Yorkshire Ambulance Service NHS
NHS Trust

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<tr><td>Author</td><td colspan="2">Alison Lennox
Risk Manager</td><td colspan="2">Accountable Director:</td><td colspan="2">Steve Page, Executive Director of Standards and Compliance</td></tr>
<tr><td colspan="5">RISK ASSESSMENT</td><td>Yes</td><td>No</td></tr>
<tr><td colspan="5">Changes to the Corporate Risk Register and/or Board Assurance Framework</td><td></td><td>X</td></tr>
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ASSURANCE/COMPLIANCE		
CQC Registration Outcome(s)	**Auditors' Local Evaluation**	**NHSLA Risk Management Standards**
16		2 – Learning from Experience

1. PURPOSE

1.1 This report provides the Trust Board with a briefing on significant adverse events highlighted through Trust reporting systems and by external regulatory bodies. The report also focuses on actions taken and lessons learned and provides a summary of the actions taken.

1.2 The report covers the period 26 June 2012 – 31 August 2012.

2. BACKGROUND

2.1 The report is intended to brief the Trust Board on significant events highlighted through Trust reporting systems, and to provide assurance that actions are taken and lessons learned following investigations.

2.2 This report brings together information from the following sources:

- Incidents
- Serious Incidents
- Complaints and Concerns
- Clinical Case Reviews
- Patient Experience Reports

2.3 The following sources are also part of the systems for lessons learned, however there have been no issues highlighted or recommendations received during the period.

- Rule 43 Letters – The National Ambulance Quality Governance and Risk Directors group has recently collated Rule 43 letters issued to different ambulance organisations in recent months. YAS has reviewed the recommendations made to other ambulance trusts and considered changes to practice where necessary.
- Serious Case Reviews
- Ombudsman Requests

2.4 The report highlights learning identified through the investigation of specific incidents and consideration of issues, themes and trends.

2.5 Reporting and management processes are in place to identify, risk assess, investigate and follow up adverse events from a range of different reporting streams. Corporate support and guidance for investigation is provided by the Standards & Compliance and Clinical Directorates, working with individual managers with responsibility for investigation and follow up within their own areas of responsibility.

2.6 Where necessary, immediate action is taken to ensure patient and staff safety following an incident. This is supported by a more formal incident review and root cause analysis proportionate to the seriousness of the event and to ensure that all relevant lessons are learned.

2.7 Review and follow up of individual adverse events of a serious nature is monitored through the Incident Review Group, and consideration of broader themes and issues arising is part of the remit of a number of Trust management groups, including primarily the Clinical Governance Group and Health & Safety Committee.

3 INCIDENTS

3.1 The table below shows the numbers of new incidents reported each month.

Table 1: New Incidents Reported

New Incidents Reported	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
Ops - A&E	260	244	378	371	411	355	302	319	360	365	373	332
A&R	61	41	65	84	216	45	42	30	28	23	52	48
PTS	59	54	79	74	90	68	68	66	79	67	72	89
OTHER	161	223	12	8	14	20	17	17	24	13	21	35
TOTALS	541	562	534	537	731	488	429	432	491	468	518	484

The number of new incidents reported has remained consistent in comparison to recent months. An increase in “other“ area incidents is primarily related to incidents with non-operational vehicles and information governance issues. The information governance issues were minor in nature mainly surrounding loss of ID badges and individual issues involving loss of data internally during ICT upgrades. There has been no significant loss of personally identifiable data during this period.

Table 2: Patient-Related Incidents

Patient Related Incidents	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
Ops - A&E	24	25	33	43	18	18	24	29	47	38	34	31
A&R	0	2	2	1	1	0	1	0	0	1	1	0
PTS	28	20	27	28	32	26	21	22	30	29	27	24
OTHER	1	2	0	0	0	0	0	1	1	0	1	0
TOTALS	53	49	62	72	51	44	46	52	78	68	63	55

The most common type of incident was 'near miss'. The 'near miss' incidents were primarily PTS patients who almost fell during their journey either entering or leaving the vehicle. Other 'near miss' incidents involved a vehicle running out of fuel but without any adverse patient outcome and a small number of incidents related to reported patient attitude which had the potential to cause difficulties for staff. The most common incident type leading to harm involved slips or falls on of PTS patients while they were walking from home to vehicle or vice versa. This has been brought to the attention of the PTS management team.

