TRUST BOARD (Public session)	23 MAY 2018	AGENDA ITEM	10

Report title:	Thematic Review of Serious Incidents

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Purpose:	Decision	Assurance	For information	Disclosable	X
		X		Non-disclosable	

Executive summary:

Winter 2017/18 was a difficult period for all ambulance services. Unprecedented demand was seen across the country, and the east of England was no exception. Nationally, ambulance handovers rose by 72% compared with 2014/15 figures[1].

In January 2018 the Trust declared 22 SIs between 17th December 2017 to the 16th January 2018.

An independent harm analysis overseen by NHS Improvement concluded that no patient died. Yet, three patients were caused severe harm by the ambulance delays during this extremely busy winter.

The Trust has also undergone a period of increased scrutiny of its processes and has approached this with openness and transparency.

The report that follows shows a thematic analysis of SIs, lessons learned and actions being taken, including those that are already completed.

The Trust is extremely grateful to those families and patients who have contributed to this process following the Duty of Candour conversations, and wishes to reiterate its most sincere apologies for those patients and families who have been affected in any way by these cases.

Other key issues to draw to the Board's attention:	During this process, a number of external regulators reviewed the Trust's governance processes for SIs and the Trust has received no recommendations to make changes. Senior clinicians took part in an independent harm analysis which has determined the final harm scoring via the National Reporting and Learning System (NRLS).

Action required by the Board:

To receive this report as assurance of the governance processes around patient safety, the completion and independent assurance during the review and the thematic local, regional and national learning from these Serious Incidents.

The Trust Board is also asked to agree that further monitoring will be undertaken by the Quality Governance Committee and reported to the Trust Board through the normal reporting process.

Previously considered by and recommendation(s) made:

N/A

Related Trust strategic objective(s):	*Please indicate those applicable (X):*
Putting into place a new responsive operating model to deliver sustainable performance and improved outcomes for patients	X
Maintaining the focus on delivering excellent high quality care to patients	X
Guarantee we have a patient focused and engaged workforce	
Delivering innovative solutions to ensure we are an efficient, effective and economic service	
Playing our part in the urgent and emergency care system, being community focused in delivering the NHS Five Year Forward View	

Other:	*Please indicate if applicable (X):*
To ensure effective governance and compliance	X

	Please answer Yes or No. If yes, please provide appropriate brief details
Legal implications	
Regulatory requirements	Yes, Health and Social Care Act 2012 (regulated activities)
Equality and diversity impacts	

Background
Winter 2017/18 was a difficult period for all ambulance services in the UK. Unprecedented demand was seen across the country, and the east of England was no exception. Nationally, ambulance handovers rose by 72% compared with 2014/15 figures[1].

The Trust's Quality Governance Committee (QGC) met on the 10 January 2018 and reviewed the pattern of Serious Incidents (SI) that had been raised by the Trust's Patient Safety Team and then declared as such by the Trust's Senior Clinical Panel. The QGC subsequently requested a "deep dive" for assurance purposes, which included the preparation of a list of incidents to review.

On the 17 January 2018, Clive Lewis MP raised concerns in Parliament and made claims that 19 patients had died as a consequence of delayed ambulance responses. The following week, Norman Lamb MP raised concerns and made claims that 40 patients had died as a consequence of delayed ambulance responses. He further claimed that up to 81 patients may have died.

The subsequent regulatory level of scrutiny in response to these claims meant that the Trust's preceding internal actions were overshadowed.

Between the period from 17th December 2017 to the 16th January 2018, the Trust received over 100,000 calls. The Trust identified 138 calls as having experienced a significantly delayed response. A further review by the Trust's Patient Safety Team identified that 47 incidents required more detailed scrutiny. Of those the Trust declared 22 SIs. These were coded via the defined national harm coding process.

Subsequent to the Risk Summit on 30th January 2018 meeting, all 22 of these were confirmed as Serious Incidents on the national SI reporting system. The purpose of this system is to ensure all Trusts have the opportunity to learn lessons from any investigations and enable learning for the future.

Clinical Risk and Mitigation
The Trust recognises that providing health care is not without risk. The East of England Ambulance Service (EEAST), which cares for the seriously ill and patients in extremis on a daily basis, covers a geography which contains a population of over 5.8 million people.

The Trust deals with expectant death and dying on a daily basis and not every patient who calls for our service can be helped or saved. However, in relation to those who can, there is an increased level of risk for those patients where the level of demand exceeds available capacity resulting in a delayed response.

EEAST has an evidence based gap between capacity and demand and hence, much of the focus of the Trust is to ensure that systems and processes are in place to ensure we mitigate that risk in so far as possible. Some examples over the winter period are additional command and control arrangements, Patient Safety Intervention Teams to ensure crews were released from hospitals, enhanced Hear and Treat to provide welfare calls and patient safety netting, additional response capacity through overtime and incident/reporting systems.

