NHS
Yorkshire
Ambulance Service
NHS Trust

Investigations & Learning Policy v3.3

Document Author: Head of Investigations & Learning

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Version	Date	Author	Status (A/D)	Description of Change
1.0	February 2016	Rebecca Mallinder Head of Investigations & Learning	A	
1.1	June 2016	Rebecca Mallinder Head of Investigations & Learning	A	Updates to 3.10, 3.4.11 following Union comment. Interim review agreed for January 2016.
1.2	January 2017	Rebecca Mallinder Head of Investigations & Learning	A	Minor amends through the document with reference to certain groups/committees. Appendix G updated in line with current process for sharing learning. Additions of 3.9.10 and 3.9.11 to acknowledge learning from major incidents.
1.3	January 2018	Rebecca Mallinder Head of Investigations & Learning	D	Minor changes in track changes throughout document – updates to job titles, groups, process.
1.4	June 2018	Rebecca Mallinder Head of Investigations & Learning	A	Following May 18 TMG policy was discussed at JSG. No amends. Policy Approved.
2.0	December 2019	Nicola Greenwood Head of Investigations & Learning	D	Minor Amendments
3.0	April 2020	Simon Davies Safety Governance Manager	A	Policy Approved at TMG – Amended post holders/Job Roles
3.1	November 2020	Simon Davies Head of Investigations and Learn	D	Major Amendments Addition of 3.4.5. 3.4.13/14 referencing PSIRF (2021)
3.2	April 2022	Simon Davies Head of Investigations and Learn	D	Amendments in preparation for a transitional period between SIF and PSIRF
3.3	13 May 2022	Simon Davies Head of Investigations and Learn	D	Reviewed and approved at Clinical Governance Group (CGG)
4.0	June 2022	Risk Team	A	Approved at TMG
4.1	July 2023	Risk Team	A	TMG approved extension until December 2023

A = Approved D = Draft

Document Author = Post Holder - Head of Investigations & Learning

Associated Documentation:

- Risk Management Procedures
- Incident & Serious Incident Management Policy
- Policy for Managing Compliments, Comments, Concerns and Complaints
- Safeguarding Policy
- Courts and Evidence Policy
- Claims Management Policy
- Disclosure Policy
- Freedom of Information Policy
- Supporting Staff Involved in an Incident, Complaint or Claim Policy
- Being Open (Duty of Candour) Policy
- Disciplinary Policy & Procedure
- Issue Resolution (Grievance) Policy
- Freedom to Speak Up (Raising Concerns) Policy
- Bullying and Harassment Policy
- Clinical Incident Review Policy

- Post Incident Care Guidance

Staff Summary

Investigations form a vital part of informing learning and improvement across Yorkshire Ambulance Service NHS Trust. Understanding why things go wrong and learning from these cases influences the safety and quality of care provision across the Trust.

The Investigations & Learning Policy is designed to provide structure and clarity around the process for receiving, investigating, responding, reporting and learning from all investigations handled by the Trust.

An investigation can be initiated following, but not limited to:

- Receipt of a complaint from a patient and/or other person
- Input of an incident report from a staff member
- A concern being raised by a staff member
- Receipt of a claim being made against the Trust
- Request for information to inform a coronial investigation or other legal process
- A concern raised as part of an external process within the Safeguarding arena
- A concern raised by external parties such as another healthcare provider, commissioners and regulators
- Through audit or management processes

All of the above have the potential to progress to declaration of a Serious Incident dependent on severity

The Trust uses the Datix Cloud IQ record management system to record all adverse events, and, upon notification of an adverse event, details will be logged on Datix by the relevant team responsible for that input.

Once the severity of the event has been determined, the appropriate grade of investigation will be decided (Appendix C). This will be done via Datix IQ and the persons administering the process/system.

Investigations will look to establish the facts of the event, gather the appropriate documentation and evidence, analyse the information including conducting an RCA, and make appropriate recommendations based on the information found.

In the case of grade 1 investigations, an ‘After Action Review’ approach will be adopted in most cases which will be led by the investigator allocated to the case to ensure quality of information and understanding between all parties. Engagement will be essential to review the timeline and to develop appropriate learning points; this will take the form of either direct or virtual meetings. Administration of this process will sit with the Quality, Governance, Performance Assurance directorate and overall oversight will remain with the Safety Governance Manager to provide expert knowledge and guidance to the investigation process.

Investigations should be carried out with an independent view, with the main aim to identify where something has gone wrong and how learning can be implemented. The Trust operates within the principles of ‘Just Culture’ with a focus on learning, restorative practice and removal of individual blame. The process for conducting an investigation should be carried out with openness and transparency from all involved.

With the planned introduction of the NHS Patient Safety Incident Response Framework (PSIRF) in Q2/Q3 of 2022, investigation methodology will be adjusted and enhanced to include any new and additional training which may come online whilst this policy remains in place. A full programme of learning for all NHS staff is expected to be launched in 2022; this will include modules on Human Factors, Culture and investigation process, with higher level modules available for colleagues involved directly with patient safety.

Patient safety specialists (PSS) are in post to support all learning directly involving patient care; these colleagues are a vital link between national methodology/steer and local implementation and should be accessed in all cases for specialist knowledge and expertise.

These colleagues are:

- Interim Executive Director Quality, Governance & Performance Assurance
- Head of Investigations and Learning
- Head of Safety and Infection Prevention and Control Lead

From October 2014, following parliamentary approval, NHS providers are required to comply with the Duty of candour, meaning providers must be open and transparent with service users about their care and treatment, including when it goes wrong.

Reference should be made to the relevant policy for that investigation type for specific information on timescales and the timescale will be outlined to the investigation lead at the start of the process.

Learning will be shared Trust wide and coordinated by the Trust Learning Group, with appropriate levels of learning being cascaded to different levels within the organisation. This will be in a variety of formats including (but not limited too) newsletters, training packages, YAS TV, safety update posters, face to face feedback, emails, and other formats appropriate to the material being delivered.

The Trust is committed to providing feedback to staff who are involved in an adverse event or who have reported an adverse event. This will be done through a variety of methods dependent on the severity of the adverse event and the preferences of those involved.

1.0. Introduction

1.1. Investigations form a vital part of informing learning and improvement across Yorkshire Ambulance Service NHS Trust. Understanding why things go wrong and learning from these cases influences the safety and quality of care provision across the Trust.

1.2. The Trust undertakes an investigation when an adverse event occurs. Other investigations may also take place across the Trust as part of a Human Resources (HR) process, for example a disciplinary or grievance case.

1.3. Identifying and sharing appropriate learning across the Trust enables improvement to be made. It is important that investigations identify good practice and areas for improvement, both of which can be shared Trust wide within a culture of openness and transparency to ensure lessons are learned.

2.0 Purpose/Scope

2.1 The Investigations & Learning Policy is designed to provide structure and clarity around the process for receiving, investigating, responding, reporting and learning from all investigations handled by the Trust. This policy will focus on investigations following an adverse event and will not include detailed information about HR investigations. Information regarding these investigations is held within the relevant HR policies. Appendix B includes the NHS Improvement 'A just culture guide' which advises staff on when it might be appropriate during an investigation to involve HR. This guide replaces the pre-existing NPSA Incident Decision Tree from 2018 however this is included and referenced in part as the Trust is operating in a transitional period between two NHS investigation frameworks.

2.2. The policy is part of the organisation's internal control system and provides assurance to the Board that robust processes are in place to mitigate the risks associated with the management of investigations.

3.0. Process

3.1. Initiation of an investigation

3.1.1. An investigation can be initiated following, but not limited to:

- Receipt of a complaint from a patient and/or other person
- Input of an incident report from a staff member
- A concern being raised by a staff member
- Receipt of a claim being made against the Trust
- Request for information to inform a coronial investigation or other legal process
- A concern raised as part of an external process within the Safeguarding arena
- A concern raised by external parties such as another healthcare provider, commissioners and regulators
- Through audit or management processes

All of the above have the potential to progress to declaration of a Serious Incident dependent on severity

3.1.2. The above processes are managed by the Quality, Governance & Performance Assurance Directorate with input from other directorates as appropriate. As such all records of the above investigations are held at a corporate level.

3.1.3. The Trust uses the Datix Cloud IQ record management system to record all adverse events and upon notification of an adverse event details will be logged on Datix by the relevant team responsible for that input.

3.2. Investigation Grading

3.2.1. Upon notification of an adverse event, it will be graded in accordance with the Trust's Risk Matrix (Appendix A) based on the consequence of the event that has occurred.

3.2.2 It is also useful for reference to be made to the NHS Improvement 'A just culture guide' (Appendix B) which advises where it might be appropriate to seek HR advice depending on the nature of the incident.

3.2.2. Once the severity of the event has been determined, the appropriate grade of investigation will be decided (Appendix C). This will be done via Datix Cloud IQ and the persons administering the process/system.