Table 3: Staff-Related Incidents

Staff Related Incidents	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
Ops - A&E	75	82	82	79	90	71	50	66	63	79	71	83
A&R	0	4	2	1	1	2	1	4	2	2	3	3
PTS	14	20	12	20	22	15	16	13	8	15	20	18
OTHER	5	9	6	4	2	1	4	3	7	3	3	2
TOTALS	94	115	102	104	115	89	71	86	80	99	97	106

The most common type of incident in Operations is 'moving and handling'. 12 of these moving and handling incidents related to the blue equipment bag however work is continuing to find a replacement bag which will be more suitable with a specification being developed to inform the replacement based on the output from a Loughborough University study. 6 incidents related to staff handling of bariatric patients and 9 of these incidents were related to staff suffering injuries while using equipment i.e. stretcher, carry chair.

3.3 No major information security incidents have been identified, although a number of low level incidents (approx 4% of new incidents reported in July and August) have been highlighted through the Prism incident reporting system as outlined in section 3.1 above. Following this, an article was issued in Operational Update reminding staff of their responsibilities when handling patient records, and specifically;

- To ensure the confidentiality and security of patient records from completion and up to the point where the records are placed in the locked PRF boxes on stations.
- To keep PRF forms out of sight of patients and the general public, where possible.
- To never to leave a PRF folder unattended, e.g. in an unlocked vehicle.
- To empty the contents of the PRF folder on return to station to ensure that the minimum number of PRFs are on vehicles at any point in time.
- To report confidentiality breaches, losses and near misses relating to PRFs through the Trust's incident reporting process.

3.4 The table below shows the numbers of medication related incidents reported each month.

Table 4: Medication-Related Incidents

	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
TOTALS	62	39	21	48	53	34	44	31	43	42	23	42

The number of medication incidents remains within the previously reported range. The main reason for reporting remains drug discrepancies identified during routine audits and morphine vial breakages however no significant medication incidents with harm to patients have been reported.

3.5 The table below shows the numbers of serious incidents reported each month.

Table 5: Serious Incidents

SI Incidents	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug
Ops - A&E	1	0	0	0	0	0	0	1	0	0	2	0
EOC	0	1	0	0	2	1	1	2	1	2	4	1
PTS	0	0	0	1	0	0	0	0	0	0	0	0
OTHER	0	0	0	0	0	0	0	0	0	0	0	0
TOTALS	**1**	**1**	**0**	**1**	**2**	**1**	**1**	**3**	**1**	**2**	**6**	**1**

There have been 7 new serious incidents (SIs) reported to the commissioners during the period of this report:

- 10 December 2012: Delay in Double Manned Ambulance backing up Rapid Response Vehicle for female not responding. Incident not reported at the time hence the delay in reporting the SI.

- 12 June 2012: Delayed response to 2 month old baby in cardiac arrest and incorrect CPR instructions given.

- 13 July 2012: Delay in shocking patient due to suggested error with defibrillator pads.

- 13 July 2012: Delay in responding to patient due to crew not keying clear, and delay in mobilising to incident.

- 17 July 2012: Delay in Double Manned Ambulance backing up Rapid Response Vehicle, and cardiac arrest patient was refused at Pontefract General Infirmary and diverted to Pinderfields General Hospital.

- 30 July 2012: Delay in conveyance of patient (inter hospital transfer).

- 12 August 2012: Delayed response due to incorrect coding of call for patient heavily bleeding, unconscious and not breathing.

The SIs reported in July and August are currently being investigated and lessons learned from these incidents will be reported on in the next Board report. YAS currently has four other SIs open which have undergone full investigations. These reports are awaiting commissioner review & comment.

Key lessons learned from these include:

- The importance of using call centre Pro-QA system correctly to enable the appropriate coding of all incidents without delay, particularly when there is a significant change in a patient’s condition during the process of a call; the call handler should ensure one of the following actions are taken:
  - Reconfigure the incident by changing the answer in key questions from ‘breathing’ to ‘not breathing’.

OR

- If available, activate the ‘dead clown eye’ icon in Pro-QA as soon as you are aware of a significant change (the patient as stopped breathing/ineffective or agonal breathing/cardiac arrest).

Both actions will allow for the incident to be re-coded immediately and the dispatcher will be notified simultaneously, avoiding any delays in patient care. Further guidance has been issued as an operational alert to notify EOC staff.

- The importance of reinforcement and adherence to protocols within EOC and requirement for additional management action to support this.

- The Head of Quality has conducted an independent review of incidents reported in relation to the EOC function to determine any underlying themes or issues. The report was presented to the September meeting of the Quality Committee. The Committee supported the recommendations in the paper, including the establishment of a task and finish group led by the Associate Director of Risk & Safety supporting the EOC management team in implementing actions identified in the review.

4 COMPLAINTS & CONCERNS

4.1 A breakdown of complaints and concerns reported between July 2012 and August 2012 is provided in YAS Integrated Performance Report.

