Yorkshire Ambulance Service NHS
NHS Trust

Risk, Quality & Safety Compliance Report 2015-16

Section 1.0

Introduction

1.1 Purpose

The purpose of this report is to

- Provide a summary of Trust developments in relation to risk, safety and clinical quality in 2015-16 – providing 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.

1.2 Introduction – Risk and Safety

Patient and staff safety are a priority for YAS. 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 2015-16 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 and Infection Prevention and Control.

1.3 Introduction – Clinical Quality Strategy

High Quality Care for All (2008) and other recent NHS guidance identify three key dimensions of quality:

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

The *YAS Clinical Quality Strategy 2012-2015 and the updated 2015-18* has set out Yorkshire Ambulance Service's (YAS's) approach to clinical quality for this time. 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 2012-15 and 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 reviewed within 2015 and has included input from our staff, our stakeholders and 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 also builds on the YAS Clinical Quality Strategy 2012-15. It is informed by national and international evidence on best practice, together with learning from internal reporting and learning systems and risk assessments.

Our vision is that we 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 15-16 a Sign up to Safety Lead was employed by the Trust to lead key developments in relation to this area. The work programme includes focus on EOC human factors, the deteriorating adult and child and moving patients safely.

The Clinical Quality Strategy also includes the Trust's CQUIN programme and for 15-16 the A&E CQUIN programme included; paramedic pathfinder, EOC human factors, sepsis, pain management and mental health.

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 and Infection Prevention and Control.

2.1.1 Delivery of work plans for 2015-16

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 2015-16 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. A further internal audit review undertaken in 2015/16 examined the management of risk at local business unit level. This again provided YAS with significant assurance of the understanding, engagement, management and escalation of risk from Clinical Business Unit (CBU) level, through the Directorate and to the relevant governance groups or committees. This audit recognised the need to strengthen arrangements further and directed the focus of the risk management work programme within 2015/16 and into 16/17 on embedding processes and improving the functionality of the risk module on YAS's Datix Risk Management System. During 2016-17 a further assessment of the Trust's risk management maturity will be conducted to support assessment of progress since a similar exercise in 14-15.

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 2016-17, 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.

2.1.5 Looking ahead - key priorities for 2016-17

The following priorities have been set for 2016-17:

- 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
- Design and implement a risk profiling process to ensure alignment of learning from internal audit recommendations and to inform the future internal audit programme.
- Develop an assurance map for the organisation to ensure there is strong, objective, Board assurance in relation to all key areas of Trust activity.
- 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.

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 2015-16 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 2015-16 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 three financial years the Trust has increased its self-assessment submission score by 10% to a score of 83% during a period where the Toolkit standards have become more stringent year on year (Rated 'satisfactory' against a satisfactory/unsatisfactory rating regime).

In 2015-16 our internal auditors (East Coast Audit Consortium) audited around 45% of the Information Governance Toolkit requirement areas, reporting 'significant assurance' against the requirements examined.

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 make sure our staff are trained in the confidentiality, data protection and information security of personal information. During the year 80.59% of staff received 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.

Statement in Respect of Information Governance Serious Incidents Requiring Investigation

During 2015-16 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 2015-16		
Category	**Breach Type**	**Total**
A	**Corruption or inability to recover electronic data**	**1**
B	**Disclosed in Error (within a secure NHS environment)**	**33**
C	**Lost in Transit**	**3**
D	**Lost or stolen hardware**	**1**
E	**Lost or stolen paperwork**	**30**
F	**Non-secure Disposal – hardware**	**0**
G	**Non-secure Disposal – paperwork**	**3**
H	**Uploaded to website in error**	**0**
I	**Technical security failing (including hacking)**	**4**

J	**Unauthorised access/disclosure**	**8**
K	**Breach of confidentiality (Verbal)**	**1**
L	**Inappropriately secured paper/electronic transmission/transfer of identifiable information (Via email, FTP or removable storage)**	**1**
M	**Other**	**65**

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.

Work to reduce the category, Disclosed in Error (within a secure NHS environment), during 2015-16 has included bespoke training for staff working within environments where email sharing of data is common, such as Business Intelligence. This has focused on ensuring that their processes include regular checks to ensure data sent has an adequate data sharing agreement in place, holds no additional hidden data, is going to the correct source and that source emails are checked to ensure they are valid and current on a regular basis. Business areas are expected to audit these processes on a regular basis.

Stolen or lost paperwork remains an issue as patient care records (PCR) remain paper based. The number of paper records generated in 15/16 was approximately 730,000 Staff are reminded to take care of their PCRs but at times accidental loss remains a possibility. Transfer to e-records is the only complete solution to this issue. Stickers to remind staff to look after their records are situated within the cab areas of all vehicles to act as a prompt.

Further improvements in data security across the Trust have been made with the installation of i-gel ‘dummy’ terminals at all ambulance stations. These can be centrally controlled by the Information Technology department and are less likely to be the cause of a breach.

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 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 2015-2016 two important legislation changes have occurred which will impact health and safety management for the Trust.

Care Quality Commission (CQC) enforcement

On the 1st April 2015, a memorandum of understanding between the CQC and the Health and Safety Executive (HSE) came into force. The document reflects the new enforcement powers that have been given to the CQC with regards to patient safety under the Regulated Activities Regulations (RAR) 2014. It replaces all previous agreements between the CQC and the HSE.

In summary any employee safety breaches will be enforced by the HSE and any patient safety breaches will be enforced by the CQC. Exceptions to this are; where an incident affects both employees and patients, enforcement is likely to be the HSE and where an individual has committed a safety offence, even if this results in patient harm, enforcement will be by the HSE.

This does not affect the Trust's reporting obligations with regards to Reporting Injuries Diseases and Dangerous Occurrences Regulations (RIDDOR) and National Reporting and Learning System (NRLS).

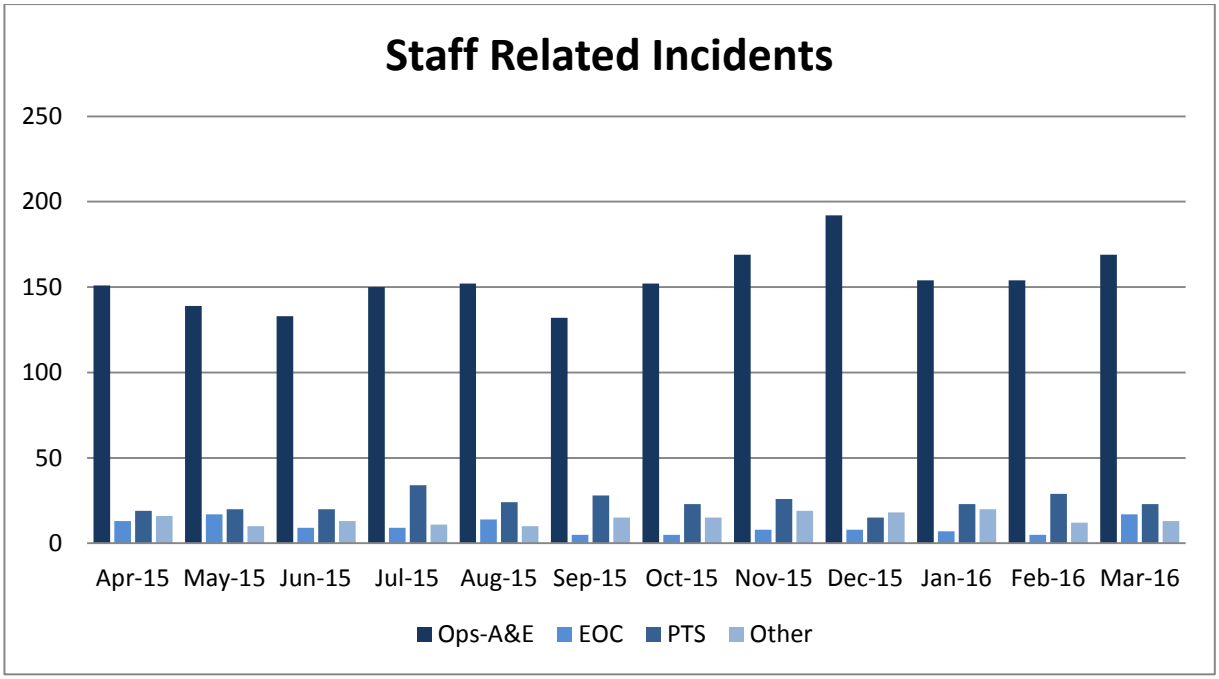
New sentencing guidelines for health and safety offences

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 and custodial sentence imposed.