3.2.3. The grades are based on the National Patient Safety Agency (NPSA – now disbanded) grading criteria with relevant amendments made for the Trust and the introduction of a grade 3 streamlined investigation in addition to grade 1 comprehensive and grade 2 concise levels of investigation.

3.2.4. The grades provide guidance for the investigation lead on what information may be sought as part of the investigation, the depth of analysis required, the level of learning that should be identified and the feedback mechanisms (Appendix C)

3.3. Allocation of Investigations

3.3.1. The allocation of investigations is specific to the investigation area, the nature of the event and the severity of the event.

3.3.2. For grade 1 investigations, the investigation lead will be fully trained, or supported by someone fully trained, in Root Cause Analysis (RCA). For lower grades of investigation, it is not compulsory that the investigation lead is fully trained in RCA but support will be available from a member of the Quality, Governance & Performance Assurance directorate that is trained.

3.3.3. For specific guidance on how investigations are allocated, reference should be made to the associated policies and procedures held within those investigation areas, for example the Policy for Managing Compliments, Comments, Concerns and Complaints.

3.4. Investigation

3.4.1. Once the grade of investigation has been determined, the investigation should commence. Investigations will include the appropriate level of RCA proportionate to the grade of investigation and RCA tools are available to assist, particularly for use in grade 1 investigations.

3.4.2. Teams within the Quality, Governance & Performance Assurance Directorate are responsible for providing adequate support throughout the duration of an investigation.

3.4.3. Investigations will look to establish the facts of the event, gather the appropriate documentation and evidence, analyse the information including conducting a RCA, and make appropriate recommendations based on the information found.

3.4.4. RCA tools should be used when investigating an incident. Datix Cloud IQ has been designed to record investigations and identify causes with RCA methodology in mind. As a minimum, all grade 1 investigations will be subject to a full RCA, including use of best practice tools and techniques. Human factors should be fully explored and analysed throughout the course of the investigation.

3.4.5 In the case of grade 1 investigations, an 'After Action Review' approach will be adopted in most cases which will be led by the investigator allocated to the case to ensure quality of information and understanding between all parties. Engagement will be essential to review the timeline and to develop appropriate learning points; this will take the form of either direct or virtual meetings. Administration of this process will sit with the Quality, Governance, Performance Assurance directorate and overall oversight will remain with the Safety Governance Manager to provide expert knowledge and guidance to the investigation process.

Suggested roles required to participate are as follows:

- Serious Incident Investigator or Nominated Trust Senior Manager
- Safety Governance Manager
- Colleagues noted to have been in the timeline for the incident*
- Relevant Head of Department
- Relevant Audit/Compliance Leads
- Clinical Governance Manager
- Relevant Locality or Directorate Management Leads
- Patient Safety Specialist
- A nominated patient representative from the Trust Critical Friends Network

*NB – During periods of high demand / REAP 4 protocols where arrangements for standdown are more challenging, it may be necessary to substitute management representatives to attend meetings and discuss the case rather than colleagues who have been present. Colleagues involved in the timeline should be involved by cascade and sharing of all documentation/notes created in all cases.

3.4.6. Investigations should be carried out with an independent view, with the main aim to identify where something has gone wrong and how learning can be implemented. The Trust operates within the principles of 'Just Culture' with a focus on learning, restorative practice and removal of individual blame. The process for conducting an investigation should be carried out with openness and transparency from all involved.

3.4.7. Fact Finding/Audit/Review
Incidents of a clinical nature may require a Clinical Case Review (CCR) or a clinical based discussion (CBD) to inform the investigation and this will be conducted by a suitably qualified clinician in accordance with the relevant policy.

3.4.8. The investigation may require input from another NHS organisation. These will be managed on a case-by-case basis and relevant information sought to inform the investigation. Where appropriate an end-to-end review may be deemed necessary.

3.4.9. On occasion it may be necessary for an investigation to be conducted by an external independent investigator or for specialist expertise to be input independent to the Trust. This will be determined on a case-by-case basis. The Serious Incident Framework 2015 (SIF) outlines guidance for Trusts in instances when an independent investigation is determined to be appropriate.

3.4.10. Support will be available to all staff involved in an investigation. This may be through their line manager or through alternative support services such as Occupational Health. Please refer to the Post-Incident Care guidance for specific details of this.

3.4.11. Information from staff will be required at an early stage of an incident being reported to understand as much about the adverse event as possible. This can be taken initially in a 'version of events' from the individual. If the investigation escalates to a higher severity, such as when there is a requirement to comply with legal processes or HR investigation, an official statement will then be required from the individual which will be held on record along with other documents relating to the incident being reviewed.

3.4.12. A case review may be necessary if there are elements of an investigation where concerns are raised. This may be related to adherence to timescales for example or the impartiality of an investigating manager. Case reviews should be requested via the Head of Investigations & Learning and will be reviewed on a case-by-case basis.

3.4.13. With the planned introduction of the NHS Patient Safety Incident Response Framework (PSIRF) in Q2/Q3 of 2022, investigation methodology will be adjusted and enhanced to include any new and additional training which may come online whilst this policy remains in place. A full programme of learning for all NHS staff is expected to be launched in 2022; this will include modules on Human Factors, Culture and investigation process with higher level modules available for colleagues involved directly with patient safety.

3.4.14. Patient safety specialists (PSS) are in post to support all learning directly involving patient care; these colleagues are a vital link between national methodology/steer and local implementation and should be accessed in all cases for specialist knowledge and expertise.

These colleagues are:

- ❖ Interim Executive Director Quality, Governance & Performance Assurance
- ❖ Head of Investigations and Learning
- ❖ Head of Safety and Infection Prevention and Control Lead

3.5. Duty of Candour

3.5.1. From October 2014, following parliamentary approval, NHS providers are required to comply with the Duty of candour, meaning providers must be open and transparent with service users about their care and treatment, including when it goes wrong.

3.5.2. The statute outlines this will be applied when an adverse event has occurred, or appears to have occurred, resulting in a moderate or above level of harm being caused to the patient while under the care and treatment of an NHS provider.

3.5.3. The Trust's process for management of the Duty of candour statute is outlined in the Being Open (Duty of Candour) Policy and is managed within the Quality, Governance & Performance Assurance directorate. Investigation leads may be required to input into this process and will be required to support feedback to families or relatives on completion of the investigation.

3.6. Timescales

3.6.1. The Trust is committed to managing all adverse events involving patients, staff, and others who may be affected by our activities, in a timely manner and in accordance with specified regulatory and national guidance timeframes and within local agreements.

3.6.2. Reference should be made to the relevant policy for that investigation type for specific information on timescales and the timescale will be outlined to the investigation lead at the start of the process.

3.6.3. Adherence to the timescales in this policy will always be aspirational and may not always be achieved. This non-compliance can be due to a number of factors including Trust reliance on external stakeholders to deliver necessary information, to support the identification of a conclusion, pending for example, investigations by a Police force or through Court processes/directions from HM Coroner.

3.7. Documentation

3.7.1. All information relating to an adverse event should be saved on the relevant Datix IQ record. This includes any statements from staff, call logs, audits, clinical documentation, relevant policies and procedures reviewed as part of the investigation, email conversations and any other relevant information.

3.7.2. Where an investigation covers two different inputs, for example an incident and a complaint, the records should be linked, or documentation added to both identifying their linked status.

3.7.3. All mandatory fields on Datix Cloud IQ must be completed before the investigation can be approved and the Datix Cloud IQ record takes the place of an investigation report in most cases.

3.7.4. For investigations completed using an After-Action-Review (AAR) approach, the Trust AAR Template will be utilised (Appendix E).

3.8. Approval and Sign Off

3.8.1. All investigations must be approved before closure. The process for approval is outlined in Appendix F and is dependent on the type of investigation and the grading of the investigation.

3.9. Learning from Investigations

3.9.1. Appropriate restorative learning placing emphasis on alignment with the NHS 'Just Culture' guide learning will be identified from each investigation and consideration given as to whether the learning should be done on an individual, team or organisational basis.

Guidance on the level of learning can be found in the investigation grades information included in Appendix C.

3.9.2. Local actions will be taken where necessary following conclusion of an investigation and managed on an individual basis. Learning and actions at this level will be recorded on Datix IQ.

3.9.3. The Trust Learning Group (TLG) will coordinate learning relating to patient safety matters, to ensure the effective management and cascade of learning and improvement.

3.9.4. Analysis of investigations and learning will be carried out at team levels but triangulated through the Head of Investigations & Learning to inform reports to the relevant groups and committees. These reports include, but are not exhaustive to:

- Integrated Performance Report (IPR).
- Lessons learned and trend analysis reported quarterly to the Clinical Quality Development Forum (CQDF) and Clinical Governance Group (CGG) and the Health & Safety Committee.
- Significant Events & Lessons Learned reports to the Trust Management Group, Trust Board and Quality Committee.
- Local learning reports sent to operational business areas.
- Quarterly learning and trend analysis report to commissioners (Schedule 6).
- Incident Review Group (IRG).
- Learning From Deaths Group (LFD).
- Low and No Harm Group (LNGH).
- Trust Learning Group (TLG).

