Public Trust Board				27 November 2012	
Title	Significant Events and Lessons Learned			**Paper Ref**	6.3
PURPOSE (X)		**Information**	**X**	**Strategic Goal**	**Business Plan Objective**
Approval		**Decision**			
Assurance	**X**	**Discussion**		Always Learning	5
Purpose of the paper	This report provides the Trust Board with a briefing on significant events highlighted through Trust reporting systems and by external regulatory bodies. The report also focuses on actions taken and lessons learned.				
Recommendation	The Trust Board notes the contents and supports the actions detailed in the paper.				
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RISK ASSESSMENT	**Yes**	**No**
Changes to the Corporate Risk Register and/or Board Assurance Framework		**X**
Resource Implications		**X**
Legal implications		**X**

ASSURANCE/COMPLIANCE	
CQC Registration Outcome(s)	**NHSLA Risk Management Standards for Ambulance Trusts**
1, 16	2.6

1. PURPOSE

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

1.2 The report covers the period 21 August – 19 October 2012.

2. BACKGROUND/CONTEXT

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

2.2 Where necessary immediate action is taken to ensure patient and staff safety following an event. This is followed by more formal incident review and analysis proportionate to the seriousness of the event, to ensure that all relevant lessons are learned. Trust timescales for these reviews are in line with national and regional guidance.

2.3 Specific sources of significant event & lessons learned within the scope of this report include:

- Serious Incidents reported to the Trust's commissioners.
- Incidents.
- Complaints – including requests received from the Ombudsman.
- Claims.
- Coroners Inquests – including Rule 43 letters received by the Trust.
- Safeguarding Serious Case Reviews.
- Professional Body Referrals.
- Clinical Case Reviews.
- Patient Experience.
- Information Commissioner's Office notifications.
- Health & Safety Executive notifications.
- Being Open.

2.4 Other sources may be included from time to time, based on the nature of the events occurring.

3. SERIOUS INCIDENTS

3.1 New Serious Incidents (SIs) reported to the commissioners between *21 August & 24 October (please note the reporting period is slightly longer than the other elements within the report to allow for more up to date notification of SIs)*

- 30 July 2012: a delay in an Inter-Facility Transfer.

- 14 August 2012: failure to transport a Patient Transport Service (PTS) patient on the requested day.

- 30 September 2012: a Road Traffic Collision (RTC) between a pedestrian and a Trust vehicle.

- 1 October 2012: a small electrical fault in the YAS headquarters caused significant disruption to service.

3.2 Some lessons learnt and actions taken from Serious Incidents (SIs) reported in previous periods include:

- Work is underway between YAS and other Trusts within the area to explore the possibility of devising pre-alert instructions to ensure accurate and appropriate information is conveyed between all staff.

- Changes have been proposed within the EOC to amend the requests made for Double Manned Ambulance (DMA) back-up. The changes will include three methods of requesting back-up; request immediate back-up, request back-up on next available DMA and request back-up within a specified timeframe. This would assist the EOC staff in ensuring back-up is provided efficiently when required.

- A training calendar has been devised within EOC to accommodate refresher training, workshops and briefings for staff to ensure they fully understand all policies and procedures.

- New procedures have been developed in the Ingleton area to ensure staff correctly book on/off duty. This followed an incident where a crew were available to respond to an emergency but who did not appear as available to the EOC.

- Changes have been made locally within the EOC to the headache protocols following a delay in responding to a seriously unwell patient. YAS have raised this as a suggestion for changing the protocols nationally.

- Following an incident relating to the Obvious & Expected Death cards used within the Advanced Medical Priority Dispatch System (AMPDS), all EOC staff have been re-trained on how to use these appropriately.