For an organisation the size of YAS, the financial penalties imposed for health and safety offences will be significantly higher than could previously have been expected prior to the new guidelines. This, therefore, increases the level of financial impact that could occur following a health and safety prosecution.

2.3.2 Incident reporting

This graph shows the number of staff related incidents reported in 2015-16.



Of the staff related incidents reported in 2015-16, 4.6% were graded with a severity of moderate or above (table below).

	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Total
Moderate and above	7	8	4	8	13	14	13	8	9	5	12	10	111
Total	199	186	175	204	200	180	195	222	233	204	200	222	2420
% Mod and above of total	3.5	4.3	2.3	3.9	6.5	7.8	6.7	3.6	3.9	2.5	6.0	4.5	4.6

The overall incident rate for staff related incidents has increased over the year. The yearly average is 44.0 (number of incidents per 1000 employees) with a peak of 52.3 in March 2016.

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 towards our staff.

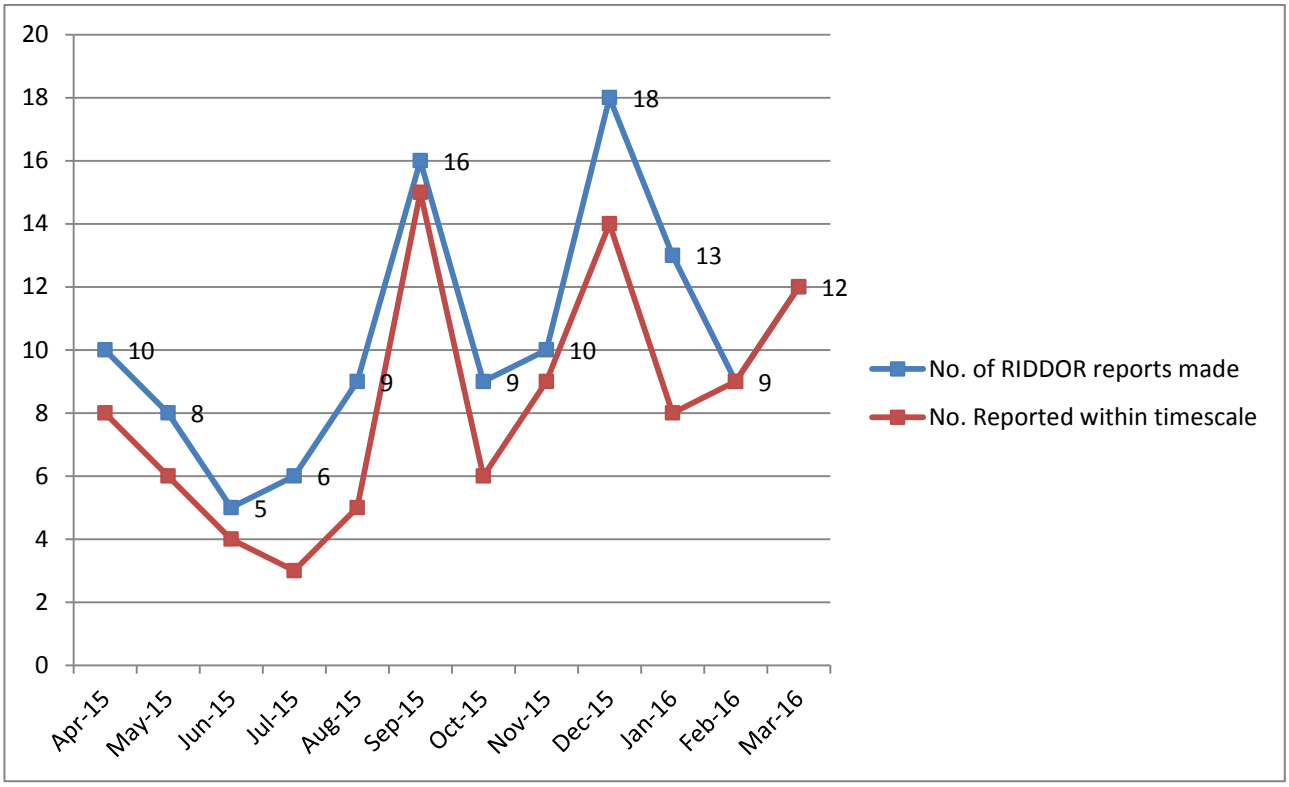
The A&E and PTS operation services are where the Trust faces the greatest risks and subsequently these areas record the largest number of incidents. The number of moving and handling incidents relating to response bags has reduced following the introduction of new equipment, but there has been an increase in relation to the Mercedes van conversion vehicles, in particular the tail lifts. Action is being taken to address both of these risks.

Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 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).

A number of new measures / procedures have been in place since the end of 2014 which has led to the Trust achieving good compliance with RIDDOR reporting timescales as shown in the graph below.

RIDDOR Reports for 2015 / 2016



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

Incident Type	Apr 15	May 15	June 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Total
Contact with electricity or an electrical discharge	1	0	0	0	0	0	0	0	0	0	0	0	1
Fall from a height	0	1	0	0	0	0	0	0	0	0	1	0	2
Hit by a moving vehicle	0	1	0	0	0	0	0	0	0	0	0	0	1
Hit by a moving, flying or falling object	1	2	0	0	0	0	0	1	3	0	0	2	9
Hit something fixed or stationary	0	0	0	0	0	0	0	1	1	1	0	1	4

Injured while handing, lifting or carrying	**6**	**4**	**4**	**5**	**10**	**10**	**5**	**4**	**7**	**4**	**6**	**6**	**71**
Other kind of accident	**0**	**0**	**0**	**0**	**0**	**1**	**0**	**1**	**0**	**0**	**0**	**0**	**2**
Physically assaulted by a person	**0**	**0**	**0**	**0**	**1**	**1**	**0**	**0**	**2**	**1**	**0**	**1**	**6**
Slipped, tripped or fell on the same level	**3**	**1**	**1**	**0**	**0**	**3**	**3**	**3**	**6**	**2**	**2**	**5**	**29**
Total	**11**	**9**	**5**	**5**	**11**	**15**	**8**	**10**	**19**	**8**	**9**	**15**	**125**

These figures show that the highest number of incidents with harm 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 2015-16 work plan includes focused work on moving and handling, via the Sign up to Safety programme.

2.3.3 Delivery of Work Plan for 2015-16

Development of new structure for Health and Safety service provision

In March 2015 NHS Employers published “Health and Safety Competences for NHS Managers”. The Trust Health and Safety Manager reviewed the Trust’s health and safety competency programme, in line with this document, and identified a number of health and safety knowledge and skills competency gaps at line manager and senior manager level.

Following the health and safety training review, work was started to address the knowledge and skills gaps and secure adequate training provision for the appropriate Trust management groups.

Specific actions in relation to this issue were added to the 2015-2016 work plan. Progression of actions will continue through to the 2016-2017 work plan as it is essential to support the effective functioning of the Trust’s health and safety management system

Moving and Handling

To address the issue of moving and handling, a task and finish group was set up in May 2014. Members of the group include representatives from Risk and Safety, Training school, A&E Ops, PTS, a YAS expert patient and Unison safety representative.
The group identified and progressed a number of actions including:

- a comprehensive review of the Trust’s patient risk assessment form
- a review of the moving and handling policy

- a review of moving and handling training materials
- scoping for the provision of specialist moving and handling advice

Work has been continuing on these actions throughout 2015-2016.

In addition, a specialist post was recruited in December 2015 to progress the “Sign up to Safety” agenda. This agenda includes a specific objective around the safe movement of complex patients. With this dedicated focus on moving and handling, the Trust is now much closer to ensuring the provision of specialist equipment for moving and handling of complex, including bariatric patients.

Mercedes Van conversions

The biggest increase in moving and handling incidents for 2015-2016 has been in relation to “Other tools and equipment”. These incidents are mainly made up of issues relating to the operation of the Mercedes van conversion ambulances.

A number of issues have been identified with the vehicle including a lack of space and difficulties operating the tail lift.

