NHS
Yorkshire
Ambulance Service
NHS Trust

Risk, Quality & Safety Compliance Report 2016-17

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Improvements

2016 - 2017

Yorkshire Ambulance Service
NHS Trust

98.1%
Complaint response satisfaction

61%
Reduction in PTS falls with harm

25%
Reduction in PTS injuries with harm

50%
Reduction in medicine errors

87.1%
would recommend Yorkshire Ambulance Service NHS Trust to friends and family

80%
of senior managers have now undertaken IOSH accredited training

IOSH

91%
Average Inspections for Improvement compliance score

110
New style ambulances purchased, which have been designed in conjunction with unions and staff

117
Bright Ideas submitted in 2016-17

310
patients survived following an out-of-hospital cardiac arrest. This is more lives saved than any other year

51

Staff accessed
Freedom to Speak Up
in the first year

Over **3000**
patients with sepsis provided with life-saving treatment and transferred to hospital

SEPSIS

Section 1.0

Introduction

1. Purpose

The purpose of this report is to

- Provide a summary of Trust developments in relation to risk, safety and clinical quality in 2016-17 and provide an additional level of detail to that in the Trust Annual Report and Quality Accounts.

- Meet the statutory and best practice reporting requirements for NHS risk, safety and quality functions.

1.1 Introduction

YAS provides emergency, urgent care and non-emergency patient transport services. Meeting the needs of our local population is at the heart of everything we do and we are committed to ensuring that patients receive the right response and the right care. Our staff are focussed on providing high quality care, excellent patient experience and improved health outcomes.

Safe, evidence based care is underpinned by robust governance arrangements, risk management and an improved educational and training infrastructure which empowers staff and embeds patient centred professionalism.

1.2 Introduction – Risk and Safety

Patient and staff safety are a key priority in YAS, and the promotion and delivery of safe care is the foundation of the organisation. Learning is promoted through a culture of openness which is supported through the Trust values and the behaviours of staff. This is underpinned in practice by systems and processes which encourage and seek staff and patient involvement and opportunities for learning and improvement. The management and analysis of the incident reporting system including near miss and issues/concerns is a critical function of the Risk and Safety teams. By analysis investigation of incidents, analysis of themes and trends, feedback to directorates and clinical business units we can help to ensure that YAS is always learning and that we are continually developing our safety culture toward one that is generative – or put more simply to a culture where safety is integral to all that we do.

Risk management is the overall process of risk identification, risk analysis and risk treatment. The process assists the Trust to reduce or eradicate identified risks in order to protect the safety of patients, staff, visitors and the organisation as a whole. The management of risk takes many forms and involves both a pro-active and retrospective approach.

YAS's systems of risk management for 2016-17 are set out in the Trust's Annual Governance Statement.

YAS recognises that in order to be most effective, risk management must become part of the organisation's culture. The Trust strives to embed risk management into the organisation's philosophy, practices and business processes rather than be viewed or practiced as a separate activity.

Underpinning YAS's overall approach to patient safety, staff safety and risk management, are a number of specialist functions that ensure the further management of risk and safety in essential areas; these include Health and Safety,

Information Governance, Security, Medicines Management and Infection Prevention and Control.

1.3 Introduction – Clinical Quality Strategy

Historically, *High Quality Care for All* (2008) has provided the NHS with an underpinning framework to define, describe and measure the quality of care. Since then a large number of NHS publications and guidance have set out the priorities for ambulance services. Most recently this has raised the profile of the Emergency and Urgent Care agenda (Next steps on the NHS Five Year Forward View NHS England 2016), in terms of improving services and promoting more integrated services to maintain and improve the three well recognised key dimensions of quality:

- Patient safety (including medicines management and safeguarding)
- Clinical effectiveness
- Patient experience

The Care Quality Commission have also maintained this clear focus on quality through the refresh of their regulatory framework, updated standards and Key Lines of Enquiry (KLOEs). The updated Well Led Framework is fully aligned across NHS Improvement and CQC regulatory processes.

The *YAS Clinical Quality Strategy 2015-18 has* set out Yorkshire Ambulance Service's (YAS's) approach to clinical quality. It focused on the potential contribution of all YAS employees in delivering high quality care and supporting improvements in our services.

The strategy consisted of a number of important elements:

- A focus on improvement in relation to a small number of priority clinical developments and service quality issues, where there is strong evidence that we can make a real difference to patient outcomes over the next three years.

- Ensuring that we deliver higher quality care without increasing costs, by eliminating waste from our systems and processes.

- Action to embed quality and innovation in everything we do, through education and training, the personal development review process, developing quality management arrangements, and through the development of effective systems and processes for learning and improvement.

- Developing clinical leadership at all levels to support teams in the delivery of excellent care and services.

- Development of measures which will enable us to track the quality of our services from the front line to the Board, and to demonstrate our continuous improvement.

- An approach to communicating about the quality of our services to the general public, which demonstrates our commitment to openness and public accountability.

- Delivering the recommendations of the Mid Staffordshire NHS Foundation Trust Public Inquiry, specifically in relation to safety culture, embedding patient centred professionalism, clinical leadership and supervision, and listening to staff

Building on the YAS values, the 2015-18 Clinical Quality strategy has delivered significant improvements in the quality of care and services. This has provided a strong foundation for further development over the coming years.

The Clinical Quality Strategy was developed with engagement from our staff, our stakeholders and our patients. Our partner organisations and agencies, commissioners, service user bodies and our staff have all been invited to contribute to the identification of clinical quality priorities. Patient stories and the feedback from our patient survey programme have also informed the strategy for 2015-18.

The strategy is further informed by national and international evidence on best practice, together with learning from internal reporting and learning systems and risk assessments.

Our vision set out in 2014 was that YAS will provide first class care for the local communities. This forms the foundation of the Clinical Quality Strategy for 2015-18.

In order to realise this vision we want to embed quality and innovation in all we do. This will be realised through strong and visible leadership at all levels of the organisation who can lead best practice, articulate goals and outcome measures and build an environment where staff feel empowered, valued and are focussed on patient outcome.

The Sign up to Safety work stream is embedded as part of the Clinical Quality Strategy and during 16-17 significant progress was made with work-streams within the campaign, specifically in relation to focusing on the human factors which impact on caring in the Emergency Operations Centre (EOC), implementing best practice for the deteriorating adult and child and moving patients safely.

The Clinical Quality Strategy also includes the Trust's CQUIN programme and for 16-17 the A&E CQUIN programme included the introduction of end to end reviews to promote system wide learning, improving care for patients with suspected sepsis and also using learning to improve the outcomes for patients who suffer a cardiac arrest. In the Patient Transport Service (PTS), the CQUIN focussed on the development of a

patient portal which allows patients to view their transport bookings to validate the information.

The Trust mission, vision and values have been refreshed and re-launched in 2017 and this will inform the new Quality Improvement Strategy, which is currently being developed for launch in April 2018.

Section 2.0

Risk and Safety

2.1 Risk Management

Introduction – Risk and Safety

Risk management is the overall process of identification, assessment and treatment of risk. This systematic process supports the Trust to consistently manage risks, by reduction or eradication, to maintain the safety of patients, staff, the public and the assets of the organisation.

YAS recognises that in order to be effective, risk management must be integral to the culture of the organisation. The Trust strives to embed risk management into the organisation's core business rather than it being conducted as an isolated activity.

Underpinning YAS's overall approach, a number of specialist functions provide expertise to support the effective management of risk and safety in essential areas these include Health and Safety, Security Management, Legal Services, Information Governance, Medicines Management and Infection Prevention and Control.

2.1.1 Delivery of work plans for 2016-17

YAS's systems of risk management are set out in the Trust's Annual Governance Statement. Risks are identified proactively by the Board and senior management team as part of the 5-year and annual business planning cycles and are aligned to the strategic objectives within the Board Assurance Framework.

The Risk Management and Assurance Strategy sets out the corporate risk management framework and describes our strategic approach to processes and monitoring arrangements for managing risk. The strategy describes the Trust risk management system and the mechanisms for providing the Trust Board with assurance that risks are managed efficiently and effectively. It also describes the Trust's appetite to risk in relation to its different domains of activity.

During 2016-17 an Internal Audit of the Trust's risk management procedures provided significant assurance, concluding that the Trust had in place a sound risk management strategy and process which was communicated throughout the organisation, and that risks were effectively defined. During 2016-17 a further internal audit review was conducted to review the adequacy of systems in place to assess the effectiveness and maturity of risk management across the Trust. The overall maturity level has been assessed as 'Risk Defined' (*The organisation has considered risk management and put in place strategies led from a risk management team. Strategy and policies are also in place and communicated; and the "risk appetite" is defined*).

The Trust has sustained its maturity level assessed in 2014 in the context of substantial organisational change. As the risk management infrastructure further develops to achieve greater consistency of engagement by managers the maturity matrix assessment should progress to 'Risk Managed'.

2.1.2 Local Risk Management

All Directorates within the Trust use the Datix system to report and manage risks. A designated risk lead has been identified within each area; this individual takes responsibility for monitoring the management of risk. Within the specific business areas, the Risk Manager meets regularly with the designated risk lead to review and update risks, providing necessary guidance and expertise.

Senior members of the Quality, Governance and Performance Assurance Directorate attend locality meetings and service governance groups support review of quality and risk issues, this includes offering support in the identification and management of risk. This supports the effectiveness of local risk management and appropriate escalation of key risks to Trust level. This arrangement further embeds risk management as part of the core business of the meeting and integral to each agenda item rather than being a disconnected process.

Relevant Committees and Groups have taken ownership of specific areas of risk to ensure they are reviewing Trust wide issues. For example Clinical Governance Group (CGG) review specific types of risk; patient safety, clinical, safeguarding and infection prevention and control, and Health and Safety Committee receives information relating to health & safety of staff, patients and the public, and security of staff and Trust assets. This process provides a clear audit trail of local management and escalation where appropriate of risks with a risk rating of 12 or above to the Corporate Risk Register.

2.1.3 Corporate Risk Register (CRR) and Board Assurance Framework (BAF)

The governance of the CRR is initially at department level supported corporately via Risk and Assurance Group (RAG) on a monthly basis. This comprises scrutiny of Strategic and Operational risks with a current risk rating of 12 and above, based on the YAS risk matrix, assessment of gaps in control, appropriate mitigating action and progress in delivering this. The RAG is chaired by the Executive Director of Quality, Governance & Performance Assurance.

Risk scoring = Likelihood x Severity (L x S)

	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

The table above shows how the overall risk rating is determined, based on a likelihood x severity (5x5) grid.

Designated Risk Leads attend RAG and collectively review the CRR, having an opportunity to update on their own directorate higher level risks as well as contributing to discussion on others that require consideration by the group.

The Risk Manager and Associate Director of Performance Assurance and Risk are responsible for ongoing monitoring of the CRR to ensure risks are regularly reviewed and mitigations are in place to manage. There is a monthly cycle of review of the CRR and Board Assurance Framework (BAF) via the RAG and Trust Management Group. On a two-monthly basis there is a review of the assurances on the key risks on the BAF and CRR through the Board committees and the Trust Board.

The BAF is a Board level document that provides concise assurance to the Board and its committees on the management of principal risks to the Trust's strategic objectives. In 2017-18, risks are aligned to 5 strategic objectives within the BAF and monthly updates made to the BAF actions prompted by assurance reports. The BAF and Corporate Risk Register are closely aligned and subject to comprehensive Executive and Non-Executive review through a quarterly cycle as described above.

2.1.4 Key risks and emerging themes and trends

The Directorate of Quality, Governance and Performance Assurance continue to analyse data arising from incidents, complaints, claims and interpret feedback from patients, staff and stakeholders. Triangulation of this data identifies themes and trends and highlights potential risks for consideration, complementing the view of risks identified through routine management processes.

During 2016/17 the Trust worked closely with commissioners and other system partners to manage risks relating to the wider health and social care system, particularly relating to hospital reconfigurations.

2.1.5 Looking ahead - key priorities for 2017-18

The following priorities have been set for 2017-18:

- Continue to embed and enhance effective risk management processes throughout the organisation
- Support risk leads and operational management groups to proactively identify and manage risk as an integral part of their core business
- Continue to risk profile internal audit recommendations to support mitigation of risks
- Continue to develop and refine Trust-wide Assurance Map
- Continue to assess the quality impact of Cost Improvement Programmes and other planned service changes.
- Maintain and develop the BAF with Executive Directors to ensure key risks to delivery of strategic objectives are being appropriately governed.
- Continue to utilise identified themes and trends arising from incidents, complaints, claims, coroner's inquest and other sources to support identification of risk.
- Further enhance the Datix risk management system to provide an accessible view of local and corporate risks for end-users, and improve reporting functionality at local level.

- Establish risk Deep Dive process and alignment of risk management approaches to our Performance Management Framework

- Further work with commissioners and other system partners to manage risks arising from local service reconfigurations

2.2 Information Governance

Information governance ensures and provides assurance to the Trust and to individuals that information, in particular personal and sensitive information, is dealt with legally, securely, efficiently and effectively. This, in turn, helps the Trust to deliver the best possible care to patients and to meet legal and good practice responsibilities in relation to information.

YAS aims to ensure that all information it holds is processed in accordance with the Data Protection Act 1998, Freedom of Information Act 2000, the Caldicott Guardian Framework and other related legislation.

The Senior Information Risk Owner (SIRO) during 2016-17 was Steve Page, Executive Director of Quality, Governance & Performance Assurance. The SIRO is an executive director or senior management board member who takes overall ownership of the organisation's Information Risk Policy, acts as champion for information risk on the Board and provides written advice to the Accounting Officer on the content of the organisation's Governance Statement in regard to information risk.

The Caldicott Guardian during 2016-17 was Dr Julian Mark, Executive Medical Director. A Caldicott Guardian is a senior person responsible for protecting the confidentiality of patient and service-user information and enabling appropriate information-sharing.

Yearly self-assessments against the Information Governance Toolkit requirements enable the Trust to measure compliance against the law, best practice and NHS guidelines. The Information Governance Toolkit is a continual improvement tool published and managed by the Health and Social Care Information Centre which draws together the legal rules and central guidance and presents them in one place as a set of information governance requirements (or standards).

Evidencing of 35 Information Governance Toolkit requirements supports assurance of the level of information governance within the Trust. Over the last four financial years the Trust has increased its self-assessment submission score by 12% to a score of 85% during a period where the Toolkit standards have become more stringent year on year (Rated 'satisfactory' against a satisfactory/unsatisfactory rating regime).

In 2016-17 our internal auditors (East Coast Audit Consortium) audited around 42% of the Information Governance Toolkit requirement areas, reporting 'significant assurance' against the 15 requirements examined as part of the typical sample approach.

The Information Governance Toolkit self-assessment submission is now also being used to monitor the implementation of the 'Caldicott2' recommendations by health and social care organisations. Following a request from the Secretary of State for Health,

Dame Fiona Caldicott carried out an independent review of information sharing across health and social care over 2012 to ensure that there is an appropriate balance between the protection of patient information and the use and sharing of information to improve patient care. The review generated a number of recommendations for health and social care organisations to take forward. These recommendations are set out within the publication "Information to share or not to share:
The Information Governance Review". The Trust is currently reporting as 'amber' which means 'working towards' full implementation of the relevant recommendations.

In line with the requirements of Information Governance Toolkit the Trust has undertaken an audit against NICE Clinical Guideline 138, specifically against the quality statements concerned with sharing information for direct care. From the audit the Trust has identified a number of areas for further work to ensure continued improvement of information sharing with other health and social care professionals.

Over the last year, the Trust has again continued to make progress against its Information Governance work programme and this has contributed to the internal audit assurance given.

This year the process of improvements included:

- Continuing to ensure our staff are trained in the confidentiality, data protection and information security of personal information. Staff continue to receive annual refresher training.
- Continuing to make sure our transfers of paper and electronic personal information are secure.
- Reviewing our policies and strategies in relation to Information Governance
- Working with departmental Information Asset Owners to embed effective information risk management arrangements.
- Continue to strengthen information sharing agreements and identifying rigorous risk assessments and privacy impact assessments for new developments impacting on the management of information.
- The introduction of the IG and Fire Refresher annual workbook

Statement in Respect of Information Governance Serious Incidents Requiring Investigation

During 2016-17 there were no personal data-related incidents that met the Information Governance Serious Incidents Requiring Investigation (IG SIRI) criteria at level 2 severity or above. Such incidents require reporting to the Information Commissioners Office, Department of Health and other regulators as well as detailing within NHS Trust annual reports. However, the Trust had a number of personal data-related incidents of a lower level of severity (level 1) and these are detailed in the table below.

SUMMARY OF OTHER PERSONAL DATA RELATED INCIDENTS IN 2016-17		
Category	**Breach Type**	**Total**
A	**Corruption or inability to recover electronic data**	**1**
B	**Disclosed in Error (within a secure NHS environment)**	**42**
C	**Lost in Transit**	**2**
D	**Lost or stolen hardware**	**4**
E	**Lost or stolen paperwork**	**36**
F	**Non-secure Disposal – hardware**	**0**

G	**Non-secure Disposal – paperwork**	**2**
H	**Uploaded to website in error**	**1**
I	**Technical security failing (including hacking)**	**4**
J	**Unauthorised access/disclosure**	**11**
K	**Breach of confidentiality (Verbal)**	**0**
L	**Inappropriately secured paper/electronic transmission/transfer of identifiable information (Via email, FTP or removable storage)**	**0**
M	**Other**	**27**

The learning from information governance incidents has been shared across the Trust, with regular updates about issues and common errors/breaches being included within the monthly staff update. This work is supported at a local level by the network of Information Asset Owners and Information Asset Administrators; who attend the IG working group on a bi-monthly basis.

There was an increase in the number of incidents categorised as Disclosed in Error (within a secure NHS environment) and Lost or stolen paperwork and these remain an issue. Part of the explanation is due to the re-categorisation of the data. This would indicate that the awareness raising around the better categorisation of incidents amongst all staff has been successful.

Stolen or lost paperwork has to be taken in context with the quantity of paper based records generated within YAS on an annual basis. The number relating to stolen or lost paperwork is minimal in this context and the risk will remain whilst paper records are still generated. The Trust's strategy to move to paperless working and the introduction of the ePR (electronic Patient Record) in late 2017 will have a positive effect in reducing this category of incident.

In compiling this report, we have considered breach incidents for data for which we were the data controller, as defined by the Data Protection Act (1998).

We take all incidents seriously and all are investigated to ensure that we improve our processes to prevent future incidents occurring.

Reports relating to any personal data-related incidents are analysed and presented to the Information Governance Working Group and Incident Review Group to ensure that the organisation learns from any incidents and puts supportive measures in place to prevent reoccurrence where required. All staff are proactively encouraged to report incidents relating to the loss or disclosure of personal data.

2.3 Health and safety

YAS is committed to ensuring the health, safety and welfare of all our staff and all those people who are affected by our services. Our legal responsibilities as an employer are set out in the Health & Safety at Work Act 1974 and the Management of Health and Safety at Work Regulations 1999. We also take account of all NHS requirements and guidelines.

Working together with all staff, we are committed to the effective management of health and safety in the workplace. Our approach to Health and Safety is set out in our Health and Safety Policy and is delivered through our health and safety management system.

2.3.1 Legislation changes

During 2016-2017 there have been limited changes to health and safety legislation affecting the Trust.

Fee for Intervention

Fee for Intervention (FFI) is the Health and Safety Executives' (HSE) cost recovery regime implemented from 1 October 2012. The Health and Safety (Fees) Regulations put a duty on HSE to recover its costs for carrying out its regulatory functions from those found to be in material breach of health and safety law.

The cost of FFI to organisations was originally set at £124 / hour however; this was increased to £129 / hour on the 1st April 2016.

New sentencing guidelines for health and safety offences

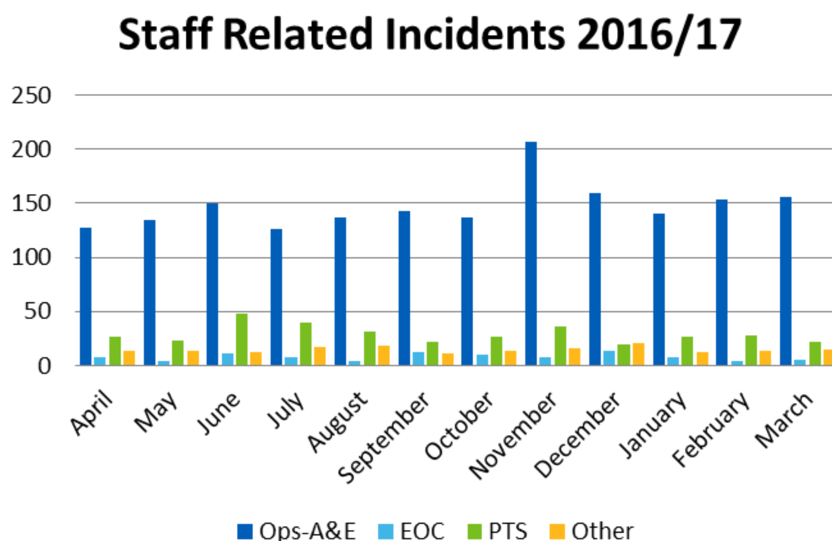
In February 2016 new sentencing guidelines for health and safety offences were introduced. Previously these were only used where a fatality had occurred. The new guidelines use culpability, level of harm risked (not level of harm that has occurred) and the size of the organisation to determine the level of financial penalty / custodial sentence imposed.

For an organisation the size of YAS, it was expected that the financial penalties imposed for health and safety offences would be significantly higher than could previously have been expected prior to the new guidelines thus increasing the level of financial harm incurred should a health and safety prosecution take place.

This has been evidenced throughout 2016 /17 where the largest fine nationally in 2016 was two-and-a-half times the size of the largest fine in 2015 and almost ten times larger than the largest fine in 2014.

2.3.2 Incident reporting

This graph shows the number of staff related incidents reported in 2016-17.