3.3 Serious Incident reporting timescales

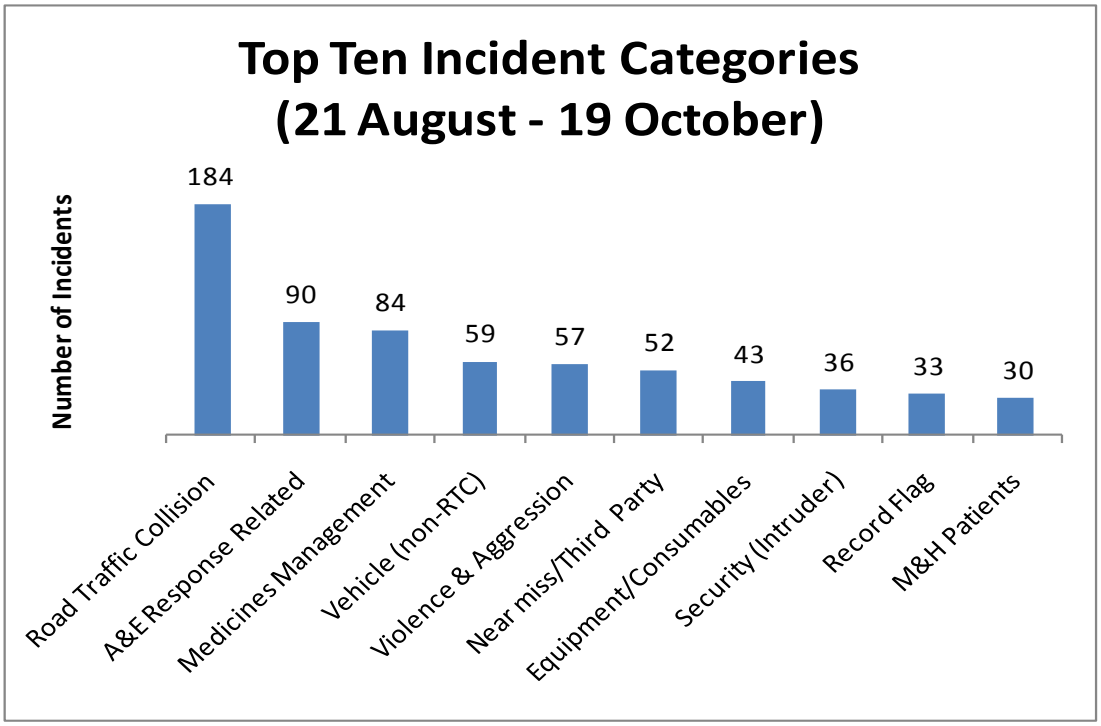
Serious Incident investigations must be conducted within 12 weeks of the date they are reported to the commissioners. Currently all open SIs are within the required timescales and YAS has not requested an extension on any SI since November 2011.

Improvements are required around the prompt reporting of SIs. In agreement with the Schedule 12 contract held between YAS and NHS Bradford, Airedale & Leeds, all SIs should be reported within 1 working day of the incident occurring. Currently, this does not happen in all cases; partly due to the delay in incidents being reported on the Prism incident reporting system.

Work is underway to educate staff on the importance of prompt reporting. The implementation of Datix (the Trust's new incident reporting system); which will take the place of Prism in March 2013 should assist in prompt fact-finding to allow decisions to be made quicker.

4. INCIDENTS

4.1. Top 10 incident categories across the Trust.

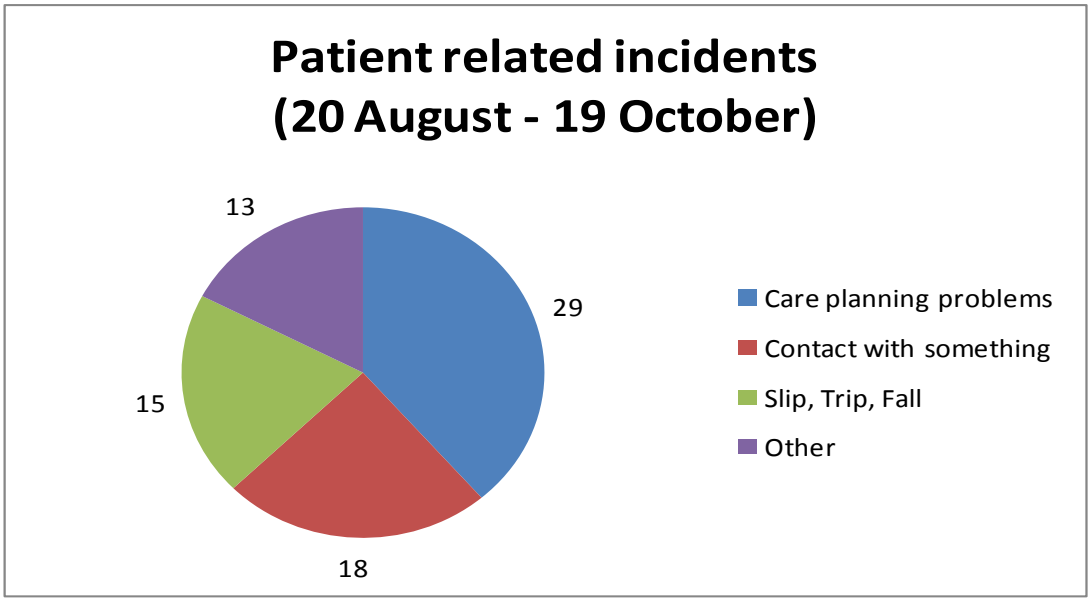


- **Road Traffic Collisions**
  Road Traffic Collisions is the highest incident category in this period. This is common across previous reporting periods. The implementation of the Driving at Work Policy should facilitate a reduction in the number of RTCs over the coming months. A Cost Improvement Programme (CIP) is in place aimed at reducing the number of RTCs and early indications suggest this is having a positive impact with a reduction in incidents in comparison to previous quarters.