Ad hoc reports may also be requested for certain groups or operational areas throughout the course of the year.

3.9.5. Data analysis will be conducted primarily using the Datix Cloud IQ system, with additional qualitative data analysis carried out within the Quality, Governance & Performance Assurance directorate.

3.9.6. All learning will be recorded on the Datix Cloud IQ system and monitoring of specific recommendations relating to serious incident investigation will take place via continued analysis of quantitative and qualitative data and recorded within the Quality, Governance & Performance Assurance directorate.

3.9.7. Learning will be shared Trust wide and coordinated by the Trust Learning Group, with appropriate levels of learning being cascaded to different levels within the organisation. This will be in a variety of formats including (but not limited to) newsletters, training packages, YAS TV, safety update posters, face to face feedback, emails, and other formats appropriate to the material being delivered.

3.9.8 The key groups for responding to lessons learned and implementing the actions are the Incident Review Group, Clinical Quality Development Forum and Trust Learning Group.

3.10. Feedback

3.10.1. The Trust is committed to providing feedback to staff who are involved in an adverse event or who have reported an adverse event. This will be done through a variety of

methods dependent on the severity of the adverse event and the preferences of those involved.

3.10.2. Feedback will be provided by the relevant investigation lead for the adverse event and/or the line manager and/or through the Datix Cloud IQ system. Details of levels of feedback are outlined within the investigation grading document in Appendix C. It is important that staff are kept informed throughout the investigation, particularly if there are any delays in adherence to timescales.

3.10.3. An investigation de-brief may be initiated if felt appropriate by the investigation lead to feedback to all persons involved.

3.11. Media Involvement

3.11.1. The Trust's Corporate Communications Team will be notified of any serious incidents where there is potential for media interest. The Corporate Communications Team will apply the appropriate level of media management depending on the level of interest, liaising with the Quality, Governance & Performance Assurance directorate throughout.

4.0. Training expectations for staff

4.1. The Trust will provide RCA & Investigation Skills Training for managers across the Trust. This training is aimed at investigation leads who will undertake grade 1 investigations.

4.2. A training package is also available for those undertaking lower-level investigations.

4.3. eLearning from the national patient safety syllabus at Levels 1 and 2 is available via the Trust ESR function in relation to investigation principles and practice. Level 1 (and Board Level 1) will be mandated as statutory training for all colleagues in line with national expected standards from Q1 2022.

4.3. In cases where training cannot be provided internally, or for colleagues within the quality function who require specialist skills, external sources will be sought from the NHS Patient Safety - Training Procurement Framework.

5.0. Implementation Plan

5.1. The following stakeholders have been consulted in the development, consultation, and review of this policy:

Clinical Quality Development Forum (CQDF)	Clinical Governance Group (CGG)	Legal Services Manager
Patient Relations Manager	Information Governance Manager	Information Systems Manager
Associate Director of Operations	Head of EPRR & Special Operations	Head of Employee Relations
Safety Governance Manager		

5.2. The policy has been reviewed by members of the Clinical Governance Group and has been recommended to the Trust Management Group for approval.

5.3. The latest approved version of this Policy will be posted on the Trust Intranet site for all members of staff to view. New members of staff will be signposted to how to find and access this guidance during Trust Induction.

5.4. Archived documents will be stored electronically within the Document Library archive. A copy of previous versions of the policy will be additionally held by the policy author.

6.0. Monitoring compliance with this Policy

6.1. Regulatory compliance reports will be presented by the Head of Investigations throughout the year to a range of executive committees and groups. The committees review the reports, note any deficiencies and remedial actions in their minutes. Progress against relevant action plans associated with this policy will be monitored as part of routine business and will be subject to the Trust's performance management process.

6.2. The effectiveness of this policy is monitored against adherence to national frameworks and requirements, each of which will be specified within the individual investigation area policies. Key Performance Indicators (KPIs) based on national and local standards have been agreed and performance against these KPIs is monitored through reports to executive committees and through dashboards.

7.0. References

7.1. The following sources of information have been used in the creation of this document.

NHS Improvement 'A just culture guide'
NHS England » A just culture guide

Root Cause Analysis (RCA) report writing tools and templates.
https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incidnt-framwrk-upd.pdf

CQC Regulation 20: Duty of Candour
Regulation 20: Duty of candour | Care Quality Commission (cqc.org.uk)

Serious Incident Framework (2015).
https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incidnt-framwrk-upd.pdf

FutureNHS – Training Procurement Framework (2022)
Training Procurement Framework - NHS Patient Safety - FutureNHS Collaboration Platform

NHS Patient Safety Incident Response Framework (2020) (Introductory Framework).
Report template - NHSI website (england.nhs.uk)

NHS Improvement (NRLS)
NHS England » Report a patient safety incident

8.0. Appendices

8.1. The following appendices are included within the document:

- Appendix A Risk Matrix
- Appendix B NHS Improvement ‘A just culture guide’
- Appendix C Investigation Grading Matrix
- Appendix D Investigation Grading Definition and National Mapping
- Appendix E Investigation Grades Descriptors
- Appendix F After Action Review – Report Template (v1.5)
- Appendix G Investigation Sign Off
- Appendix H Definitions
- Appendix I Roles and Responsibilities

Appendix A – Risk Matrix

Risk Matrix

For grading risk, the scores obtained from the risk matrix are assigned grades as follows;-

Key to managing risk scores:		
Risk score of 1 - 6	Low	Managed at a local team/departmental level. Local management to determine and develop risk treatment plans or to manage through routine procedures; and consider including on the risk register. This level of risk may be short-lived or aggregated into a higher risk.
Risk score of 8 – 12	Moderate	**Consider implications for Risk Register.** Managed at local team/departmental level, unless escalated to Directorate or Trust/Subject specific group. Where there is a severity score of 4 or 5 alone, this may be considered for escalation to the Risk & Assurance Group regardless of the likelihood score.
Risk score of 15 – 25	High	**Consider implications for Risk Register.** Managed at local team/departmental level and/or Directorate or Trust/Subject specific group depending on management control, treatment plan, or wider strategic implications for the Trust. Risk Leads consider escalation and review at Risk and Assurance Group (RAG) where consideration is given to escalating the risk into the Corporate Risk Report and/or Board Assurance Framework (BAF).

Risk scoring = Consequence x Likelihood (CxL)

	Likelihood score				
Severity score	**1**	**2**	**3**	**4**	**5**
	Rare	**Unlikely**	**Possible**	**Likely**	**Almost certain**
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

Consequence Score (C) Guidance

Choose the most appropriate risk descriptor for the identified risk from the left-hand side of the table, then work along the columns in the same row to assess the severity of the risk on the scale of 1 to 5 to determine the consequence score, which is the number given at the top of the column.

	Risk Consequence score and examples of descriptors				
	1	**2**	**3**	**4**	**5**
Risk Descriptors	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Safety **Harm to patients/staff and/or public (including physical and/or psychological harm)**	Minor injury not requiring first aid or no apparent injury	Minor injury or illness, requiring minor intervention 1-2 people affected No long term consequences.	Moderate injury which impacts on an individual or a small number of people Some degree of harm up to a year. RIDDOR/MHRA/agency reportable incident	Major injury leading to long-term incapacity/disability Serious mis-management of care with long-term effects 16-50 people affected	Death /life threatening harm Multiple permanent injuries or irreversible health effects More than 50 people affected
Staff **Competence and training, poor staff attendance for mandatory/key training**	Insignificant effect on delivery of service objectives due to failure to maintain professional development or status	Minor error due to a lack of appropriate skills, knowledge and competence to undertake duties.	Moderate error due to limited skills, knowledge & competence to undertake duties	Major effect on delivery of service objectives due to failure to maintain professional development or status	Significant effect on delivery of service objectives due to failure to maintain professional development or status

