Yorkshire Ambulance Service NHS
NHS Trust

An Aspirant Foundation Trust

MEETING TITLE Public Trust Board		**MEETING DATE** 21/05/2013	
TITLE of PAPER	Significant Events & Lessons Learned	**PAPER REF**	5.2
STRATEGIC OBJECTIVE	To develop culture, systems and processes to support continuous improvement and innovation		
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.		
For Approval	☐	**For Assurance**	☒
For Decision	☐	**Discussion/Information**	☒
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PREVIOUSLY CONSIDERED BY	**Committee/Group:** Quality Committee	**Date:** 14/05/2013	
RECOMMENDATION	The Trust Board notes the contents and supports the actions detailed in the paper.		

RISK ASSESSMENT	**Yes**	**No**
Corporate Risk Register and/or Board Assurance Framework amended	☐	☒
Resource Implications (Financial, Workforce, other - specify)	☐	☒
Legal implications/Regulatory requirements	☐	☒
Quality and Diversity Implications	☐	☒

ASSURANCE/COMPLIANCE	
Care Quality Commission Registration Outcome(s)	4: Care and welfare of people who use services 10: Safety and suitability of premises 17: Complaints 9: Management of medicines
NHSLA Risk Management Standards for Ambulance Trusts	2: Learning from Experience

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 1November 2012 to 30 April 2013.

2. BACKGROUND/CONTEXT

2.1 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.

2.2 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.
- Information Commissioner's Office notifications.
- Health & Safety Executive notifications.
- Being Open.

2.2 The Trust Incident Review Group (IRG) meets bi-weekly and considers all cases rated as ‘red’ or ‘amber’ via the Trust risk grading system. IRG is the key forum for ensuring that themes and trends across multiple sources are identified and that lessons learned are shared across teams and appropriate action plans are in place. This group is chaired by the Trust Medical Director and includes all associate director-level clinical leads as well as managers responsible for managing the work above.

2.3 The nominated local investigating manager is responsible for ensuring that action plans to address lessons learned are delivered. They are accountable for this work via their line management structure. Additional monitoring systems are in place for serious incidents and notifications from external agencies. Local Operational Management Boards receive reports on lessons learned within their governance or standards & compliance updates.

2.4 At a corporate level, lessons relating to clinical care are reported monthly to Clinical Governance Committee and bi-monthly to Quality Committee.

3. SERIOUS INCIDENTS (SIs)

3.1 A total of 28 SIs have been reported during this period.

3.2 A key theme arising from SIs is in relation to delayed responses. These correlate with the incident data being reported details of which can be found in section 4.2 of this report.

3.3 In recent months there has been an increase in the number of SIs where patients have fallen from a wheelchair or stretcher whilst being transported by YAS. This trend has not arisen previously and investigations are underway into all of the incidents to understand the reasons for this sudden increase. The findings from these investigations will be reported to Incident Review Group and Quality Committee. A separate action plan is also being undertaken by the Strategic Health & Safety Committee in relation to this theme.

3.4 Four SIs have been reported relating to the PTS directorate. These incidents are not similar in nature and at present do not suggest any recurring issues.

3.5 Lessons arising from SIs and mitigating actions are tracked internally by the Risk & Safety Team and reported by exception to Quality Committee and Private Trust Board.

4. INCIDENTS

4.1 Road Traffic Collision (RTC) incidents have been consistently high in number across the Trust, accounting for almost a third of all incidents reported. The Accident Reduction Manager for the Trust is working on different initiatives to try and reduce the number of these. There is also a Cost Improvement Programme (CIP) that has been developed which should facilitate a reduction.

4.2 A&E response related incidents have been in the highest categories of incidents reported between November 2012 and April 2013. Some of these incidents have been as a result of errors within the EOC; either the call handlers missing certain information which has lead to the wrong code being selected. Dispatcher error has also been a root cause with dispatchers failing to allocate the nearest, most appropriate resources to the incident. More recently, there has been an increase in the number of delayed back-up incidents which after investigation has been due to a lack of available resource available to respond to emergencies.

4.3 There has been a significant amount of moving and handling incidents reported by staff during this period. These are primarily staff injuries sustained when using the carry chair or the blue equipment bag. Projects are underway across the Trust to source alternative equipment which are designed to reduce the number of injuries sustained.