To tackle this issue, within 2015-2016, the Trust developed a new ambulance design which was agreed following an extensive consultation process with staff forum members and health and safety representatives from the unions.

To mitigate the risk with the Mercedes tail lift, modifications to the design from the original, which eases assembly of the tail lift, have been made. In addition, vehicles with this tail lift have been distributed across the Trust so that no one ambulance station has a concentration of them.

Carry chairs

New track carry chairs began to be rolled out across the Trust towards the beginning of 2014 to support staff in maneuvering patients on stairs. In each area 100% of all Clinical Supervisors were trained by the end of 2014-15. The average compliance in 2015-16 for Operational areas is now 82%. Staff feedback indicated that whilst the new chairs have helped to address risks related to moving patients downstairs, they are not optimal for other scenarios. The Trust has therefore continued to explore other carry chair option during 2015-16 to supplement existing provision.

Face Fit Testing

A training needs analysis for ambulance respiratory protection was completed and provided a comprehensive assessment and recommendations for the Trust.

Work has been ongoing since September 2014 to ensure face fit testing for respiratory protection is completed for all staff and a new procedure for PPE was approved in March 2015.

Fit testing is being provided through training schools and Clinical Supervisors. Current fit testing compliance i.e. staff who have passed the fit test, varies greatly across the Trust and ranges between 25% - 78% in operational areas.

The Trust is looking to improve its fit testing compliance and within 2015-2016 it arranged for Sheffield Hallam University to carry out fit testing in house for student paramedics.

Premise Risk Assessments

The Inspection 4 Improvement (I4I) process is an annual site inspection, 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.

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.

To increase the focus on health and safety, a table top risk assessment of all trust premises was carried out during 2015-2016 as part of the work plan. This risk graded each premise using information from the Estates 6 facet survey, compliance with statutory requirements, incident rates and recorded risks. The “top 20” premises were then visited by the Health and Safety Manager and Safety Systems Manager and site risk assessments completed.

Health and Safety Policy and Procedures

Scheduled review of procedures and a review of the COSHH procedure following a change in legislation have been completed in 2015-16

Significant progress has been made with the implementation of a formal written risk assessment procedure. The procedure includes a manager’s guide to completing a risk assessment and risk assessment templates have been standardised and are now available on the intranet along with a risk assessment library which provides access to all staff.

2.3.4 Key Risks

During 2015-16 five new health and safety risks were added to the risk register, three of which relate to the effective functioning of the Trust’s Health and Safety Management System as follows:

1) *Implementation of the risk assessment procedure.*

As detailed in the section above, a formal standardised risk assessment procedure has been put in place during 2015-2016. However, the process has yet to be embedded in the Trust and therefore a new risk was raised. Awareness raising is required to mitigate this risk along with skills training for managers.

2) *Health and Safety Training for middle and senior managers*

An educational gap has been identified with regards to Health and Safety training and awareness for some managers.

This has increased in priority following changes in the structure for Health and Safety service provision in the Trust and work is currently underway to resolve this.

Additional new risks –

Mercedes van conversion ambulances

The continued use of the Mercedes van conversion ambulances means that there is a continued potential for staff to suffer musculoskeletal problems caused by the operation of the tail lift and from working with and moving patients in a confined environment. As detailed above, no more ambulances of this design will be purchased and work is underway to secure a more suitable alternative.

Fit testing

As detailed above fit testing processes in the Trust are not as effective as they need to be and further work is ongoing to support compliance with the Control of Substances Hazardous to Health Regulations (COSHH) and Personal Protective Equipment (PPE) Regulations.

Existing moving and handling risks

The Trust has two risks on the register relating to moving and handling issues which include the track carry chair and the lack of training on bariatric equipment vehicles and deployment. Both issues are being addressed as part of the moving and handling work stream within the Sign up to Safety programme.

2.3.5 Looking ahead – priorities for 2016-17

An important focus for the coming year will be the continued development of a new structure for Health and Safety service provision and the implementation of the measures needed to support this such as manager training. The provision of health and safety training to senior management is also a priority.

Both these are essential to ensure the continued effective functioning of the Trust's health and safety management system.

In addition, work will be on-going in relation to moving the patient safely.

Slip, trips and falls are the second highest RIDDOR incident for the Trust and are logged on the Trust risk register. Work to tackle these still forms a significant part of the 2016-2017 work plan.

A new work stream added for 2016-2017 is focused in supporting Health & Safety management in the Trust's Fleet Department.

Premise risk assessment visits will also be undertaken in 2016-2017 on a risk prioritised basis starting with the Trust's Fleet workshops.

2.4 Security

2.4.1 Introduction

Security management is overseen by an accredited Local Security Management Specialist (LSMS) who reports to a designated Director responsible for Security (Executive Director of Quality, Governance & Performance Assurance)

There is an annual work plan for security issues informed by internal priorities, the National Security Management Standards and other in year developments. In 2015-16 a Trust wide security and management workshop was held to help identify appropriate security priorities. This has informed the risk assessment and annual plan for 2016-17 and a further workshop is planned for autumn 2016 to support development of the strategy for the next 3-5 year period.

2.4.2 Delivery of Work Plan for 2015-16

Premises Security

Work to maintain and monitor access control and the use of CCTV on Trust sites has continued during 2015-16; with existing systems being quality audited and new elements added to improve working arrangements at some sites.

During 2015-16, a full risk assessment was undertaken of all YAS premises, in order to inform a risk graded Security Improvements Action Plan.

The risk assessment took into account findings from the '6 Facet Survey'; risks identified from incident reports; anecdotal information from staff/staffside; and issues identified through Inspection for Improvement visits. All available information was then considered in context with the Crime Profile of each area.

Funding has been approved within the 2016-17 capital plan for the most significant actions (Red and Amber), with many of the remaining actions to be picked up within standard improvements by the Estates Department.

The Trust is in the process of reviewing its contract for CCTV and area control and further improvements in 2016-17 will be informed by this review.

Vehicle and Staff Security

Funding has been approved to invest in the upgrade of all vehicle CCTV equipment to enable footage to be downloaded remotely via Wi-Fi connectivity. This will make use of the work that is currently being carried out to install Wi-Fi on all YAS Ambulance Stations. It is anticipated that the system will work in a similar way to most Police forces, whereby footage is automatically uploaded and stored each time the vehicle returns to a station. The specification is currently being put through the Trust's procurement process and will go out for tender. This development will significantly enhance the Trust's ability to support staff in relation to violence and aggression incidents and to effectively manage vehicle related accidents. It will also provide real time assurance on the functionality of vehicle CCTV.

Self-Review Tool (SRT) NHS Protect

YAS submitted our SRT to NHS Protect for 2015/16, and self-assessed against the 31 standards declaring full compliance with 27, and partial compliance with 4; the Trusts' SRT submission was not selected for audit by NHS Protect. Work to complete the 2016/17 SRT is in progress and is due for submission in November 2016. YAS 2016/17 Internal Audit programme will include validation of our self-review assessment which will report through Health and Safety Committee, providing assurance at Audit Committee and to Trust Board.

There are a number of minor changes to the 2016/17 standards, which are as follows:

- 1.5 now requires organisations to align with NHS Protect's anti-crime strategy, which will be reflected within the Trust's Strategic Security Investment Plan.
- 3.1 relates to Conflict Resolution Training (CRT) and further role risk assessment are required to ensure that we have captured all roles who may come into contact with patients or the public as part of their job.
- 3.2 is a new standard and relates to the requirement for awareness training in Clinically Related Challenging Behaviour, which is currently being developed by the Clinical Directorate, supported by the LSMS.
- 3.14 relates to the Security Threat Level and the Trust's ability to increase its resources in response to an escalation of the Threat Level, which will be developed in consultation with the Resilience Team.
- 4.3 relates to the requirement of a Communication Strategy for the publication of sanctions, including the reasons why sanctions are not publicised. This will be written into the Sanctions, Redress and Recovery Policy, which is on the LSMS work plan for 2016/17.

The pilot standard for the reporting of incidents on the Security Incident Reporting System (SIRS) database, which was introduced into the 2015/16 standards, remains a pilot standard for 2016/17. YAS already meets this standard, as the SIRS website is used to complete its annual Reporting Physical Assaults (RPA) submission.