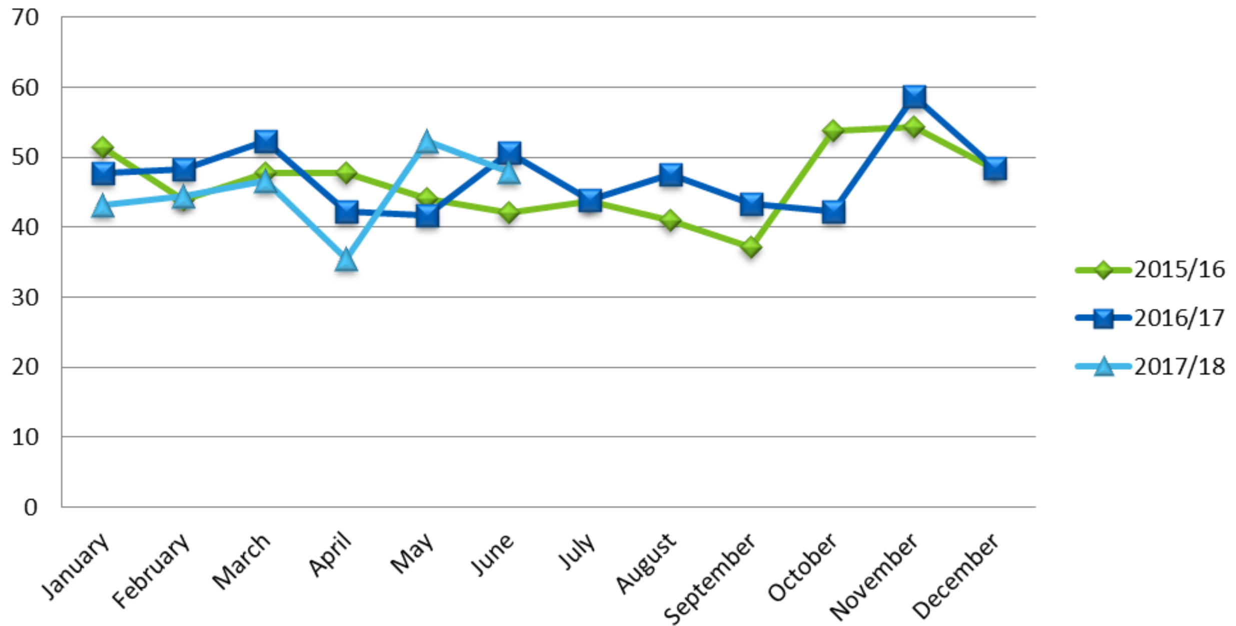


A&E and PTS operation services are where the Trust faces the greatest risks and subsequently records the largest number of incidents. A gradual increase in PTS incidents has been seen over the year, and there was a significant increase in the incident rate for Hull and East A&E CBU which rose from 8.1 in Q4 15/16 to 10.1 in Q4 16/17. Other A&E areas saw a general upward trend but were less dramatic.

Of the staff related incidents reported in 2016-17, 6.53% were graded with a severity of moderate or above (table below).

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Total
Total Moderate and above	7	7	15	17	6	14	18	16	16	12	16	12	156
Total	175	175	221	190	190	188	187	267	214	185	198	198	2388
% Mod and above of total	4.00%	4.00%	6.79%	8.95%	3.16%	7.45%	9.63%	5.99%	7.48%	6.49%	8.08%	6.06%	6.53%

The overall incident rate for staff related incidents has risen since the beginning of the year. The yearly average is 42.3 (number of incidents per 1000 employees) - down from 44.00 in 2015/2016 - with a peak of 58.7 in November.



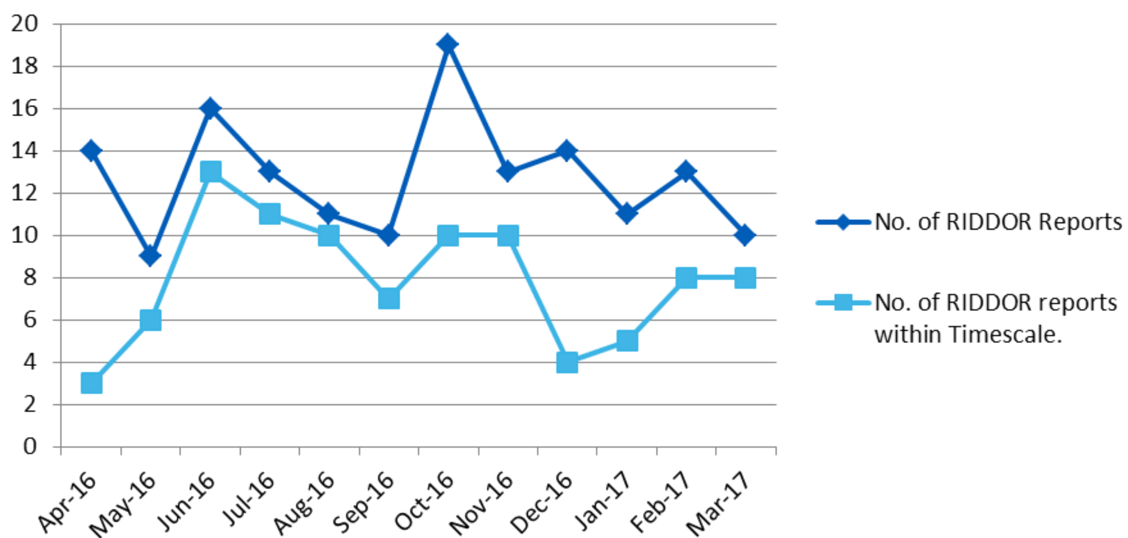
The top 3 reported incidents have been consistent over the year and relate to moving and handling, slip, trip and falls and violence and aggression.

RIDDOR reporting

Health & Safety related incidents that fall into certain categories are required to be reported to the Health and Safety Executive (HSE) under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR).

These incidents are mainly made up of accidents where a member of staff has suffered harm (moderate grading) and been absent from work for over 7 days or has suffered a specified injury such as a broken bone. These reports also include where a patient has been injured in YAS care and taken to A&E for treatment for that injury.

RIDDOR Reports for 2016 / 2017



Analysis of the numbers of incident types reported under RIDDOR are shown below.

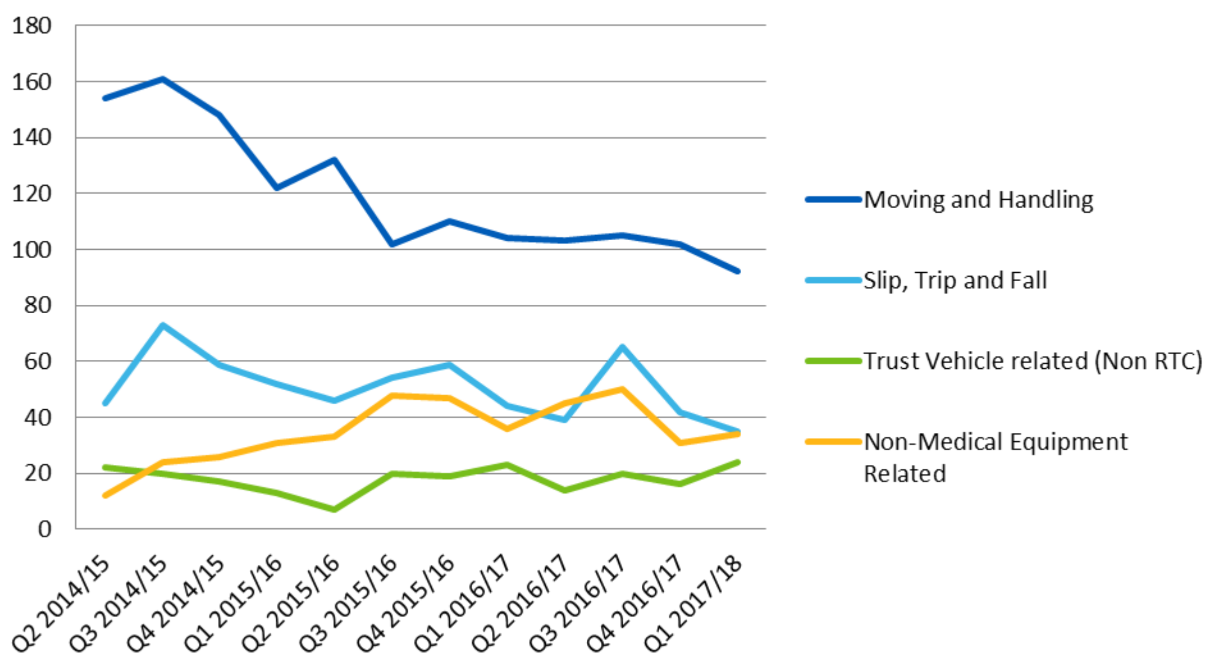
Incident Type	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Total
Accidental release of substance which may damage health	1	0	0	0	0	0	0	0	0	0	0	0	1
Biological Agent – Known Exposure	0	0	0	0	0	0	0	0	0	1	0	0	1
Biological Agent – Unknown Exposure	0	0	0	0	0	0	1	0	0	1	0	0	2
Fall from a height	1	2	1	0	2	0	2	1	0	0	0	0	9
Hit by a moving vehicle	1	0	0	0	0	0	0	0	0	0	0	0	1
Hit by a moving, flying or falling object	1	0	2	0	0	0	0	0	2	0	1	1	7
Hit something fixed or stationary	1	0	0	0	0	1	0	0	0	0	0	0	2
Injured while handing, lifting or carrying	6	3	9	9	6	5	12	8	6	4	9	7	84
Other kind of accident	0	0	1	1	0	0	0	1	1	0	0	0	4
Physically assaulted by a person	0	0	0	0	1	1	0	1	1	1	1	0	6
Lifting equipment	1	0	0	0	0	0	1	0	0	0	0	0	2
Slipped, tripped or fell on the same level	2	4	3	3	2	3	3	2	4	4	1	2	33
Blank	0	0	0	0	0	0	0	0	0	0	1	0	1
Total	14	9	16	13	11	10	19	13	14	11	13	10	153

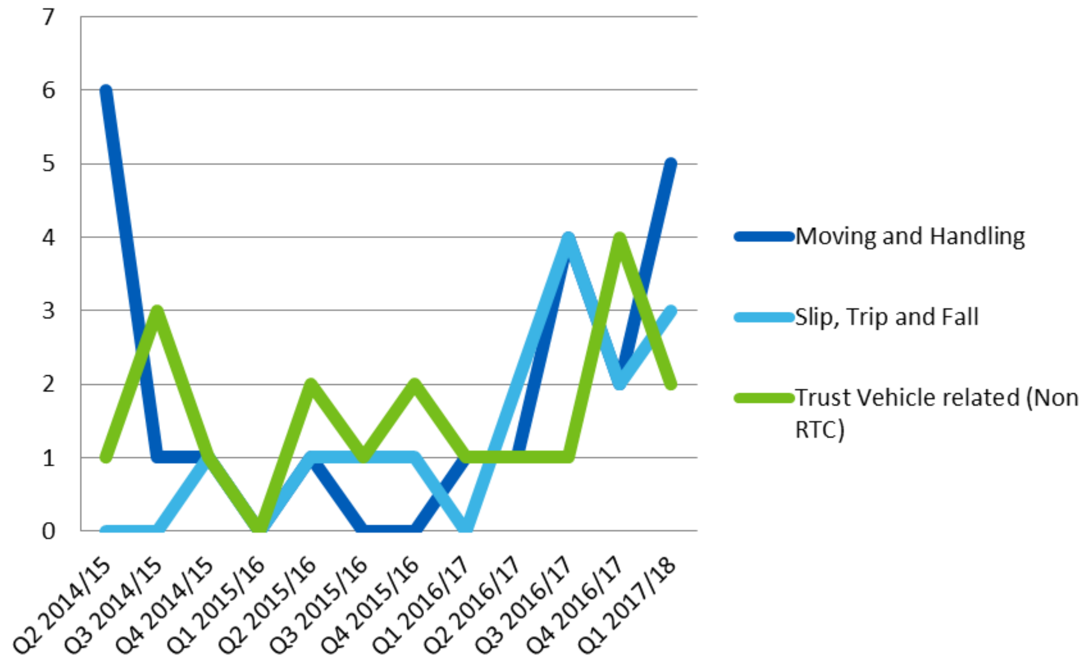
These figures show that the highest number of harm incidents relating to staff are occurring from injuries sustained during moving and handling or as a result of slips, trips and falls. Addressing these areas of harm is a priority for the Trust and the 2016-17 work plan included focused work on moving and handling, which are detailed in section 2.3.3

Wider learning from RIDDOR is communicated via the Trusts monthly Safety Update, and all RIDDOR reported incidents are discussed at local heath and safety groups.

Year on Year improvements

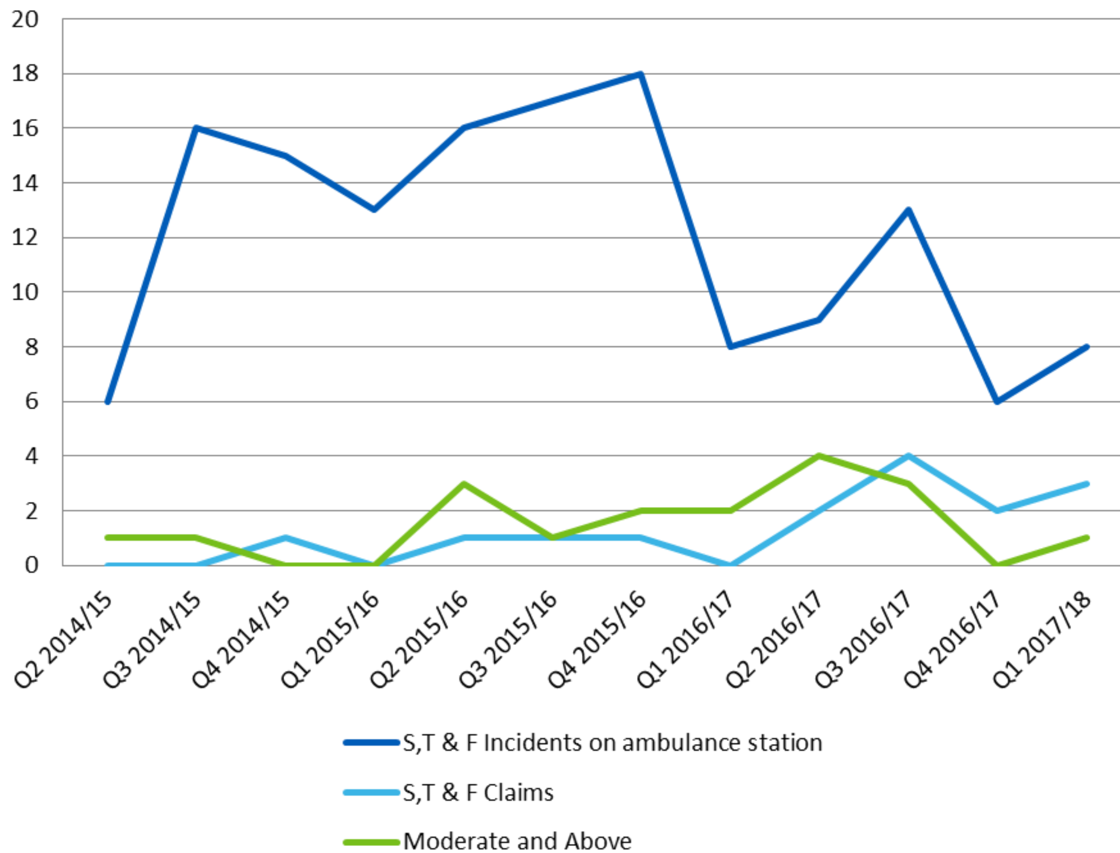
The graphs below show staff incidents and staff new claims received tracked back to Q2 2014/2015.





It is clear that moving and handling incidents have significantly reduced over the last 3 years, thought to be due to initiatives such as the introduction of the new green response bag in November 2013 and the track carry chair mid 2014. A corresponding reduction in new moving and handling claims can also be seen over the period.

Another area where there has been a significant reduction in staff incidents is in relation to slip, trip and falls on ambulance stations.



During 2016/2017 investment was made in relation to the rectification of potholes on ambulance stations and a corresponding drop in staff slips, trips and falls at that type of location can be seen.

However, an increase in new claims received can be seen developing from Q3 2016/2017 onwards for all categories but without a corresponding increase in incident type suggesting alternative influences.

2.3.3 Delivery of Work Plan for 2016-17

Health and Safety Training

In March 2015 NHS Employers produced a document titled "Health and Safety Competences for NHS Managers". Using this document the Trust H&S Manager reviewed the Trust's health and safety competency programs and identified a number of health and safety skills gaps at line manager level. In addition, a lack of training provision for senior managers was noted.

Throughout 16/17 work took place to address the skills gap with the design of a health and safety training program for the appropriate management groups.

The initial part of the training program consisted of a 1 day Institution of Occupational Safety and Health (IOSH) accredited health and safety training course for all Trust Senior Managers, including Executive Directors, non-Executive Directors and Deputy /

Associate Directors and a 4 day IOSH accredited training course for a selected group of middle managers, primarily drawn from the Fleet, Estates and Facilities Directorate.

In December 2016, the Trust allocated funding to deliver the IOSH training demonstrating support for the Trust's Health and Safety Management System and its commitment to good health and safety standards.

Delivery of the IOSH training commenced in March 2017 and attendance rates of 80% and 100% were achieved respectively for the 1 day IOSH Leading Safely course and 4 day IOSH Managing Safely course with excellent feedback received all round.

Moving and Handling

To address the issue of moving and handling, the Moving Patients Safely Group was established in early 2016, replacing an earlier task and finish group for moving and handling. This was initially led by a specialist post recruited to progress the "Sign up to Safety" agenda which included a specific objective around the safe movement of patients with complex mobility needs, such as bariatric patients.

Members of the group include representatives from Quality and Safety team, Education and Training, A&E Operations, HART, EOC, PTS, YAS expert patient and Unison health and safety representatives.

The group identified and progressed a number of actions including:

- a comprehensive review of the Trust's patient risk assessment form
- a review of moving and handling training materials
- scoping for the provision of specialist moving and handling advice
- improvement of provisions for the safe movement of complex patients

A significant amount of work was completed with regards to these actions throughout 2016/2017 which laid the foundations for:

- A new patient risk assessment form *(Pilot commenced in Sept 2016)*
- A new 4 hour statutory and mandatory training program for moving and handling *(commenced in June 2017)*
- Request for a subject specialist to be included in the new Training Department restructure
- Introduction of a new SOP - "Moving and Handling Patients with Complex Needs including Bariatric Patients " *(in place from August 2016)*

In addition, the group led a moving and handling survey for staff, the information from which has informed improvements and the above work.

As is evident, significant progress in the area of moving and handling, in particular with regards to the movement of complex patients, has been made during 2016/2017.

Plans for 2017/18 include further review of the equipment provided for the safe movement of patients, co-design of a patient held mobility passport and embedding of the SOP - Moving and Handling Patients with Complex Needs including Bariatric Patients to include a map me function where patients with complex mobility needs can self-identify and undergo a proactive risk assessment process.

Vehicles: Mercedes Van conversions

A number of issues were identified in 2015/2016 with the Mercedes van conversion including a lack of space and difficulties operating the tail lift. These difficulties led to a significant increase in moving and handling injuries attributed to the operation of this vehicle.

To manage this issue during 2016/2017, the Trust purchased 110 new style vehicles with a wedge ramp instead of a tail lift. The new design came about following an extensive consultation process with staff and Unions.

In addition, to mitigate the risk with the Mercedes, modifications to the design from the original which eases assembly of the tail lift have been made in addition to the removal of one of the internal chairs. The Trust has allocated significant funding to carry out these modifications again demonstrating its investment in good health and safety.

Premise Inspections

The Inspection 4 Improvement (I4I) program, which ensures that all YAS premises are inspected and assessed for compliance with Health and Safety, Security, Information Governance, Infection Prevention and Control and Risk Management Standards, was sustained throughout 2016/17.

An electronic tool is used for recording inspection findings, which also supports immediate feedback of any issues to managers. Significant issues are also now highlighted to the senior management team through reports to the Trust Management Group.

During 2016/2017, the I4I inspection pack underwent a full review. All elements of the health and safety sections were checked to ensure they were capturing suitable and sufficient information. Additional health and safety information was added in to the pack to support the understanding of the I4I inspectors and ensure a robust inspection takes place.

Health and Safety Consultation with Employees

During 2016/2017 a review was undertaken regarding the provisions in place for health and safety consultation with staff within the Trust. It was found that, whilst consultation was successfully taking place centrally e.g.at the strategic Health and Safety Committee, Trust Procurement Group, consultation in local areas was less regular with no formal means of consultation in some business areas.

To address this, a new process was implemented to strengthen the existing consultation structures and to establish new provision where necessary.

Following the introduction of the new process, the following health and safety consultations are now once again occurring regularly:

- West Yorkshire CBU Health and Safety Meeting
- North Yorkshire CBU Health and Safety Meeting
- South Yorkshire CBU Health and Safety Meeting
- Hull & ER CBU Health and Safety Committee

A new Health and Safety Committee has also been set up under the new consultation process for the Fleet, Estates and Facilities Directorate with the first meeting held on 8th June.

Consultation meetings for other areas of the Trust such as EOC, 111, PTS Comms and Support Services are planned for 2017-2018.

Enhanced Health and Safety Support to Fleet Department

A new work stream added to the work plan for 2016-2017 was in relation to the Trust's Fleet Department as this was an area of work that has been identified as specifically requiring health and safety improvement.

Significant progress has been made within this area with the use of an external consultant to refresh the departments' risk assessments and the delivery of IOSH accredited Health and Safety Training for the whole Management structure from Director to Team Leader.

In addition, a local Health and Safety Committee has now been set up under the new consultation process, with the first meeting held on 8th June. In addition a new post of Fleet Compliance, Safety and Security Manager created in the recent restructure.

Inspections of all Fleet Workshops by the Health and Safety Team were also undertaken during 2016/2017. An emerging theme was that much of the equipment used in the workshops, whilst still operating safely, it is old and would benefit from replacement.

2.3.4 Key Risks

During 2016-17 significant progress has been made with a number of health and safety risks.

Health and Safety Training for middle managers

As detailed in the section above, a skills gap has been identified with regards to health and safety training for middle managers.

PROGRESS: This has been partially addressed by the provision of IOSH accredited Health and Safety training to a selected group of middle managers.

Senior Management H&S Training

As detailed in the section above, a lack of Health and safety training provision had been identified for senior management.

PROGRESS: This has now been address by the provision of IOSH accredited training to 80% of the Trust's senior management.

Mercedes van conversion ambulances

Mercedes van conversion ambulances – the continued use of the Mercedes van conversion ambulances will increased the likelihood that staff could suffer musculoskeletal problems caused by the operation of the tail lift and from working with / moving patients in a confined environment.

PROGRESS: As detailed above, a new ambulance design has been rolled out for new vehicles and funding allocated to modify the existing Mercedes.

Tail lifts

There have been some mechanical faults identified with tail lifts following a small number of tail lift failures over the past 18 months. The faults have been brought together under one risk heading and each requires specific rectification work.

PROGRESS: Funding has been made available to carry out the necessary rectification work which is underway. Monitoring to identify any fault development is also taking place whilst the rectification is carried out.

Bariatric Patients

A risk of harm to patients and staff due to insufficient number of staff having completed training on the Bariatric Equipment Vehicle and lack of process for utilising the resource in A&E and PTS across the region is on the risk register.

PROGRESS: As detailed above, an SOP for the “Moving and Handling Patients with Complex Needs including Bariatric Patients “ is now in place which provides a process for the utilisation of both vehicles and trained staff, of which numbers have continued to increased.

Fit testing

Fit testing processes in the Trust are not as effective as they need to be resulting in the Trust being potentially non-compliant with the Control of Substances Hazardous to Health Regulations (COSHH) and Personal Protective Equipment (PPE) Regulations.

PROGRESS: Fit testing is still taking place at Training Schools and a new post of Patient Safety and Nursing Development Manager is in place who will be working with A&E operational areas to ensure they have a sustainable fit testing process for existing staff in place.

Carry chairs

Use of the carry chair is still the highest reported incident relating to moving and handling issues which include the track carry chair and risk is on the risk register.

PROGRESS: Staff surveys have been conducted in both A&E and PTS to identify the exact issues staff are having which will inform future actions and improvements.

Implementation of the risk assessment procedure

A formal standardised risk assessment procedure was put in place during 2015-2016, however, the process has yet to be embedded in the Trust

PROGRESS: This has been partially addressed by the provision of IOSH accredited Health and Safety training to a selected group of middle managers which included training on the Trust’s risk assessment procedures.