4.4 Slips, trips and falls is another incident category which has featured highly in reports. These are occurring primarily on PTS journeys and the Trust is developing a safety thermometer designed to identify harms across the Trust and to implement initiatives which will see a reduction in harm in this area.

5. COMPLAINTS INCLUDING OMBUDSMAN REQUESTS & PATIENT EXPERIENCE

PTS

5.1 **PTS injuries whilst entering/exiting vehicle**
A number of complaints have been received from PTS patients who have been injured whilst entering or exiting a YAS vehicle. Many of these incidents appear to have occurred from lack of a dynamic risk assessment on the patient upon collection and/or not following the booked mobility. Work to reduce this type of harm to patients is being carried out as part of the Patient Safety Thermometer work programme which has been agreed as part of YAS's 2012-13 Commissioning for Quality & Innovation (CQUIN) programme.

5.2 **PTS contractors not adhering to contractual requirements**
Ongoing feedback is being received from patients regarding YAS sub-contractors. Issues raised include lack of cleanliness on taxis, journeys not being carried out in a timely manner, the wrong mobility vehicle being sent and lack of care from drivers. Local PTS managers continue to meet regularly with sub-contractors as part of contract performance management. The majority of issues are resolved, but concerns are not satisfactorily resolved then the PTS management team will terminate contracts.

A&E

5.3 **Alcohol consumption masking an underlying condition**
Two recent clinical case reviews (CCRs), which were held further to complaints received, identified that the fact the patient had consumed significant amounts of alcohol had led to the clinician(s) involved missing an underlying injury/illness. A further similar case is scheduled for CCR later this month. At this stage the recommendations from the CCRs have been individual learning for the clinicians involved.

5.4 **Equipment for monitoring, treatment and transport of babies and young children**
A number of concerns have been raised regarding the equipment carried in A&E ambulances for monitoring, treatment and transport of babies and young children. The Health and Safety Committee are overseeing a piece of work to review equipment and procedures for safely securing babies and young children in vehicles. The clinical managers, reporting to the Associate Medical Director, are assessing the issues raised regarding equipment carried, in particular oxygen saturation monitoring.

5.5 **Knowledge of Local Care Pathways**

A complaint received in April 2013 related to an incident where an out-of-area crew, responding to a call in Leeds, appeared not to be familiar with local pathways. This highlighted the need to remind staff that the Clinical Hub is available 24/7 as a definitive source of information about local pathways and that, particularly when working out-of-area, staff should check the available pathways if they are in any doubt. The learning from this incident was discussed at the Incident Review Group (IRG) and it was agreed that guidance would be reissued to staff.

5.6 **Delayed back up/response**

An ongoing theme identified through staff-reported incidents, serious incidents and patient complaints is the time taken to back up the rapid responder clinician with a double-crew ambulance. This has been logged as a risk on the EOC risk register and the EOC Task and Finish Group implemented an action plan to reduce the risk of dispatch errors. More recent investigations have showed that on a number of occasions the most appropriate resources were allocated however due to demand and the resource available, the nearest ambulance was a considerable distance away. Action being taken on operational efficiency as part of the Service Transformation Programme will seek to address the root causes of this issue.

5.7 **Ombudsman requests**

During this six month period, four requests were received from the Ombudsman. Two of these were related to delays in PTS journeys in 2012 and these have been managed by the Patient Relations team. One was EOC related referred by the Ombudsman due to YAS' case handling; this response has now been submitted and the Trust is awaiting feedback. The final referral was regarding an A&E complaint and the Ombudsman has referred the case back to YAS as a 'premature referral' giving YAS further attempts for local resolution.

6. CLAIMS

6.1 The general theme across claims during this period is relating to staff injuries sustained from using the carry chair or the blue equipment bag. This is an ongoing issue however projects are being implemented across the Trust in relation to procuring the new carry chair and alternative equipment bag.

7. CORONER'S INQUESTS INCLUDING RULE 43 LETTERS

7.1 No Rule 43 letters have been received by the Trust during this period.

7.2 Lessons learnt from inquests during this period include action for the Emergency Operations Centre (EOC) in relation to escalation of incidents. EOC Team Leaders and Duty Managers need to be reminded of their responsibilities to take prompt action if an incident remains un-resourced for a period of time (timeframe to be agreed by the EOC senior management team).