- **A&E Response Related**
  The general theme of 'A&E Response' related incidents appears to be around the allocation of incidents from EOC and the response of emergency vehicles. An EOC Task & Finish Group has been established following September's Quality Committee and the action plan for this group is in the process of implementation.

- **Medicines Management**
  These incidents primarily relate to drug accounting discrepancies (33 incidents), drugs lost, damaged (13 incidents) and failure to follow YAS protocol (11 incidents). All medicines management related incidents are managed and monitored through Medicines Management Group and any issues relating to themes or trends are appropriately actioned through this group. Action has been taken recently to improve controlled drug storage and thereby reduce breakages.

4.2. Patient related incidents



Patient related incidents currently include categories such as care planning problems, slips, trips & falls, patient contact with something i.e. a piece of equipment, amongst others.

Care planning problems
The care planning problems relate to poor advice being given by external parties and where appropriate these will be dealt with as service-to-service complaints. They also include lack of an appropriate care plan or clinical pathway being in place. These incidents are highlighted to the Clinical Pathways Advisor and dealt with appropriately.

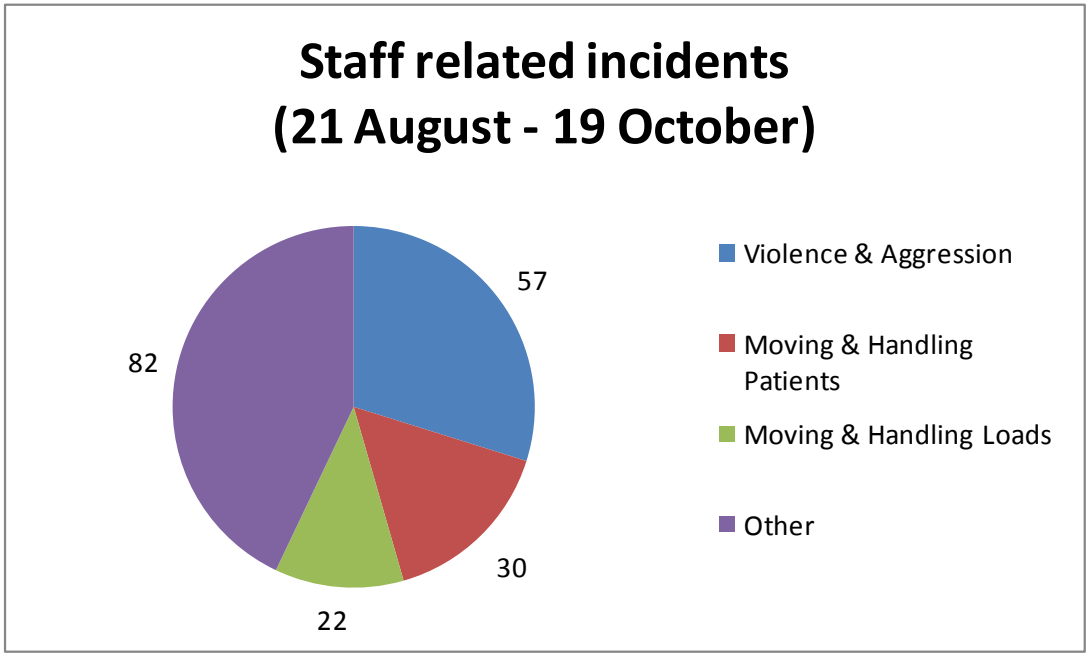
Contact with something
Most of these incidents are involving contact with furniture or fittings either inside a Trust vehicle or when patients are leaving their home for appointments. A small number of these incidents also include contact with the outside of the ambulance.

Slips, trips & falls
Work is ongoing through CQUIN indicator 4 (Development of a patient safety thermometer) relating to slips, trips & falls and interventions are being identified that will help reduce the number of these incidents.

Other
Other incidents include:

- Manual handling – most of these incidents involve patients falling when being moved using a wheelchair or a stretcher.
- Equipment related – most of the equipment related incidents were near misses primarily when using IV access equipment. One incident related to a CAT tourniquet and one incident related to a combi board splitting.
- PTS patient falling ill while in transport – 2 incidents were reported in this category and both incidents were minor.