2.3.5 Looking ahead – priorities for 2017-18

An important focus for the coming year will be the continuation of the Health and Safety training program.

Arrangements are being made to ensure the remaining 20% of the Trust's senior management are able to complete the IOSH accredited training. Work will also commence on the delivery of training to the remaining middle managers, which is to be provide in-house as collaboration between Training Department and the Health and Safety Manager.

The delivery of the training program is essential to ensure the continued effective functioning of the Trust's health and safety management system and further reduce the health and safety skills gap which has been identified.

Moving and handling and the reduction of musculoskeletal injuries remains a top priority for the Trust. Therefore, the Moving Patient Safely Group will continue to meet 6 weekly and address the issues faced by the Trust, building on the excellent work completed in 2016/2017.

Implementation of the risk assessment process will also be automatically progressed as the health and safety training is rolled out plus ways of integrating the process into existing Trust procedures will be explored.

Slip, trips and falls remain the second highest RIDDOR incident for the Trust. Work to tackle these still forms a significant part of the 2017-2018 work plan.

A new work stream added for 2017-2018 is in relation to the Trust's review of health and safety consultation arrangements and the implementation of the new procedure.

The Health and Safety work programme complements the wider Trust well-being programme which has been refreshed for 2017/18 particularly in relation to violence and aggression (see security work programme).

The goals for 201/18 include :

- To reduce MSK staff injuries within our workforce
- To focus on reducing incidents of violence and aggression towards our staff

2.4 Security

2.4.1 Introduction

Security management is overseen by an accredited Local Security Management Specialist (LSMS). There is an annual work plan for security issues informed by internal priorities, national Security Management Standards and other in year developments. In 2016 a trustwide security workshop was held to identify security priorities, this has informed the annual plan for 2017-18 which will be closely monitored through Security and Estates with contributions from other services where appropriate.

2.4.2 Delivery of Work Plan for 2016-17

Security resilience – The Security Team

Throughout 2016/17 the development of a cohesive security team has enabled effective systems and processes to be established and embedded which has resulted in stronger management of risk and enhanced resilience. Reviews of policy and procedures have been undertaken to reflect improved arrangements.

Standard Operating Procedures have been developed and implemented. These include management of incident investigations and completion of the NHS Protect Security Incident Reporting System (SIRS) dataset which was a requirement of the NHS Protect Security Management Standards in 2016/17, and also produces the RPA (Reporting of Physical Assaults) subset which is used to benchmark nationally on physical assaults and sanctions.

Self-Review Tool (SRT) NHS Protect

YAS submitted the NHS Protect Security Management Standards 2016/17 Self-Review Tool in November 2016. The declaration was developed through a Security Workshop with representation from relevant services within YAS and follow-up meetings with identified standard leads. An independent assessment of our process and declaration was provided by an Accredited Security Management Specialist from our Internal Auditors. The 'East Coast Audit Consortium Internal Audit Report; Security Management Arrangements and the NHS Protect Quality Assurance Compliance provided us with *'Significant Assurance'* that *the processes undertaken in support of the SRT submission and subsequent scorings/ratings are comprehensive and robust and have accurately and realistically assessed the Trust's actual security management arrangements and the extent to which they are embedded'* and that processes were transparent, detailed, thorough and comprehensive and achieved the aim of '*producing a 'realistic assessment of the actual position of the Trust in relation to security management arrangements against NHS Protect standards'*.

YAS declared 15 requirements as fully compliant which means that work had been carried out in response to an identified risk, with mitigation or significant progress demonstrable. Fourteen standards were considered partially compliant and action plans are in place. Progress made within 2016/17 in respect of these action plans is detailed in the sections below, and further actions have been incorporated into the Security Workplan for 2017/18.
From April 2017, NHS Protect's functions in respect of security management were decommissioned, and responsibility for national oversight now sits with NHS England. YAS will continue to go through the self-assessment process against the Security Management Standards and to deliver the requirements set out by the standards.

Premises and Vehicle Security

A centralised log of premises and vehicle security requests for both internal and external (Police) investigations is established and maintained in accordance with the requirements of YAS CCTV Policy.

Timescales for responding to requests are monitored and improvements in process have been introduced, for example, additional personnel have been trained to retrieve vehicle CCTV, and trained to view both vehicle and premises CCTV to provide resilience. The CCTV Policy has been amended to reflect these arrangements.

The quality of premises CCTV is monitored and issues reported to our contractor for remedial works, or to the YAS Estates Team where groundworks are required.

The NHS Protect Security Management Standards declaration for 2016/17 identified areas where site security arrangements could be further reinforced and this will be scoped as part of the Security and Estates joint working during 2017/18. Part of this work will be to increase staff vigilance and awareness of best practice, and to monitor this as part of routine inspections.

Staff Security

A Task and Finish Group was commenced during 2016 to review the Data Flagging Procedure. The group has conducted an end-to-end review of the Data Flagging process for violence and aggression incidents as well as reviewing policy and processes to ensure consistency of messages, roles and responsibilities and approach and how we communicate sensitively but effectively with victims of physical and verbal assault.

The Data Flag Group has continued with BAU concurrently to the Task and Finish review with changes in process and clarity of roles and responsibilities and strengthening of working arrangements between members of the group being embedded during the review period. The Security Team have established closer working arrangements with the EOC Data Flag coordinator to collate evidence and validate intelligence to support decisions on placement and retention of Data Flags.

Towards the end of 2016/17 the Security team commenced a review of our mandatory training materials in accordance with NHS Protect guidance; Standard 3.1, which requires a risk-based role-assessed approach to delivery of Conflict Resolution Training (CRT).

An increase in A&E Operations abstraction was agreed by Trust Executive Group in 2016/17 to allow for enhancements in face-to-face training in Conflict Resolution and associated topics to be developed in line with national guidance and best practice. The CRT for A&E Ops has now been developed and was launched in early 2017/18 and includes focus on Clinically-Related Challenging Behaviours and Acute Behavioural Disturbance, Safer Responding and the Joint Decision Model (JDM), awareness of incident reporting, Data Flagging, Post-Incident Care (PIC) and Staff Welfare. This piece of work was coordinated by the Training and Development Team with subject matter expert contributions from across the Trust. Work will continue into 2017/18 to develop CRT for other relevant staff groups.

2.4.3 Incident reporting – local and national

To support capture of comprehensive incident data for 2016/17, the Security Team have developed and implemented Standard Operating Procedures to validate the quality of data recorded. This contributes to achievement of Security Management Standard 2.6: *record details of physical assaults in a systematic and comprehensive manne*r. Whilst reporting of incidents to NHS Protect is not required in 2017/18, the processes put in place will be maintained to support themes and trends analysis and for organisational learning, and also to enable regional and national benchmarking.

A more detailed understanding of contributory factors, whether clinical or aggravating factors, will ensure that the training we deliver to staff in managing violence and aggression is relevant to the situations that they may encounter in order to protect the welfare of our staff.

The table below shows the number of violence and aggression incidents against YAS staff reported by year for physical assault and non-physical assault, by patients, relatives or members of the public.

Incident type	2014-15	Mod +	2015-16	Mod +	2016-17	Mod +
Physical assault	**166**	**12**	**134**	**3**	**219**	**10**
Non-physical assault, includes verbal assault, threats, uncooperative behaviour	**415**	**1**	**488**	**4**	**527**	**1**

The increase in the number of incidents reported in 2016/17 may be attributed to a combination of factors including greater staff awareness of the incident reporting process, implementation of the Safer Responding Procedure and Joint Decision Model, and improved data quality in incident management.

Pursuance of Sanctions

Timely retrieval and collation of evidence is imperative to pursue sanctions against perpetrators of violence and aggression to our staff. The improved processes described above support this objective. Sanctions may include Data Flag warning letters issued by the Trust, Police cautions, fines, or potentially a prosecution. Continued improvements in our processes for managing incidents and a consistent and coordinated approach to Data Flag reviews will increase sanctions in 2017/18 in respect of warning letters.

It is recognised that work is needed to increase the support available for staff through the prosecution process and to publicise successful prosecutions.

2.4.5 Key Risk

The key risk identified in 2016/17 was in relation to developing resilience for key pieces of work that formed part of the Security Workplan. Managed by the Risk Manager, a Coordinator and Administrator support the operational delivery of the key tasks that underpin effective delivery of the Trust's security function and contribute to organisational resilience in respect of security arrangements. The resilience of the Security function remains under constant review.

For 2017/18 our focus is on taking a risk-based and proportionate approach to prioritisation of investment of our capital and our resources into identified security priorities.

2.4.6 Looking Ahead – Priorities for 2017-18

The following are identified as priorities within the 2017-18 work plan:

- To continue to progress action plans resulting from the annual Security Workshop and NHS Protect Security Management Standards submission

- To ensure that any future submissions are made in accordance with national requirements

- To undertake a further Trust wide workshop to inform development of the 3-5 year security management plan.

- To monitor delivery of approved capital bids and to take a risk-based approach to prioritisation of investment

- To improve capture of sanctions and redress for violence and aggression and security-related incidents

- To identify themes and trends from incidents and address required actions and incorporate lessons learned into training materials where indicated

- To strengthen our support to staff who are pursuing potential prosecution following a violence and aggression incident

- To ensure our policies and procedures are routinely updated to reflect best practice and national guidance and are assessed for their effectiveness.

Three KPI's have been set out in the Security Workplan, these are:

a) Increase the capture of sanctions totalling 80% of all sanctions implemented.
b) Increase the number of staff meaningfully supported and advised through the prosecution process to improve staff welfare and likelihood of successful prosecution
c) Increase redress for criminal damage to Trust property by 10%

2.5 Infection prevention and control

2.5.1 Report from the Director of Infection Prevention Control

In 2016-17 the YAS Director of Infection Prevention and Control remains Steve Page, Executive Director of Quality Governance and Performance Assurance.

The qualified Infection Prevention and Control Practitioner within YAS is the Head of Safety.

Infection prevention and control (IPC) is fundamental to the safety of both our patients and our staff. YAS must demonstrate that we are compliant with the requirements of the Health & Social Care Act 2008 and the Care Quality Commission (CQC) Key Lines of Enquiry. This includes providing our staff with adequate resources to adhere to IPC standards and follow best practice and ensuring that directorates work effectively together, for example Fleet, Estates and Operations, to set and monitor standards.

The key IPC compliance requirements for YAS are:

Hand hygiene: All clinical staff should demonstrate timely and effective hand-washing techniques and carry alcohol gel bottles on their person. This includes being bare below the elbows during direct delivery of care.

Asepsis: All clinical staff should demonstrate competency in aseptic techniques during insertion or care of invasive devices.

Vehicle cleanliness: Vehicles should be clean inside and out and any damage to stretchers or upholstery reported and repaired. Between patient cleans should be undertaken by operational staff at the end of every care episode to reduce the risk of transmission of pathogenic microbes.

Vehicle deep cleaning: Vehicles should receive regular deep cleans in accordance with the agreed deep cleaning schedule of 35 days in and line with the agreed Standard Operating Procedures. Effective deep cleaning ensures reduction in the bio-load within the clinical setting.

Premises cleanliness: Stations and other sites should be clean and have appropriate cleaning materials available and stored appropriately. Deep cleaning of key clinical storage areas, such as consumable cupboards, medical gases and linen storage areas should take place on a monthly basis. Clinical waste and linen should be disposed of in line with Waste Guidelines.

2.5.2 Delivery of work plan for 2016-17

The YAS IPC annual work plan is approved and monitored via the Clinical Governance Group.

The 2016-17 annual programme of work described the activity in relation to maintaining compliance to both the Health Care Act (2008) and the CQC Key Lines of Enquiry. The key priorities are delivered through agreed work-plan.

Progress with the 2016-17 work-plan has included:

- On-going advice for staff who require additional information about infection prevention and control out with agreed policy statements; includes contact tracing for staff members and risk assessments for both staff and patients where appropriate and reporting via RIDDOR to HSE where an exposure has occurred. Alterations to the Datix reporting system has streamlined this reporting process.

- A schedule for the review of IP&C procedural documents is in place. The current list of IP&C procedural documents meet Health and Social Care Act 2012 requirements, are in date and fully ratified. Adherence to infection prevention and control (IPC) policies and procedures remains a key priority in order to promote both patient and staff safety. The number of IPC related policies has been reduced in order to assist staff to find the information they require quickly and easily. During 2016-17 the following policies have been reviewed or developed;

  - Infection Prevention and Control policy
  - Post Occupational Exposure Policy
  - Decontamination of medical devices and vehicles
  - Standard Operating Procedure for replenishment of supplies
  - Norovirus management guidance
  - Aseptic Technique and Invasive Devices Guidance
  - Dress Code and Uniform Policy
  - Hand Hygiene policy
  - Vehicle ATP Swabbing Procedure

- Full review of the information included in YAS IPC policies has been undertaken with a specific view to information required by the Clinical Hub and PTS Team Leaders. This was undertaken to ensure they have access to the correct information to be able to support staff to make decisions around personal protective equipment and decontamination of the vehicle following possible occupational exposure to a communicable disease. Standard Operating Procedures for common microorganisms have been developed for these two groups of advisory staff and others who act in this advisory capacity out of hours.

- The Infection Prevention and Control Practitioner undertakes validation audits of vehicle cleanliness and hand hygiene at relevant Emergency Departments to ensure compliance with hand hygiene and vehicle cleanliness is maintained.

- Infection prevention and control elements for station are assessed during the Inspections for Improvement programme, which includes an overall compliance rating. Compliance with IPC related elements has increased over the annual inspections during 2016-17 largely due to the re-supply of the recliner chair.

- The Infection Prevention and Control practitioner continues to work with the Occupational Health provider to ensure all staff are offered the correct immunisation, health surveillance and follow up services as required. A full re-launch of the post occupational exposure checklist with briefing for Clinical Supervisors at their away day and review of compliance via the Datix incident reporting system.

- A visual reminder sticker has been developed and placed in the back of all ambulances to ensure they undertake the between patient cleans following patient handover. A check to confirm that the daily clean of PTS vehicles has taken place has been added to their PDR checklist.

- Support to the Health and Well Being Officer is on-going, this has included input to the new structure including development of the Head of Occupational Health and Well-Being roles and responsibilities; this is a new post within the structure that will be recruited to during early 2017/18.

- Assessment of the Deep Cleaning programme given to the Embrace team has been undertaken by Infection prevention and Control practitioner in conjunction with Head of Facilities and the local facility supervisors. The Standard Operating Procedures have been reviewed and updated in line with feedback from the Embrace Clinical Team. Specific training for Embrace YAS support staff has been developed and delivered.

- The new Replenishment of Supplies SOP has already been reviewed following learning and developments noted during the CQC inspection preparation process. Areas of concern remain overstocking of all vehicles, in particular the RRV additional boot space and the green bag.

2.5.3 Compliance with CQC standards

During 2016-17 YAS continued to focus on maintaining compliance with the requirements of the *CQC Essential Standards of Quality & Safety* – outcome 8: cleanliness and infection control.

The inspection in September 2016 identified an overall improvement in compliance with all IPC and decontamination practices; however some inconsistencies remained, in PTS in particular. This included cleaning of vehicles between shifts and consistent region wide compliance with bare below the elbows policy. These issues were immediately addressed and overall the CQC were complimentary about the speed and extent of the progress made since the previous inspection.

2.5.4 IPC audit

The clinical audits for hand hygiene, vehicle cleanliness and premise cleanliness were carried out monthly in each clinical business unit and are reported to the Trust Board monthly via the Integrated Performance Report (IPR). Audit compliance across all areas has improved over the year, with the majority of business and practice areas achieving 95% compliance.

Where areas were found to be non-compliant targeted action was taken by the Quality and Safety team. Premise cleanliness audits were the most frequent area of reported lower compliance.

Validation of the hand hygiene audits provides further information about any perceived or actual barriers to hand hygiene in clinical practice and gives us a deeper understanding about the current use of gloves.

IPC audits are communicated through to station level and are visible on the compliance notice boards. Compliance with this standard is monitored through the Inspection for Improvement process.

IPC good practice reminders have been publicised regularly through the Staff Update throughout the year; examples include articles about the patient safety implications for being bare below the elbows, bug of the month which includes a focussed article on a hot infection topic and how to respond if you have a sharps injury. Where required safety alerts have been used to inform staff of changes in practice or equipment that affects their IPC practice.

2.5.5 Vehicle deep cleaning and premise cleanliness

Deep cleaning is undertaken by a dedicated cleaning team for every vehicle at least every 35 days. Deep cleaning audit results are reported via the IPR. Where the audit results show a fall in acceptable levels of compliance the Head of Safety will work collaboratively with the Locality Managers and Facilities team to determine and resolve the issues.

The DIPC issues a letter to enforce the vehicle off road policy to facilitate deep cleaning where the vehicle has gone beyond the target cleaning window. This process has ensured a sustained improvement with the assurance associated with the deep cleaning programme.

Pilots of Make Ready and vehicle preparation processes, that include a more standardised vehicle cleaning system, have been implemented and supported in order to assess efficiency and effectiveness. ATP swabbing has been utilised to ensure high compliance with the cleaning processes and is now used as standard within the Facilities Deep Cleaning team.

2.5.5 IPC training

IP&C training is provided on appointment to the Trust through corporate and local induction. Refresher training is provided on a 2 yearly basis via the Statutory and Mandatory Workbook. Training content and delivery is reviewed by the Head of Safety and representatives from Education and Training Department. The proportion of YAS staff compliant with IP&C training continued to increase in 2015-16 and at year end was at 94%.

2.5.6 Infection Prevention and Control Incident review

IP& C Incidents by Sub Category	2013-14	2014-15	2015-16	2016-17
Clinical/Medical Sharp Injury	44	61	46	50
Contact with communicable infection	28	29	28	38
Contact with Blood/Bodily Fluids	17	25	27	36
Cleanliness Issues	7	5	2	16
Availability of PPE	0	2	3	5
Bite	2	6	5	7
Lack of availability of Equipment	1	2	0	3
Waste Disposal	5	3	3	3
Failure to follow YAS Procedure/Protocol	1	5	3	5
Vaccinations/Immunisations	0	0	0	2
Totals	105	138	117	165

Incident reporting has increased during 2016-17. This is likely to be due to increased awareness of reportable infection prevention and control incidents and the focus on the importance of reporting incidents per se.

Clinical medical sharps include significant exposure incidents as well as clean unused sharps incidents. Significant exposure incidents make up 50% of the reported total for 2016/17 with 25 staff having a significant occupational exposure. The IPC Practitioner works closely with operational staff and Occupational Health Advisors to ensure timely support and treatment is given to these staff members.

Staff are becoming more aware of the infection risks posed by the care they deliver as during their training, best practice events and CPD events. During 2017/18 we will have a strong focus on protecting yourself by undertaking a dynamic risk assessment and utilising the correct personal protective equipment.

2.5.7 Key risks

Current risks on the risk register relate to sustaining HCAI focus via compliance with hand hygiene and bare below the elbows. This risk has reduced but remains a key focus for both A&E and PTS. Validation audit and local challenge remain a constant requirement for clean, safe hand hygiene to be promoted.

An additional risk added during 2016/17 relates to the Trust responsibilities outlined in the Green Book. This includes a requirement to have provision for post occupational exposure prophylactic treatment with antibiotics, should this be deemed necessary following potential exposure. Currently YAS staff are supplied these antibiotics, where they are required, by the Emergency Department where the infection was identified; however this is not a guaranteed service from ED's and relies somewhat on good will. The Director of Infection Prevention and Control and People and Interim Executive Director of People & Engagement have discussed this issue and this will be taken forward by the new Head of Occupational Health and Well-Being and reviewed as part of the 2018-19 Occupational Health Contract review.

2.5.8 Next steps for 2017-18

- Further audit work to embed and review practices in relation to bare below the elbow.
- Development of a Clinical Audit process for insertion of indwelling devices including cannula insertion.
- Response and key actions following feedback from CQC inspection including an increased focus on IPC practice within PTS service.
- Further engagement with service users and public, and exploration of hand hygiene audits undertaken by frequent users of the PTS service.
- The IPC practitioner will undertake a full review of refresher training session undertaken by clinical tutors following updates to the IPC training course which will include a new 30 minute face to face training session. Induction training and Mandatory training packages available in the Statutory and Mandatory training manual will be reviewed in line with statutory requirements.
- Focus on ensuring all staff employ the correct personal protective equipment when caring for patients with known or suspected infection.

2.6 LEGAL SERVICES

2.6.1 REQUESTS FOR INFORMATION

The Legal Services Team deals with all requests made for disclosure of information under the Data Protection Act (1998), Access to Health Records Act (1990) and recently the function that deals with Freedom of Information Act (2000) requests has transferred under the legal function.

There are strict timescales defined within law for requests under the various legislation in which the organisation must comply with.

The majority of requests received for person identifiable information made to the Trust are for patients own health records. A smaller number of requests relate to staff records e.g. personnel files. Requests are also received from the police under section 29 of the Act. This section deals with requests for personal data processed for a number of purposes including the prevention or detection of crime, and the apprehension or prosecution of offenders.

A large volume of requests are received each month. The figures for 2016-17 are shown below, in comparison to previous years.

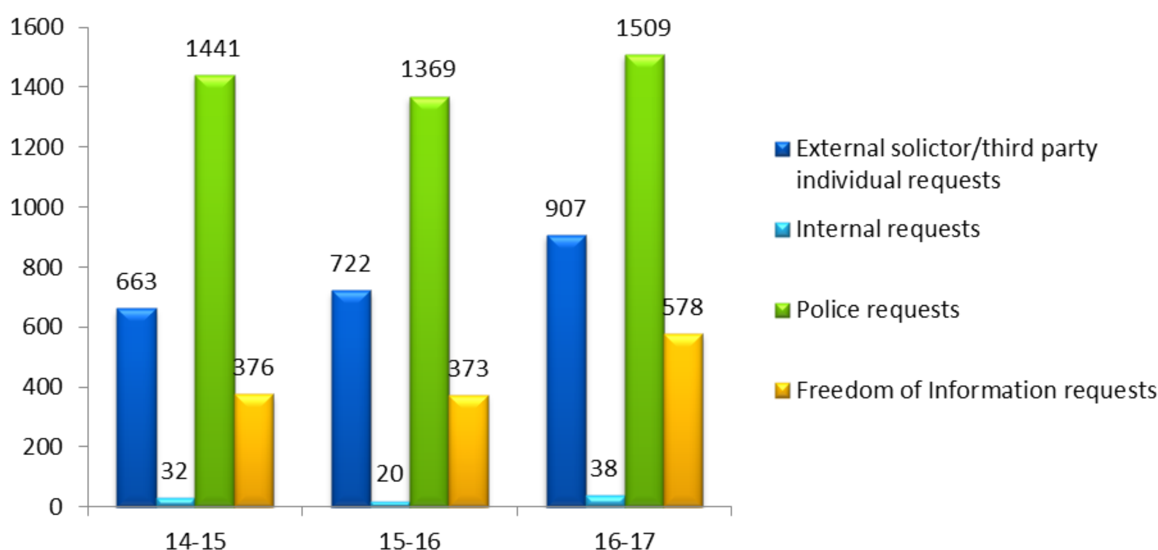


Figure 1: Total number of information requests received by year

All types of information requests dealt with by the legal services team have seen a significant increase in 2016-17. The overall compliance rate for 2016-17 against for requests under the Data Protection Act was 95% for the Department of Health's 21 working day target and 100% against the 40 calendar day requirement which is a positive achievement given the rise in workload volume.