Despite all of these mitigation actions, 22 patients out of a potential 100,000 calls waited significantly longer for an ambulance response than we would want and were subsequently declared as Serious Incidents. Although this represents a very small percentage of the patients we treated during this period, it is still unacceptable that any of our patients could have suffered harm as a result of a delayed response. In this regard, the purpose of every investigation is to identify any lessons, obvious or otherwise, that may be learned.

Investigation Outcomes
Each of those 22 Serious Incidents have now been investigated and reports completed. Those reports are being provided to the patients/families and where they are willing to do so, the Trust will

meet with each of the recipients to ensure they have received and understood the report and have any questions answered.

Each of the 22 investigations has sought to identify whether or not the patient whom was the subject of the 999 call experienced harm. As previously indicated, healthcare, including all ambulance services, must deal with expectant death and dying every day. Therefore, the focus of any harm analysis is to understand whether or not the death was expectant or if in these cases, the delayed response caused death or actual harm.

To ensure the outcome of the harm analysis was independently validated, an Independent Review Panel, overseen by NHS Improvement, reviewed the outcomes of the 22 investigations. We can now confirm the outcome of that independent analysis has confirmed the following:

- No patient died as a consequence of a delayed response
- 3 patients experienced severe harm
- 4 patients experienced moderate harm
- 8 patients experienced low harm
- 7 patients experienced no harm

Contributory Factors
The Trust considered three contributory factors to the increase in demand this year; the higher acuity of patients, which saw a higher proportion of callers in Category 2.; the evidence based gap between the Trust's capacity and demand which has now been highlighted in the recently published Independent Service Review (ISR); and the increase in arrival to handover times at many of our regions hospitals.

<u>Thematic Review of 22 Serious Incident Investigations</u>
As part of the Trust's wider learning from these incidents, this thematic review has been undertaken to ensure that all local, regional and national learning is taking place. This will support the Trust for our winter 2018/19 plan and will be shared with the wider NHS system and other national ambulance service colleagues.

There are five broad themes for the Trust and wider regional system learning which are as follows:

- There is a gap between capacity and demand
- Arrival at Hospital to Handover Delays are a significant factor affecting available capacity
- Strengthening our capacity and forecasting processes will help mitigate some of these risks
- Ambulance Clinicians need to maximise the use of the Directory of Services to ensure patients can wherever clinically safe to do so, refer patients to local services, e.g. patients experiencing a fall.
- The need to expedite recruitment of additional Emergency Operations Centre (EOC) staff to reduce human factor issues which lead to human error

Lessons learned from this thematic review of serious incidents (SIs) will enable a system-wide collaboration for future periods of high demand. It will also allow the Trust and the wider health system to learn and implement lessons from this winter period and provide patients with reassurance that the Trust is taking the outcomes of the reports very seriously.

From this learning, the Trust has developed an action plan. The actions reflect the local, regional and national lessons and are being overseen by the executive team and supported by our external partners.

Local (Trust) actions:

Learning	Actions
To ensure capacity and demand is forecast well in advance to enable the safest response to patients.	*The Trust has ensured focus on forecasting and planning is maximised and monitored through weekly interrogation.*
To ensure early escalation of hospital handover delays through the appropriate chain to ensure opportunities for early action and response.	*With the support of NHSE, the Trust has led the development of a regional Arrival to Handover for use by all Acute Trusts.*
To ensure the Trust support the continued reduction in handover to clear times which will enable crews to respond quickly to call waiting in the community.	*The Trust has seen a continued reduction in this figure and will continue monitoring this.*
To review the use of the unfunded Patient Safety Intervention Teams (PSIT) teams and Hospital Ambulance Liaison Officers (HALO) with commissioner colleagues, alongside the launch of the Hospital Handover process agreed by the Trust and NHSE.	*PSIT teams have now ceased but HALOs continue in hospitals across the region which are challenged.*
Expedite recruitment of additional EOC staff to reduce human factors issues brought about through reduced staffing. To also support staff for coding issues and the management of the stack when at surge.	*The Trust has a recruitment plan for EOC and has already provided one-to-one support for call handlers and dispatchers on escalation, patient safety and use of clinicians within the room for guidance.*
Further work is needed to ensure that directory of services are up to date and actively utilised.	*The Trust is working with its commissioners and has been publicising MiDoS to staff to support increased usage.*
To review with the CCGs the process of inter hospital transfers and to provide some education regarding the requirement of a \`paramedic ambulance' to provide the transfer.	*NHS England are expected to release guidance in the near future*

Regional actions:

- The Ambulance Trust should ensure that the CCG provided directory of services is easily accessible and part of the script in EOC i.e. falls services, parish nurses, crisis interventions etc.
- Commissioners and providers (including the Ambulance Trust) to work with local Primary Care networks to develop a more effective approach to managing GP/HCP calls with a view to reducing demand on EEAST.