2.4.3 Security Incidents

During the period April 1st 2015 to March 31st 2016 the following number and types of incidents were reported via the Trust incident reporting system (DATIX).

Incident type	2014-15	2015-16
Thefts of trust property	**23**	**21**
Incidents of criminal damage to trust property (i.e. vehicles, equipment and premises)	**5**	**5**

2.4.4 Violence/Aggression Incidents

During the period April 1st 2015 to March 31st 2016, the following number and types of Violence & Aggression incidents were reported via the Trust incident reporting system (DATIX).

Incident type	2014-15	2015-16
Physical assault on staff by patient, relative or public	**167**	**138**
Threats of physical violence and verbal abuse by patient, relative or public	**431**	**510**

Prosecution of Offenders

The 2015 Staff Survey showed that, in the reporting of Violence & Aggression incidents, YAS compares 'least favourably' with other Ambulance Trusts in England. YAS also compares 'less favourably' in terms of the percentage of staff, experiencing physical violence in the last 12 months, reporting their most recent experience of violence. It is recognised that in 2015-16 this was adversely affected by unplanned changes in the LSMS role which were resolved with the appointment of a new LSMS.

Implementation of the updated Management of Violence & Aggression Policy will be used to raise awareness of the need to report incidents, to improve the support given to staff when they are assaulted, encourage better reporting and increase the number of successful prosecutions.

In an attempt to increase the number of sanctions taken against individuals who assault YAS staff and to improve the recording of those sanctions that are awarded, the LSMS is working towards developing a designated Police Point of Contact. This will enable the LSMS to receive regular reports in respect of YAS staff who have reported an assault, the actions that are being taken to pursue a prosecution, details of court appearances and details of successful prosecutions.

Successful Prosecutions

A former member of YAS staff, who pleaded guilty to the theft of a Lifepak 15 defibrillator from the Trust, was sentenced at Bradford Crown Court. He received an eight-month prison sentence, suspended for 12 months, together with 80 hours' community work, to be supervised by the Probation Service.

2.4.5 Key Risk

Resilience needs to be developed for key pieces of work that are currently only undertaken by the LSMS and plans are in place to ensure management and ownership of security management issues and practical support from other members of the Directorate team.

2.4.6 Looking Ahead – Priorities for 2016-17

The following are identified as priorities within the 2016-17 work plan:

- To ensure that national submissions are made in accordance with requirements of NHS Protect Security Management Standards.

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

- Strengthen follow up of potential prosecution following violent and aggressive incidents to staff.

- Address any recommendations of Internal Audits of the SRT NHS Protect submission

- Launch the secure access portal to Restricted Security Alerts, with a pilot phase and evaluation by the HART Team to iron out any issues with system before it is rolled out.

- Support site security arrangements with security upgrades to those sites that are identified as being at the highest risk, and a review of the current G4S contract.

- Train staff within the Performance Assurance and Risk Team to undertake tasks to support the LSMS workload including viewing CCTV, proactive management of incident investigations, reporting of incidents on SIRS to support prompt investigation, reporting and follow up of incidents.

2.5 Infection prevention and control

2.5.1 Report from the Director of Infection Prevention Control

In 2015-16 the YAS Director of Infection Prevention and Control remained Steve Page, Executive Director of Standards and Compliance.

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 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. Clinical waste and linen should be disposed of in line with Waste Guidelines.

2.5.2 Delivery of work plan for 2015-16

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

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

The 2015-16 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 2015-16 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.

- Mandatory Infection Prevention and Control training for all clinical staff has been reviewed. Induction training for all new clinical staff has also been reviewed and refreshed.

- 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 2015-16 the following policies have been reviewed or developed;

    - Decontamination of Medical Devices and Vehicles Procedure
    - Premise cleaning procedure
    - Waste Management Procedures
    - Vehicle Aseptic Swab and ATP testing procedure and guidance (new policy)
    - Replenishment of Supplies Standard operating Procedure (new policy)
    - Dress Code and Uniform Policy
    - Pest Control Policy

- The Infection Prevention and Control Practitioner has attended all Emergency Departments to undertake validation audits of vehicle cleanliness and hand hygiene.

- 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.

- 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. Progress has been made with the implementation of the Post Occupational Exposure management guidance. All staff have been briefed about recent changes to the policy.

- Assessment of the Deep Cleaning programme 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 a CQC inspection. Monitoring via visual inspection continues. Specific training for Deep Cleaning Operatives has been developed and delivered.

2.5.3 Compliance with CQC standards

During 2015-16 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 January 2015 identified a number of areas where IPC and cleaning practices was inconsistent across the Trust. This included cleaning of vehicles between deep clean and compliance with bare below the elbows policy. These issues are being addressed by the ongoing actions monitored below.

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 Risk and Safety team. Premise cleanliness audits were the most frequent area of reported lower compliance. Work is on-going to ensure all staff are now compliant with Dress Code Policy, being bare below the elbows during direct care delivery. It is notable that the North Yorkshire region have a high level of compliance with bare below the elbows at all times and their process for monitoring of compliance is being adopted throughout the Trust.

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. It allows for on the job information and refresher training as required.

There is growing evidence that 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. The provision of new compliance notice boards across all stations is complete.

IPC good practice reminders have been publicised through the weekly Operational Update staff bulletin throughout the year; examples include articles about the patient safety implications for being bare below the elbows and how to maintain safer sharps.

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.

Inspections for improvement have highlighted a number of improvements that are required within the Estate of YAS. Facilities team have updated their cleaning schedule to include medical gas storage areas, clinical storage areas, linen storage and morphine storage areas.
Ambulance stations are being refurbished to ensure all these rooms meet the basic IPC standards.

Work to improve the supply and storage of consumables has been a focus for 2015-16 with a new standard operating procedures for delivery of consumables agreed and implemented. New delivery vehicles are in place and at every deep clean the operatives check and remove any consumables that are out of date.

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%.

The IPC practitioner has completed in depth training sessions with clinical tutors following updates to the generic IPC training course. Induction training and Mandatory training packages have also been reviewed in line with statutory requirements.

2.5.6 Infection Prevention and Control Incident review

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

Incidents reported within 2015-16 have decreased slightly from 2014-15 with a promising reduction within Occupational exposure incidents; however these remain the highest reported incident category. Each incident and near misses involving exposure is reviewed by the Risk and Safety team prior to allocation to a local manager for action and where appropriate staff are advised to attend an occupational health appointment for assessment and to arrange any further support required.

Collaborative work has been undertaken to ensure colleagues in acute hospitals give appropriate support staff who are subject to an occupational health exposure. In line with learning from incidents the Post Occupational Exposure management policy has been reviewed and simplified. Reporting and assessment has improved in line with HSE requirements and work undertaken during 2015-16 has further embedded this important process.

2.5.7 Key risks

All risks related to infection prevention and control are reviewed by the IPC practitioner and reviewed at Clinical Governance Group as required.

Hand hygiene compliance and bare below the elbow dress code compliance were noted as a key risk for the organisation during 2015-16.

Fob watches have been provided to all staff to ensure their compliance and a hand hygiene campaign has been undertaken across the Trust; this work will continue into 2016-17 and remains a key focus for the Trust currently.

2.5.8 Next steps for 2016-17

- The IPC Practitioner will continue to review all reported infection prevention and control incidents and take a proactive response to themes and trends in year to ensure improved safety for staff and patients.

- YAS will work collaboratively to ensure a flexible response to on-going infection prevention and control issues and outbreaks that emerge, be that locally, nationally or internationally; this may range from the Middle East Respiratory Syndrome (MERS) to a local measles outbreak.

- The IPC Practitioner will review and develop YAS IPC procedural documents to ensure that they are in date, evidence based, clear and accessible to frontline staff.

- The IPC Practitioner will continue to work collaboratively with Estates, Facilities and Operational staff to ensure all stations and vehicles are clean and safe for patients and staff, using the Inspection for Improvement process and monthly audits to inform and measure this standard.

- A review of processes for training and competence for intravenous cannulation will take place in Q3/Q4 2017.

- The IPC Practitioner will undertake a review of the infection prevention and control information available for public on the Trust website with a view to updating it in line with new guidance and evidence.

- The IPC Practitioner will support PTS service to understand common infections and give them clear and available guidance on the actions required to prevent further spread, developing further the clinical APP that A&E services use currently.