The Legal Services Team work hard to maintain this level of compliance and regularly review and revise the processes to maximise efficiency. Further work is planned for 2017-18 to improve the education and understanding of the FOI requirements for departments across the Trust with the aim of improving compliance rates. Further work will also be taken forward with the communications team to enhance the Trust publication scheme. To date there have been no complaints made to the Information Commissioners Office around the handling of requests for information.

2.6.2 CORONERS INQUESTS INCLUDING PREVENTION OF FUTURE DEATHS (PFD) REPORTS

The Legal Services Team actively manage all Coroner Inquests, which is inclusive of identifying and managing risk, Trust reputation, identifying learning and providing staff support. The Trust's involvement in inquests continues to remain high in relation to attendance of staff as witnesses, particularly within the Hull and East area which received 202 Coroner requests in 2016/17. During 2016/17 YAS received 428 Coroner requests and employees gave evidence (oral or written) to 215 inquests this year. 213 are still awaiting a hearing date.

During 2016-17, those inquests that involve potential risks to the Trust focussed on delayed response times within the A&E service, and these were mainly concerned with delays to lower priority coded calls in which time the patient has deteriorated, as opposed to any Purple delays and how they are managed within the Emergency Operations Centre. Those reported have consisted of a combination of demand/resource issues and human factors within the EOC. Lessons and actions have been taken on an individual case basis and are also fed back into wider Trust work streams.

In all cases where a concern is raised YAS provides an investigation report and representation from the Trust is made by an appropriate senior manager at the inquest. The conclusions, including lessons and recommendations are added to the report to ensure that this is captured and further informs analysis of themes and trends.

Both individual learning points and common themes are identified and actions implemented from review and management of inquest cases. During 2016-17 there were a number of inquests involving NHS111 and GPOOH services. The main focus of these relate to human factors within the call handling processes. Learning from a case which went through both the inquest and claim routes, a change in process for those calls within NHS 111 that reach an outcome of a Red 2 ambulance response has been implemented. Previously where these calls reached an outcome of a Red 2 ambulance response, call handlers had the option of referring the call to a clinician within the service for further assessment. This process was criticised and it is now the process that a call handler must offer the patient an ambulance in these circumstances, and only if the caller refuses are they then passed to a clinician.

Additional organisational learning actions from inquests have included a review of and implementation of a suicide risk assessment process within EOC and the development of a Trust wide procedure for gaining entry and for when a patient can't be located.

Prevention of Future Death Reports

Under the Coroners and Justice Act 2009, a Coroner has an obligation to issue a Regulation 28 notice or Prevention of Future Death (PFD) report in any matter where they consider action is necessary with a view to preventing future deaths.

During 2016/17 YAS received three PFD reports, briefly detailed below:

- An inquest that was held in West Yorkshire concerned a bariatric patient who had fallen and been in a kneeling position all night before being found by a friend who contacted 999. The call was given a Green 4 coding which was found to be compliant and the overall response time was 2 hours and 2 minutes. The Coroner felt that a further review of the protocols in place were required in relation to incorporating more enquiries with respect to long lays, particularly in the case of obese patients, and

issued a PFD on this basis. The case was discussed at the National Medical Directors Meeting and with the International Academy of Emergency Dispatch to look at any additional actions that could be put in place for ‘long lay’ patients.

- An inquest that was North Yorkshire concerned a patient who was feeling suicidal and had been conveyed by ambulance to an emergency department where he was later discharged and found deceased later the same day. YAS were not informed that the inquest was taking place, nor were any witnesses from YAS asked to attend the inquest, and as a result of concerns raised from the family during the inquest that they weren’t told that the patient was being taken to hospital, the Coroner issued a PFD report to the organisations involved to review the processes relating to this. YAS considered the report but felt that all appropriate systems and processes were in place and a response was provided from the CEO confirming this.

- An inquest that was held in South Yorkshire which concerned the death of a maternity patient who had suffered a cardiac arrest and was conveyed to A&E. During the inquest it was identified that the crew on scene had requested EOC to make a pre-alert to the hospital, but unfortunately this had not been actioned and the hospital were not aware that this patient was being brought in. Whilst there are clear guidelines and processes in place around the pre-alert process, the Coroner was still concerned with the reliability of the system that is in place for pre-alerts and issued a PFD report. Since the inquest guidance for operational staff around the pre-alert process has been re-communicated, and a process has been put in place within EOC to ensure that any pre-alerts that are requested are recorded within the system and confirmed with the staff member initially requesting that one has been done.

Risks

The implementation of strict timescales for concluding an inquest means that Coroners now set inquest dates much earlier, with short timescales for the Trust to review the cases and implement any actions that are required. Coroners are now able to enforce a fine of up to £1,000 if deadlines are missed. The Legal Services Team identify witnesses/commence an investigation and ensure that statements are prepared and all relevant documents collated for sending to the Coroner without delay.

PFD reports have taken on a more central role within the Coronial process. It is possible for a PFD report to automatically be made in circumstances where the Coroner is not provided with a final Serious Incident Report and a fully implemented Action Plan; or where there is evidence that the recommendations arising from the Serious Incident Report or Action Plan have not been adequately implemented or communicated to staff. Given both the volume of inquest cases and the tight timescales for concluding Inquests, this is challenging to manage both in terms of meeting the timescales for information, and effectively identifying and managing risks to the organisation. The Legal Services Team continues to work closely with other departments across the Trust to provide support and assistance to any member of staff involved in the inquest process.

All Coroner’s inquests are reviewed individually by the Executive Medical Director, and moderate and high risk cases are regularly reviewed at the fortnightly Incident Review Group so any risks can be identified early and managed effectively.

2.6.3 Claims

The Legal Services Team actively manages claims in conjunction with the Trust's insurers. This is inclusive of reports to specific departments on minimising future risk, identifying learning, managing reputation and staff support.

The NHS Litigation Authority (NHS LA) act as the Trust's insurers and from April 2017 is now known as NHS Resolution. They responsible for the management of all Employer's Liability (EL), Public Liability (PL), Clinical Negligence (CNST) and Property (damaged and lost) claims on behalf of the Trust.

In August 2013 the Ministry of Justice extended its Claims Portal which is used for motor personal injury to include Employers' Liability and Public Liability (EL and PL) claims. Over the last two years the use of the Portal has become much more embedded and it is now the compulsory route for EL and PL claims valued at up to £25,000 for damages. For these claims there is a limited time to investigate of 30 days for employer liability claims and 40 days for public liability claims. The result of this scheme is that claims are settled much quicker, and the costs associated remain low. The risk associated with this scheme is that the shorter timescales puts pressure on departments within the Trust to investigate the claim and make a decision on liability.

Claims reporting

The table below details the total amount of open claims (inclusive of new claims reported). At the end of 2016/17 there are 206 open claims, with 93 new claims being reported. 146 of these are EL claims (71%), 9 PL (4%) and 18 CNST claims (9%). The remainder of the open claims relate to motor personal injury claims (33, 16%) which are managed by QBE insurers and a small number of property claims. The data shows that the number of new claims reported has slightly increased this year, along with the number of open claims.

Figure 1: Total number of new and open claims (EL/PL/CNST).

New Claims

The table below details the new claims reported over the last 5 years. The highest volume of claims is Employer Liability claims which have seen a slight increase this year in reported claims. CNST claims are increasing slightly each year which is consistent with an increase in activity as an organisation and a growing claims culture. Overall these figures remain low. PL claims have markedly reduced this year which is positive. Prior to 2014/15, property claims were dealt with through a number of processes and often at locality level with no formal recording mechanism. The focus of these claims is for loss or minor damage to patient's property. Since 2014, all property claims are managed by the Legal Services Team and are recorded on the Datix system. The graph below therefore reflects this change in process.

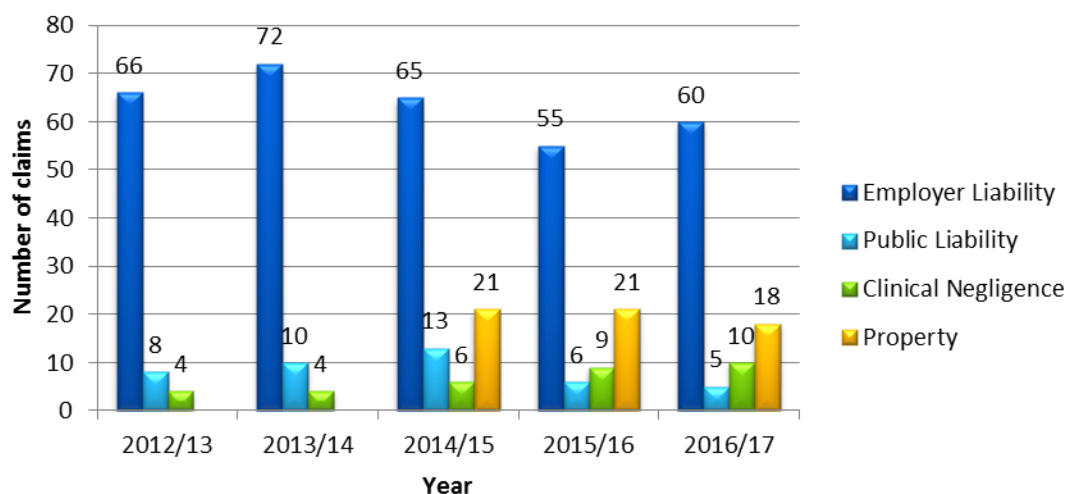


Figure 2 – New claims reported (EL/PL/CNST/Property)

Employer Liability (EL) Claims

Employer Liability Claims continue to be the main focus of claims within the Legal Team, 60 new claims were reported in 16-17, with 146 open. The highest volume of these claims relates to musculoskeletal injuries from moving and handling incidents (44 open claims). The moving and handling claims mainly relate to injuries arising from equipment, for example carry chairs, stretchers and wheelchairs and from assisting patients with movement.

Vehicle related claims are also high (33 open claims) as a result of problems with tail-lift, seats, heavy steering and vehicle doors. On-going risks associated with vehicles are reviewed at a number of Trust meetings and learning from claims feed in to these meetings. Work has also continued during 2016-17 in relation to manual handling risk assessments for vehicles and equipment.

The on-going work streams from the Moving Patients Safely group continue to support with the reduction of staff injuries, and new guidance on manual handling risk assessments for equipment and vehicles is being produced. New risk assessments, including improved manual handling assessments have commenced. The Health and Safety team are working closely with the training department to identify and address key issues

Public Liability (PL) Claims

In 2016-17 there were a total of 5 PL claims reported, which is a slight decrease from last year and the numbers remaining relatively low over the years. This demonstrates a positive patient safety culture within the Trust. The majority of these claims were from injuries sustained during transfer of the patient to the vehicle, either as a result of a trip or fall, or injury from equipment.

A Moving Patients Safely working group was established in 2016 as part of the Sign up to Safety work-streams and this has had a positive impact on the reduction of patient injuries and claims. This group is focussed on the continuous improvement of systems and processes in order to achieve a reduction of injuries to both patients and staff. Patient safety and experience is paramount to this group and its membership includes the Expert Patient. So far the group has overseen the development of the Standard Operating Procedure for Patients with Complex Mobility Needs which was launched in early September across both PTS and A&E services. Staff surveys about equipment available to support the safe movement of patients have been completed and led to developments in staff training; for example working with Ferno to ensure optimal use of the Track 2 carry chair. Next steps include a full review of the Moving Patients Safely training programmes, including bariatric training, on-going review of new equipment, including patient user selection using the Critical Friends Network and YAS Forum membership and development of a staff and patient focus group to establish a set of always events for patient movement.

CNST Claims

In 2016-17 there were 10 new CNST claims reported. Although this is a minor increase compared to previous years, these continue to remain in low numbers. The NHSR risk profile for the Trust indicates for the value of claims paid and the number of reported claims the Trust is rated in the top 20% best performing Trusts for CNST.

Even though there is nil excess on CNST claims, they are potentially very high value claims with reputational impacts on the Trust.

The main focus of the reported claims is in relation to clinical assessment on scene, particularly in patients who have deteriorated following a decision not to convey to hospital. A work stream within the Sign Up to Safety Campaign is focused on deterioration in adults and children which will include further training and education around clinical assessments and recognising and responding to deterioration.

All cases are reviewed individually by the Clinical Directorate and any lessons learned are disseminated through the Trust.

During 2016/17 the 2 clinical negligence claims were taken to trial and successfully defended on both occasions. One of these was a long standing maternity claim from 2000 valued at £4.5 million.

Looking ahead – priorities for 2017-18

- Standardised directorate and CBU dashboards were developed and implemented during 2016-17 and the focus will be to embed these within the business areas so that there is more transparency and ownership of claims within locality areas. It is hoped that the enhanced reporting process will allow for a focus on earlier identification of themes and trends of reported claims, and any lessons learned as a result. This aims to both support improvements to staff and patient safety, and reduce the number of claims reported.

- Continue to work closely with the Quality, Risk and Safety team to enhance investigation skills across the Trust, and encourage early investigation at incident stage which supports the management of the claim at a later stage.

- Continue to work with operational management groups across the Trust to ensure themes and trends arising from claims and inquests are reviewed and identified actions are implemented to demonstrate learning.

- Improve the training, education and awareness for staff involved in legal proceedings.

- More communication for localities and departments in relation to claims to ensure they remain a focus with local performance and governance arrangements.

2.7 MEDICINES MANAGEMENT AND OPTIMISATION

Medicines management and optimisation includes the purchasing, procurement, safe storage and handling, guidelines and, administration of medicines, incident reporting and error monitoring.

YAS's approach to medicines management is set out in the Trust Medicines Management Policy and the underpinning Drug Management Protocol and Controlled Drug Medicines Standard Operating Procedure. This SOP has been embedded in practice by the Clinical Managers who provide vital assurance of frontline implementation of policy and practice. The Trust Pharmacist offers expert advice and ensures effective medicines management.

During 2016-17 the Accountable Officer for Controlled Drugs has been the Executive Medical Director.

2.7.1 Background

The YAS Clinical Governance Group delegates responsibility for overseeing medicines management arrangements to its subcommittee, the Medicines Management Group (MMG). MMG is responsible for ensuring that procedures are followed in practice and that YAS complies with all national guidance and for providing assurance to the Trust Board via CGG and Quality Committee.

YAS adhere to national guidelines as well as the regulations and guidelines for medicines management from:

- National Institute for Health and Care Excellence (NICE)
- Quality, innovation, productivity and prevention programme (QIPP)
- UK Ambulance Service Clinical Practice Guidelines
- Care Quality Commission (CQC)

The Ambulance Service Clinical Practice Guidelines set out the list of drugs which may be used by any qualified paramedic trained A&E clinician. In addition, Patient Group Directions (PGDs) allow suitably trained staff to administer and/or supply specific drugs which are not within the ASCG list when specifically indicated by a patient's condition.

2.7.2 Medicines Management Work plan

Developments during the last year include:

- Introduction of new medicines to the YAS formulary including Ketamine, Midazolam, Magnesium, Activated charcoal and intravenous antibiotics for open fractures.
- YAS took part in the national monitoring of temperatures of medicines in UK ambulance services survey during 2015/16 and the report was published during July 2016. The results demonstrated that temperatures of medicines stored in ambulances and response cars were rarely above 40°C and on occasions were below 0°C but not for sustained periods longer than 24 hours. Transient spikes up to 40°C or below freezing are permitted so long as they do not exceed 24 hours
- Improvements during 2016/17 in how Clinical Managers review, coordinate and report POM audits of all operational vehicles has seen significant improvement in the reduction of failed audits and increase in the number of safe audits, reducing risk and contributing to patient safety.
- Increased clinical audit activity was focussed on medicines management, and provided valuable information on the frontline use of medicines. Clinical Audits included use of benzylpenicillin, IV Paracetamol, and use of oral antibiotics by specialist and advanced Paramedics.
- Rollout of the "Green Bag" scheme which allows frontline clinicians to collect all the patient's own medication to be taken into hospital. The green bag allows for easy identification of the medicines, allowing for the hospital pharmacists to easily review the patient's own medication

2.7.3 Review of Adverse Incidents Relating to Medication

The MMG review all adverse incidents, complaints and issues surround Medicines Management.

There has been an increase in reported incidents, with 397 non-controlled drug related incidents reported to Datix during 2016/17 compared with 322 during 2015/16. The highest category of incident reported was failure to follow YAS protocol or procedure, followed by drug check discrepancy. However there has been a decrease in incident involving patient harm In 2016/17, 22 minor harm incidents were reported, compared with 61 in 2015/16. Near miss incidents have increased from 29 in 2015/16 to 83 in 2016/17. This was due to increased compliance with drugs audits and detection of drug discrepancies. There have been no moderate or severe harm incidents involving PoM.

The Medicines Management Group identified a number of incidents with wrong drug administration involving Saline/Glucose and Aspirin/paracetamol in 2015/16, and changed the presentation and packaging of these drugs. There are no reported wrong drug administrations involving these drugs during 2016/17.

Improvements during 2015/16 in how Clinical Managers review, coordinate and report POM audits of all operational vehicles has seen significant improvement in the reduction of failed audits and increase in the number of safe audits, reducing risk and contributing to patient safety.

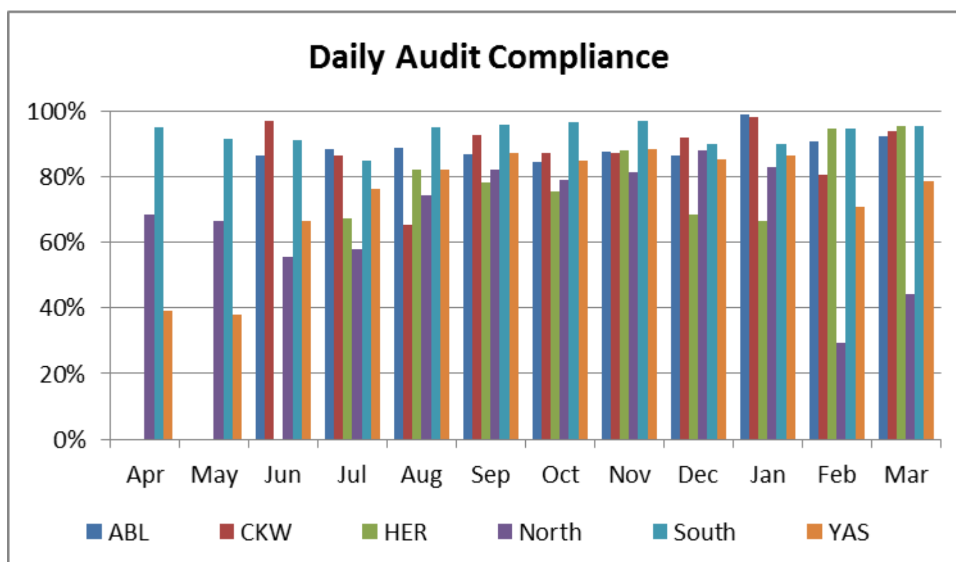
Improved compliance auditing identified that the main reason for out of date drugs in the PoM check was GTN tablets which had a three month use by date once the canister was opened. The decision was made to change to GTN spray and since this change we have seen an improvement in audit outcomes.

2.7.4 Monitoring Usage of Controlled Drugs

Controlled Drugs (CDs) are substances that are designated as controlled substances under the *Misuse of Drugs Act 1971*. They are arranged into three Classes (A, B or C) with Class A drugs being the most likely to cause harm. Controlled drugs are also classified into Schedules (1 to 5) under the *Misuse of Drugs Regulations 2001*. It is illegal for anyone other than a doctor, pharmacist or licensed/authorised courier to possess CDs. However, under the *Misuse of Drugs Act* 1971, ambulance paramedics are specifically allowed to possess morphine sulphate (Schedule 2, Class A) and diazepam (Schedule 5, Class C

Due to the requirement of YAS to have a controlled drug licence, the way in which YAS procure, store and transport CDs across the region has been reviewed during 2016/17. There is now a single point of entry and storage of CDs into the Trust. From this store the CDs will be delivered to individual stations when requisitioned.

The Controlled Drugs safes must be check and audited every 24 hour period, to ensure that the stock levels are correct, and that all Morphine has been returned. The following graph shows compliance over the 2016/17 period for each CBU. General improvement can be seen across most CBUs with the exception of the North CBU. Issues identified in the North are due to the rurality and staffing of some of the stations, and is being address by the Sector Commander.



There have been 399 controlled drug incidents in 2016/176, compared with 404 in 2015/16. The highest category reported was due to drugs damaged, followed by lost keys. In 2016/17, 55 keys were lost compared with 2015/16 were 36. The main reason for lost keys is lack of karabiner use. Regular karabiner audits are undertaken to

provide assurance that the karabiners are available, to highlight areas where there are gaps and to ensure all staff understand the re-order process which is quick and easy.

2.7.5 Patient Group Directions (PGD's)

Patient group directions allow healthcare professionals to supply and administer specified medicines to pre-defined groups of patients, without a prescription. PGDs in current use include;

All Paramedics;

- Misoprostol tablets
- Tranexamic Acid injection
- Prednisolone tablets

Critical Care including YAA and HART paramedics and Red Arrest Team;

- Amoxicillin injection
- Midazolam injection
- Ketamine injection

Urgent Care including specialist and advanced Paramedics

- Amoxicillin capsules
- Chlorphenamine tablets
- Codeine tablets
- Diazepam tablets
- Diclofenac suppositories
- Doxycycline tablets
- Flucloxacillin tablets
- Lidocaine injection
- Trimethoprim tablets

2.7.6 Introduction of New Patient Group Directions and ASCG medicines

- Introduction of new medicines to the YAS formulary:

    1. Ketamine for the treatment of pain for the red arrest team
    2. Midazolam for post ROSC management for the red arrest team
    3. Magnesium sulphate for the treatment of life threatening asthma for the critical care doctors
    4. Activated charcoal for accidental and intentional overdose
    5. Co-amoxiclav for open fractures for the red arrest and critical care teams

2.7.7 Management of key risks

Due to new legislation there is now a requirement for YAS to hold a controlled drugs license. To ensure preparedness for this process, Morphine and other controlled drugs are now procured and delivered to a single point of access within the Trust, and are delivered to stations by the internal logistics team. This has led to greater efficiencies

in frontline manager's time, and a safer, more secure process for ordering controlled drugs.

2.7.8 Next steps for 2017-18

- Medicines Management to be included in the Ambulance Vehicle Preparation project, and pilots planned for 2016/17.
- Further developments for specialist and advanced paramedics in Urgent and Critical care areas.

2.8 FREEDOM TO SPEAK UP

2.8.1 Purpose

The purpose of this report is to:

- Provide assurance to the trust board that Freedom to Speak Up has been implemented in Yorkshire Ambulance Service and that the associated processes are being utilised by staff.
- Identify the visibility and reach of Freedom to Speak Up to both internal and external groups and organisations.

2.8.2 Introduction

"Freedom to Speak Up (FTSU): An independent review into creating an open and honest reporting culture in the NHS" (Francis) was published in February 2015. The aim of the review was to provide advice and recommendations to ensure that NHS staff feel it is safe to raise concerns, confident that they will be listened to and the concerns will be acted upon.