These actions are already in discussion with our commissioners.

National actions:

- The welfare call process is established to safeguard patients and to mitigate risk and therefore needs to be resourced appropriately.
- Call triage scripts for patients who have fallen and remain on the floor should be reviewed as this could cause harm to some patients, e.g. those with diabetes.
- Call coding and quantification of harm should be reviewed nationally for consistency in light of this review. The coding does not cover ambulance-specific elements.
- Commissioners need to ensure that ambulance services are involved in the development of local service delivery options and that ambulance trusts are utilising those alternative pathways efficiently and effectively, i.e. a falls response service.
- National review of an engagement strategy with the relevant independent care providers to review policies and procedures in relation to patients who have fallen with no apparent harm. This would also apply to end of life care policies.

Openness and Transparency

Keeping patients safe is our main priority, both now and in the future and aligns with our recognition of Sir Robert Francis' report recommendation that "fostering a common culture should be shared by all in the service of putting the patient first."

Now that these SI reports are formally signed off by the lead Clinical Commissioning Group and an action plan is agreed, the families are now being contacted again to support any further explanations they may require and to ensure the Duty of Candour process continues. The Trust will offer a formal meeting with each of the families should they be willing to do so whilst recognising and respecting their right to privacy and dignity at this difficult time. While the Trust will release this paper on request, it would be inappropriate to release any of the 22 investigation reports as these are specific to individual families and the release of such information would clearly facilitate identification of the patients concerned.

Assurance and Governance

The Trust was also involved in two additional scrutiny processes following the risk summit, which were external to normal governance processes and allowed the Trust to learn more from the reports and patients' experiences. The first was an additional layer of scrutiny from the Clinical Commissioning Groups for the SI reports themselves. This comprised of a senior panel representative of the three locality CCGs and the lead CCG, Ipswich and East Suffolk. The panel meet each week to review all the reports and to discuss their contents prior to agreeing any formal sign-off and closure. Feedback was received via the senior group to the Trust for suggested changes to the reports and then final versions were presented back to the senior panel prior to formal closure.

The second was an independent harm analysis for coding of harm for these cases. This consisted of four senior clinicians; one an independent Emergency Medical Consultant, one a Senior Clinician from NHS Improvement and two senior clinicians from two separate CCGs. The harm analysis, overseen by NHS Improvement, had its own Terms of Reference and a full and thorough process was undertaken for consideration of harm as per the National Learning and Reporting System (NRLS) code sets. It should be noted that this code set is not wholly appropriate for the ambulance service due to its categorisation being mostly based around hospital functions. This has previously been raised nationally as a risk. However, the coding is normally completed by our Patient Safety Officers who have done this consistently for some time. As such, it should be recognised that this Independent Review Panel were able to review the harm independently and recommend any changes as per their expert clinical judgement. The final analysis concluded that nine remained as per the Trust score, five increased (two to low harm and three to severe harm) and eight decreased.

One of the key messages for the Trust Board is that the process for determining the levels of harm followed the NRLS system, which is adopted by all NHS organisations for mandated harm reporting.

The Trust has been tested and challenged through detailed and thorough independent and regulatory scrutiny of its governance processes and, the patient safety process in particular. The Trust has dealt with this in an open and transparent manner and has welcomed all feedback and opportunities for learning from the CCGs, NHSI and the CQC. The Trust processes have been found to be robust and comprehensive and we have received no recommendations for improvement. Whilst this is reassuring to note, the Trust will not be complacent and will ensure its processes are continually reviewed and monitored.

The Trust will begin work with our commissioners and stakeholders on a Mortality Review process which, whilst not mandated for ambulance services nationally, will be another way to support a full root cause analysis of patient deaths, acknowledging that many patients are fatally ill or injured at the point of calling for an ambulance in the first instance.

Apology
We offer our sincere apologies for the experiences of the patients and their families, for the 22 incidents in particular and for all of those patients that did not get a response in the way we would want or expect.

Recommendation
The Board is asked to accept this paper as assurance that the Trust and the wider health system has identified learning and developed actions resulting from the Serious Incidents arising from ambulance delays over the defined winter period. The Trust Board will receive ongoing assurance of adherence to these actions along with monitoring of harm via the Quality Governance Committee and in line with normal NHS processes.

1. A full report (NHS Winter Pressures 2017/18, England) can be found at http://researchbriefings.files.parliament.uk/documents/CBP-8210/CBP-8210.pdf