- The IPC Practitioner will continue to benchmarking YAS IPC systems and processes with other ambulance services and be active within the National Infection Prevention and Control Ambulance group, including taking part in research project for deep cleaning frequency.

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 2015-16 are shown below, in comparison to previous years.

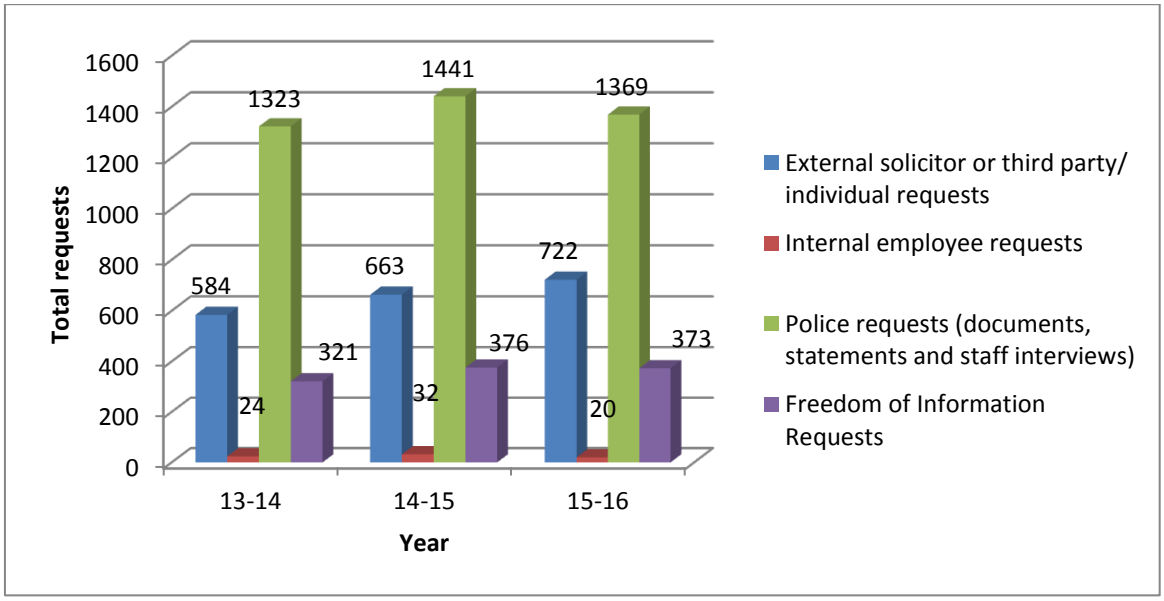


Figure 1: Total number of information requests received by year

Subject Access Requests continue to increase in number year on year (722) however the number of internal requests has decreased this year.

The overall compliance rate for 2015-16 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. Compliance rates for FOI was 90%.

The Legal Services Team work hard to maintain this level of compliance and regularly review and revise the processes to maximise efficiency. Work is planned for 16-17 to improve the education and understanding of the FOI requirements for departments across the Trust with the aim of improving compliance rates. 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

All Coroners' requests are reviewed by the Executive Medical. 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. Director.

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 200 Coroner requests in 2015/16. There has been an overall year on year increase in inquest cases, with 440 being reported in 2015/16 compared to 360 in 2014/15, and 300 cases in 2013/14. YAS employees gave evidence (oral or written) to 236 inquests this year. 204 are still awaiting a hearing date.

The number of inquests opened by the Coroner as a result of delayed response continues to be reported, however this number has decreased during Q3 and Q4. Inquests relating to patients who have suffered a spinal injury also continue to be reported. The Clinical Directorate continue to re-inforce the assessment and treatment of a potential spinal injury through clinical practice and training, and a new spinal injury assessment tool was recently introduced which aims to further assist clinicians in these circumstances.

In all cases where a concern is raised YAS provides an investigation report and representation from the Trust is made. 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.

Coroner recommendations this past year have triggered a significant amount of work within EOC and the wider Trust on how standoff situations are managed and the communication around these. At a recent inquest the Coroner commended YAS on the work that had been undertaken in this area.

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 2015/16 YAS received two PFD reports.

YAS were involved in a complex inquest which was heard in October 2015 which concerned the death of a patient who had a history of mental health issues and was a frequent caller of the Trust. The patient called the 999 service on the day she died and unfortunately there was a delay in the response and she was found deceased on arrival. The Coroner felt that there should be provisions within the 999 AMPDS system to identify those patients who are alone and vulnerable and that these calls should then be managed differently. A PFD report was issued as a result of this. The recommendations from this case have triggered a review of the processes within EOC for the management of overdose cases and the mental health nurse role. The Executive Director of Operations has written the International Academy of Emergency Medical Dispatch (IAEMD) and NHS England to share the learning from this case in order to inform future developments. The IAED are currently working with YAS to review the relevant protocols with a view to making any necessary improvements.

The second report involved attendance to a patient who was choking and the first responder omitted to take in a suction unit to the incident. The Coroner was concerned that there was no set guidance within the Trust for first responders to prioritise what equipment should be taken in to different situations.

This case and the report were considered by the Clinical Directorate, however it was felt that the emergency response bags include the essential equipment required to manage life-threatening emergencies and clinicians are advised to take this bag, along with the AED, in to all incidents. As it is not uncommon that the information received during the 999 call is different from the scenario that the clinician finds when they arrive on scene, it would be difficult to produce written guidance to cover all incidents. The importance of clinicians performing a Dynamic Risk Assessment in deciding on the additional equipment to take into the incident has been communicated to staff.

During 2015-16 there has been a small number of high profile cases involving NHS111 including a historical NHSD case heard in the last quarter. In these cases the Coroner raised concerns about the processes for sharing information between services (111/999/GP services) in that previous contacts/assessments are not all available to each service. Whilst YAS have provided assurance of the processes locally, the Coroner for the Bradford area is planning to make a PFD report to NHS England to look at whether any lessons can be learned and implemented across NHS 111 services nationally. YAS will review the recommendations within the report and apply any learning to the services. The Vanguard work streams will also support this issue with the development of a single patient care record.

Both individual learning points and common themes are identified and actions implemented from review and management of inquest cases. Organisational learning actions have included the on-going review of the procedures for managing patients who are identified as being alone, work around spinal injuries has continued and a new spinal assessment tool has been implemented.

During 2015-16, as one of the successor organisations of South Yorkshire Metropolitan Ambulance Service, the Trust continued to contribute to the Hillsborough Inquests. We have done our best to ensure all relevant evidence about the ambulance response was put before the Court and we fully accept the jury's conclusions. I would like to extend my deepest sympathy to the bereaved families of the 96 people who lost their lives as a result of the tragedy. Our thoughts remain with them.

The Trust has also continued to make a significant contribution, as one of the successor bodies to the former South Yorkshire Metropolitan Ambulance Service (SYMAS), to the new inquests associated with the Hillsborough disaster. The Trust has sought to impartially assist the Coroner throughout, to thoroughly and fairly examine the response of the former SYMAS, drawing on its experience as the region's ambulance service provider. The Board has been briefed at each meeting on progress and key issues, within the limitations of confidentiality laid down by the Coroner.

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 for 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 are 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. All Clinical Negligence claims are reviewed by the Executive Medical Director.

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 2015/16 there are 178 open claims, with 91 new claims being reported. 153 of these are EL claims (86%), 11 PL (6%) and 13 CNST claims (7%). The data shows that the number of new claims reported continues to increase, but the past year has seen a reduction in the amount of open claims.

2.7 MEDICINES MANAGEMENT

Medicines management 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 2015-16 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)
- Ambulance Service Clinical Guidelines (ASCG) for drug administration.
- Care Quality Commission (CQC)

The Ambulance Service Clinical Guidelines (ASCG) 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

YAS adopts an evidence-based approach to the use of medicines within the Trust. This ensures that patients are treated safely and effectively whilst ensuring cost effectiveness. This process is managed by the YAS Medicines Management Group which meets on a monthly basis and is chaired by the Trust Pharmacist.