A paper was presented to Quality Committee in May 2015 which outlined the processes that the trust currently had in place to facilitate staff in being able to raise concerns. These included an established process for reporting incidents and near misses, the 'Raising Concerns at Work' policy and process however it was acknowledged that this process was underutilised. The Staff Forum which is effectively embedded across the organisation provides staff with an additional channel to raise concerns and staff views are also represented by Union members in a number of forums. Establishment of a Black and Minority Ethnic (BME) forum and Lesbian, Gay, Bisexual and Transgender (LGBT) forum has also allowed the Trust to manage some concerns often experienced by vulnerable groups.

Despite the above processes and systems being in place, the Trust acknowledged there were areas for improvement and in September 2015 established a Freedom to Speak Up working group. The group included representatives from across the organisation including operational colleagues, union representatives, staff forum members, support service staff and is chaired by the Executive Director of Standards & Compliance. Work conducted by this group included identifying the most suitable FTSU model for the trust, develop and implementation our FTSU Policy and SOP and recruit a suitable FTSU Guardian and supporting advocates.

The Trust FTSU Guardian and supporting Advocates were appointed in June 2016 with Freedom to Speak Up launching on the 4th July 2016.

2.8.3 YAS FTSU Model

It was proposed by the FTSU working group that the trust should employ a FTSU Guardian to work 22 ½ hrs per week supported by a number of FTSU advocates who would represent the business function to which they are most closely aligned. As such the model adopted was a single Guardian model supported by 10 advocates who would be granted up to two days per month to support the Guardian in their duties.

Jock Crawford
Role: FTSU Guardian
Business Area: Trust Wide

Simon Talbott
Role: Advocate
Business Area: A&E Ops (West)

Mark Wright
Role: Advocate
Business Area: A&E Ops (North)

Gemma Gould
Role: Advocate
Business Area: EOC

Pauline Clegg
Role: Advocate
Business Area: PTS

Olivia Eames *
Role: Advocate
Business Area: Support Services (Finance, ICT, Quality, Governance & Performance Assurance, Business Development)

Lee Murphy
Role: Advocate
Business Area: A&E Ops (All)

Jon Thordarson
Role: Advocate
Business Area: A&E Ops (East)

Louise Whittaker **
Business Area: A&E Ops (South)

Patrick Gorman
Role: Advocate
Business Area: NHS 111

Fiona Goulding *
Role: Advocate
Business Area: Support Services (Fleet, Procurement, Estates, HR and Learning & Development)

* Olivia is currently on maternity leave; Fiona will cover Olivia's area of responsibility until her return.

** Louise intends to stand down as advocate in July 2017

The trust FTSU Guardian and advocated aim to meet every 2 months although it is anticipated that this period will be increased to 3 months come September 2017.

2.8.4 Recording of Concerns

From the outset it was agreed to configure the trust Datix system to assist with the recording and management of concerns raised through Freedom to Speak Up. Over the past twelve months a number of alterations have been made to the forms used to input data thus ensuring that our system continues to meet the current and future need of the trust and the National Guardian's Office (NGO) with respect to reporting requirements. Our Information Systems Manager has also provided advice and support to other NHS Trusts who wish to configure their own Datix systems to support FTSU.

Covering the period of this report there have been fifty one concerns logged on the Freedom to Speak Up Datix database. The criteria for recording concerns have altered slightly since first launce insomuch that concerns that were not felt to be appropriate for FTSU and originally signposted to other departments or processes without being recorded are now logged on the system at the request of the Quality Committee on the 8th December 2016. These concerns are still 'signposted' to other departments and processes but now provide a better understanding of the types and nature of concerns staff wish to raise. A subsequent reporting requirement published by the National Guardians Office (NGO) has also resulted in some minor alterations to the system. The trust is required to provide its first data feedback report to the NGO by the end of July 2017.

Work is also underway to establish a mechanism for feedback to be collect by those staff that chose to engage with the FTSU process. This is also a requirement specified by the NGO and the trust hopes to be in a position to have this element of the process fully established by September 2017.

The breakdown of 51 concerns raised during this reporting period is as follows:

Departments within which concerns have been raised (with number):

- A&E Operations – 22
- EOC – 21
- Fleet – 3
- NHS 111 – 2
- PTS – 2
- Estates – 1

Categories of concerns logged (with number):

- Departmental communication issues (internal) – 14
- Bullying and Harassment – 12
- Disregard to legislation particularly Health & Safety – 9
- Failure to follow YAS protocol or procedure – 8
- Signposted concerns – 4

- Failure to comply with legal duty – 2
- Damage or risk of damage to the environment or trust property – 1
- Financial malpractice – 1

2.8.5 Engaging with external organisations:

Yorkshire & Humber FTSU Guardian Network

A FTSU Guardian network has been established to include all NHS trusts across the Yorkshire and Humber region. This network meets quarterly to discuss learning opportunities and provide peer to peer support for Guardians.

National Ambulance Network for FTSU Guardians

A network for ambulance FTSU Guardians has also been established to promote the sharing of learning between ambulance trusts. Initial communications with the Quality Governance and Risk Directors (QGARD) are underway to establish a mechanism to articulate common themes and trends identified across ambulance trusts. The YAS FTSU Guardian Co-chairs this group which meets every 3 months. Members include:

- East Midland Ambulance Service
- East of England Ambulance Service
- London Ambulance Service
- North East Ambulance Service
- North west Ambulance Service
- South Central Ambulance Service
- South East Coast Ambulance service
- South West Ambulance Service
- West Midland Ambulance service

Other external organisations

The trust Guardian regularly presents to Student Paramedics at Sheffield Hallam, Teesside and Bradford Universities. It is hoped that by engaging early in their careers, staff will be able to appreciate the benefits of raising concerns which may also influence a change in organisational culture. Hull University is also in discussion with the FTSU Guardian to present to their Student Paramedics.

Following our trust Guardian presenting at the National FTSU Conference in London in February we were contacted by a number of organisation to assist in establishing or developing their own FTSU policy and structure. Organisations engaged with include:

- South London and Maudsley NHS FT
- Leicestershire Partnership NHS Trust
- Brighton & Sussex University Hospital
- Minehead Minor Injuries Unit
- Shropshire Community Health NHS Trust
- Nottingham University Hospitals NHS trust
- Public Concerns at Work Charity
- Kings Hospital London

As a result of work undertaken, the FTSU Guardian has also engaged with the following organisations:

- Freedom to Speak Up National Guardians Office
- Public Concerns at Work (Whistleblowing Charity)
- West Yorkshire Fire & Rescue

Other engagement opportunities have included attendance at:

- Best Practice Days
- Staff Forum meetings
- BME Network meetings
- LGBTQ Network meetings

2.8.6 Learning from FTSU

It has been recognised by both the regional and national ambulance FTSU networks that the concerns being raised are not predominantly patient safety concerns as experienced during the Mid Staffs enquiry. Trusts are identifying that many of the concerns being raised are suggestive of a culture of bullying and harassment. Often these allegations can be closely linked to either poor communications or a deviation from documented policy.

When conducting some analysis of the concerns being raised at YAS, a similar pattern can be observed. While the numbers of concerns is still relatively low to conduct any detailed and qualitative root cause analysis it was felt that the lack of management training for newly appointed team leaders or middle managers is having a contributory effect on the type of concerns being raised. This hypothesis is supported somewhat by the latest NHS staff survey (2016).

This has been discussed with the Executive Director for Operations and the Associate Director for Education and Learning where it was hoped that the work being undertaken as part of the YAS Values and Behavioural Framework will go some way to address these issues.

Staff from in EOC have raised a number of concerns regarding staffing levels and the impact this was having on team performance and the health and wellbeing of staff. Frequent meetings by EOC management and the FTSU Guardian and EOC advocate culminated in a statement being distributed to EOC staff acknowledging the shortage of staff with a planned course of action to improve the situation. It is believed that staffing levels continue to increase in EOC.

2.8.7 Summary

In summary, Freedom to Speak Up continues to establish itself at YAS with staff increasingly engaging with the process. There is still work to be done in regards to collecting feedback from staff who have raised concerns and more work is required to perform detailed analysis of those concerns raised.

Concerns categorised as Bullying and Harassment and Communication issues dominate the concerns raised to date but basic analysis suggests the cause of these concerns to be a lack of core management training for lower/middle managers. It is hoped that the work being undertaken as part of the YAS Behaviour and Values framework will go some way to improving this situation. Increasing staffing levels in EOC has already had a positive impact on the number and types of concerns being raised by EOC staff.

2.9 Next steps for 2017-18

A one year review was completed 23 August 2017including the Guardian, Advocates and members of the original project team. The overall feedback for the service was very positive. A number of areas for further development have been identified, which will inform the plan for 2017/18 including:

- Training for managers in relation to human recourses and staff management
- Sharing learning from FTSU
- Further equality monitoring to ensure all vulnerable groups appropriately represented.

Section 3.0

Clinical Quality

3.1.1 Introduction

The Clinical Quality Strategy 2015-18 set out a 3 year programme of clinical quality improvement. This is underpinned by an annual implementation plan focused on each of the key domains. The Clinical Quality Strategy is within its final year and work has already begun to refresh the strategy for 2018-2021, in line with the Integrated Business Plan, best practice guidance and learning from both national and local agenda.

The annual programme of patient safety improvements is informed by the priorities in the Clinical Quality Strategy including relevant national Sign up to Safety priorities and CQUINS.

3.1.2 Progress against the work-plan for 2016-17 includes:

Sign up to Safety Campaign

The Quality, Governance and Performance Assurance Directorate and Clinical Directorate continue to support and promote the Sign up to Safety pledges which include;

- putting safety first
- continually learning
- being honest
- collaborating
- being supportive

These pledges are upheld and progressed with staff during every interaction, from reporting of incidents, during the investigation process, clinical supervision and education and training packages. The safety culture of teams within Yorkshire Ambulance Service has a direct influence on reporting levels and any team's willingness to learn and act on investigation findings. Encouraging honest reporting and supporting staff during incident investigation facilitates an improved safety culture and ensures learning from adverse incidents is shared across the whole organisation.

The Freedom to Speak up Guardian and local advocates, are pivotal in supporting staff to raise concerns about the quality and safety of the care that is delivered. Hosting this role within the Quality and Safety team ensures any new learning from this route is identified and actions to resolve are in line with other relevant work-streams. The Freedom to Speak up process also supports the open learning culture within the organisation.

During 2016-17 the system for Bright Ideas was reviewed and re-launched, with a stronger emphasis on quality improvement methodology to ensure we are listening to staff, learning from their experience and supporting appropriate ideas to take forward. The Bright Ideas process is being more widely utilised by all staff groups to share their ideas for improvement across the Trust.

In collaboration with provider organisations and Commissioners YAS have developed an end to end review process for incidents where different services have inputted to the care delivery and something has gone wrong within that patient pathway. This has given the opportunity for system wide learning and has enabled changes to be made at key points to improve the patient experience and care delivery in the future.

A Sign up to Safety roadshow was undertaken at all Emergency Department during August and September 2016. This was a collaborative programme supported by both the Clinical Directorate and Quality, Governance and Performance Assurance Directorate to communicate the pledges and key work streams out to the frontline staff within their workplace. It was well received by staff as it gave them an opportunity to link with clinical staff with specific knowledge; for example care pathways team and Infection Prevention and Control nurse and to understand the Sign up to Safety programme.

The Sign up to Safety Programme has four established work-streams to progress during 2015-18;

- EOC Human Factors, including intervention of safety huddles
- Moving Patients Safely group; includes the promotion of excellence in supporting movement of patients to promote both patient and staff safety.
- Recognition and treatment of deteriorating adult; including sepsis CQUIN.
- Recognition and treatment of deteriorating child.

EOC Human Factors

All EOC staff have been trained in “Safety Huddles” as an intervention to support communication and reduce errors related to human factors; two of the five EOC teams now use Safety Huddles as part of their daily practice. Clinical Duty Managers and Duty Managers have been encouraged to expand their knowledge and skills further by undertaking Bronze and Silver Quality Improvement training established by the Improvement Academy. Work is underway to analyse incidents reported from EOC to understand further the impact of human factors on incidents and review learning to make sustainable improvements.

Moving Patients Safely

The Moving Patient Safely Group’s main focus in 2016-17 was the development and implementation of the Moving and Handling Patients with Complex Needs including Bariatric Patients Standard Operating Procedure. This SOP continues to be monitored by the group and they will lead the review of the document during 2017-18.

The group has also undertaken surveys of equipment available to support the safe movement of patients in both PTS and A&E services with a view to make recommendations about future purchasing of equipment to Trust Procurement Group; ensuring equipment is fit for purpose and used appropriately. Further training for the Ferno Track 2 chair has been initiated and progressed by the group; with staff who are not able to effectively use this piece of kit offered an alternative following a specific risk assessment.

Musco-skeletal (MSK) incidents for staff have fallen during 2016-17 and the level of harm associated with these has reduced but they remain the second most common reason for absence and a considerable number cumulate in a staff claim.

Recognition and treatment of deteriorating adult; including sepsis CQUIN.

Identifying patients at risk of deteriorating is central to initiating timely management and improving patient outcomes. An early warning score is based on a simple scoring system in which a score is allocated to physiological measurements, and is then aggregated. This aggregated score then enables clinicians to rapidly assess how unwell the patient is, communicate consistently with other health care professionals, and monitor deterioration. The National Early Warning Score (NEWS) is a standardised tool which YAS adopted 2 years ago, and is now in routine use. The most recent audit during 2016/17 Quarter 4 demonstrated a 72% compliance with calculating and documenting the score. Further developments include use of the NEWS in the electronic patient record as a mandatory field, and electronic warnings with NEWS sent to the receiving hospital

Recognition and treatment of deteriorating child.

YAS has developed the NICE Traffic Light system for identifying deteriorating children, and developed the Paediatric Sepsis Screening Tool. This ensures frontline clinicians have a simple, easy to use tool to aid effective and safe decision making. "Deteriorating Children" is now included in the Clinical Refresher and teaches frontline clinicians how to recognise sick children and how to manage them more effectively. A full review of clinical equipment was undertaken following the AACE recommendations to ensure that frontline clinicians have the right equipment to aid identification and management of sick children.

Patient Safety Thermometer

The Patient Safety Thermometer data is used to monitor, report and inform interventions that can be used to reduce the level and risk of harm occurring in the three identified areas of falls, injuries and medicine errors, has continued. Progress has been made in reducing both falls whilst in receipt of care and injuries whilst in receipt of care in key service areas, with PTS seeing a 60% reduction in falls and a 25% reduction in injuries. Working groups have been established across the Trust to lead the key interventions relating to these work areas. Medicine related incidents have also reduced again during 2016-17; this work is supported by the Medicines Management Group, chaired by the Trust Pharmacist.

National Ambulance Safety Group

YAS representatives regularly attend the National Ambulance Safety Group and have shared their work on the serious incident framework for excessive responses with other services. Work in 2017-18 includes establishing a system to monitor safety culture climate within the EOC environment and collaborative work with the Health and Safety Executive (HSE) to understand and reduce the mechanisms for MSK injury within the Ambulance Sector.

3.1.1 Incident reporting

Yorkshire Ambulance Service encourages all staff to report patient safety incidents. A positive safety culture is indicated by high overall incident reporting levels but with few serious incidents and we continue to work towards achieving this. In 2016/17 further awareness and increase in the ease of reporting ensured a 5% increase in reporting for all incidents.

Staff are encouraged to report all incidents and near misses, whether major or minor. This has allowed YAS to resolve immediate issues and to identify themes and trends which have been addressed through changes in policies and/or procedures. The 24/7 phone line has assisted in this increased reporting. The Quality and Safety team present a session to all new starters within YAS at induction that outlines the importance of reporting incidents, how to report an incident and what happens once an incident has been reported using Datix. This session enables frontline staff to consider the link between their reporting of incidents and actions taken within the wider organisation.

Operational managers have been supported to investigate and resolve issues occurring in their local areas and escalate when serious issues have arisen. The Quality and Safety team have developed and delivered a bespoke session about the effective use of the Datix system as a manager that is part of the Management Essentials course. Datix trained operatives have also worked with managers on a one to one basis to develop dashboards and monitoring systems to assist staff to improve their use of this valuable data.

The way we use Datix as an organisation was reviewed during 2016-17, this was the first review since the original implementation in 2013. It included review of all work flows, categories and the supporting systems and processes. Changes were made to ensure the system was streamlined for ease of use, gives valuable learning and ensure we can yield data from the categories and levels of harm. An automated feedback system is now included in the workflow; allowing staff who have reported the incident to receive email feedback once the incident has been fully investigated and approved. The new system was ready to go live on 1-4-17 and has been supported by a number of initiatives including the first version of Datix News, local Datix roadshows and specific Datix Surgeries for those staff who use the system for investigation.

The Quality and Safety team continually analyse incident and complaint data to track levels of harm and identify causal factors, triangulating common themes and increasing trends to determine required interventions. Monthly reporting to the National Reporting and Learning System continues. In the last publication which represented data submitted from 1 April – 30 September 2016 YAS reported 944 incidents via the NRLS reporting process. With 74.5% of these resulting in no harm and 21.0% low harm. A low proportion of incidents reported resulted in moderate or above harm to patients and YAS has met the KPI for 16-17 to reduce this further to less than 3% of the total of all incidents with only 2.2% of patient safety incidents reported as moderate or above. Recognising and reporting incidents resulting in severe harm or death is an important sign of an organisation's reporting culture; YAS has a rate that is comparable with other ambulance services suggesting a good safety reporting culture is being developed.

The Incident Review Group (IRG), chaired by the Executive Medical Director and attended by our clinicians at director and associate director level, has reviewed themes and trends across incidents, complaints, claims, coroners' inquiries and safeguarding cases and identifies what can be learnt for the future to reduce the risk of re-occurrence.

3.1.2 Number of Adverse Incidents for 2016-17

Within 2016-17 the most commonly reported incident was Response Related EOC (1660 incidents), with Trust Vehicle Related second most common (1613 incidents). Violence and aggression against staff is the third highest reported category, with Care Pathway and Moving and handling reported as fourth and fifth. Actions to reduce these commonly reported adverse incidents are progressed by relevant sub-groups that focus on learning from incidents and interventions to reduce, such as the Vehicle Accident Reduction Group (VARG).

The exception to this is Care Pathways; here it is generally accepted that the current levels of incidents reported into this category do not reflect the actual number of Care Pathway incidents, but rather incidents are related to more general issues with care delivery. The Quality and Safety team have worked closely with the Clinical Directorate the re-categorise these types of incidents so they are reported correctly and actual issues with agreed Care Pathways can be quickly escalated and reviewed by the relevant Care Pathway team and appropriate service providers.

A&E operations reported the most incidents during 2016-17, however it would be important to note that a number of their incidents relate to EOC operations, being response related. Reporting in other areas is in line with expectations, with the exception of PTS where you may predict higher levels of reporting than seen currently. Specific work is planned within 2017/18 to ensure PTS staff feel able to report freely both patient and staff related incidents.

	A&E Operations	EOC (Emergency Operations Centres)	NHS 111 (incl LCD)	PTS (Patient Transport Services)	Others	Total
Apr 2016	409	80	59	90	37	**675**
May 2016	501	79	52	104	24	**760**
Jun 2016	490	70	31	132	27	**750**
Jul 2016	442	80	60	115	35	**732**
Aug 2016	517	82	65	131	30	**825**
Sep 2016	486	49	50	84	26	**695**
Oct 2016	490	100	52	89	31	**762**
Nov 2016	575	91	59	122	38	**885**
Dec 2016	516	81	57	89	34	**777**
Jan 2017	484	83	57	120	36	**780**
Feb 2017	455	65	61	96	25	**702**
Mar 2017	502	67	55	89	27	**740**
Total	**5867**	**927**	**658**	**1261**	**370**	**9083**

In summary these figures equate to:

- Around one adverse incident/near miss relating to A&E operations reported for every 189 emergency responses
- Around one adverse incident/near miss relating to the Emergency Operations Centre reported for every 1,818 emergency calls
- Around one adverse incident/near miss relating to PTS reported for every 2,760 patient journeys.
- Around one adverse incident/near miss relating to NHS111 reported for every 1,857 calls taken.

The most commonly reported patient incident is Response Related EOC, with Response related 111 second most commonly reported incident and Care Pathways (acute) third. Slips, trips and falls, Moving and Handling and Medication incidents all remain within the top10 ten of reported patient incidents but have reduced in frequency since the increased focus on monitoring and interventions via the Patient Safety Thermometer data.

	A&E Operations	EOC (Emergency Operations Centres)	NHS 111 (incl LCD)	PTS (Patient Transport Services)	Other	Total
Apr 2016	85	46	48	26	5	**210**
May 2016	110	56	34	29	2	**231**
Jun 2016	100	49	20	39	3	**211**
Jul 2016	95	54	44	29	3	**225**
Aug 2016	97	46	35	45	1	**224**
Sep 2016	109	26	33	23	4	**195**
Oct 2016	118	59	31	27	2	**237**
Nov 2016	93	63	44	38	3	**241**
Dec 2016	114	56	37	29	3	**239**
Jan 2017	105	54	38	32	4	**233**
Feb 2017	79	42	36	34	4	**195**
Mar 2017	92	47	32	18	1	**190**
Total	**1197**	**598**	**432**	**369**	**35**	**2631**

A higher number of incidents have been reported during 2016-16 and this is thought to be in line with an increase in overall activity, as well as a focus on the importance of reporting incidents.

Key learning during 16-17 arising from all incidents and near miss investigation includes;

- Sustain staff awareness and focus on reducing the causes of vehicle related accidents, including the development of a VARG, led by Operations, to reduce the number of incidents and accidents. This work has enabled an improved, streamlined investigation process that includes a rapid response to incidents at a local level, along with monitoring and support for those drivers who have more frequent incidents.

- Sustain the work of the Moving Patient Safely working group in response to incidents related to staff musculoskeletal injuries. This group also provides input to

the Trust Procurement Group about relevant moving and handling equipment. The group will also complete the Standard Operating Procedure for patients with complex moving and handling needs.

- Monthly reporting via the safety thermometer data for falls, injuries and medication errors allows a continued focus on reducing these particular patient harms. Monthly updates are communicated to staff via the patient safety thermometer dashboard and summarised actions are included in a monthly bulletin. Key work, including safety huddles, in PTS will begin in 2017-18. This will ensure learning from incidents and ensure reductions in harm from all falls and injuries in this service.

- On-going learning from reported medicines errors has allowed for focused work on human factors, such as safe and clear storage. Reported medication errors continue to reduce year on year.

- Safety huddles roll out within EOC to support effective communication and ensure reduction of incidents related to human factors within the challenging work environment.

