued to the Trust in Q1.

7. SAFEGUARDING

Statutory Reviews

7.1 The most common theme running through all 13 DHR requests was domestic abuse. All 13 cases reported history of domestic abuse and 5 out of the 13 involved death of the victim during an episode of domestic abuse (2 women were stabbed and one female was found deceased – cause of death to be determined).

7.2 A paper has been produced to present through the Business Opportunity and Gate Review Process for support. The proposal is to recruit a Specialist Domestic Abuse Practitioner to support the trust to fulfil its duties under the Domestic Abuse Act 2021 which places responsibility on healthcare service to strengthen the response to victims and perpetrators of domestic abuse.

If successful, the role will have a similar function to the IDVA role (Independent Domestic Violence Advisor) but will have a broader role in training staff and supporting the Trust response to Domestic Abuse and will also support staff who are victims of domestic abuse, including developing safety plans and supporting referrals.

7.3 The number of rapid reviews were significantly increased during Q1, this was due to two of the cases both involving three children.
Interesting to note that two of the Rapid Reviews were relating to knife crimes committed by a parent with mental health issues, and three were in relation to a group of young people participating in serious crime.

Child Death

7.4 In Q1, the safeguarding team provided 59 reports for Child Death Overview Panel (CDOP) reviews across Yorkshire and Humber.

7.5 Significant learning and information has been disseminated to staff during Q1, including, reminder to refer and professional curiosity, and the NHSE prevent quarterly newsletter. Safeguarding was in the spotlight for a week in June to mark Safeguarding Awareness Week with key topics including, domestic abuse, County Lines, FGM, Hoarding and Self Neglect, Safer Sleep for Infants. All of this information has been retained on the intranet for staff to refer to.

8. PROFESSIONAL BODY REFERRALS (PBRs)

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

9. HEALTH & SAFETY EXECUTIVE (HSE) NOTIFICATIONS

9.1 There have been no notifications from the HSE during Q1.

10. DUTY OF CANDOUR – BEING OPEN

10.1 During Q1 39 new cases were opened under statutory Duty of Candour, 12 were closed following due process and the remaining 27 are open for communication at time of reporting.

10.2 At the time of report completion, 74 candour cases remain open in total.

11. FREEDOM TO SPEAK UP

11.1 During Q1, 28 concerns were raised via the Freedom to Speak Up Process. These are reported in detail in a separate paper.

12. RISK ASSESSMENT

12.1 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.

13. RECOMMENDATIONS

13.1 It is recommended that the Board note the current position and is assured in regard to the effective management of, and learning from, adverse events.

14. APPENDIX

14.1 Appendix A – YAS Trust-wide Safety Update

YAS Trust-wide safety update – April 2022
Themes – Dynamic Risk Assessment. Sharps, Reducing Injuries to our Patients, and Moving and Handling

NHS Yorkshire Ambulance Service NHS Trust

Listen, Learn, Act

Dynamic Risk Assessment

A dynamic risk assessment is the process of continually observing and analysing risks and hazards in a changing environment.

The process involves identifying hazards, assessing risk, taking action to eliminate or reduce risk, monitoring and reviewing in the rapidly changing circumstances at an operational incident.

Dynamic risk assessments should be carried out routinely to ensure both staff and patient safety.

Clinical Safety

Sharps - Safe Use, Storage and Disposal

- Only use safety hypodermic needles provided by the Trust – these have an easy to activate sharps protection system.
- Activate the hypodermic needle cap as soon as possible after use.
- Dispose of sharps immediately after use into a sharps bin.
- Sharps containers must be disposed of once 3/4 full.
- Whilst in transit, the temporary closure element of the sharps bin should be used to prevent spillage.
- Sharps containers must be checked to ensure lids are secure and the opening is closed and locked before removal from the ambulance.
- Never put a small sharps container into a larger one.
- The label attached to the sharps container must be completed with the appropriate details before disposal.

Safety Update
April 2022
Sign up to
SAFETY

Patient Safety

Reducing Injuries to our patients

Every month we report any harm that we cause our patients during their time in our care. The most common injury is skin tears, usually caused during patient movement.

Skin tears are defined as a wound caused by shear, friction and or blunt forces resulting in separation of skin layers.

Reducing the risk of skin tears:

- Wrapping the patient in a blanket in a carry chair to protect limbs.
- Observing the patient skin integrity when removing dressings, surgical tape or ECG electrodes.
- Following hand hygiene principles and remaining bare below the elbow.
- During any moving and handling always perform a dynamic risk assessment.
- Communicate to the patient any moving and handling task, to ensure the patient has awareness and preparedness prior to being moved.

If a patient does sustain an injury within our care, provide first aid and report on the DATIX line. Within PTS, if a patient sustains a significant injury, further advice can be sought from the Clinical Hub.

Staff Safety

Moving and Handling

Moving and handling is one of the most common causes of injury at work for staff when carrying out any kind of lifting, carrying, pushing or pulling involving patients or objects.

Always remember to carry out a dynamic risk assessment taking into account the key factors of TILE.

Report an incident on 0300 330 5419 (24 hours a day/7 days a week)

YAS Trust-wide safety update – May 2022

Themes – Needlestick injuries, Medication errors, Use of blankets using a carry chair and Staff safety

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Listen, Learn, Act

Needlestick injuries - post occupational exposure

- Perform immediate first aid.
- Immediately complete a risk assessment of the incident. This would normally be performed by the Team Leader on duty. If a TL is not available another staff member should assess

For significant exposure:

- Attend ED for blood tests/vaccinations/treatment.
- Obtain donor patient details - name, date of birth, hospital ward if admitted, GP surgery name if not attending hospital.
- Report incident to team leader and complete DATIX.
- Refer to Occupational Health team.

Please refer to the Post Occupational Exposure Management Procedure available on pulse for full details including risk assessment guidance and checklists.

Clinical Safety

Medication errors

Error can occur at every stage of the medication preparation and distribution process. One third of those that harm patients are attributed to the administration phase, particularly when managing time critical patients. Common themes include wrong medication given and medication out of date.

- Before giving medication, please check if the patient has recently taken their own medication including paracetamol.
- Be careful when drawing up medication from ampoules; ensure you check that you have drawn up the correct medication before administration.
- Please ensure all medications are in date before administration.

Remember:

Safety Update
May 2022
Sign up to
SAFETY

Patient Safety

Use of blankets when using a carry chair

A blanket is an essential part of ambulance equipment and supports patients being transferred in a safe manner. When using Compact 2 or the Compact 2 - track carry chair, a blanket should be used in conjunction with the chest and leg belts on the chair. It helps with patient comfort, maintains patients' modesty and helps protect the patients arms and legs when performing moving and handling procedures. Using a blanket prevents injury to both patients and staff and provides a safe and secure way of transferring patients.

Staff Safety

- Only use sharps where necessary.
- Assess the patient and the environment before using a sharp to ensure optimum safety.
- Wear appropriate PPE especially when dealing with blood and bodily fluid.
- Only use safety cannula provided by the trust - these have in built safety mechanisms
- Activate safety cannula mechanisms correctly, following failed cannulation ensure you remove in two pieces to activate the device.
- Secure the cannula immediately to reduce the risk of needing to re-cannulate.
- Dispose of sharps immediately after use into a sharps bin. Always dispose of your own sharps.

Report an incident on 0300 330 5419 (24 hours a day/7 days a week)