Developments during the last year include:

- The Trust has continued to carry out audits on medicine administration. All audits continue to be published on the YAS intranet site which allows front-line clinicians to access and use the information to inform their practice.
- Specific medicines have been audited and improvements in practice have been made as a result, for example of the use of intravenous paracetamol and re-audit of antibiotics.
- The Trust has engaged in a national project around temperatures of medicine storage within vehicles and stations. Temperature monitors have been placed across the region in double-crewed ambulances and rapid response vehicles and Morphine safes in a selection of stations.

- The Medicines Management Group has developed its data collection in relation to medicine audit, enabling YAS to identify themes, trends and practitioner non-adherence to agreed practice and protocol. This has enabled more effective and timely lessons learnt and individual reflection.

2.7.3 Review of Adverse Incidents Relating to Medication

The MMG review all adverse incidents, complaints and issues surround Medicines Management. Two common themes are;

- Accidental administration of the wrong medication

To reduce the number of errors with paracetamol and aspirin it was decided that the use of boxes instead of strips would be implemented.

To minimize the risk of saline and glucose being administered in error it was decided that YAS would procure change saline bags from 500ml to1 litre bags to differentiate them from the glucose bags.

The above actions have produced a 50% reduction in medicines errors. There has been a reduction in paracetamol/aspirin and saline/glucose errors, however there have been a number of errors where atropine has been given instead of naloxone, and where the wrong paediatric dose of paracetamol has been administered.

To reduce the incidence of these errors naloxone and atropine have been separated within the pouch. The ASCG paracetamol dose guide relates to a different strength of paracetamol to the strength YAS carry, there are also accuracy issues with the ASCG guidance around paracetamol. It was decided to continue to stock the higher strength but to provide a specific dosing schedule which was added to the mini memo that all paramedics carry.

- Missing or out of date medicines

Prescription only medicines audit continues to be undertaken to help reduce the number of out of date and missing medicines. A new database has been produced that allows the medicines management group to view the data in much more detail and identifies whether a bag is safe to be used on the next patient. This has led to much quicker and easier delivery of actions.

2.7.4 Monitoring Usage of Controlled Drugs

- UCP and paramedics morphine usage is reviewed every month and discussed at the monthly medicines management group. To identify over/under usage. The 5 top middle and bottom users PRFs are reviewed for pain scores, indication and dose used. To date there have been no issues identified with regards to usage. It has been noted in the MMG that the documenting of pain scores before and after administration has improved in the samples that are reviewed for MMG.

- An in-depth controlled drug breakages report has been produced by the Trust Pharmacist to provide assurance to the Board and Commissioner's around the high numbers of breakages that occur every month within YAS. The report was also presented to all the Controlled Drug Local Intelligence committees, this was well received and a led to a greater understanding of the ambulance service procedures. The report provided the assurance that the breakages were not suspect in nature. YAS continue to work to reduce breakages. The make ready medicines being the action that will hopefully lead to a reduction in breakages of all medicines.

2.7.5 Patient Group Directions (PGD's)

- The specialist paramedics (SP) role has continued to be rolled out and another cohort have received training in 5 PGDs, Amoxicillin, flucloxacillin, trimethoprim, prednisolone and doxycycline. The SP's have been provided with fit for purpose response bags that hold the entire kit required for the role.
- The storage and documentation of codeine and diazepam now adheres to schedule 2 controlled drugs regulations to reduce the risk of theft and loss.

2.7.6 Introduction of New Patient Group Directions and ASCG medicines

- Use of Midazolam, to facilitate external cardiac pacing and the management of agitation following successful resuscitation from cardiac arrest, has been introduced for the Critical Care team and Red Arrest Team.

2.7.7 Management of key risks

- All areas of YAS are now working to the same procurement procedure for controlled drugs and prescription only medicines. YAS no longer procure medicines from Acute Trusts, but from multiple registered wholesale dealers.

- YAS have taken part in a national temperature monitoring project along with nine other Ambulance Trusts to identify the variation in temperatures that medicines are exposed to depending on their location. YAS obtained 50 temperature loggers and placed them in Rapid Response Vehicles, Double Crewed Ambulances, Clinical Supervisor Cars and morphine safes (we placed loggers in the safes that had been identified through DATIX for being higher than normal temperature). The loggers were placed throughout the summer and winter months, the temperature recorded every 30 and 60 minutes respectively. The results have been downloaded from the loggers and combined with the national results. The results have shown that temperature variation, although outside the boundaries for prolonged storage, sits within the safe range for intermittent variations in temperature. These findings have been presented to the National Ambulance Service Medical Directors (NASMED) and the Association of Ambulance Chief Executives (AACE) with recommendations for individual trusts and nationally.

- The introduction of Make Ready Medicines to reduce the risk of out of date medicines and missing medicines is in the planning stage.

2.7.8 Next steps for 2016-17

- The Trust Pharmacist is working with the Make Ready Project Manager and Procurement team to produce a plan for medicines make ready bags throughout the region; to produce more efficient working – enable paramedics to spend more time treating patients, reduce errors, improve patient safety, and ensure YAS is working within the updated legislation and regulations whilst negating the requirement for multiple government licences. Change to vehicle CD possession to reduce the number of CD breakages will also be discussed.
- Continue to work with the National Temperature Monitoring Project to monitor medicines and also look at how YAS can action the recommendations that will come out of the report.
- Audit of the specialist Paramedic PGD medicines
- Continue to audit medicines, with the aim to bring a medicines audit to every MMG meeting.
- Continue to work with West Yorkshire stakeholders to establish a medicines bag scheme to encourage patients and staff to transport and transfer patients medicines from their home and throughout their patient journey.
- Continue to improve the end of life care YAS can offer patients

Section 3.0
Clinical Quality

3.1 Patient Safety

3.1.1 Introduction

The Clinical Quality Strategy 2015-18 sets 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 annual programme of patient safety improvements is informed by the priorities in the Clinical Quality Strategy including relevant national Sign up to Safety priorities.

3.1.2 Progress against the work-plan for 2015-16 includes:

- The Trust recruited a Sign up to Safety Lead to develop and implement the different work streams that YAS signed up for as part of the Sign up to Safety campaign. The work streams include; developing an improved awareness of human factors within the Emergency Operations Centre (EOC) with the aim of reducing incidents caused as a result of human factors; a focus on moving patients safely; monitoring and caring for the deteriorating adult and the deteriorating child.

- Continued use of the Patient Safety Thermometer data to monitor, report and inform interventions that can be used to reduce the level and risk of harm occurring in the three identified areas. Progress has been made in reducing both falls whilst in receipt of care and injuries whilst in receipt of care. Working groups have been established across the Trust to lead the key interventions relating to these work areas. A reduction in medicine related incidents has also been delivered.

- 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 intervention. Monthly reporting to the National Reporting and Learning System continues. In the last publication which represented data submitted from 1 April – 30 September 2015 YAS was the second highest reporter within the ambulance service. This is a positive development made by the Trust during the year showing an increased awareness of incident reporting with 78.4% of these resulting in no harm and 16.4% low harm. A low proportion of incidents reported resulted in moderate or above harm to patients and YAS has a KPI for 16-17 to reduce this further to less than 3% of the total of all incidents reported.

- The Clinical Directorate and Quality and Safety team continue to engage widely on the safety culture within the Trust using a range of activities. A key activity for the Quality and Safety team during 15-16 was the lessons learned survey which sought information from staff on YAS' approach to sharing lessons learned from safety investigations. This highlighted areas for improvement and a pivotal development arising from the survey was the introduction of the monthly Safety Update poster. This highlights key learning relating to clinical quality and safety issues and has been well received by staff. Further work to share learning across the Trust is continuing in 2016-17.

- YAS representatives regularly attend the National Ambulance Patient Safety Group and have shared their work on the safety thermometer amongst other teams. Work in 2016-17 is likely to include a focus on moving patients safely particularly within the non-emergency Patient Transport Service (PTS).

- The Quality & Safety Team have led on the development and implementation of Freedom to Speak Up during 15-16. The national requirement has been adopted locally and a working group established in September 2015 to develop key processes. The recruitment of a Freedom to Speak Up Guardian for the Trust has been planned for early 2016-17 in addition to a number of supporting Advocates and the process will go live during this year. The Freedom to Speak Up process will provide an additional opportunity for staff to raise concerns relating to quality, safety & matters of public interest.