4.3. Staff related incidents



The staff related incidents primarily relate to reports of violent and aggressive behaviour towards staff and moving and handling issues.

Violence & aggression
22 of these incidents relate to verbal abuse from patients and staff being made to feel intimidated by these threats. A further 22 incidents relate to actual violence from patients. All violence and aggression incidents are investigated by the Local Security Management Specialist.

There has been some recent work to encourage staff to report these types of incidents so that analysis and aggregation can be conducted to identify potential interventions.

Moving & handling patients
A third of these incidents involved the carry chair. The Vehicle & Equipment Group have put forward a recommendation to purchase the new Compact 2 carry chair with extending handles and a detachable track. The Trust will be beginning the replacement of the carry chairs as part of the 2013/14 capital programme. Other incidents involved bariatric patients and incidents where patients have fallen from stretchers or wheelchairs and injured staff. The Trust has procured five fully-equipped bariatric vehicles and the Operations Directorate is currently developing a staffing model and implementation plan for their use.

Moving & handling loads
Almost half of the incidents related to the blue equipment bag. Work has been completed with Loughborough University regarding the design of an emergency response bag which will provide comfort to staff using it and reduce the risk of injury. A tender process for a new bag is under way and a trial period is to run for 3 weeks in February 2013 to enable staff to participate in the selection process. The Trust expects to place an order for new bags in April 2013 and to be in a position to roll out the new bags by June 2013.

Other
The other incidents include:

- Employee attitude: 24
- Contact with harmful substance: 4
- Contact with sharps: 10
- Contact with something (i.e. furniture, machinery, ambulance): 18
- Infection prevention: 2
- Slips, trips & falls: 16
- Stress: 5
- Training related: 3
- Staff welfare: 9

All the above incidents have been investigated and managed appropriately by the managers in those areas. The majority of incidents were graded Green or Yellow requiring local investigation. An area of concern for the Trust is related to slips, trips & falls with the potential for litigation. A quarter of these incidents are falls in potholes, and a quarter are falls from the vehicle step. These incidents have been highlighted to the Estates and Fleet team and will be monitored to see if these are recurring issues.

5. COMPLAINTS & PATIENT EXPERIENCE

5.1 Understanding of the EOC

We continue to receive complaints and feedback via our A&E survey that shows that callers have not understood the statement given by EOC call takers relating to the call being passed to the Clinical Hub/NHS Direct. It has been agreed that this statement will be reviewed, including members of the public in this work, to improve the clarity of this statement.

One of the most frequent issues raised with YAS is dissatisfaction with calls being referred for clinical triage rather than receiving an immediate 999 response. We understand that in many cases this is a case of expectations not being met. The Patient Experience Team is working with the Leadership and Learning Foundation Trust and Corporate Communications teams to build key messages into Communications Plans and to share engagement opportunities.

A review of the 'what happens when you call 999' leaflet to reflect current EOC practice is being taken forward by the Corporate Communications Team. It has been proposed that the leaflet is updated in November/December 2012 once the latest changes planned for EOC have been implemented.

5.2 YAS Staff Attitude Toward Care Home Staff

The Trust has received a recent increase in numbers, from South Yorkshire in particular. The patient experience team have passed the information onto the South Yorkshire clinical supervisors and the Sheffield Locality Manager to request that they reinforce good practice with their teams.

The YAS Lead Nurse for Urgent Care (interim) Angela Harris is working to improve the understanding of care homes on the use of the emergency number. It is proposed that information about this programme is shared with staff so they understand how the Trust is working to manage demand. Clinical tutors are also requested to remind staff about the dignity code and the need to remain professional in all circumstances.

5.3 End of Life Issues

Three recent complaints related to end of life issues. Key points in these cases were:

- Lack of clarity at nursing homes about how to handle the death of a resident and obtain verification of death. This led to the attendance of a crew and a discussion about whether the Police needed to be called. The home felt this was undignified for the deceased.

- Lack of DNACPR paperwork leading to a terminally ill patient being taken to hospital against the wishes of the family and the care team who were supporting him to remain at home

- Lack of clarity at nursing homes about how to obtain out-of-hours support when terminally ill residents require assistance – leading to ambulance clinicians being sent. YAS Lead Nurse for Urgent Care (interim) is currently leading a piece of work around nursing homes and end of life care, and this will be addressed as part of that project.