Statutory duty/ inspections	No or minimal impact or breech of guidance/ statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breeches in statutory duty Critical report	Multiple breeches in statutory duty Prosecution Severely critical report, zero performance rating
Service/business interruption	Loss of ability to provide services (interruption of >1 hour)	Loss of ability to provide services (interruption of >8 hours)	Loss of ability to to provide services (interruption of >1 day)	Loss of ability to provide services (interruption of >1 week)	Permanent loss of service or facility
Business programmes/ projects	Temporary defects causing minor short term consequences to time and quality	Poor project performance shortfall in area(s) of minor importance	Poor project performance shortfall in area(s) of secondary importance	Poor performance in area(s) of critical or primary purpose	Significant failure of the project to meet its critical or primary purpose
Financial loss/Contracting	Small loss of budget (£0 -£5,000)	Medium financial loss (£5,000 - £10,000)	High financial loss (£10,000 - £50,000)	Major financial loss (£50,000 - £100,000) Purchasers failing to pay on time	Huge financial loss (£100,000 +), loss of contract / payment by results Unrecoverable financial loss by end of financial year
Information governance risks	Minimal or no loss of records containing person identifiable data. Only a single individual affected.	Loss/compromised security of one record *(electronic or paper)* containing person identifiable data.	Loss/ compromised security of 2-100 records *(electronic or paper)* containing confidential/ person identifiable data.	Loss/ compromised security of 101+ records *(electronic or paper)* containing person identifiable data.	Serious breach with potential for ID theft compromised security of an application / system / facility holding person identifiable data *(electronic or paper)*.
Adverse publicity/ reputation/Public confidence	Rumours No public/political concern	Local media area interest – short-term reduction in public confidence	Extended local/regional media interest. Regional public/political concern.	Regional/national media interest with less than 1 day service well below reasonable public expectation	National media interest with more than 1 day service well below reasonable public expectation.
Litigation	Likely repudiation at pre-action stage.	Damages valued at less than £10,000 Minor concerns relating to care highlighted, no systemic issues identified Allegations not substantiated and claim likely to be successfully defended and discontinued at pre-action stage.	Civil action / Criminal prosecution / Prohibition notice-proceedings issued Likelihood of success at trial >50% Damages) valued between £10,000 and £100,000 Concerns relating to treatment/care/systemic issues identified which are not likely to have impacted on the outcome Low level risk of reputational damage.	Civil action / Criminal prosecution/Prohibition notice – proceedings issued Likelihood of success at trial <50% Damages between £100,000 and £1 million Major concerns as to treatment/care/systemic issues which are likely to have impacted on the outcome Reputational damage (local level) Raises individual employee failings and or Trust policy concerns	Civil action/Criminal prosecution/Prohibition notice – indefensible Damages >£1 million Catastrophic / significant systemic issues/concerns which have significantly contributed to the outcome Damage due to never event Reputational damage (national level)
Coroner's requests / inquests	No issues or concerns identified No identified risk of criminal or civil litigation No identified risk of reputational damage	Minor concerns identified unrelated to management of patient No identified risk of criminal or civil litigation No identified risk of reputational damage	Concerns relating to treatment/care/systemic issues which are not likely to have impacted on the outcome Does not raise significant individual or Trust policy failings	Significant concerns to treatment/care/systemic issues which are likely to have impacted on the outcome Areas of concern not addressed receiving a Coroner's Prevention of Future Death report (PFD).	Catastrophic / significant issues/concerns which are likely to have significantly contributed to the outcome High likelihood of a Coroner's Prevention of Future Death report-

	Witness statements admitted under Rule 23 YAS not an Interested Person	YAS not an Interested Person.	Low level risk of civil litigation claim Low level risk of reputational damage Family and/or other Interested Persons legally represented	Consideration given to legal representation at Inquest YAS has Interested Person Status Concerns raised by Coroner/other Interested Persons Potential for for Prevention of Future Deaths report- issues addressed pre- inquest Notification of civil claim- contemplated or actual Reputational damage (local level) Jury/Article 2 inquest Family and/or other Interested Persons legally represented	issues not addressed pre-inquest YAS has interested person status. Raises issues of national importance Potential to result in public national enquiry (i.e. London Bombings, Mid Staffordshire enquiry) Potential for criminal prosecution or civil claim proceedings issued Reputational damage (national level) Jury/Article 2 inquest Family and/or other Interested Persons legally represented.
Complaint	Minor injury not requiring first aid or no apparent injury Misunderstanding of an element of the service which can be corrected Local rapid resolution anticipated with no service change requirements	Minor injury or illness, requiring minor intervention Single failure to meet internal standards with no consequence Local resolution anticipated, local service change may be required	Moderate injury which impacts on a small number of people Single failing resulting in loss of appointment or care Resolution service wide with possible escalation of actions	Major injury leading to long-term incapacity/disability Repeated failure to meet internal standards within organisation Resolution service wide with possible escalation of actions	Death /life threatening harm Unacceptable level or quality of treatment/service . Grossly substandard care Resolution expected to be protracted, major trust wide service change may be required
Safeguarding children & Adults at Risk ***Actual or alleged abuse; sexual abuse, physical or psychological ill-treatment, or acts of omission which constitute neglect, exploitation, financial or material abuse, discriminative and organisational abuse, self-neglect, domestic abuse, human trafficking and modern day slavery***	No issues or concerns identified clinically or with reputation Progression to strategy meeting or multi-agency review unlikely No media interest Response to query responded to within 2 working days No, or minimal impact or breech of guidance/statutory duty	Minor concerns over patient care CDOP/Form B with uncomplicated information gathering Minor delay in response to external agency request (more than 5 working days) No allegations against Trust or employees Short term service impact from brief investigation involving discussions Police, Social care and HR	Moderate concerns about patient care, response times, clinical interventions CDOP requiring moderately complex information gathering and analysis Referral to LADO and Police. Disciplinary process commenced, suspension from front line duties Possible media interest anticipated	Major concerns with patient care that could have affected outcome Major injury leading to incapacity or disability Repeated failure to reach internal standards Regional media statement requested Abuse enquiry becomes public enquiry	Incident leading to death or permanent disability Healthcare did not take appropriate action/intervention to safeguard against abuse occurring Abuse that resulted in (or was identified through) a SCR, DHR, LLR Inquest requiring safeguarding information Staff/ex-staff member is found guilty of abuse and convicted Media interest highly likely

Likelihood Score (L) Guidance

What is the likelihood of the consequence occurring?

The frequency-based score is appropriate in most circumstances and is easier to identify. It should be used whenever it is possible to determine the frequency.

Likelihood score	**1**	**2**	**3**	**4**	**5**
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Probability	< 5% 1 in 100,000 chance	6-20% 1 in 10,000 chance	21-50% 1 in 1000 chance	50-80% 1 in 100 chance	>81% 1 in 10 chance
	This will probably never happen/recur Will only occur in exceptional circumstances	Unlikely to occur Do not expect it to happen/recur but it is possible it may do so	Reasonable chance of occurring Might happen or recur occasionally	Likely to occur Will probably happen/recur but it is not a persisting issue	More likely to occur than not Will undoubtedly happen/recur, possibly frequently

Appendix B – NHS Improvement 'A just culture guide'

NHS Improvement

A just culture guide

Supporting consistent, constructive and fair evaluation of the actions of staff involved in patient safety incidents

This guide supports a conversation between managers about whether a staff member involved in a patient safety incident requires specific individual support or intervention to work safely. Action singling out an individual is rarely appropriate - most patient safety issues have deeper causes and require wider action.

The actions of staff involved in an incident should **not** automatically be examined using this *just culture guide*, but it can be useful if the investigation of an incident begins to suggest a concern about an individual action. The guide highlights important principles that need to be considered before formal management action is directed at an individual staff member.

An important part of a just culture is being able to explain the approach that will be taken if an incident occurs. A just culture guide can be used by all parties to explain how they will respond to incidents, as a reference point for organisational HR and incident reporting policies, and as a communication tool to help staff, patients and families understand how the appropriate response to a member of staff involved in an incident can and should differ according to the circumstances in which an error was made. As well as protecting staff from unfair targeting, using the guide helps protect patients by removing the tendency to treat wider patient safety issues as individual issues.

Please note:

- **A just culture guide** is not a replacement for an investigation of a patient safety incident. Only a full investigation can identify the underlying causes that need to be acted on to reduce the risk of future incidents.
- **A just culture guide** can be used at any point of an investigation, but the guide may need to be revisited as more information becomes available.
- **A just culture guide** does not replace HR advice and should be used in conjunction with organisational policy.
- **The guide** can only be used to take one action (or failure to act) through the guide at a time. If multiple actions are involved in an incident they must be considered separately.

Start here - **Q1. deliberate harm test**

1a. Was there any intention to cause harm?

→ **Yes** → **Recommendation:** Follow organisational guidance for appropriate management action. This could involve: contact relevant regulatory bodies, suspension of staff, and referral to police and disciplinary processes. Wider investigation is still needed to understand how and why patients were not protected from the actions of the individual. → END HERE

No go to next question - **Q2. health test**

2a. Are there indications of substance abuse?

→ **Yes** → **Recommendation:** Follow organisational substance abuse at work guidance. Wider investigation is still needed to understand if substance abuse could have been recognised and addressed earlier. → END HERE

2b. Are there indications of physical ill health?

2c. Are there indications of mental ill health?

→ **Yes** → **Recommendation:** Follow organisational guidance for health issues affecting work, which is likely to include occupational health referral. Wider investigation is still needed to understand if health issues could have been recognised and addressed earlier. → END HERE

if **No to all** go to next question - **Q3. foresight test**

3a. Are there agreed protocols/accepted practice in place that apply to the action/omission in question?

3b. Were the protocols/accepted practice workable and in routine use?

3c. Did the individual knowingly depart from these protocols?