4.2 The following are key lessons learned by the Trust resulting from investigation of reported complaints and concerns:

Staff attitude to volunteers, care home staff and other healthcare professionals

Whilst small in number this is a theme in complaints and concerns and relates to poor staff attitude towards other healthcare professionals, care home staff and volunteers such as first-aiders. Some staff have been reported as being dismissive towards these groups of people on arrival on scene (A&E) or in attendance at a care/residential home (PTS). There is an indication that some staff are not listening carefully or communicating professionally, and therefore failing to provide the standard of care expected. Work is underway to improve communication with carers/first-persons-on-scene and to raise awareness of the importance of listening to the information they provide for the benefit of patient care.

EOC coding of arterial bleeds

Three complaints relate to emergency calls, where patients reported bleeding following the removal of arterial stents. The investigation process identified an issue with Advanced Medical Priority Dispatch System (AMPDS) coding. This issue is being investigated further by management teams from the Emergency Operations Centre and the Clinical Directorate.

EOC Headache Card

Three concerns relate to a further AMPDS coding issue. The cases relate to the inappropriate coding for headache being selected on the information available, when the patients actually suffered more serious conditions, such as; subarachnoid haemorrhage. The Associate Medical Director lead for EOC is currently reviewing the coding for the headache card.

5 CLINICAL CASE REVIEWS

5.1 Two Clinical Case Reviews took place during this period from which there are no organisational learning points identified.

6 PATIENT EXPERIENCE

6.1 Work is ongoing in the Quality Team to complete patient experience surveys, in order to identify areas for improvement. The most significant process during this period includes:

PTS Discharge Policy

6.2 A report was received from East Riding of Yorkshire Local Involvement Network (ERY LINk) into 'Joined-Up Hospital Discharge'. The report highlighted a number of occasions where patients stated that they had been transported home by the PTS service and left in a situation where they did not feel safe or able to care for themselves. The LINk recommended that the Trust should have a specific policy for handling hospital discharges.

6.3 The Trust has identified that hospital discharges are a point of potential risk for vulnerable patients. For this reason our Safeguarding Team is working on a pilot project in the Bradford area to review the discharge process in conjunction with local hospitals. The focus of this work is to identify people who may be vulnerable and to put additional measures in place to ensure they are not left in unsafe circumstances and that they are referred to the appropriate sources of support and care. If this work is successful The Trust will aim to share the best practice across all areas.

6.4 The East Riding of York PTS Locality Team has invited ERY LINk to support them in developing a hospital discharge policy.

Welfare of PTS patients while waiting for return transport

6.5 A concern identified from patient groups and from PTS surveys and comments cards relates to the welfare of patients waiting for return transport following their hospital appointment. In the majority of hospitals patients are brought into a dedicated waiting area away from their clinic. Whilst here, but before they are collected by PTS drivers, it is the responsibility of the hospital to meet welfare requirements such as nutrition/hydration and toilet access. It has been identified that few waiting areas are routinely staffed by a member of hospital staff/volunteers and that there are no formal procedures for welfare checks if long waits do occur.

6.6 A mapping exercise has been completed on arrangements in each hospital to which the Trust PTS service take patients, and where the patient experience issue is clear. It was agreed at the Quality Committee that this issue will be placed on the agenda for addressing at the Regional Director of Nursing meeting.

Understanding of how the ambulance service works

6.7 The clearest theme from complaints, concerns and patient experience survey results is that of patients' experience of the ambulance service not meeting their actual expectations if they call with a non-life-threatening condition. It has been identified that patients/public do not expect to have their call triaged. The Quality Team is feeding this learning into the CQUIN development focussed on public information about the ambulance service with the aim of raising public awareness.

6.8 A Trust engagement group has been established by the Director of Corporate Affairs involving; Leadership and Learning, Foundation Trust, Corporate Communications and members of the Quality Team to improve work around public engagement. Working together to improve public understanding will be a key objective of the group and work has already commenced to strengthen this area.

7 BEING OPEN

7.1 The Incident Review Group determines cases where contact is deemed appropriate under the Trust's Being Open Policy, from all significant events reported to each meeting. The Trust Being Open Policy has been applied appropriately during the reporting period and contact with families in the majority of SIs is currently being pursued.

8 NEXT STEPS

8.1 The Trust Standards and Compliance Directorate continues to develop the Trust's approach to learning lessons. A significant development will be the implementation of a new data management system to enhance the Trust's ability to store, analyse and report data. An implementation plan has been developed and agreed with the suppliers Datix and it is anticipated that this system will replace Prism by the end of March 2013.

9 RECOMMENDATIONS

9.1 The Trust Board note the contents and supports the actions detailed in the paper.