5.4 **Conveyance of Wheelchair Users**

We have received additional feedback on this previously highlighted issue. Wheelchair users are expressing concerns that emergency ambulances are unable to transport them to hospital in their own wheelchairs. This adds significantly to their distress. The current YAS position is that clinicians must assess each situation and decide on a course of action based on the seriousness of the patient's condition.

This issue continues to be raised via patients' groups. It is proposed that the Trust Conveyance Policy is reviewed in light of this recent feedback and that wheelchair users are consulted. Information for wheelchair users also needs to be developed and made available to patients to explain the Trust's position.

5.5 **Staff Communication to Patients When Considering Safeguarding Referrals**

A number of recent staff attitude complaints have arisen where a staff member has had to make a judgement about whether to make a safeguarding referral. On investigation it has become clear that staff have been focused on ascertaining key information about the patient/child's safety in line with their training. But that in doing so they have not seen how this would be perceived by the person involved. New information has been passed to the Safeguarding Team to be included in training programmes. This includes some learning from experience and a reminder of the Trust Dignity Code.

5.6 **Welfare of PTS patients while waiting for return transport**

An on-going theme from feedback from patient groups and from PTS surveys and comments cards is 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 in the waiting area, but before they are collected by our PTS drivers it is the responsibility of the hospital to meet welfare requirements such as nutrition/hydration and toilet access.

However, few waiting areas are routinely staffed by a member of hospital staff/volunteer and there are no formal procedures for welfare checks if long waits do occur. A mapping exercise has been completed of arrangements in each hospital to which YAS PTS take patients and 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.

6. CLAIMS

6.1 A number of recent claims have been related to staff injuries associated with carrying the blue equipment bag and carry chair. Work is ongoing to address these issues, as detailed in section 4.3 of the report. Another area of concern within claims is staff claims for injuries from falling in potholes on site. Funding has been allocated to repair potholes.

7. CORONERS INQUESTS

7.1 A lesson that has been identified following a Coroner's Inquest during this period is around correct completion of Patient Report Forms. Staff are to be reminded of the importance of completing PRFs as in the coroner's case, the incorrect completion led to a possible delay in treatment of a patient. Training school is also to incorporate accurate completion of PRFs as a learner outcome.

8. SAFEGUARDING SERIOUS CASE REVIEWS (SCRs)

8.1 No notifications of SCRs have been received during this period.

8.2 No SCRs were received in the previous reporting period therefore there are no lessons learnt to update the Trust Board on.

9. PROFESSIONAL BODY REFERRALS

9.1 Information is reviewed in the fortnightly Incident Review Group meetings. No significant cases are highlighted in this report. A discrete exercise is under way in relation to the Hillsborough disaster. The Trust is currently in correspondence with the HCPC in relation to a review commissioned by the Department of Health.

10. CLINICAL CASE REVIEWS (CCRs)

10.1. The CCRs conducted in this period related to appropriate completion of paperwork. The individual issues have been addressed and there are no organisational lessons learnt to be taken from the reviews.

11. INFORMATION COMMISSIONERS OFFICE (ICO) NOTIFICATIONS

11.1 No letters from the ICO have been received during this period.

11.2 As there were no letters from the ICO detailed in the last report, there are subsequently no lessons learnt to update the Trust Board on.

12. HEALTH & SAFETY EXECUTIVE (HSE) NOTIFICATIONS

12.1 No formal notifications from the HSE have been received during this period.

12.2 No further action was required from the concern raised in the previous report relating to the vehicle lift failing its statutory inspection. The lift was fixed accordingly and the matter closed.

13. BEING OPEN

13.1 The Trust continues to be committed to being open with patients and/or families involved in incidents.

13.2 The Trust has exercised the being open policy in relation to a number of Serious Incidents in recent months. Individual cases are reviewed in the Incident Review Group.

14. TRUST-LEVEL OVERVIEW

14.1 A common theme has been identified across claims and incidents, relating to issues with the blue equipment bag. As detailed above there is a project ongoing within the Trust to identify a more suitable equipment bag to reduce the number of moving and handling injuries.

14.2 There are currently no other themes or trends arising across departments.

14.3 The EOC Task & Finish Group is now working on implementing change within the EOC following a number of incidents and SIs that occurred in 2012. This includes amendments to the read-and-sign policy to ensure staff are aware of all policies and procedures within the EOC. Amendments to the audit process have also been made to ensure any capability issues are addressed.

15. PROPOSALS/NEXT STEPS

15.1 Future reports will cover a 2 month period covering any new significant events which have occurred since the reporting period of this report.

16. RECOMMENDATIONS

16.1 The Trust Board accept the contents and supports the actions detailed in the paper.