→ If **No** to any → **Recommendation:** Action singling out the individual is unlikely to be appropriate; the patient safety incident investigation should indicate the wider actions needed to improve safety for future patients. These actions may include, but not be limited to, the individual. → END HERE

if **Yes to all** go to next question - **Q4. substitution test**

4a. Are there indications that other individuals from the same peer group, with comparable experience and qualifications, would behave in the same way in similar circumstances?

4b. Was the individual missed out when relevant training was provided to their peer group?

4c. Did more senior members of the team fail to provide supervision that normally should be provided?

→ If **Yes** to any → **Recommendation:** Action singling out the individual is unlikely to be appropriate; the patient safety incident investigation should indicate the wider actions needed to improve safety for future patients. These actions may include, but not be limited to, the individual. → END HERE

if **No to all** go to next question - **Q5. mitigating circumstances**

5a. Were there any significant mitigating circumstances?

→ **Yes** → **Recommendation:** Action directed at the individual may not be appropriate; follow organisational guidance, which is likely to include senior HR advice on what degree of mitigation applies. The patient safety incident investigation should indicate the wider actions needed to improve safety for future patients. → END HERE

if **No**

Recommendation: Follow organisational guidance for appropriate management action. This could involve individual training, performance management, competency assessments, changes to role or increased supervision, and may require relevant regulatory bodies to be contacted, staff suspension and disciplinary processes. The patient safety incident investigation should indicate the wider actions needed to improve safety for future patients. → END HERE

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Based on the work of Professor James Reason and the National Patient Safety Agency's Incident Decision Tree

Supported by: Academy of Medical Royal Colleges; avma action against medical accidents; CareQuality Commission; General Medical Council; National Guardian Freedom to Speak Up; NMC Nursing & Midwifery Council; NHS England; Royal College of Nursing

collaboration trust respect innovation courage compassion

Appendix C – Investigation Grading Matrix (NPSA – Now disbanded but relevant to SIF 2015)

Refer to the risk matrix in order to determine the level below.

For each category within therisk matrix the following applies:

Negligible and Minor = **Low**
Moderate and Major = **Moderate**
Catastrophic = **High**

	Incident	Concern/ Complaint	Serious Incident	Claim	Inquest	Safeguarding
Low	Grade 3	Grade 3		Grade 3	Grade 3	Grade 3
Moderate	Grade 2	Grade 2		Grade 2	Grade 2	Grade 2
High	Grade 1	Grade 1	Grade 1	Grade 1	Grade 1	Grade 1

Appendix D – Investigation Grading Definitions and National Mapping

No Harm

No harm has been identified in the timeline of the incident, and where learning may be present – this has not impacted on patient or staff safety.

Near Miss

Learning is present within the timeline of the incident; however, this has not directly impacted patient or staff safety. The learning has identified that intervention is present to stop harm occurring and if a similar incident should occur in the future with similar parallels – that harm could be caused as a result.

Minor (NHS Improvement / NRLS Category – Low Harm)

Learning is present within the timeline of the incident which indicates that patient or staff safety has been affected to a minor degree based on the Trust risk matrix. The incident should be investigated under the Trusts process for review of incidents, and duty of candour should be carried out if there is presence of a notifiable patient safety event.

Moderate (NHS Improvement / NRLS Category – Moderate Harm)

Learning is present within the timeline of the incident which indicates that patient or staff safety has been affected to a moderate degree based on the Trust risk matrix. The incident should be investigated under the Trusts process for review of incidents, and duty of candour should be carried out if there is presence of a notifiable patient safety event. Consideration should be given to raising the incident as a 'Serious Incident' on the national STEIS reporting system.

Major (NHS Improvement / NRLS Category – Severe Harm)

Learning is present within the timeline of the incident which indicates that patient or staff safety has been affected to a major degree based on the Trust risk matrix. The incident should be investigated under the Trusts process for review of incidents, and duty of candour should be carried out if there is presence of a notifiable patient safety event. Consideration should be given to raising the incident as a 'Serious Incident' on the national STEIS reporting system.

Catastrophic (NHS Improvement / NRLS Category – Severe Harm)

Learning is present within the timeline of the incident which indicates that patient or staff safety has been affected to a catastrophic degree where either death or catastrophic outcomes have been present, based on the Trust risk matrix. The incident should be investigated under the Trusts process for review of incidents, and duty of candour should be carried out if there is presence of a notifiable patient safety event. Consideration should be given to raising the incident as a 'Serious Incident' on the national STEIS reporting system.

Catastrophic; Death Caused by Incident (NHS Improvement / NRLS Category – Catastrophic (Death))

Learning is present within the timeline of the incident which indicates that patient or staff safety has been affected to a catastrophic degree AND where either death or catastrophic outcomes have been caused as a direct result of care provided by YAS, based on the Trust risk matrix. The incident should be investigated under the Trusts process for review of incidents, and duty of candour should be carried out if there is presence of a notifiable patient safety event. Consideration should be given to raising the incident as a 'Serious Incident' on the national STEIS reporting system.

Appendix E – Investigation Grades Descriptors (NPSA – Now disbanded but relevant to SIF 2015)

Grade 1	**Investigation:** Statements/reflection required from all staff involved (internal and external where appropriate) Call to be audited if EOC/111 related and the call should be listened to by at least the lead investigator. Full review of call required. Review of the PRF by a Senior Clinician. Brief background / context to be provided on the patient (further detail may be sought by the Coroner as appropriate). Analysis of demand and performance information if a delayed response event. Detailed reference to adherence to Clinical Guidelines to assess best practice. Thorough review of all relevant policies and procedures. Interview / learning review with staff involved if deemed relevant. RCA conducted by a trained expert with specialist advisors informing the lead investigator. Relevant reports should be sought i.e. equipment reports, training records. Patients and / or relatives should be involved in the investigation. **Investigator:** Lead investigator should be independent to the staff members involved. A full review should take place of the call log if an emergency response incident. **Feedback:** Face to face feedback should be given to the staff members involved. **Learning:** Learning should be recorded within the report / record and an action plan developed. A process should be in place to monitor completion of the action plan & risk considered for addition to risk register. **Sign off:** The report / record should be signed off by a member of the Senior Management Team.
Grade 2	**Concise investigation** **Investigation:** Statements /reflection to be taken from key staff involved directly in the patient care. A review of the PRF should take place if it is a clinical event. Analysis of the call log should be undertaken. Dependent on the nature of the event i.e. delayed response, audit of the call to be requested. A review should be undertaken of the relevant policies and procedures to understand if these were followed. A RCA should be undertaken by a trained expert or supported by a trained expert. **Investigator:** The investigating manager or person providing information (i.e. for a complaint) can be a locally identified manager and may seek input from others as part of the investigation. **Feedback:** Written feedback should be given to the staff members involved by the investigator. **Learning:** Learning should be recorded within the report / record and appropriate actions recorded and risk considered for addition to risk register. **Sign off:** The investigation should be signed off by the appropriate lead for that area.
Grade 3	**Streamlined investigation** **Investigation:** Fact-find conversation may be held with the individuals involved to fact find if deemed appropriate by the investigator or person involved in the investigation. A statement may be taken in certain circumstances if deemed relevant by the investigator. A review should be undertaken of the relevant policies and procedures to understand if these were followed. **Investigator:** The investigation should be done by a local investigator within area or involve a local investigator. **Feedback:** The event should be acknowledged and feedback given to the staff members (this may be feedback that highlights wider pieces of work that are underway to address the event if a wider theme is identified). **Learning:** Actions should be taken to held reduce risk of recurrence and learning recorded within the report / record and risk considered for addition to the risk register. **Sign off:** The investigation should be signed off by appropriate lead for the area as per the matrix.