3.1.4 Serious Incidents

The Trust reports Serious Incidents in line with the National SI Framework and during 16-17 reported the following:

Serious Incidents	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Ops - A&E	0	3	0	1	4	3	1	0	1	1	1	0
EOC	1	1	4	3	3	0	3	2	0	0	3	4
PTS	0	0	1	0	1	0	0	0	0	0	0	0
111	2	2	1	0	1	1	0	0	0	1	0	0
LCD	1	0	0	0	0	0	0	0	0	0	0	0
Other	0	0	0	0	0	1	0	0	0	1	0	0
TOTALS	**4**	**6**	**6**	**4**	**9**	**5**	**4**	**2**	**1**	**3**	**4**	**4**

Many of the SIs reported during 16-17 related to an extended response time to a patient. In January 2017 the Trust reviewed the process for identification of extended response incidents that met the SI reporting criteria and strengthened this through the addition of a 'Time Related Decision Tree' to aid decision making. This has allowed the organisation to really focus on cases where there is significant organisational learning. One example of this during 16-17 has been in relation to calls where it was not identified at an early stage that a patient was ineffectively breathing. The identification of this theme has prompted a significant piece of work including further training and education for all call handlers in relation to ineffective breathing and a quality improvement plan developed to monitor the effectiveness of this over the coming months.

A key progression for the Trust during 16-17 was the appointment of a Serious Incident Investigator. This is a new role developed by the Trust to ensure appropriate time and resource is dedicated to high acuity investigations where there is potential for significant organisational learning. This has been a shift from the previous model where managers across the organisation carried out these investigations. Whilst

operational managers are still involved to provide expert advice, the SI Investigator has the appropriate skills, knowledge and experience to be able to conduct a comprehensive investigation whilst being able to add in that specialist knowledge from other managers to enhance the quality and robustness of investigations.

The development of an SI approving panel has also strengthened the SI process. All completed investigation reports must be presented and approved by the Incident Review Group before it can be finalised and submitted to commissioners. This was introduced from January 2017 and allows a holistic view to be taken on all investigations, drawing on skills, knowledge and experience from a multi-disciplinary team to ensure all appropriate learning is identified and actioned. This has been a positive improvement made by the Trust and the quality of investigations has been acknowledged by commissioners.

3.1.5 Next steps for 2017-18

- Review Clinical Quality Strategy with internal and external stakeholders, to ensure focus and interventions for 2018-21 strategy are in line with organisational, local and national direction in patient safety.
- Sustain on-gong work on Datix system; focussing on Datix Surgeries, Datix News and education and training of new and existing staff in the effective use of the Datix system to support organisational wide learning from when things go wrong.
- Achieve the metrics included in Integrated Business Plan of:
    - Incident reporting increased by 5% in 2017-18
    - Moderate harm – under 3% of reported incidents
- Increase ability to learn from all incidents, including low harm and near miss incidents to ensure we continue to progress our safety reporting culture to one that is generative not reactive and constantly learn from incidents; thereby improving safety for our staff and patients. This will include in depth review of identified root causes and contributory factors from investigations undertaken.
- Embed safety huddles within EOC and PTS to ensure effective communication and learning from incidents occurs in a swift, proactive manner.
- Sustain end to end review process to ensure continued learning from incidents that span care delivery systems.
- Expand the number of trained SI investigators and make recommendations for consideration of an investigative team going forward.
- To review and further embed the Moving and Handling Patients with Complex Needs including Bariatric Patients Standard Operating Procedure – working with Critical Friends Network and Frontline staff to develop supporting patient led risk assessment and care record.
- To achieve the patient safety metrics included in Integrated Business Plan of:
    - No more than 12 Medicines incidents per year – defined as wrong drug, wrong dose or wrong route
    - Patient falls in A&E – reduction of 10%
    - Patient falls in PTS – reduction of 10%
    - Patient injury in A&E – reduction of 10%
    - Patient injury in PTS – reduction of 10%

- To achieve the staff safety metrics included in the Integrated Business Plan of:
    - MSK incidents reduced by 5%
    - MSK claims reduced by 2.5% (likely 3 year lag on incident data due to 3 year claim period)

3.2 SAFEGUARDING

The Safeguarding Team continue to build positive relationships both internally and externally with partner agencies to safeguard children, young people and adults at risk from harm or abuse.

The key priorities for the team include:

- Ensuring all staff are aware of their role in protecting the unborn, children and adults at risk from harm
- The development of effective and appropriate safeguarding policy and associated guidance which accurately reflect statutory and mandatory safeguarding requirements
- The review and development and delivery of effective training packages, to include face to face training for all substantive staff and volunteers
- Developing effective systems for the safeguarding referral processes
- Investigating incidents and allegations against staff through robust root cause analysis methodology and reporting findings
- Working in partnership with external agencies and partners, sharing appropriate and relevant information that contributes to case reviews
- Ensuring learning is shared across the organisation.

3.2.1 Safeguarding referrals

Referrals	Total 2013-14	Total 2014-15	Total 2015 - 16	Total 2016 - 17
Child referrals	3,956	4,441	5,994	5,645
Adult referrals	4,401	5,503	6,868	8,855

The number of adult safeguarding referrals to Adult Social Care continues to increase, with adult referrals doubling since 2013/14. The safeguarding team have been successful in engaging front line staff in the referral process and have developed a strong working relationship with the key members of the Clinical Hub. The safeguarding team are working with the clinical hub and social care teams via the Yorkshire and Humber Network group and Lead Safeguarding Commissioners to review the quality of the current safeguarding referral forms and information shared. This year the Child Safeguarding Referral Form, an Adult Safeguarding Referral Form have been refreshed in collaboration with Local Authority safeguarding partners, and in addition a Social Care Assessment referral form has been developed. In practice it is envisaged the majority of Adult referrals will be for a Social Care Assessment. These are due to be introduced in autumn 2017.

The essential fields have been enhanced in the adult referral forms, to ensure the forms meet the requirements expected particularly in relation to the Care Act 2014, and will include the ten adult categories of abuse. The forms will provide clarity with regard to the concept of Making Safeguarding Personal, to ensure involvement of the Adult in their own care and decisions have been recorded. The referral forms will also provide clarity regarding the importance of consent and recording an assessment of mental capacity if required.

With regard to Safeguarding Children, the referral form has been strengthened to consider who has parental responsibility for the child and whether the child is a Looked After Child.

The new referral forms will include a structured handover tool, SBAR:
Situation
Background
Assessment
Recommendation

SBAR offers a simple way to help standardize communication and allows parties to have common expectations related to what is to be communicated and how the communication is structured. This will support staff to give clarity of information in the referral form and ensure recommendations are clear.

3.2.2 Training compliance

The Intercollegiate document for Safeguarding Children and Young People (Royal College of Paediatrics and Child Health 2014) sets out the roles and competencies for organisations and YAS is compliant with this document. The final document of Safeguarding Adults: roles and competencies for healthcare workers (draft January 2016), is awaited which will set out the mandatory training requirements for adult safeguarding. In anticipation of the Adult Intercollegiate Document, the identified gaps have been scoped and a plan is in development to enable the workforce to be trained to the appropriate level. A trajectory and delivery plan will need to be agreed with the Lead Commissioners as part of this delivery plan.

The training compliance for 2016/17 is:

Safeguarding level 1 adult 94.61%
Safeguarding level 1 children 95.76%
Safeguarding level 2 children 88.73%
Prevent Basic Awareness 95 %

Safeguarding Children level 1 Trust-wide compliance has been consistently above 95% in 2016/17.

Safeguarding Children level 2 Trust-wide compliance has been consistently above 88% in 2016/17. February 2017 the highest compliance at 89.6%. Due to staff movement monthly figures vary though this is a significant improvement from April 2016 which was 82.6%.

Trustwide compliance for Prevent basic awareness has consistently increased from 90% during 2016/17

Trustwide compliance for **W**orkshop to **R**aise **A**wareness of **P**revent (WRAP) has consistently increased from 72% during 2016/17

Operational frontline staff figures for WRAP at the end of Q4 A&E Operations is **92.84%,** and for Patient Transfer Service **73.75%**

A Trust-wide Safeguarding Adult, Children and Prevent Basic Awareness eLearning product for all YAS service lines is currently being developed. This will enable training material and lessons learned to be updated in a timely manner and all staff groups will

be able to access three yearly via the YAS 24 7 intranet site. The eLearning product will be complaint with legislation, mandatory and statutory requirements.

ELearning will be the main basis for Safeguarding training with additional face to face case focused Roles and Responsibilities training which will be bespoke to service lines during mandatory training and within training schools.

The safeguarding team is now fully established and will be facilitating delivery of the training. Train the Trainer sessions have been introduced to Clinical Support and Development Tutors to expedite delivery.

A corporate communication plan will launch and promote the new Trust wide safeguarding training.

In order to support staff with their knowledge of safeguarding adults and their role and responsibilities when an adult is at risk of harm or abuse, there has been dissemination of NHS England Safeguarding Adult resources to frontline practitioners and is available to all staff Trust wide via the Trust Intranet site.

Level 2 Adult

The Head of Safeguarding has developed a training product for adults level 2 safeguarding as historically YAS have not had this in place. This has become integrated into the Newly developed Trust wide e-learning safeguarding product. A robust plan is in place for the implementation of this during Q3 2017/18. Safeguarding Adult level 2 Trust-wide compliance accounts for 181 practitioners from 4311 eligible staff. The Deputy Director of Quality and Nursing and the Head of Safeguarding has met with the lead commissioner for safeguarding and described the plan of action for increasing compliance to adult training. This will be in line with the Care Act 2014 which became statute in 2015, and the draft Intercollegiate document “Safeguarding Adults: roles and competencies for healthcare workers “ (draft January 2016).

3.2.3 Key achievements

The profile of safeguarding children and adults at risk continues to grow and change and is a key priority across YAS. There has been an increased focus on quality within the safeguarding function and this has led to refreshed policy and guidance for staff in relation to referrals and relationships with safeguarding partners. There has been an improved approach to information sharing, education and training and clinical audit resulting in a greater understanding of the quality of the safeguarding agenda and the service provided. Safeguarding Audit is now embedded with both quantitative and quality measures, working internally and with our multiagency partners.

We are working with partner agencies, including commissioners, social care and health providers to improve our systems and processes to modernise and continually improve the service we provide to YAS staff and our children and adult board partners.

An audit methodology to better understand the quality of safeguarding referrals has been developed and will continue during 2017 - 18.

To ensure a holistic approach to safeguarding across the Trust the team have continued to work inclusively with NHS 111, volunteers and Community First Responders (CFRs). All are now included in the safeguarding training work plan for safeguarding adults, children and Prevent.

The internal risk management and reporting software system (Datix) has been reviewed and strengthened to include a specific and bespoke Safeguarding Incident Reporting Module. This has become part of the contained module within the Standards and Compliance Directorate to ensure information flows between Safeguarding, Legal Services and complaints, concerns, compliments and comments (4C's). This will avoid duplication, enhance work flows, identify themes and provide a coordinated approach to service users, partner agencies and YAS staff.

All Safeguarding Policies and Guidance are accessible within the YAS intranet site.

All face to face training has been reviewed and aligns to legislation, National Guidance, good practice guidance, and lessons learned from Domestic Homicide Reviews, Learning Lessons Learned, Serious Case Reviews and Safeguarding Adult Reviews.

3.2.4 Contribution to external Local Adult Safeguarding Boards (LSAB) and Local Safeguarding Children's Boards (LCSB) and External Investigations.

The safeguarding team contribute to and represent YAS on a number of external partnership meetings and investigation panels. There are 13 Local Safeguarding Adult Boards and 13 Local Safeguarding Children Boards across the region. The safeguarding team represent YAS, specifically at the high profile, significant for YAS cases, however the number of Boards is a challenge. YAS have in place a Memorandum of Understanding with Clinical Commissioning Groups (CCGs), this memorandum describes an agreement that Designated Safeguarding Nurses with CCGs attend, not to represent YAS, but attend with a commitment to share any information relevant to YAS including the outcome of the meetings.

The safeguarding team also have a relationship with the health representatives on the local Multi-Agency Safeguarding Hubs (MASH) and ensure any appropriate information relevant to YAS is shared securely.

Reports sent to Child Death Overview Panels

Child Death Overview Panels (CDOPs) are held in the case of any unexpected death in child hood. They are responsible for reviewing all available information and making recommendations to ensure that similar deaths are preventable in the future. CDOPs are accountable to their local safeguarding children board and there are representatives present from health and social care, the police and coroners. The safeguarding team provides relevant and proportionate YAS information that informs the Child Death Overview Panels and contributes to any learning, which informs both policy and practice.

The safeguarding team at YAS, ensures relevant representation by frontline crew members at Rapid Response meetings, which contribute to the Sudden Unexpected Death in Childhood (SUDIC), as per multi agency protocols.

Serious Case Reviews, Safeguarding Adult Reviews, Domestic Homicide Reviews and safeguarding Lessons Learned Reviews

The data below provides an update on the number of Serious Case Reviews (SCR), Safeguarding Adult Reviews(SAR) Domestic Homicide Reviews (DHR) and Learning

Lessons Reviews (LLR) that YAS has contributed to during 2016-17. Cases and associated action plans are monitored to completion via the YAS Incident Review Group (IRG) and approved for closure at Clinical Governance Group.

Table 1 shows the number of Serious Case Reviews, Safeguarding Adult Reviews Domestic Homicide Reviews and Learning Lessons Reviews that YAS Safeguarding team have contributed to and provided information.

YAS attendance at Child Death Overview Panels and the completion of CDOP Form B accounts for 97 cases during 2016 – 17.

	2014/5	2015/16	2016/17
Serious Case Reviews	3	5	6
Serious Adult Reviews	0	0	4
Domestic Homicide Reviews	9	6	5
Learning Lessons Reviews	1	5	3
Child Death Overview Panel	31	65	97

3.2.5 Key Risks

- Safeguarding training to incorporate Level 2 safeguarding adults training presently recorded on the Trust Risk Register as 'Moderate Risk'
- Work has commenced to develop the Safeguarding Training products that include both eLearning and face to face sessions. The Safeguarding Training plan will be developed in line with the Trust Wide Statutory Training Plan and the safeguarding team are presently contributing to the Trust Wide Training Needs Analysis.

3.2.6 Work plan for 2017-18

- Information governance: embed safeguarding practice within Safeguarding module Datix
- Development of Safeguarding Adult, Children and Prevent eLearning product
- Face to face safeguarding case focused training to all service lines
- Train the Trainers for Clinical Development Tutors and NHS 111
- Increase compliance with Safeguarding Adults training
- Embed new Safeguarding referral process and referral forms
- Maintain all training compliance to over 85% in line with contractual requirements
- Development of the Internet and Intranet (PULSE) safeguarding pages
- Review safeguarding policies and guidance

3.3 Patient Experience

Understanding the experience of patients and their families and carers is a core element of the YAS 2015-18 Clinical Quality Strategy. This draws on the learning and recommendations from national drivers including the Francis Report (2014), and Compassion in Practice (NHS England 2014). The importance of listening to patients in a meaningful and valuable way is important to maintaining and improving the delivery of safe, high-quality services.

Listening to feedback from patients also promotes organisational learning where there is an effective feedback mechanism to staff. This is being strengthened as part of the Clinical Quality Strategy work stream.

The Trust is committed to listening and acting upon what our patients, service users and carers have to say about the standard of our care. We continue to review and improve upon our methods of obtaining Patient Experience so that we can achieve a high response rate from our patients, the greater the response, the more we learn as an organisation.

3.3.1 Complaints, Concerns, Comments and Compliments

YAS Staff strive to get the job right first time, every time, however, in any complex service, mistakes can happen and problems occasionally occur. When people tell us about their experiences we listen, we aim to find out what has happened and to respond in a timely manner. We always aim to put things right and to learn for the future.

Positive feedback is always a pleasure to receive and is also an important source of learning. We regularly receive appreciations and commendations for staff for their professionalism and dedication. This is shared with the individuals concerned along with an acknowledgement of their good service from the Chief Executive.

YAS strives to deliver best practice in complaint handling and, in addition to working in accordance with the Complaints Regulations, is committed to the Principles of the Parliamentary and Health Service Ombudsman in relation to good complaint handling and remedy.

Complaint: an expression of dissatisfaction made by a patient, their family member or a member of the public regarding a YAS service or the specific behaviour of a member of YAS staff in the course of their duties to which a response is required; and where a person specifically states that they wish the matter to be dealt with as a formal complaint at the outset, or where the complaint or concern raises issues for the Trust which are significant and are likely to present moderate to high risks for the organisation.

Concern: an expression of dissatisfaction made by a patient, their family member or a member of the public regarding a YAS service or the specific behaviour of a member of YAS staff in the course of their duties to which a response is required; and where attempts to resolve the matter as speedily as possible, focused on delivering the outcomes being sought are successful.

Service-to-Service Concern: where a healthcare professional wishes to make YAS aware of an issue, event or incident relating to the care of a patient and receive feedback.

3.3.2 Progress in 2016-17

- In 2016-17 the average response time to complaints was within the 25 working days target at 24 working days.
- 91% of complaints met timescales agreed with complainants against a target of 85%.
- There was a high level of satisfaction with complaint responses – 98.1%
- Only 0.9% of cases handled progressed to Ombudsman investigation
- In 83% of the cases referred to the Ombudsman the regulator found that the Trust response was appropriate.

3.3.3 Number of Complaints, Concerns, Comments and Compliments received 2016-17

Complaints and Concerns (including issues raised by healthcare professionals) received by subject				
	A&E	**PTS**	**111/LCD**	**TOTAL**
Attitude	195	101	94	390
Operational issues	206	79	784	1069
Clinical/Patient Care	159	101	394	654
Delayed response/timeliness	419	604	0	1023
Call Handling	109	49	0	158
Other	29	2	15	49
Total	**1117**	**936**	**1287**	**3343**
Demand	902,017	720,632	1,570,254	3,954,003
Proportion	0.12%	0.13%	0.08%	0.08%

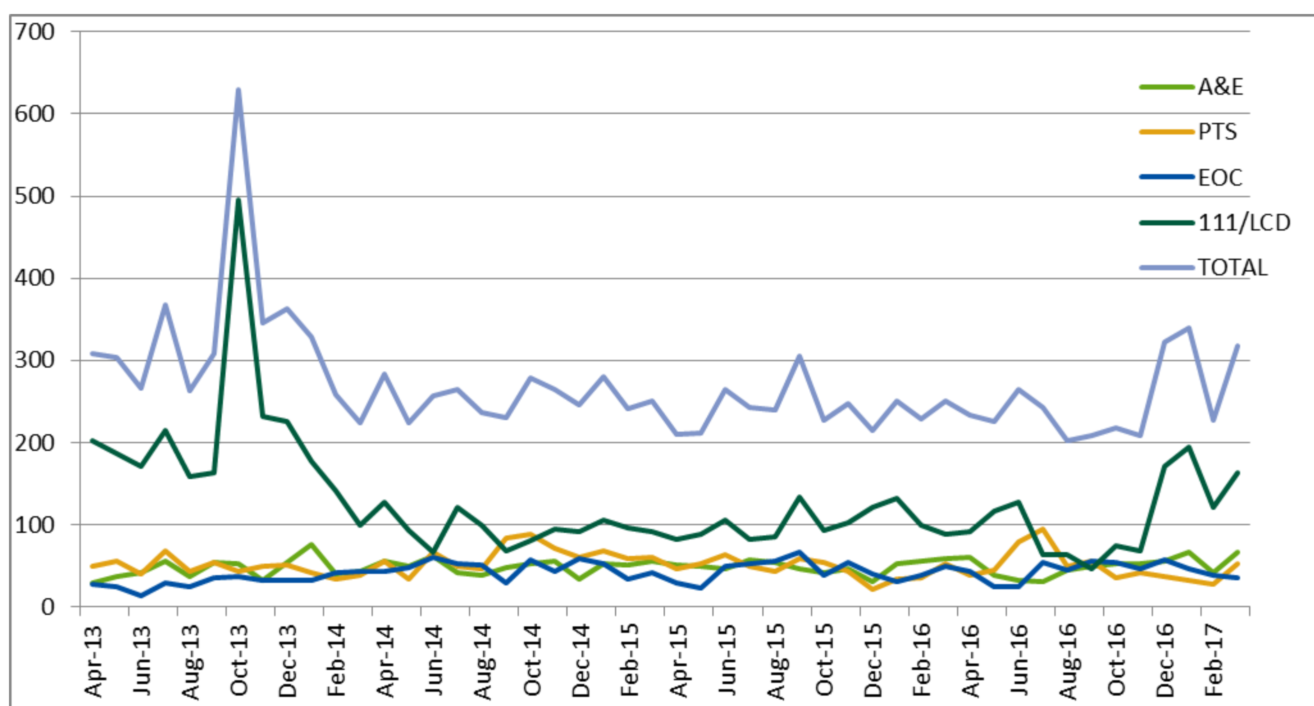
Compliments received				
	A&E	**PTS**	**111/LCD**	**TOTAL**
Total	**563**	**30**	**136**	**729**

3.3.4 Referrals to the Parliamentary and Health Service Ombudsman

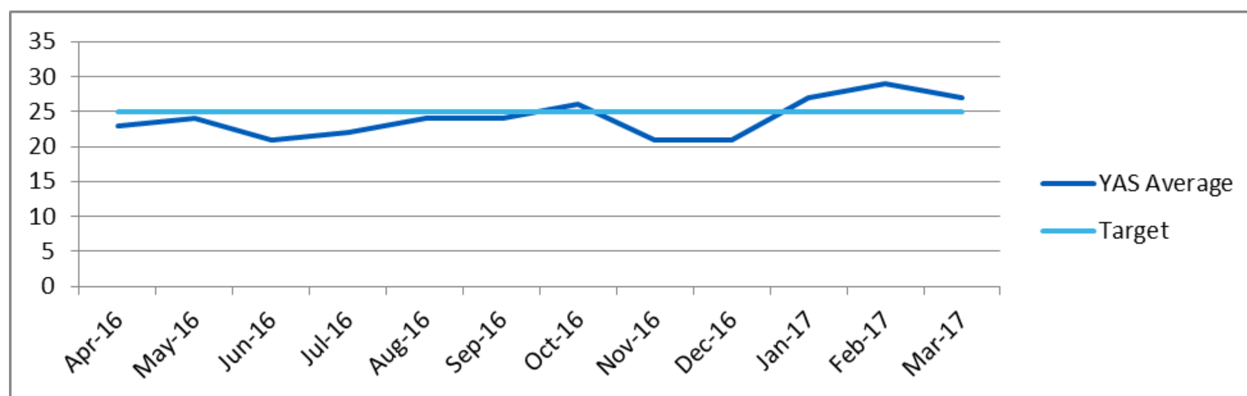
In 2016-17, 16 people referred their complaints to the Parliamentary and Health Services Ombudsman (PHSO). Six cases were closed with no further action. During the year the PHSO completed 12 investigations. Ten cases were not upheld, one was upheld and one was partly upheld.