- With a key requirement to improve the quality of investigations and to ensure shared learning across the Trust, a new role was introduced within the Quality & Safety Team with a Head of Investigations & Learning appointed in Quarter 3. This role will allow for improved quality and consistency in all safety investigations across the Trust. A revised Investigation Skills & Root Cause Analysis (RCA) training package was developed during 2015-16. 2016-17 will see further developments in this area with a significant focus on triangulation of incident data, occurring at the Incident Review Group, chaired by the Executive Medical Director, and the sharing of learning.

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. Plans for 2016/17 include further awareness raising and a further 5% increase in reporting for patient related 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 Risk 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 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.

Different levels of investigation have been introduced during 15-16 with Grade 1 (comprehensive), Grade 2 (concise) and Grade 3 (streamlined) based on the severity of the incident reported. Depending on the grade of the investigation managers are required to do a different level of investigation. This ensures more detailed focus on the higher level incidents with a more streamlined and trend analysis approach to the lower level ones.

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.

A Clinical Patient Safety Improvement group has been established with terms of reference that include taking action to rectify themes identified within IRG.

3.1.2 Number of Adverse Incidents for 2015-16

	A&E Operations	EOC (Emergency Operations Centres)	NHS 111 (incl LCD)	PTS (Patient Transport Services)	Others	Total
Apr 2015	441	51	64	79	32	667
May 2015	399	79	67	73	28	646
Jun 2015	486	56	69	93	28	732
Jul 2015	484	41	78	82	34	719
Aug 2015	438	61	91	90	23	703
Sep 2015	387	47	71	83	32	620
Oct 2015	444	49	55	76	36	660
Nov 2015	504	69	62	80	42	757
Dec 2015	543	106	64	53	23	789
Jan 2016	488	83	56	91	37	755
Feb 2016	491	47	40	98	22	698
Mar 2016	520	88	37	107	24	776
Total	5625	777	754	1005	361	8522

These figures equate to:

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

3.1.3 Adverse Incidents Relating to Patient Care 2015-16

	A&E Operations	EOC (Emergency Operations Centres)	NHS 111 (incl LCD)	PTS (Patient Transport Services)	Medical - Operations	Other	Total
Apr 2015	83	32	51	27	1	3	197
May 2015	71	38	55	19	1	4	188
Jun 2015	118	25	59	37	0	6	245
Jul 2015	96	21	68	19	1	2	207
Aug 2015	84	36	76	33	2	9	240
Sep 2015	75	22	61	26	1	6	191
Oct 2015	101	36	43	17	2	4	203
Nov 2015	99	39	46	18	1	3	206
Dec 2015	91	70	45	12	3	4	225
Jan 2016	80	61	43	23	1	1	209
Feb 2016	103	27	28	34	1	1	194
Mar 2016	89	48	27	29	1	3	197
Total	1090	455	602	294	15	46	2502

A higher number of incidents have occurred in this area in 2015-16 in line with an increase in overall activity. A significant number of these incidents relate to communication or treatment issues that are often outside the control of the Trust. During 2015-16 a new system has been developed that allows us to highlight to other services care concerns that have been reported on Datix by our staff about their services. These are now able to be excluded from YAS data to show an accurate representation of incidents happening within the Trust. A priority for 16-17 is to develop bespoke care pathway investigation forms on Datix that will allow for more in depth analysis into the YAS care pathway incidents.

Key learning during 15-16 arising from incidents and near miss investigation includes;

- Requirement to increase staff awareness and focus on vehicle related accidents, including the development of a working group, led by Operations, to reduce the number of incidents and accidents reported. This work is continued into 2016-17 and 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.
- Development of the Moving and Handling 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 during 2016-17.
- 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 2016-17. 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. Medication errors reported within 2015-16 have reduced by 50% when compared to reported 2014-15 figures.
- A clear focus on improvement of the handover process, including use of National Early Warning scores, handover tools; such as SBAR and ATMIST, and when to pre-alert. These initiatives have helped to ensure that patients are transferred quickly to the correct emergency team.
- Awareness of the mental capacity act and clear contacts for support when assistance with interpretation is required.

3.1.4 Serious Incidents

Serious Incidents	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Ops - A&E	3	1	0	1	1	0	0	0	1	3	1	1
EOC	1	1	2	1	2	3	2	1	2	3	2	3
PTS	0	0	0	0	0	0	0	0	0	1	0	0
111	0	0	0	2	1	1	1	2	0	1	2	2
LCD	1	1	0	2	0	0	0	0	2	0	1	1
Other	0	0	0	0	0	0	0	0	0	0	0	1
TOTALS	**5**	**3**	**2**	**6**	**4**	**4**	**3**	**3**	**6**	**8**	**6**	**8**

Serious incidents (SIs) include any event which causes death or serious injury, involves a hazard to the public, causes serious disruption to services, involves fraud or has the potential to cause significant reputational damage.

Key learning during 15-16 arising from SI investigations includes;

- Development of a PTS Governance Group to review incidents, complaints and learning and to ensure appropriate Standard Operating Procedures (SOPs) and governance arrangements are in place for the service.
- Revisions to NHS Pathways as a result of a number of 111 cases relating to headaches and sepsis.
- A focus on human factors analysis to reduce human errors made when handling calls within EOC, including development of the safety huddles to improve team work and communication.
- Focus on recognition of requirement for spinal immobilisation, including review and update of the clearance process for possible spinal injuries.
- Learning from incidents relating to safe transportation of patients includes promotion of consistent use of seat belt and wheelchair restraints within PTS.

- Implementation of the Safer Responding SOP; this SOP was developed following a number of serious incidents relating to stand off incidents for lone responders. The roll out of this SOP and continued monitoring of its use has led to an improved understanding of scene safety and improved time in attainting attendance at the patients' side, in the incidents where scene safety is an issue. All stand-off decisions must have a rationale recorded using the National Decision Model.

3.1.5 Next steps for 2016-17

The Sign up to Safety work streams have progressed well in 2015-16 with direct input from the Programme Lead. Work to sustain these into 16-17 will allow all work-stream to become embedded during the year with key targets outlined to monitor their success. Whilst the work streams are project based, with focus on particular areas of the service, it is anticipated that learning from these projects can be expanded to other areas of the service; for example using the learning from EOC project to develop human factors awareness and reduction in these types of incidents within the NHS 111 service or spreading the use of safety huddles to reduce falls and injuries within the PTS service.

Freedom to Speak Up will go live in Quarter 2 of 2016-17 and this will assist in the identification of issues and concerns across the Trust in relation to quality, safety and matters of public interest. This data and information will be triangulated with other data inputs such as incidents and complaints to gather an overall view on common themes and trends.

Further work will continue to improve the overall quality of investigations taking place across the Trust and to improve learning and feedback mechanisms to staff. This will be explored using a variety of media to target all staff.

Clinical managers and the Clinical Audit Lead will be working with operational staff to support learning from audits and incident review themes.

3.2 SAFEGUARDING

The Safeguarding Team continue to build positive relationships both internally and externally with partner agencies to safeguard children, young people and vulnerable adults. The key priorities for the team include:

- ensuring all staff are aware of their role in protecting 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 development and delivery of effective training packages for all staff
- developing effective systems for 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, contributing to case reviews and ensuring learning is shared across the organisation.

3.2.1 Safeguarding referrals

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

The number of referrals continues to grow, specifically for adults at risk. The safeguarding team have been successful in engaging front line staff in the referral process and have also developed a strong working relationship with the clinical hub. The safeguarding team have worked with the clinical hub and also social care teams to inform the recent review and development of a revised referral forms, one for child referrals and one for adults. The adult referral now reflects and differentiates between adults at risk and those needing a care assessment.

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. An Intercollegiate document for vulnerable adults 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.

YAS have led on the development of a national Level 2 safeguarding adult work book. This will be combined with the updated Children's Level 2 work book and recommended by the National Ambulance Safeguarding Group (NASG)

The training compliance for 2015/16 was:

Safeguarding level 1 94.45%
Safeguarding level 1 (children) 95.59%
Safeguarding level 2 (children) 83.68%

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. During 2015-16 both policy and practice have been reviewed to ensure we remain complaint with legislation and good practice guidance. 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 a refreshed approach to education and training and clinical audit resulting in a greater understanding of the quality of the safeguarding service. 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 referrals has been developed and will be undertaken quarterly from Q2 2016/17. The pilot audit across both child and adult referrals has contributed to a greater understanding of the profile and patterns of safeguarding referrals. The audit found that the referrals are of a good quality and contain good information for social care to plan care and actions. It is identified a need to develop a social care assessment pathway and work will continue to progress this in 2016/17.