Yorkshire Ambulance Service NHS Trust

After Action Review - Report

DCIQ Reference		**Date of Report**	
Written by *(Job title)*	**Name**, Job Title		
Adastra/C3/CAD Log		**StEIS Reference**	
Date of Incident		**Time**	
Incident description *(Summary only)*			
Service Area		**Location of Incident**	
Incident theme *e.g. medication error, delayed response*	Delayed response		
Scope of investigation *(describe focus of investigation)*	To review the circumstances leading to this patient's death, with a view to identifying any action/improvement required to reduce the risks resulting from delayed attendance during periods of extreme pressure.		
Family Liaison / Duty of Candour	A Duty of Candour letter was sent to the patient's next of kin on the XXXXXXX informing them that an investigation would be taking place and inviting the family to be involved in the investigation process. On the XXXXXXX, the patient / patient's next of kin telephoned the Quality and Risk Coordinator to advise of receipt of the letter – expand as per DOC section on Datix		
Support for staff involved (Consider PIC/OH Referral if required)	Consideration has been given to Trust PIC (Post Incident Care) processes. Operational staff wholly appreciated being included in the fact find process and noted that they found it very useful to hear how the Trust was reviewing the dispatch elements. AAR process established greater understanding for attending crews of the actions taken before arrival and any associated delays.		
Terms of Reference	An After-Action Review is a structured review of a patient safety incident which involves an in-depth analysis and exchange of ideas, in a safe and non-blame environment. The term of reference for this AAR involves identifying: **What was expected to happen –** a review of National guidance, local policy, and Standard Operating Procedures (SOPs). **What actually occurred** – reviewing the Sequence of events, electronic/ paper Patient Record (documentation), discussion with colleagues involved in the case (Call takers and dispatchers, Operational Staff, subject matter experts, Patient		

	representation, and colleagues from external organisations where applicable) lead by colleagues from the safety investigation team during the AAR meeting. **Was there a difference –** identifying whether there was a difference between what was expected and what actually happened? What were the good points and didn't work so well? **Learning –** with the benefit of hindsight, what could have been done differently. Can anything be changed to improve future responses? Culminating in the development of group recommendations from the discussion and analysis of the case.
Date of AAR	**Time of AAR**
Facilitator(s)	**Name**, Job Title
Attendees and role ***Apologies***	**Attendees:** **Observer:** **Apologies:**
Discussion Points **(See Chart on next page for breakdown)**	*What was expected to happen?* *What occurred?* *Was there a difference?* *What can be learned or identified?*
Discussion Notes	**During the AAR discussion the following points were raised:**
MIRO Board	*Insert MIRO board here as an image*

Chronology of events

List key events in the patient timeline with comments to take forward to findings based on investigation

Date & Time	Event	Additional information

Conclusions	The Trust was operating at Demand Management Plan Level X at the time of these calls. however there was a peak in COVID related staff absences in EOC / CBU / Cluster…….. It was ascertained that the XXXXX cluster was down XXX double crewed ambulance on the XXX/XX/XXXX. This will have had an impact on response times during……. Xxx below forecasted requirement. *Demand Management Plan (DMP) is designed to be utilised in situations of excessive call volume or reduction in staff numbers, which results in the supply of ambulance service resources being insufficient to meet the clinical demands of patients. At DMP level 4 and 5 the Trust were under critical pressure; callers will experience a delay in response and ambulances may not be dispatched for some lower priority calls.* The call came into the Emergency Operations Centre at …. and the call was coded as XX-X-XX (Call type) a category X priority. A further call was …….. *Calls received into the Emergency Operations Centre (EOC) are coded based on the information provided by the caller. These codes categorise the incidents and determine the response time target and most appropriate resource. The system used to categorise calls is the Advanced Medical Priority Dispatch System (AMPDS) and this is an internationally approved system.* *Since 1 September 2017 the Yorkshire Ambulance Service has been operating under phase three of the Ambulance Response Programme (ARP) version 2.2. the aim of the ARP being to enable more accurate categorisation of calls to ensure the most appropriate responses are sent to patients.* *Category 1* *These calls are the highest category of call we respond to. These are for people with life threatening illness or injury such as cardiac arrest or a serious allergic reaction. The average time to respond to these emergencies from coding of call is 7 minutes and it is expected that 90% of these emergencies will be responded to within 15 minutes.* *Category 2* *These calls are emergency calls for conditions and injuries such as burns, epileptic seizures and strokes. The average time to respond to these emergencies from coding of call is 18 minutes and it is expected that 90% of these emergencies will be responded to within 40 minutes.* *Category 3* *These are urgent calls for conditions such as late stages of labour, non-severe burns, and diabetes. In some instances, patients may be treated by ambulance staff within their own home without the need to transport to hospital and referrals may be made to specialist teams within the community. For these calls it is expected that we will respond to 90% of them within 2 hours.* *Category 4* *These calls are less urgent calls that we receive for illnesses such as diarrhoea and vomiting or urine infections. In some instances, patients may receive advice over the telephone or be referred to another service such as a GP or a pharmacist. In instances*

where it is appropriate for an ambulance to respond it is expected that we will respond within 3 hours for 90% of cases.

Category 5
These calls are less urgent and can be treated over the phone. A call from a Nurse or Paramedic will be made and will either direct for self-care, other services or may arrange a face to face review and escalate the call.

Both calls were audited by the EOC Quality Team.

The Trust has two Emergency Operation Centres (EOC) in operation, one in York and one in Wakefield. The EOC receives emergency calls to the service and carries out the functions of call handling, dispatch and clinical triage. It also hosts the Clinical Hub.

Emergency Medical Dispatchers (EMD) receive all incoming calls to the EOC. All EMDs undertake a robust training programme before taking any calls autonomously. EMDs are not clinically trained but they do receive comprehensive training to specifically undertake the role of EMD through the use of the computerised systems.

Calls received into the EOC are audited by a central team and are scored against the Performance Standards set by the International Academy of Emergency Medical Dispatch (IAEMD).

The first call was found to be ……..

The second call ……..

Once the calls have been answered and coded, the calls are assigned to a Dispatcher, who is responsible for allocating resources to the call, identifying the nearest available suitable resource (ambulance) on receipt of the address. Resources are allocated on a priority basis, with the Category 1 calls for life threatening conditions allocated first.

Resource checks are a process undertaken by the Dispatcher within the Emergency Operations Centre (EOC) to identify the nearest and most appropriate resource(s) (Ambulance) to respond to an incident.

The Dispatcher works within the Emergency Operations Centre (EOC) and is responsible for allocating any resources to the incident. When a call is received within the EOC, the process followed by the Dispatcher is to allocate the nearest available, suitable resource to the incident upon receipt of the address.

The first call received was coded by xx:xx hours and confirmed as a category X call. At this time a resource check …….

The second call ……

The first crew on scene was ……

An RRV is a single responder vehicle with a fully trained clinical member of staff (Paramedic), travelling in a car. Whilst they are unable to transport a patient to hospital, they are able to start treating the patient.

A Newly Qualified Paramedic is clinically trained to provide invasive and pharmacological interventions where needed, to reduce the morbidity and mortality associated with acute out of hospital medical and traumatic emergencies, they are classified as within the first two years of qualification as a paramedic.

An Emergency Care Assistant is not clinically trained, however they can respond to emergency incidents and often work under instruction from clinically trained staff.

On arrival…..

An asystole rhythm portrays an absence of ventricular contractions which means no tissue contraction from the heart muscle and therefore no blood flow to the body. An asystole rhythm is not a rhythm receptive to a shock delivered by a defibrillator.

BVM is a self-inflating bag attached to a face mask, squeezing the bag ventilates the patient through the nose and the mouth.

On arrival of the Double crewed ambulance (DCA), ……..

DCA - A specialist vehicle staffed by a two-person crew. At least one crew member will be a Paramedic or an Advanced Emergency Medical Technician (AEMT) who will be skilled and equipped to assist patients with medical emergencies or traumatic injuries. If necessary, they will be able to transport a patient to hospital or other appropriate treatment centre.

ROSC - In cardiopulmonary resuscitation (CPR), ROSC is the resumption of a normal heart rhythm with a perceptible pulse.

Initial observations:
Respiratory rate
Blood pressure

PEA is a clinical condition portrayed by unresponsiveness and the lack of a palpable pulse in the presence of coordinated cardiac electrical activity. PEA is not a rhythm that is shockable as the electrical system in the heart is working correctly in this case and delivering a shock would only work to 'reset' the rhythm and this is not needed in PEA.

Observations:
ECG
Blood Pressure
Respiratory rate

What was expected to happen?	What Occurred	Was there a difference?	What can be learned or identified?
To attend the patient within X minutes as per policy	▪ No available resources ▪ Delay handing over ▪	▪ REAP 4 pressures ▪ DMP levels ▪ Covid sickness and isolation ▪ Capacity of ED to accept patients	▪
To dispatch a resource at the earliest	▪ Initial resource checks….	▪ The difference was	▪
To establish something	▪ The caller became	▪ That this happened	▪ This was a result of
To set realistic	▪ Timescales were inappropriate	▪ This was shorter	▪

Notable practice	
YAS actions and improvements made during the global pandemic.	The global pandemic has brought with it enormous challenges on a scale never seen before in the NHS. Services within the NHS have had to be radically altered to cope with the increased demand on services combined with an increase staffing shortages due in part to Coronavirus, mandated covid-isolation and sickness as a result of continuous pressures. One of the significant challenges during the pandemic, has been ambulance response times, which not only have been impacted by sickness and increased demand, but also in delays in offloading ambulances at our local hospitals. These delays compromise safety in our community by reducing the availability of ambulances to respond to emergencies. Yorkshire Ambulance Service (YAS) has implemented a number of initiatives during the pandemic in an attempt to mitigate these delays, these are listed below: • **Hospital Ambulance Liaison Officers (HALO)** – A member of the YAS team deployed to help manage hospital-ambulance interface and release ambulances quicker to respond to the next emergency. HALOs help maintain a safe and effective handover to the hospital and ensure the deteriorating or at-risk patient is identified in the 'queue'. They also provide clinical support for the pre-hospital clinicians. This is essential to reduce the risk of avoidable harm to patients in the community awaiting ambulance response. • **Resource Escalation Action Plan (REAP)** – This was increased to Level 4 (Extreme Pressure) on the 9th July 2021 as a result of the continuation of significantly increased demand across all our operational service lines. REAP levels provide a consistent and coordinated approach to assess of the impact of operating pressures on service delivery and contingencies and options to mitigate and reduce any increased pressure on the system. o All non-essential meetings were stood down o Training, other than that for new recruits, was postponed o Clinically trained staff on secondment were redeployed to frontline services, this also includes EOC Clinical Hub o Patient Transport Services (PTS) colleagues to provide additional support with Low Acuity Transport (LAT) and Inter-facility Transfers (IFTs) – movement of patients from hospital to hospital. o Increase frontline A&E Operations (ambulances) support via the Private Provider network • **Forecasting (predicting the number of resources we need)** – In October 2021, the Trust changed the way the number of resources that were required was predicted, by changing to a shorter-term model which more accurately predicted activity levels. • **Recruitment** – A recruitment drive for more staff in the call centres, to answer calls, dispatch ambulances and cars, and clinicians to call patients back. GPs and other health care professionals joined the call centre teams to help answer calls.