7.3 Additionally, exception reporting on delayed response to red incidents is collated by the Regional Performance Team/Business Intelligence. There is an action plan in place for this analysis to be reviewed by the new Head of Service Delivery (EOC) who commenced in post in April 2013. Incidents of concern will be reviewed by the Incident Review Group, led by the Medical Director and having cross directorate membership.

7.4 An inquest during this period highlighted the need to review and amend the Language Line Policy and Caller Disconnected Policy.

8. SAFEGUARDING SERIOUS CASE REVIEWS (SCRs)

8.1 **Patient Report Form (PRF) completion**
A thematic lesson identified from the investigations relates to lack of information documented on the Patient Report Forms (PRFs). These have included failing to record the name of an adult male on scene and in another case failure to record the next of kin details.

8.2 **Staff Support**
Staff support following child deaths was highlighted as an area for improvement. The Trust has also applied some of the above learning to the EOC with an emphasis on supporting call handlers who deal with distressing child death calls.

9. CLINICAL CASE REVIEWS (CCRs)

9.1 Clarification, locally and organisation wide was required in respect of the Emergency Care Assistant (ECA) and Assistant Practitioner (AP) roles to ensure that all clinicians were aware of the scope of practice held by both of these roles.

9.2 Amendments were made to the Accident & Emergency Support (AES) and ECA training course content primarily in relation to using the appropriate communications when a patient's condition is deteriorating.

9.3 Clarification was required to clinicians relating to the out of hours arrangements for patients requiring stroke thrombolisis. This has been addressed by the Trust's Care Pathway Advisor.

9.4 A number of CCRs highlighted issues relating to Patient Report Form (PRF) completion. On several occasions these were not completed adequately by the clinicians. This was picked up with the individuals concerned and reminders have been issued organisation wide relating to the importance of full and appropriate PRF completion.

10. INFORMATION COMMISSIONERS OFFICE (ICO) NOTIFICATIONS

10.1 One notification was received from the ICO during this period and this relates to a complaint that YAS have not supplied the required information under the Subject Access Request (SAR) procedure. A SAR and chase letter from an ex-employee was sent via a department not normally involved in the SAR procedure. There was no correspondence with the subject and the 40 day legislative requirement for response expired. The subject contacted the ICO who have corresponded directly with YAS.

10.2 The request was passed to Legal Services to manage and contact was made with the subject and with the ICO. A redacted file was provided and the ICO were informed of this. No further correspondence has been received from the ICO or from the subject.

11. HEALTH & SAFETY EXECUTIVE (HSE) LETTERS

11.1 One letter was received from the HSE during this period. A member of YAS staff has made a complaint to the HSE regarding the rest break facilities at Hull Royal Infirmary (HRI). The member of staff has complained that the staff have to use the public toilets which are unhygienic, there are no facilities to heat food or make a hot drink and they have to eat and drink in the hospital restaurant.

11.2 Although the letter does not specify which part of the service this has come from it is assumed to be PTS due to the recent changes in meal break arrangements. The Risk & Safety Team are looking into the facilities provided at HRI and the specific legal requirements for staff welfare provisions. A response was sent to the HSE within the 10 day deadline and the Trust is awaiting further correspondence. The issue of public toilets at HRI being unhygienic will be raised directly with the hospital management team.

12. BEING OPEN

12.1 The Trust continues to be open and honest with patients and/or patient relatives involved in incidents whilst in YAS care.

12.2 The Trust has exercised the being open policy in relation to a number of Serious Incidents in recent months. Specific details can be found in the Private Trust Board paper.

13. CONCLUSION

13.1 Learning lessons and taking action to improve for the future is a core part of YAS's integrated governance structure.

13.2 Moving forward the new Datix incident reporting system will provide richer data that will further improve our ability to identify lessons and track themes and trends.

13.3 At a corporate level, two specific programmes have been prioritised to learn from past events and reduce the risk of future harm to patients. These are the Patient Safety Thermometer programme and the work within EOC to reduce time-to-RRV-back-up.