Date	Number of cases referred to & Parliamentary and Health Services Ombudsman	Cases closed with no further action	Cases upheld or partly upheld	Currently on-going (time of report)
2014-15	15	12	2	1
2015-16	21	14	2	5
2016-17	16	16	2	0

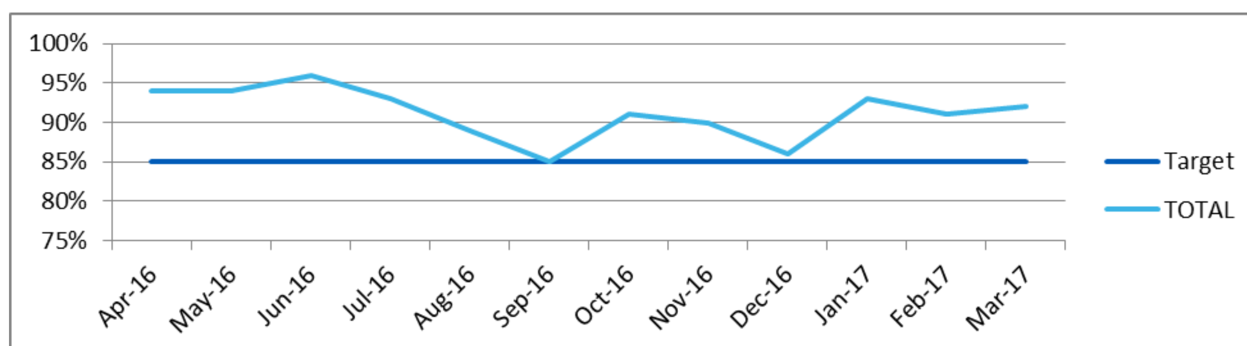
3.3.5 Number of Complaints Received 2013-17 (Trend)



3.3.6 Average Response Times



3.3.7 Percentage of cases meeting due dates agreed with complainants



3.3.8 A&E and EOC Complaints received/Activity: Comparison to peers (Q4 2016-17)

A&E/EOC complaints received/Activity

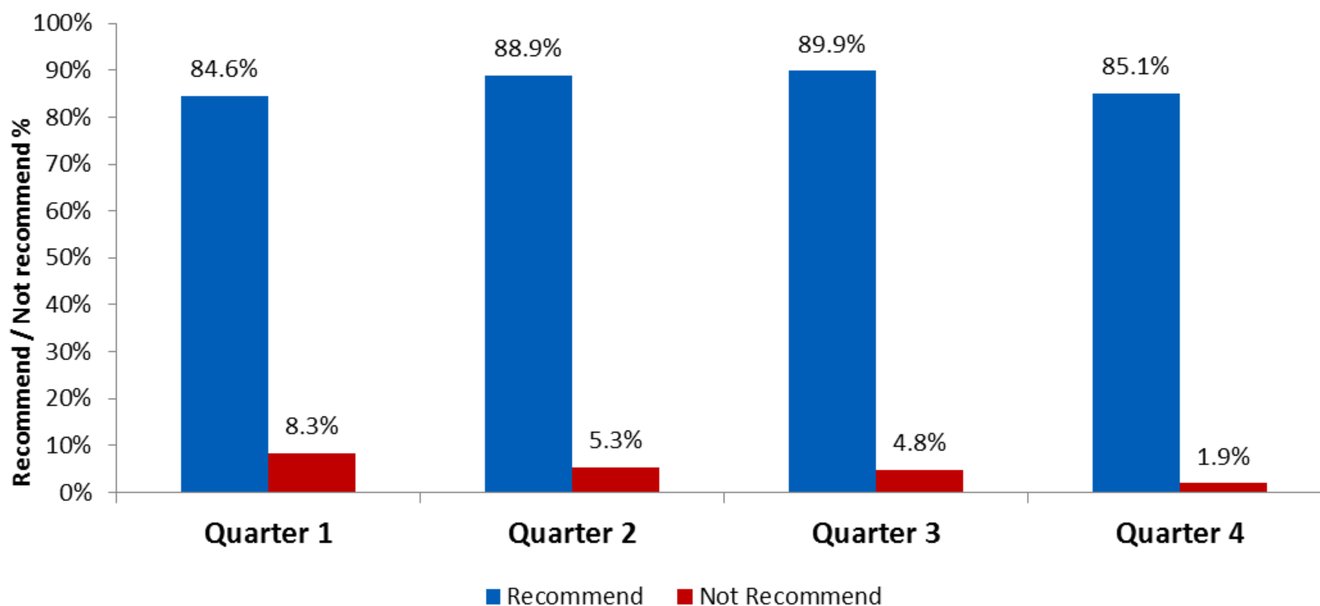
▪ EMAS	0.21%	YAS	0.09%
▪ SWAST	0.14%	SECamb	0.07%
▪ WMAS	0.11%	LAS	0.06%
▪ EEAST	0.10%	SCAS	0.05%
▪ NEAS	0.10%	NWAS	Not available

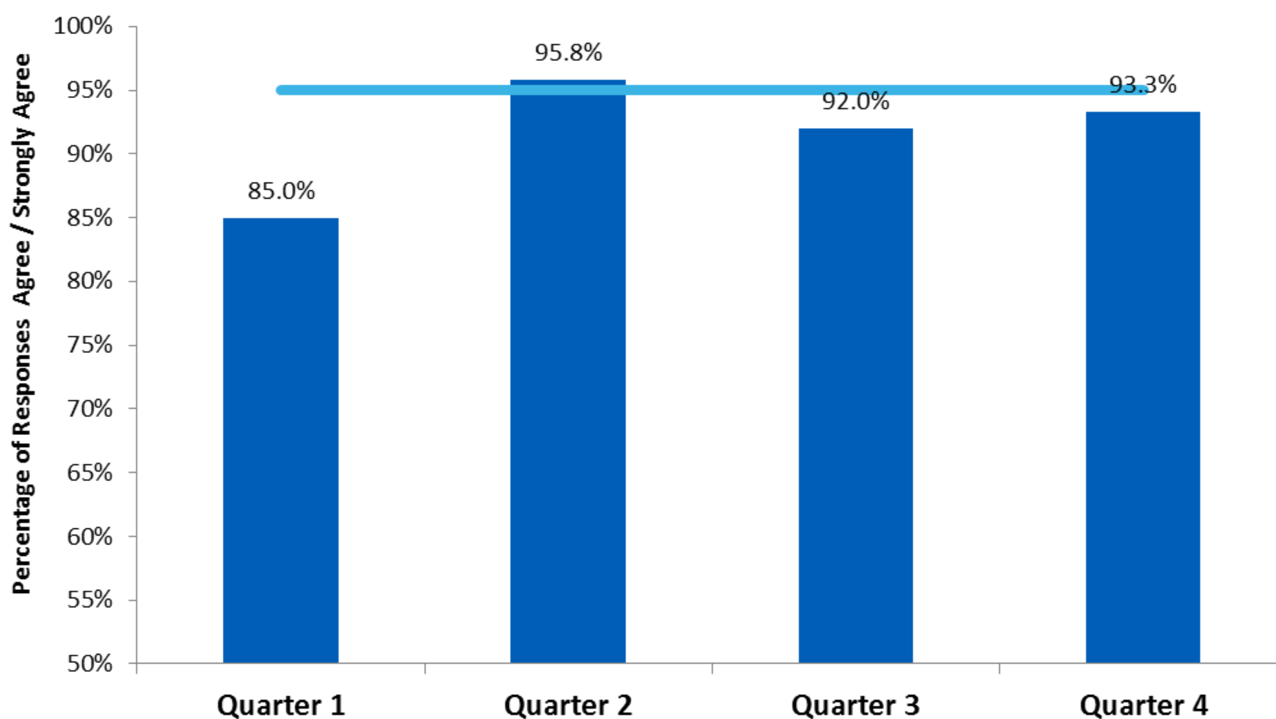
3.3.9 Patient Experience Surveys

The YAS patient survey asks service users about their experience of YAS care. These results are reported through the governance structure of the Trust and in addition at Operational Locality meetings. The analysis includes both quantitative and qualitative data.

3.3.10 A&E Survey Results

How likely are you to recommend the Yorkshire Ambulance Service to Friends and Family if they needed similar care or treatment?



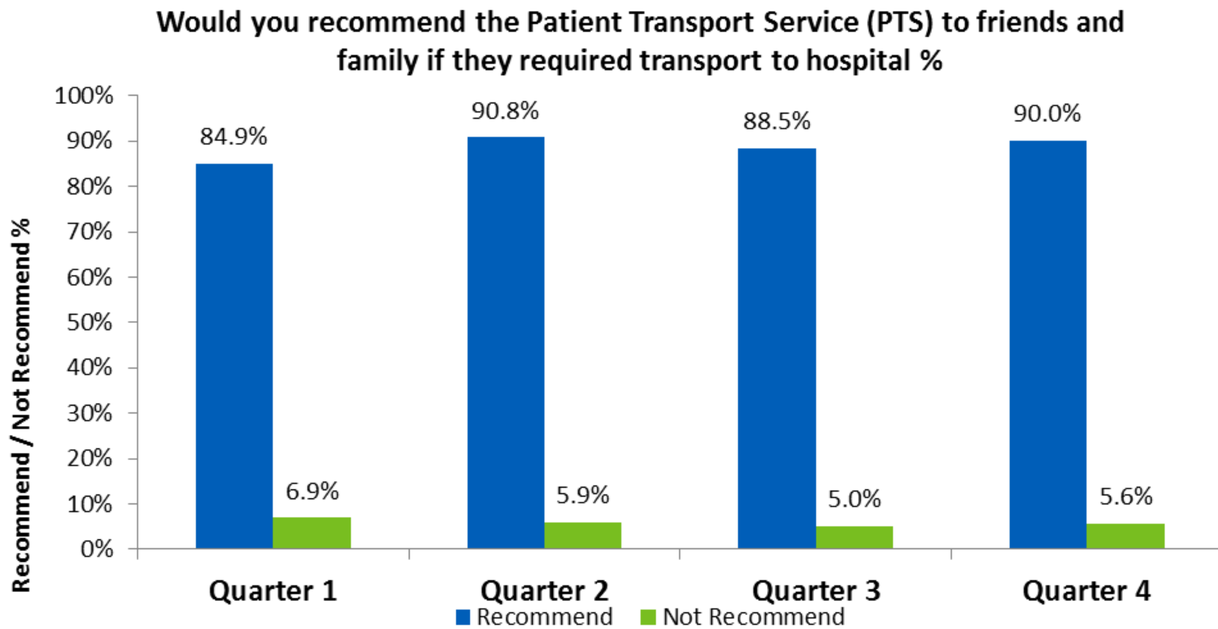


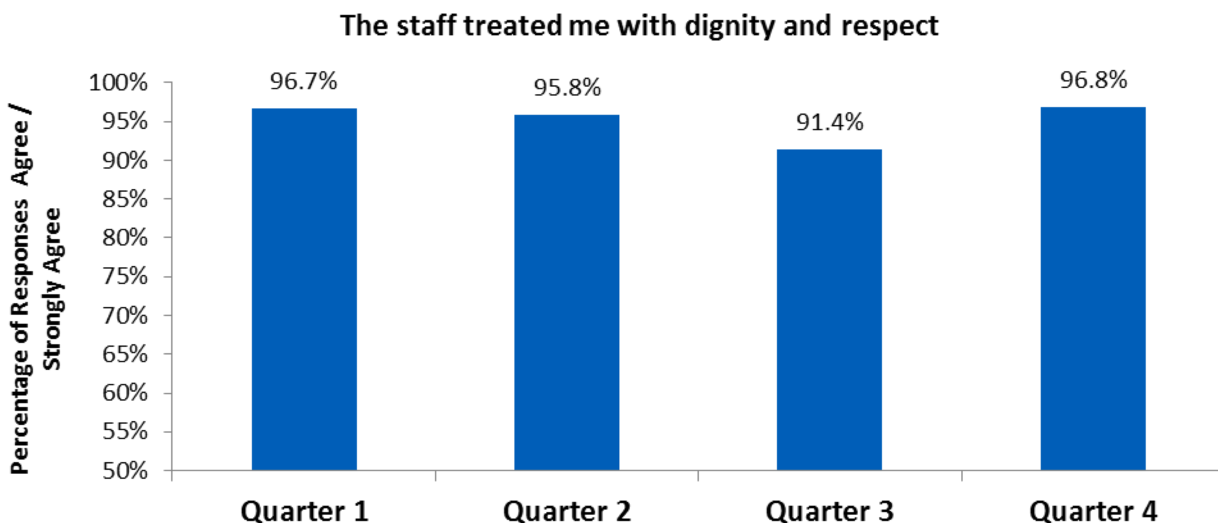
A&E: Themes and Trends from Narrative Feedback

- The greatest proportion of feedback received relates to the positive comments about customer service and attitude of our staff.
- The negative comments we have received relate mainly to the length of time waiting for an ambulance.

3.3.11 PTS survey results

How likely are you to recommend the Yorkshire Ambulance Service to Friends and Family if they needed similar care or treatment?





PTS Narrative feedback

- The greatest proportion of feedback received relates to the positive comments about customer service and attitude of our staff.
- The negative comments we have received relate mainly to the length of time waiting for their return journey home.

‘My father is the main carer for my mother who has severe dementia. They live in Wakefield, I live in Newcastle. - On Sunday am at about 9.30am Dad rang 999. - The paramedic who attended was really good with my Dad. He also spoke to me whilst I drive down from Newcastle to reassure me. They spoke to the GP about the need to be seen at home or refer to A&E. I work as Executive Director of Nursing in Northumbria at a Healthcare Trust so really appreciate the care and compassion the crew demonstrated and also that they avoided an A&E attendance and possible admission to hospital for my Mum.

‘I understand some taxis have to be used for some journeys but the sight of a Yorkshire Ambulance uniform waiting for you makes you relax knowing you will be in safe and caring hands.’

‘Found the two hour wait before appointment hard. Was nil by mouth before treatment and then waiting for transport home can be anywhere from half an hour to an hour. Went a long time without food because of this. It wasn’t made clear to me that if you were late not to worry as they would fit you in for treatment.’

‘My wife was asked if I wanted to wait while the GP was open or be taken to A&E. My wife couldn’t believe the question. On admittance I was diagnosed with sepsis, E-Coli and a kidney stone. I was critically ill and spent 2 weeks in hospital.’

‘The ambulance call taker was calm, reassuring talked to me (patients wife) until the ambulance arrived. I could not praise her enough; I could never thank her enough. - Everything that could be done was done by the ambulance crew and the paramedics. - - Sadly my husband died 8 days after being admitted to hospital, but the care, consideration and humanity extended to my husband and self were second to none. Had we been royalty we could not have received better treatment. A very sincere 'thank you' to all concerned.’

‘When we had the floods our driver did everything to get us home, he got us chips and cups of tea although it was 10.30 when he got us home. We were told he was the only driver who did that.’

3.3.12 Learning from Complaints, Concerns, Comments and Compliments

Learning from complaints, concerns and comments is very important. To help this the service report themes, trends and lessons learned through the clinical governance structure.

During 2016-17 the focus group has reconvened to continue its work on further initiatives to improve the communication skills of our Accident and Emergency staff. This has led to developments of closer monitoring and escalation to operational management to invoke a newly implemented process for ‘repeat offenders’. In addition, patient feedback has been taken into account in the design of the new values and behaviours framework. Direct patient feedback will be illustrated against each of the relevant values and behaviours in regular internal communications with staff throughout 2017-18.

The involvement of YAS in ARP pilots throughout the year has impacted on the volume of complaints received in respect of Emergency Ambulance response times.

2016-17 saw a significant impact of patient feedback on changes made to renal Patient Transport Services throughout the summer. Working together with patients as a result of this feedback has led to significantly higher levels of satisfaction with services amongst this particular patient group. The implementation of auto-planning has also impacted on patient satisfaction.

An analysis of the narrative comments made by respondents shows overwhelmingly that people are very positive and appreciative of the ‘customer service’ shown by operational staff who attend following a 999 call. This is confirmed by the number of compliments received for this area of the service and offers some perspective to the size of the problem suggested by complaints about attitude and communication skills. The analysis also shows overwhelmingly that respondents are most negative about response times. Some of the comments refer to response times of 12 minutes, 20 minutes and 40 minutes being unacceptable. Although it is not possible to identify the chief complaint in these cases, it is reasonable to assume that this dissatisfaction stems from misguided public perception and expectations as opposed to actual delays to service provided.
Following the decision to nationally implement ARP, Communications Leads in all Ambulance Service Trusts are working together in the planning of national communication to increase public understanding of what to expect, how we prioritise calls and that a 999 call will not always result in an ambulance and why.

Below are some examples of learning from complaints we have handled this year:

- Changes have been made to the accessibility of the Patient Transport booking system as a result of a complaint from a visually impaired patient who found the system difficult to use.
- Improvements in ensuring timely feedback to 111 call handlers who make errors in call handling.
- Communication with patients awaiting out of hours GP call backs or visits has been improved.
- A complaint from a parent of a child with complex needs has led to improvements in communication in respect of data flagging processes.

3.3.13 Patient Stories

Throughout 2016-17, patient stories have continued to be presented to the Trust Board meetings. These provide a unique opportunity to connect with patients, service-users, relatives and carers. YAS actively listens to real experiences reflected in order to learn from them. Methods used to record patient stories can be via film, narrative or voice recording. Patients and families that have taken part with the Story to Board process have found the process beneficial. Board members have also reported that the Story to Board reminds the Board of the patient voice.

The patient stories are also used in training and considered an effective learning resource.

The Patient Story is available to all staff via the Staff Intranet, and is shared with operational management teams and the Clinical Governance Group, to demonstrate the importance of these patients and being empowered to deliver a caring and dignified service.

Examples of patient stories recorded during 2016-17:

- A patient with sepsis who used the NHS 111 Service whom they found made the correct decisions, in a timely manner and undoubtedly contributed very significantly to saving their life.
- A patient who has complex health needs, is an oxygen user and uses a walking aid. On a temporary basis the patient has been using the Patient Transport Service (PTS) for hospital appointments and due to operational practices that were in place was not allowed to take their own oxygen or walking aid on the vehicle. The patient made a complaint and, as a result of this, and other patients with the same/similar issues, PTS have implemented a new policy enabling patients to take their own equipment when being transported.
- A family member of a patient who received lifesaving care from the Emergency Service. The patient had a possible myocardial infarction which presented an immediate threat to their life. A double crewed ambulance responded within 3 minutes and began treatment. The patient went into cardiac arrest as they were being transferred into the ambulance and the crew began Advanced Life Support (ALS) which resulted in a return of spontaneous circulation (ROSC). The experience has greatly impacted on the patient's lifestyle choices and her family member made a compliment and requested for the patient to meet with the members of staff who saved her life.
- A story regarding 111, 999 and Out of Hours GP services to a 79 year old man with complex health needs. The patient died and a serious incident investigation and an end to end review identified learning for A&E Operational and Call handling staff.

3.3.14 Patient Opinion Website

The Patient Opinion website is a patient feedback not-for-profit social enterprise enabling patients to share their experiences of healthcare services. Its aim is to help facilitate dialogue between patient and health service providers and to improve services and staff morale. It has the particular benefit of giving YAS management

access to real time patient experience feedback. YAS joined this platform in February 2013 and have used this resource as another channel to listen and respond to online service user feedback. YAS has responded to all comments received through the Patient Opinion Website.

Most of the comments we receive via this mechanism are positive in nature. We encourage all people who feedback on Patient Opinion to contact us directly in order that we can obtain personal details from them to identify the staff involved and pass on the individual's personal thanks.

3.3.15 Duty of Candour – Being Open

During 16-17 the Trust initiated the Duty of Candour process in relation to 70 cases. For all of these cases the patient and/or the relatives were informed that an investigation was ongoing into the event and given an opportunity to receive the findings from this. Findings were shared with those who requested, via a face-to-face meeting, via telephone or in writing based on their individual preference.

15 cases opened during the year had face to face meetings to share the findings. These were led by the Head of Investigations & Learning supported by the appropriate operational manager based on the location of the incident.

Audits are in place on a monthly, quarterly, bi-annual and annual basis to ensure the process for identifying cases that have met the Duty of Candour criteria, is robust. The 16-17 audit identified that all cases that had a statutory duty for candour had been taken through the 'being open' process.

The process for Duty of Candour was subject to scrutiny from the CQC during their inspection in September 2016 and no issues were highlighted with the Trust's application of the statute.

3.3.16 CRITICAL FRIENDS NETWORK (CFN)

During 16-17 the CFN was re-established across the Trust. This is a network of patients and members of the public who have an interest in the ambulance service and are keen to be involved in service developments and improvements.

In July 2016 the Trust hosted their first event for the CFN focusing on the mock CQC inspection which a number of the CFN were involved with. This allowed great insight and feedback from a patient perspective in preparation for the actual inspection in September. Since then a number of events have been held with the CFN engaging on key projects including the Trust's communication plans, moving and handling projects, the Accessible Information Standard (AIS), how we share patient information and the development of patient leaflets.

Recruitment activity has taken place during 16-17 and will continue, to actively recruit new members to be a part of the CFN. One of the key focuses for the Trust over the coming years is to develop this further with a range of different people who can bring a broad spectrum of skills, experience and knowledge from a service user perspective.

3.3.17 Work Plan 2017-18

The Patient Experience and Patient Relations Work plan for 2017-18 is reflective of the Clinical Quality Strategy priorities and contract requirements. The work plan focuses on;

- Work with the Critical Friends Network to improve complainant satisfaction with complaints handling
- Increasing the membership of the Critical Friends Network (CFN)
- Integrating the use of the CFN into YAS processes for improving effectiveness of services and the development of new initiatives
- Work with the CFN to improve complainant satisfaction with complaints handling
- Implement ongoing complainant satisfaction surveying
- Maintain high standards of quality measured through the audit tool
- Implement ongoing complainant satisfaction surveying
- Develop a systematic approach to monitoring and reporting of actions taken as a result of complaints
- Migrate the Patient Relations telephone service to a new system to allow for improved business contingency plans, recording of calls and improved monitoring of performance
- Develop a systematic approach to monitoring and reporting of actions taken as a result of complaints
- Improved systematic use of Patient Survey feedback to inform service developments
- Using patient feedback to provide both positive and negative examples of how we practice in line with our values and behaviours framework

3.4 CLINICAL EFFECTIVENESS

3.4.1 Background

Our responsibility as provider of the A&E ambulance service in Yorkshire is to use the resources we have available to us to achieve the greatest possible improvement in the physical and mental health of patients in our communities.

In order to achieve this, we need to ensure that decisions about the provision and delivery of clinical care are driven by evidence of clinical and cost effectiveness, coupled with the systematic assessment of clinical outcomes.

The YAS Clinical Directorate interprets new clinical guidelines, develops action plans for changes to clinical practice, cascades best practice guidance for clinicians and monitors improvements in clinical care through national performance indicators and local audit processes

3.4.2 New Clinical Guidelines

The Clinical Directorate interprets and develops implementation plans for new guidelines e.g. from the National Institute for Health and Care Excellence (NICE) and Ambulance Service Clinical Guidelines. Each guideline is reviewed by the subject matter expert to ensure it is applicable to Out of Hospital care and any necessary recommendations for clinical practice changes are made through the Clinical Governance Group at YAS. This, combined with the results of clinical audit, provides the Trust Board with assurance that the care we provide to our patients is current, effective, safe and efficient.

3.4.3 Pathway monitoring and Development

YAS continues to work with local health care providers to provide protocols to ensure patients receive the right care, in the right place, in a timely manner. These protocols are used by front line clinicians to ensure that bypass protocols and admission protocols are followed. YAS currently has a number of pathways in use including;

- Referral for Primary Angioplasty for STEMI
- Maternity
- Referral to Hyper-acute stroke services
- Suspected Fractured Neck of Femur (#NOF)
- Major Trauma
- Vascular emergencies
- Gastro-Intestinal (GI) emergencies

In addition YAS has produced a guide to Urgent Care services across the region which includes; Chronic Obstructive Pulmonary Disease COPD referrals in Rotherham, Leeds and Wakefield, Community Medical Units, Emergency Care Practitioners, Epilepsy, Regional Falls, in & out of Hours GP referrals, Hypoglycaemia referrals, Minor Injury and Walk in Centres, and End of Life pathways.