	• **Safer Right Care** – Development of a new structured approach to clinical assessment, setting out standards for history taking, patient assessment, decision making and documentation. This allowed:
	  ○ specialist paramedics to assess and treat the patient at home or direct them to more appropriate services instead to taking patients unnecessarily to hospital
	  ○ Recognition of serous illnesses faster with critical pathways in place for identifying the best onward care setting for the patient
	• **Clinical Support for frontline staff** – for all newly qualified paramedics, technicians and PTS/LAT crews, a dedicated clinician in EOC to provide additional clinical support and advice.
	• **Focused Falls group** – Trust established a task and finish group to focus on improving response to patient who have fallen, to reduce long lies. Emergency Operations Centre and Community First Responders worked together to ensure increase the referrals for patients who have fallen to CFR teams. These CFRs have been trained and have equipment so they can help support their early mobilisation from the floor. EOC also identified patients that were suitable for referral to local Council Falls Teams and Urgent Care Response teams. This focussed work reduced the number of delays to patient who had fallen over the busiest months of winter. The group continues to meet to develop better ways of responding to these patients.
	• **Clinical Navigator Role** –a clinical is allocated to a dispatch bay to review the workload in a specific area (e.g. South Yorkshire). They will assess each call coming into the centre and using clinical knowledge alongside AMPDS categorisation decide if calls should be upgraded, referred to the clinical hub, sent for alternative transport or remain the same coding. They also provide clinical support and guidance to crews within that area.
	• **Local Escalation Procedures** – Demand Management Plan – to allow tactical support to YAS in responding to situations where the available resource capacity does not match the demand across the Yorkshire & Humber region.
	  ○ Introduction of scripts to end calls
	  ○ No send on certain categories of call
	  ○ Increase in triage of certain categories of calls
	  ○

Contributory Factors	See Yorkshire Contributory Factors Framework form below.

Domain 1: Situational Factors		
Team factors		
Was there any failure of team function? *For example:* ◆ Conflicting team goals ◆ Poor delegation ◆ Lack of respect for colleagues ◆ Absence of feedback	☐ Yes ☐ Maybe ☐ No	Notes:

Individual staff factors		
Were there any reasons this incident was more likely to occur with the particular staff involved? *For example:* ◆ Fatigue ◆ Distraction ◆ Stress ◆ Inexperience ◆ Rushed	☐ Yes ☐ Maybe ☐ No	Notes:
Task characteristics		
Did the task features make the incident more likely? *For example:* ◆ Unfamiliar task ◆ Monotonous task ◆ Difficult task	☐ Yes ☐ Maybe ☐ No	Notes:
Patient factors		
Were there any reasons this incident was more likely to occur to this particular patient? *For example:* ◆ Language barrier ◆ Unusual physiology ◆ Uncooperative ◆ Intoxicated ◆ Complex medical history	☐ Yes ☐ Maybe ☐ No	Notes:
Domain 2: Local Working Conditions		
Workload and staffing issues		
Was there a mismatch between workload and staff provision around the time of the incident? *For example:* ◆ High unit workload ◆ Staff sickness ◆ Insufficient staff	☐ Yes ☐ Maybe ☐ No	Notes:
Leadership, Supervision and Roles		
Was there any failure of team function? *For example:* ◆ Inappropriate delegation ◆ Remote supervision ◆ Unclear responsibilities	☐ Yes ☐ Maybe ☐ No	Notes:
Drugs, Equipment and Supplies		
Were there difficulties obtaining the correct drugs and/or working equipment and/or supplies? *For example:* ◆ Unavailable drugs ◆ Inadequate maintenance ◆ Equipment not working ◆ No supplies delivery	☐ Yes ☐ Maybe ☐ No	Notes:

Domain 3: Organisational Factors Physical environment		
Physical environment		
Did the environment hinder your work in any way? *For example:* ◆ Poor layout ◆ Poor visibility ◆ Lack of space ◆ Poor lighting ◆ Excessive noise/heat/cold ◆ Poor access to patient	☐ Yes ☐ Maybe ☐ No	Notes:
Support from other departments		
Were there any problems from other departments? *For example:* ◆ This includes support from IT, HR, Clinical Supervisors, Location Managers, IUC, EOC, PTS, LAT etc	☐ Yes ☐ Maybe ☐ No	Notes:
Scheduling and Bed Management		
Did any time pressures play a role in the incident? *For example:* ◆ Delay in response ◆ Difficulties finding a bed ◆ Transfer to hospital ◆ Lack of out of hours support	☐ Yes ☐ Maybe ☐ No	Notes:
Staff training and Education		
Were there any issues with staff skill or knowledge? *For example:* ◆ Inadequate training ◆ Training not standardised ◆ No protected time for teaching ◆ No regular/yearly updates	☐ Yes ☐ Maybe ☐ No	Notes:

Domain 4: External Factors		
Design of Equipment, Supplies and Drugs		
Was there any characteristic about the equipment, disposables or drugs that was unhelpful? *For example:* ◆ Confusing equipment design ◆ Equipment not fit-for-purpose ◆ Similar drug names ◆ Ambiguous labelling and packaging	☐ Yes ☐ Maybe ☐ No	Notes:
National Policies		
Have any national policies influenced this incident? *For example:* ◆ Commissioned resources ◆ National screening policy ◆ Interference by government Organisations ◆ National paramedic/ nursing standards ◆ Ambulance response programme	☐ Yes ☐ Maybe ☐ No	Notes:
Domain 5: Communication and Culture		
Safety Culture		
Did the lack of safety culture in your clinical area contribute to this incident? *For example:* ◆ Patient safety awareness ◆ Fear of documenting errors ◆ Attitude to risk management	☐ Yes ☐ Maybe ☐ No	Notes:
Verbal and Written Communication		
Did poor written or verbal communication worsen the situation? *For example:* ◆ Poor communication between staff ◆ Inappropriate abbreviations used ◆ Unable to contact correct staff ◆ Lack of notes/communication ◆ Handover problems ◆ Unable to read notes ◆ Notes availability	☐ Yes ☐ Maybe ☐ No	Notes:
Summary		
Which are the most important contributory factors for this incident?		

Actions

Recommendations	Specific Action	Due Date	Responsible Person
1.			
2.			
3.			

Key Information

Date reported on StEIS	
Date reported on Datix	
Incident Type (including StEIS cat)	
Clinical Commissioning Group (CCG)	
Agreed Commissioner completion date	
Date report completed by investigator	
Externally reported to	NRLS, CCG, Coroner, RIDDOR

Severity level (pre-investigation) using the Trust's Risk Matrix

Consequence (1-5)	Likelihood (1-5)	Risk Rating (CxL)
4	4	**16 – High Risk**

Severity level (post-investigation) using the Trust's Risk Matrix

Consequence (1-5)	Likelihood (1-5)	Risk Rating (CxL)

Sign Off Sheet

FOR COMPLETION BY QUALITY, GOVERNANCE & PERFORMANCE ASSURANCE DIRECTORATE

The purpose of the Trust Learning Group ("the Group") is to support Trust and system learning and continuous improvement in patient safety, patient experience and clinical outcomes. The Group operates as part of the Trust's wider integrated governance arrangements, with strategic links to both quality improvement and clinical development and will review and coordinate learning from Patient Safety Incidents, Learning from Deaths, Coroners and Patient experience themes and trends.
The group will:

- Act at all in times in accordance with the Trust vision and values
- Make recommendations to review and/or amend Trust standards, systems, policies, and procedures as necessary
- Share good practice across departmental and organisational boundaries

The core membership of the group is as follows:

i. Patient Safety Partner (TBC)
ii. Executive Medical Director (the Chair)
iii. Executive Director of Quality, Governance and Performance Assurance
iv. Senior Operations Directorate manager
v. Deputy Medical Director
vi. Deputy Director for Quality and Nursing
vii. Clinical Director IUC
viii. Associate Director Paramedic Practice
ix. Head of Investigations and Learning
x. Head of Quality Improvement
xi. Trust Pharmacist
xii. Lead Paramedic for Clinical Development
xiii. Clinical Lead for EOC
xiv. Lead Nurse for Urgent Care
xv. Representative from YAS Academy
xvi. Representative from PTS
xvii. Clinical Directorate Co-ordinator

This report has been presented to the group on XX/XX/XXXX with a full review of the investigation, the learning identified and the proposed actions to address the issues. The group supports the content of this report and the actions identified.