Public Health

The NHS Constitution set out the responsibility of all NHS Trusts to improve the health and well-being of our patients, supporting them mentally and physically well and to stay as well as they can to the end of their lives. Public Health is the key element of the Five Year Forward View, and the AACE Future National Clinical Priorities for Ambulance Services in England. Increased health promotion by ambulance services is a key part of the AACE vision for “2020 and beyond”. Making every contact count, preventing illness and injury, enabling self-care are some of the focus of the YAS Public Health Plan. As the only ambulance service to have a dedicated public health lead, YAS has been recognised nationally as an exemplar of public health practice within the ambulance sector.

3.4.4 Clinical Quality Monitoring

Clinical audit is an essential part of the assurance, development and learning process for an organisation. The clinical audit programme provides a framework from which the clinical information and clinical audit staff organise audit through the year. All Ambulance services report against a set of clinical quality standards. These are the Ambulance Clinical Quality Indicators (ACQIs); which are a set of performance measures developed by Association of Ambulance Chief Executives (AACE) and agreed by NHS England.

3.4.5 Ambulance Clinical Quality Indicators (ACQI)

The ACQIs are:

- Outcome from acute ST-Elevation Myocardial Infarction (STEMI)
- Outcome from cardiac arrest: return of spontaneous circulation (ROSC – Utstein group)
- Outcome from cardiac arrest: survival to discharge – (Utstein group)
- Outcome from acute stroke
- Stroke 60

Outcome from Cardiac Arrest

In 2016/17 Yorkshire Ambulance Service attended 3131 cardiac arrests, and achieved a Return of Spontaneous Circulation (ROSC) in 27.4% patients. The Utstein group showed a ROSC rate 35.7%. (The Utstein group are patients who had resuscitation (ALS or BLS) commenced/continued by EMS following an out-of-hospital cardiac arrest of presumed cardiac origin, where the arrest was bystander witnessed and the initial rhythm was Ventricular Fibrillation (VF) or Ventricular Tachycardia (VT))

The YAS Resuscitation Plan for 2015-20 concentrates on improving survival to discharge from out of hospital cardiac arrest, which is of more significance to the patient rather than the measure of ROSC at arrival at hospital. The Survival to Discharge for 2016/17 is 10.1% for all cardiac arrests and 37.1% for the Utstein group. In 2016/17 a total of 310 patients survived to discharge following an Out of Hospital Cardiac Arrest. This is more lives saved than any other year.

The Resuscitation Plan focusses on improving the chain of survival including the quality of resuscitation from the 999 call and dispatch to post event feedback. The key areas identified for improving the quality of resuscitation are;

- Team Leader (Red Arrest Team (RAT)) to every cardiac arrest.
- Dispatch a minimum of three pairs of hands
- Checklist and “Pit Stop” approach to patient care
- Real time and Post event CPR performance feedback
- Evaluating new Cardiac Arrest Equipment such as the AutoPulse

The RAT team leader is a vital aspect to improving the quality of resuscitation and supporting advanced clinical decision making. Work has continued to develop and enhance the level of patient care delivered by the red arrest team paramedics to patients in cardiac arrest. Training has been delivered to new clinical supervisors and will be extended to a number of paramedics who will be able to provide cover for the scheme particularly in rural areas.

	2014/15	2015/16	2016/17
ROSC	22.9%	26.37%	27.4%
ROSC Utstein	51.5%	57.14%	35.7%
Survival to Discharge	10.6%	8.82%	10.1%
STD Utstein	40.2%	37.05%	37.1%

Outcome from Acute Stroke:

- Arrival at a locally defined Hyper Acute Stroke Centre within 60 minutes of call for help.
- Care bundle: blood pressure recorded and blood glucose recorded and face-arm-speech test (FAST) recorded.

Treatment of people who have a stroke can be split into distinct phases across the whole stroke pathway. The hyper acute and acute phase focuses on rapidly providing the patient life-saving treatment and then stabilising the patient’s condition sufficient enough so that they are ready for rehabilitation. Best practice identifies that the hyper acute phase should take place in a Hyper Acute Stroke Unit (HASU). A HASU is a unit that brings together clinical expertise and specialist equipment and should be accessible 24 hours a day, seven days a week.

YAS attended 3322 patients who were diagnosed with an acute stroke in 2016/17, 44.7% arriving at a HASU within 60 minutes. 98.7% patients received the full care bundle for acute stroke.

YAS patients arriving at a Hyper Acute Stroke Unit within 60 minutes of call remains a challenge, nationally especially in rural services, the downward trend continues as stroke services are centralised as part of the drive to improve the access to specialist care. Getting the public to recognise their symptoms and call the ambulance early ensures that the best possible chance for those who may be eligible for thrombolysis. There is a region wide consultation underway regarding the configuration of HASU, and the future of stroke treatment.

Outcome from acute ST-Elevation Myocardial Infarction (STEMI):

- STEMI care bundle: aspirin administered, GTN administered, analgesia administered and two pain scores recorded (pre- and post- analgesia).

The term Acute Coronary Syndrome (ACS) covers a range of conditions including unstable angina, ST-segment-elevation myocardial infarction (STEMI) and non-ST-segment-elevation myocardial infarction (NSTEMI). All patients in whom ACS is suspected should be transported to hospital Emergency Department. Patients with confirmed STEMI should be conveyed as per the YAS Primary Angioplasty Pathway to the nearest Cardiac Unit for Primary Percutaneous Coronary Intervention (PPCI).

In 2016/17 YAS received 58,520 calls coded as chest pain and during this time period clinicians diagnosed 1329 patients with ST elevation myocardial infarction (STEMI). Care bundle compliance was 86.3% at the end of 2016/17. Improvements to the STEMI pathway this year have been the rollout of posterior STEMI identification and management.

3.5 Local Audits

Handover and Pre-Alert

Good communication is essential when transferring care from one healthcare professional to another health care professional. A good quality handover is essential to protect the safety of patients. The YAS Pre Alert and Handover Guidance were published November 2016 following consultation with all the Acute Trusts in the region. The recommendation is that all handovers and Pre-alerts should be given in the SBAR (Situation, Background, Assessment and Recommendation) format unless it is a Major Trauma handover.

Direct observation handover audits have been performed at Harrogate, Northern General, York, Leeds General Infirmary, and Doncaster hospitals. In total 68 patients handover have been observed. Overall compliance is good with SBAR compliance at 78.9%.

Major Trauma

The trust continues to work with the major trauma networks across the region to ensure that those patients involved in traumatic incidents receive the best possible care. This year YAS has worked with the South Yorkshire network to provide an in situ simulation session involving staff from both YAS and the acute Trusts. We have also worked with the North Yorkshire and Humber network on the trauma intermediate life

support course where YAS provides a number of candidates and instructors for each programme. YAS has worked with the West Yorkshire network in running a mass casualty table top exercise with Public Health England which was designed to stress test the network in both the pre hospital and in hospital settings.

2016/17 saw the release of the NICE guidance on Major Trauma_which YAS adopted into frontline guidance and procedures. These guidelines included a reduction in fluid resuscitation, and titrating volume resuscitation to maintain a palpable central pulse, using Tranexamic Acid in any patient with active or suspected bleeding, applying pelvic binders following high energy trauma and supporting the destination of a Major trauma Centre. A number of CPD events have been provided providing hands on sessions practicing skills and decision making in major trauma.

For any patients who have sustained a traumatic injury, YAS assess, treat and convey each patient in accordance to the Major Trauma Triage Tool. The tool is made up of 4 steps, and ensures the patient receives the best care depending on their needs. Where the travel time is less than 60 minutes, and the patient triggers step 1 or 2, the patient should be taken to the nearest Major Trauma Centre (MTC). Step 3 or 4 should trigger a consideration to taking the patient to a Trauma Centre. In 2016/17 YAS attended 1,866 patients who triggered the Major Trauma Triage tool, with 68% triggering Step 1 or 2.

Mental Health

In mid-December 2014 Yorkshire Ambulance Service (YAS) employed mental health nurses to support front-line clinicians in the Emergency Operations Centre (EOC) for various shift patterns over the Christmas period to “better manage” demand and “improve patient experience and outcomes” for patients with mental health issues. The benefits of this service were aligned to the crisis care concordat ensuring patients get a service to support them in mental health crisis. 2016/17 saw the introduction of a full team of Mental Health nurses in the EOC, and developed a validated assessment tool to support clinical assessment and management.

Falls and Frailty

To facilitate the Trusts aims in providing a Falls service which involves both internal and external partners/stakeholders and provides the best outcome for the patient, the Trust approached the Health Foundation for funding to run a pilot project which will aim to provide a partnership response model across the Yorkshire Ambulance Service foot print to enable a minimum standard of response, remote clinical assessment and referral to appropriate service for patients who have fallen. With reducing hospital admissions, long lie times and to improve the patient experience. The demand on YAS resources to deal with falls is extremely high accounting for approximately 11% -16% of all calls. YAS had 80876 calls for falls in 2014 and 67.7% involved the over 65 high risk age group. Pilots to improve falls response took place in Hull, Sheffield and Leeds, with the Sheffield LIFE scheme shortlisted for the NHS Collaboration Award at this year’s Health Business Awards

Sepsis

Sepsis is a rare but serious complication of an infection. Sepsis is a major health care problem, affecting millions of people around the world each year, killing one in four. Similar to Major Trauma, STEMI or Stroke, the speed and appropriateness of therapy administered in the initial hours after sepsis develops are likely to influence outcome.

Following the NICE Guidance; Sepsis: recognition, diagnosis and early management, publication in July 2016, the YAS screening tool for adults and children have been updated and included in the YAS Clinical Refresher.

The Sepsis Audit was reported as part of a two year CQUIN. It was found that 83.7% of all the patients audited were defined as having red flag sepsis (the most serious type of sepsis), requiring immediate treatment with intravenous fluids, oxygen therapy and immediate transfer to hospital. IV fluid therapy was given to 61.4% of red flag patients, SpO_2 levels were recorded and maintained in 96.5% of the patients and pre-alert was completed by 80.6% of crews.

The overall compliance with the care bundle improved greatly when Quarter 4 2016-17 was compared to the previous years' data, with 54.4% meeting the care bundle. When the exceptions are included this increases to 65%. The care bundle compliance has been increasing since April 2015 mainly due to the training in the use of the YAS sepsis screening tool.

Mortality

The monitoring of mortality within the health care system is widely used to provide an indicator for patient safety... Pre hospital ambulance mortality is not commonly defined or routinely collected, and whilst not mandated for ambulance trusts, YAS has undertaken a pilot to review all deaths in the care of the service. 4.9% of all deaths had some aspect of care that steps may have been taken to prevent the death, the most common being contact with a Health Care Professional within 72 hours of the death. The Mortality Screening process is constantly being refined and improvement are being made to develop multi-disciplinary panels to review specific cases in more detail.

3.6 BRIGHT IDEAS

3.6.1 Background

The Bright Ideas Scheme was re-launched in December 2016 under the management of the Quality Improvement (QI) team. The scheme is designed to enable all staff on an equal basis to propose ideas and suggestions for anything which they think will improve the service and care delivered by YAS. Well thought out and original ideas covering the full range of YAS activity are encouraged. Suggestions made should show some efficiencies or greater effectiveness, with an emphasis on quality and patient care. Proposed solutions are also actively encouraged as part of the submission.

The QI team receive approximately five to eight ideas on average per week from staff members. Below is a selection of the ideas successfully implemented:

3.6.2 ID 623 ISSI (Individual direct dial number for hand held airwave radios) number display

Several members of staff suggested through the Bright Ideas scheme to place the ISSI number in the windscreen of all A&E vehicles. The reason for this suggestion is to aid communication between crews when attending an incident. An example would be

if a Double Crewed Ambulance (DCA) was attending an incident to back up an Rapid Response Vehicle (RRV) that had been on scene for some time and might need some extra equipment bringing to the patient, a direct conversation could be had using the ISSI number displayed in the windscreen of the RRV and the relevant equipment could be brought to the patient. This would be of particular value if the RRV was attending to a patient some distance away for example, multi-storey flats or in a field. The Bright Ideas team created the ISSI tax discs and ensured that these were distributed to all the vehicles across YAS in February 2017. The feedback from staff following implementation has been very positive.

3.6.3 ID 52 Autopulse Charger

A Bright Idea was submitted to install an autopulse charger and spare batteries at the Emergency Department (ED). On a number of occasions the auto pulse had lost charge whilst at the ED with no spare batteries or charger available. In a bid to improve patient care, it was agreed that the Bright Idea could be trialled at Leeds General Infirmary. The charger was installed with the spare batteries in May 2017. This also means that auto pulse is ready for use and immediate benefit for the next patient who may need it.

3.6.4 ID 97 NHS Blanket Amnesty

This idea was submitted to save the NHS costs and to also free up room for hospices/care homes. The idea originated when one of our crew collected over 40 NHS blankets from a nursing home and a hospice. The Bright Idea was to send someone to collect all of the blankets they could from care homes and hospices across YAS. However, it was agreed that it would be a better idea to send a letter to the residential homes /hospices asking them to return any blankets to any YAS staff that attend the address whilst attending to patients. A staff update was then distributed asking all staff to accept any blanket s they are given and return these to the nearest ED for laundering.

3.6.5 ID 127 '#hellomynameis' Dispatchers

The origin of this Bright Idea was based on the '#hellomynameis' campaign'. A staff member pointed out that whilst dispatchers know who the crews are they are dispatching, in terms of their names, their shift times and job roles, the crews were unaware of the names of their colleagues they were working with within the EOC. Dispatchers now introduce themselves to crews when they start their shift.

3.6.6 ID 112 GRS Rolling Relief

An idea submitted by a newly qualified paramedic to request for an addition to their GRS page which allows staff to see their rolling relief. Staff are now able to see whether they are in debt or credit with their hours allowing a clearer picture of the hours they are working.

3.7 DEVELOPMENT OF CLINICAL QUALITY STRATEGY 2018/21 AND APPROACH TO QUALITY IMPROVEMENT

3.7.1 2017/18 will mark the final year of the current Clinical Quality Strategy, and plans for refreshing the strategy have begun.

3.7.2 The proposal is to refresh the Clinical Quality Strategy as a Quality Improvement strategy, whilst maintaining the focus on specific improvements in safety, effectiveness and patient experience. This will then enable a Trust wide focus, since quality is not only about direct clinical care. A high proportion of the YAS team are not clinically qualified and it is anticipated that by including all service lines, this will in turn, support the approach and attitude that quality is everyone's business.

3.7.3 During 2016/17 we have begun to consider our approach to build the capacity and implementation of Quality Improvement methodology for the Trust. The Executive Director of Quality Governance and Performance Assurance, has with his team, been reviewing models of excellence around the country. This has included engagement with East London NHS Foundation Trust and Salford Royal NHS Foundation Trust and the Virginia Mason approach through the Mid Yorkshire Hospitals NHS Trust. The first two of these have been recognised as outstanding by the CQC, and East London particularly has been recognised as a centre of excellence for their approach to Quality Improvement.

3.7.4 Learning from this will inform the development of the new strategy during 2017/18.

Broadly, the Quality Improvement Strategy will be developed to enable and empower all staff in the Trust to have a positive influence on patient care, whatever their role. The strategic principles within the refreshed strategy will include:

- Improving patient care and experience and reduce harm through systematic quality improvement methodology
- Empower and equip staff to improve the service and care they provide, with a commitment to train staff in quality improvement
- Promote and support integrated working to achieve goals
- Develop systems to identify, track and learn from quality Improvement projects

Section 4.0

Assurance on Risk, Safety & Clinical Quality

4.0 Assurance on Risk, Safety and Clinical Quality

4.1 Regulatory compliance with the Care Quality Commission

The CQC conducted the planned inspection of YAS against the regulatory quality and safety standards between 13-16 September 2016 for A&E, EOC, PTS, Resilience and HART and 10-12 October 2016 for NHS 111. The reports were published on 1 February 2017 and reflected an improved position for YAS across all service lines. Corporate communication was issued by the Chief Executive and Chairman thanking all staff for their efforts in the achievement.

The tables below provide a comparison between the 2015 inspection and the 2016 report:

Overview of ratings published 21 August 2015:

Outcomes	Safe	Effective	Caring	Responsive	Well-Led	Overall
Emergency and urgent care	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	**Requires improvement**
Patient transport services (PTS)	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	**Requires improvement**
Emergency operational centre (EOC)	Requires improvement	Good	Good	Good	Requires improvement	**Requires improvement**
Resilience	Inadequate	Not rated	Not rated	Good	Requires improvement	**Requires improvement**
Overall	**Requires improvement**	**Requires improvement**	**Good**	**Requires improvement**	**Requires improvement**	**Requires improvement**

Overview of ratings published 1 February 2017:

Outcomes	Safe	Effective	Caring	Responsive	Well-Led	Overall
Emergency and urgent care	Good	Good	N/A	Good	Good	**Good**
Patient transport services (PTS)	Requires improvement	Good	N/A	Requires improvement	Requires improvement	**Requires improvement**
Emergency operational centre (EOC)	Good	N/A	N/A	N/A	Good	**Good**
Resilience	Good	Outstanding	N/A	N/A	Good	**Good**
Overall	**Good**	**Good**	**Good**	**Good**	**Good**	**Good**

A number of recommendations were made to the Trust and in summary these are:

The Trust "*must*":

A&E, PTS, EOC & Resilience

- Ensure there are sufficient numbers of suitably skilled, qualified and experienced staff
- Ensure all PTS ambulances and equipment are appropriately cleaned and IPC procedures followed
- Ensure seating for children is routinely available in ambulance vehicles

NHS 111

- None

The Trust "*should*" :

A&E, PTS, EOC & Resilience

- Review the training requirements for operational staff in the PTS service for vulnerable groups such as patients living with dementia and patients experiencing mental health concerns
- Review the arrangements for operational staff to check their vehicle and equipment at the start of the shift to ensure they have sufficient time to complete the checks
- Review the audit procedures for reviewing the recording of controlled medicines
- Continue to ensure that equipment and medical supplies are checked and fit for purpose

NHS 111

- Regularly review the changes implemented in the management and leadership structure for call handlers, in order to ensure that all staff receive regular face to face feedback on their performance and call audits via the 1:1 process
- Continue with steps to improve the access for call handlers to clinical advisors through an active recruitment programme
- Maintain processes and systems which enable staff to safely raise concerns in relation to working relationships

Rod Barnes, Chief Executive of Yorkshire Ambulance Service NHS Trust, said:

"We are delighted with the outcome of the CQC's inspection of our organisation. Their assessment reflects the high quality of service provided by our dedicated staff who work tirelessly every day to provide timely and safe services for our patients. It makes me immensely proud that the commitment of our staff and volunteers and the great care they provide have been formally recognised."

All of our services demonstrated significant improvement since the CQC's inspection in January 2015 and we are also pleased that the CQC has highlighted a number of areas of outstanding practice. These include:

- our Red Arrest Team providing senior clinical support for patients who suffer a cardiac arrest
- partnership working to improve integrated urgent and emergency care across the region
- the introduction of palliative care nurses in our NHS 111 call centres to support end-of-life care
- Clinical developments within our Hazardous Area Response Team.

They CQC inspection team also praised the Trust's volunteer community first responder schemes, our commitment to supporting the placement of public access defibrillators in local communities and our Restart a Heart campaign to train schoolchildren in the vital skill of CPR.

The Trust has a developed a quality improvement plan which will support the journey from Good to Outstanding over the coming years.

A specific PTS plan and robust monitoring process has been developed to aide PTS on its continued journey of improvement, which includes:

- Action to strengthen PTS management and leadership.
- Implementation of a PTS workforce and training plan.
- A continued focus on standards of cleanliness and infection, prevention and control.
- Support for a co-ordinated approach to quality improvement built on staff and patient engagement.

The delivery of the Quality Improvement Plan will be managed through the Trust Management Group and assurance provided to the Quality Committee.

4.2 Quality Governance

This report demonstrates the progress of our systems of safety, quality and risk management. The support provided by corporate teams has strengthened and developed significantly, specifically in the interface and relationships between corporate functions and local frontline operational staff.

4.3 Quality reporting

Information about quality and safety is reported through the operational and governance structure through locality dashboards. The Trust Board receive the monthly Integrated Performance Report (IPR). This was reviewed and refreshed during 2016/17. Both these provide a mechanism for identifying and monitoring compliance with key performance indicators and regulatory standards, as well as monitoring emerging themes. The IPR is subject to close scrutiny at the Quality Committee Audit Committee and the Trust Board. The Quality Committee has the lead committee role for scrutinising all aspects of quality and safety. Locality level scrutiny of risk, quality and safety is via the operational service lines locality operational management groups for 999 emergency service, Patient Transport Service and NHS 111.

4.4 Internal audit

During 2016-17 the YAS Internal Audit programme included a focus on key aspects of quality, risk and safety, the Assurance Level provided by these internal audits is set out below. To address the recommendations made in these reports, actions are agreed by the nominated manager, with delivery monitored by Trust Management Group and Audit Committee.

Audit subject	Outcome
Board Assurance Framework	Significant Assurance
Corporate Governance Arrangements	Significant Assurance
Healthcare Contract Management	Significant Assurance
Medicine Management	Significant Assurance
Medical Device Management	Significant Assurance
Care Pathways Acute Service Reconfiguration	Significant Assurance
Community First Responders	Limited Assurance
Fleet Management	Limited Assurance
Computer Aided Dispatch (CAD)	Significant Assurance
Nurse Revalidation	Limited Assurance
Information Governance Toolkit	Significant Assurance
Clinical Governance	Significant Assurance
Complaints, Claims and Incident Management	Significant Assurance
Risk Management maturity assessment (Institute of Internal Auditors Risk Maturity Matrix)	Risk Defined

For Limited Assurance audit reports the relevant Executive Director has responsibility for ensuring a robust action plan is in place, and this is delivered through the relevant service line. The Audit Committee receive assurance that action plans are delivered and complete as part of the Trust governance processes. No high risk actions are outstanding in relation to the limited assurance reports in this period.

4.5 External scrutiny

Planned reviews of the effectiveness of the Trust Board, Committees and Executive Management Groups were undertaken in 2016/17, using the national well led framework. These identified a number of partial refinements to further strengthen quality reporting and performance assurance and these will be implemented in 2017/18. A follow up review is planned by the Board during 2017/18

Section 5.0

Looking ahead to 2017-18

5.0 Looking Ahead to 2017-18

The 2017-18 priorities described in this report reflect available guidance and best practice on key aspects of risk management, quality and safety; and are informed by learning from a range of internal reporting and feedback processes. Specifically these are aligned to the Clinical Quality Strategy 2015/18 and also the YAS Operating Plan. Both of these are informed by national policy and guidance, statutory requirements, regional and local priorities; and also feedback from patients and service users.

Work-plans for each function have been developed and will be monitored through the existing management and governance arrangements in YAS.

A key focus for the coming year will be on how we continue to build and sustain an inclusive, open, learning culture in all parts of the organisation, which creates the maximum opportunity for staff and service users to be involved in quality and safety improvements. The new Quality Improvement Strategy will be a key element of this work, and will complement the individual work-plans through a coherent organisational approach to improvement.