Responsible Lead
This report has been reviewed by the lead for the business area and agrees to sign off the investigation.

Lead Name	Job Title	Business Area	Date Signed Off

Distribution List
The report has been shared with the following people/organisations following completion.

Name	Organisation	Date Shared

Appendix G – Investigation Sign Off (UPDATED TABLE, PREVIOUS TABLE ON NEXT PAGE)

	Incident	Complaint		Serious Incident	Claim	Inquest	Safeguarding
		Response	**Review response**				
Grade 3	Closed by final approver	Head of Service or Locality Manager	Approved & signed by Executive Director of Quality, Governance & Performance Assurance		Head of Legal Services	Head of Legal Services	Head of Safeguarding
Grade 2	Closed by final approver	Head of Service or Locality Manager	Approved & signed by Executive Director of Quality, Governance & Performance Assurance		Head of Legal Services	Head of Legal Services	Head of Safeguarding
Grade 1	Closed by final approver with review from specialist expert	Approved by Executive Director of Quality, Governance & Performance Assurance Signed off by Chief Executive	Approved by Executive Director of Quality, Governance & Performance Assurance Signed off by Chief Executive	Incident Review Group Quality & Safety Managers	Head of Legal Services Executive Medical Director/Executive Director of Quality, Governance & Performance Assurance	Head of Legal Services Executive Medical Director	Head of Safeguarding & Executive Director approval

The matrix below shows the sign off process for each grade of investigation.

	Incident	Concern/Complaint		Serious Incident	Claim	Inquest	Safeguarding
		Response	Review response				
Grade 3	Closed by designated final approver	Head of Service or Locality Manager 111: Head of Governance	Executive Director sign off 111: Head of Governance/ Associate Medical Director		Legal Services Manager approval and sign off	Legal Services Manager approval and sign off	Named Professional for Safeguarding sign off
Grade 2	Closed by designated final approver	Executive Director (of relevant service) 111: Head of Governance	CEO sign off 111: Head of Governance/ Associate Medical Director		Legal Services Manager approval and sign off from Steve/Julian non-clinical/ clinical	Legal Services Manager approval and sign off	Head of Safeguarding sign off
Grade 1	Closed by designated final approver with review and sign off by relevant specialist manager	AD Quality & Nursing approved CEO 111: Associate Medical Director review	AD Quality & Nursing approved CEO sign off 111: Associate Medical Director Review	Locality Director approval AD Quality & Nursing sign off	Legal Services Manager approval and sign off	Legal Services Manager approval and sign off	Head of Safeguarding sign approval and Executive Director of Standards & Compliance sign off

Appendix H - Definitions

Investigation
A systematic approach to establish the facts about a case in order to understand the reason as to why something has happened.

Adverse event
An unplanned event which has given rise to actual or possible personal injury, patient dissatisfaction, property loss or damage, or damage to the financial standing or reputation of the Trust.

Serious Incident (SI)
A serious incident (SI) requiring investigation is defined by the NPSA in the National Framework for Reporting and Learning from Serious Incidents Requiring Investigation as an incident that occurred in relation to NHS funded services and care resulting in one of the following:-

- unexpected or avoidable death or severe harm of one or more patients, staff or members of the public;
- a never event - all never events are defined as serious incidents although not all never events necessarily result in severe harm or death. (See Never Events Framework);
- a scenario that prevents, or threatens to prevent, an organisation's ability to continue to deliver healthcare services, including data loss, property damage or incidents in population programmes like screening and immunisation where harm potentially may extend to a large population;
- allegations, or incidents, of physical abuse and sexual assault or abuse; and/or
- loss of confidence in the service, adverse media coverage or public concern about healthcare or an organisation.

Severity
Outcome or impact of an event.

Datix Cloud IQ
The system used by the Trust to record amongst others, risks, and adverse events.

Root Cause Analysis (RCA)
A structured investigation that aims to identify the true causes(s) of a problem and the actions necessary to eliminate it.

Duty of Candour (DoC)
Statutory duty meaning NHS providers must be open and transparent with service users about their care and treatment, including when it goes wrong.

Clinical Case Review (CCR)
A review with particular focus on the clinical aspects of competency and care.

Clinical Based Discussion (CBD)
An individual review with particular focus on the clinical aspects of competency and care.

Appendix I – Roles & Responsibilities

Trust Board
The Trust Board is responsible for ensuring that effective systems are in place for the management of investigations and learning across the organisation. The Trust Board seeks assurance regarding the Trust's response to investigations through the Chief Executive Officer and the Executive Director of Quality, Governance & Performance Assurance.

Quality Committee
The Quality Committee undertakes an objective scrutiny of the Trust's clinical governance and quality plans, compliance with external quality regulations and standards and key functions associated with this, including processes to ensure effective learning from adverse events. The committee scrutinises bi-monthly reports provided by the Head of Investigations & Learning and supports the Board in gaining assurance on the effective management of investigations.

Incident Review Group (IRG)
The IRG is a working group that meets weekly, and which is responsible for reviewing and instigating appropriate action to address issues identified in relation to incidents, serious incidents, complaints and concerns, claims, coroner's inquests, professional body referrals and safeguarding cases.

Chief Executive
The Chief Executive is ultimately accountable for the implementation of the process for managing investigations. As the Accountable Officer the Chief Executive provides the Trust Board with assurance regarding the Trust's response to investigations.

Executive Director of Quality, Governance & Performance Assurance
The Executive Director of Quality, Governance & Performance Assurance has responsibility for ensuring that adequate arrangements are in place to effectively manage investigations, and for ensuring that an appropriate system is in place to identify and implement learning following investigations. The Director has responsibility for providing the Trust executive and Trust Board with updates on significant developments and assurance on the investigations and learning process.

Deputy Director of Quality & Nursing
The Deputy Director of Quality & Nursing has responsibility for ensuring practical processes are in place to adequately undertake investigations and ensure that the appropriate learning is identified. The Deputy Director will take direct management of the Head of Investigations & Learning.

Head of Investigations & Learning
The Head of Investigations & Learning has responsibility for the management of the processes associated with investigations and learning and overview and input into the processes that sit underneath these and are held with Legal Services, Patient Relations, Safeguarding and Risk Management. The Head of is responsible for the management of the administration function within the Quality & Risk Team.

Learning from Death Process (LFD)
The purpose of the Learning from Deaths Group is to support the Trust in delivering its obligations to monitor patient outcomes and ensure clinically effective care is delivered. Senior clinical leaders undertake strategic mortality reviews with cross directorate support, feeding back the learning within this forum. This is to ensure that lessons and actions are identified that

would not otherwise be commonly highlighted under other Trust processes for the purpose of reducing all avoidable deaths. The group operates as part of the Trust's wider integrated governance arrangements, with strategic links to both quality improvement and clinical care.

Trust Learning Group (TLG)
The purpose of the Trust Learning Group ("the Group") is to support system learning and continuous improvement in patient safety, patient experience and clinical outcomes. The Group operates as part of the Trust's wider integrated governance arrangements, with strategic links to both quality improvement and clinical care.

Managers within the Quality, Governance & Performance Assurance Directorate
All managers within this directorate are required to cooperate with the Head of Investigations & Learning by working with the Head of to develop systems and processes around investigations and learning within their own work areas to feed into the wider investigation analysis and learning work being undertaken across the Trust.

Patient Safety Specialist (PSS)
The requirement for NHS organisations in England to identify one or more person as their designated Patient Safety Specialist(s) is a key part of the NHS Patient Safety Strategy
These specialists will work full time 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. Specialists will also work in networks with Patient Safety Specialists from other organisations to share good practice and learn from each other, making them fundamental to patient safety across the NHS in England.

All managers
All managers are required to co-operate with the Head of Investigations & Learning and the other responsible managers within the directorate, by responding in a timely manner to requests for any information or support required during the course of their business. Managers may also be asked to participate in investigations, and it is expected that they will apply due diligence to this process, provide support to affected staff, and facilitate effective organisational learning and improvement.

Staff
All Trust staff have a responsibility to co-operate with the Head of Investigations & Learning and the teams that sit within the Quality, Governance & Performance Assurance directorate by responding in a timely manner to requests for any information and by active participation in an investigation process.