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 training work plan for safeguarding adults, children and Prevent.

The internal risk management and reporting software system (Datix) has been extended 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 and provide a coordinated approach to service users, partner agencies and YAS staff.

All Safeguarding Policies and Guidance have been reviewed and published in December 2015.

All training, both face to face and mandatory training workbooks have been refreshed to align to legislation, National Guidance, good practice guidance, and lessons learned from Domestic Homicide Reviews and Serious Case Reviews (child and adult).

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 LSAB and 13 LSCB across the region. The safeguarding team represent YAS as often as possible, and 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 representative on the local Multi-Agency Safeguarding Hubs (MASH) to ensure any information relevant to YAS is shared.

Reports to Child Death Overview Panels

Child Death Overview Panels (CDOPs) are held in the case of any unexpected child death. They are responsible for reviewing all available information and making recommendations to ensure that similar deaths are prevented in future. CDOPs are accountable to their local safeguarding children board and are made up of representatives from health and social care, the police and coroners. The safeguarding team represent YAS on the Child Death Overview Panels and ensure any learning for YAS informs both policy and practice. There has been a significant increase in the number of child deaths where YAS safeguarding team have been asked to contribute. This is as a result of proactive relationship management with LSCBs.

Serious case reviews, domestic homicide reviews and safeguarding lessons learned reviews

The data below provides an update on the number of Serious Case Reviews (SCR), Domestic Homicide Reviews (DHR) and Learning Lessons Reviews (LLR) that YAS has contributed to during 2015-16. 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, Domestic Homicide Reviews, Learning Lessons Reviews, and Child Death Overview Panels

Table 1	2014/5	2015/16
Serious Case Reviews	3	5
Domestic Homicide Reviews	9	6
Learning Lessons Reviews	1	5
Child Death Overview Panel	31	65

3.2.5 Key Risks

- The storage and retention of records to ensure compliance with requirements of national requirements will be a key focus in 2016/17 as there is risk associated with historic databases and old paper records
- Reaching 85% training compliance for Prevent WRAP by March 2017

3.2.6 Work plan for 2016-17

- Information governance: cataloguing of the electronic database and paper records
- Increase all training compliance to 85% in line with contractual requirements
- Embed Level 2 Adult training and agree a trajectory with commissioners
- Introduce and embed new referral forms for Children and Adult (separate)
- Develop a pathway for referrals for Community Care Assessments
- Development of the Internet and Intranet (PULSE) safeguarding pages

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 2015-16

- In 2015-16 the average response time to complaints was reduced and has been maintained at the 25 day target.
- 73 % of complaints met timescales agreed with complainants; however by March 2016 actual performance was 86%, above the agreed target of 80% set for March.
- There was a high level of satisfaction with complaint responses – 96.8%
- Only 1% of cases handled progressed to Ombudsman investigation
- In 88% 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 2015-16

Complaints and Concerns (including issues raised by healthcare professionals) received by subject				
	A&E	**PTS**	**111/LCD**	**TOTAL**
Attitude	176	82	84	342
Operational issues	196	62	578	836
Clinical/Patient Care	128	112	505	745
Delayed response/timeliness	357	615	0	972
Call Handling	114	82	0	196
Other	19	1	1	21
Total	**990**	**954**	**1168**	**3112**
Demand	781,557	856,362	1,367,330	3,670,932
Proportion	0.12%	0.11%	0.09%	0.08%

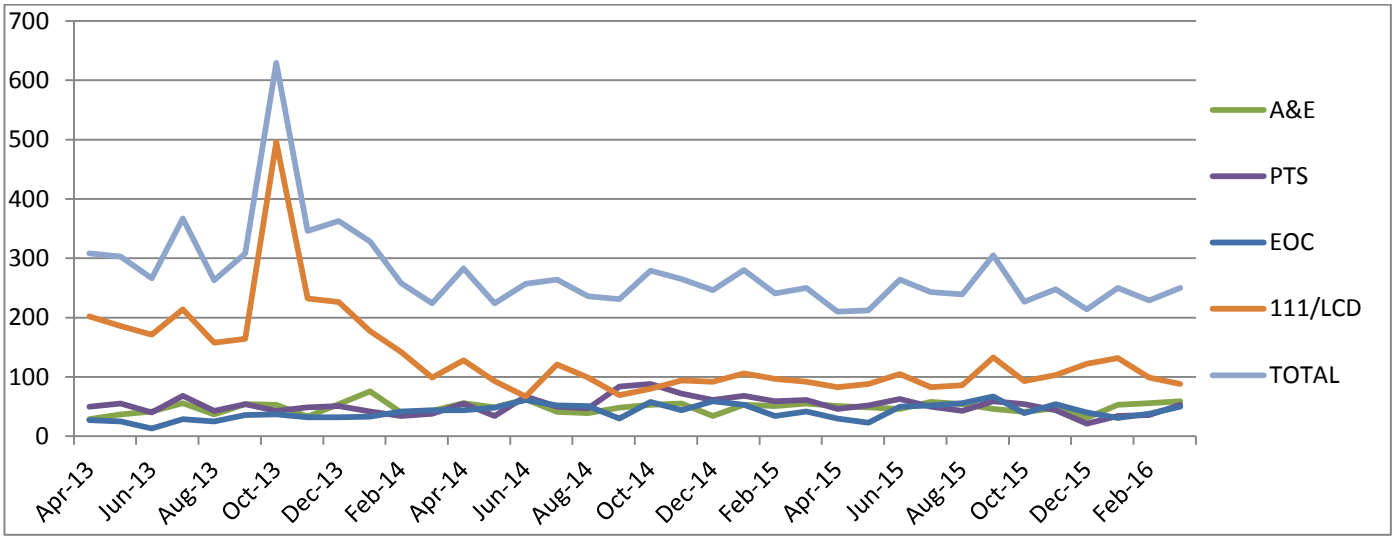
Compliments received				
	A&E	**PTS**	**111/LCD**	**TOTAL**
Total	**661**	**55**	**107**	**823**

3.3.4 Referrals to the Parliamentary and Health Service Ombudsman

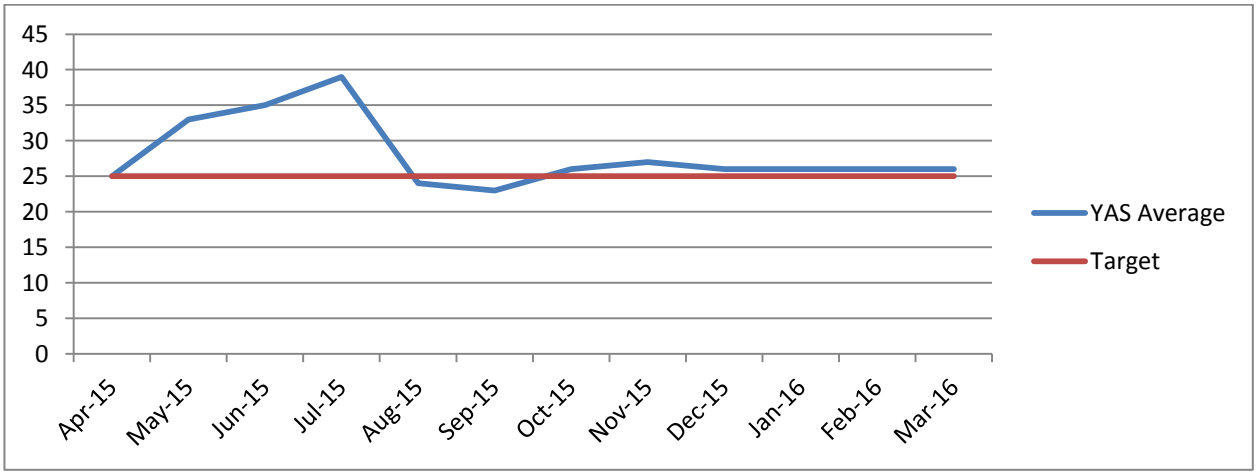
In 2015-16, 21 people referred their complaints to the Parliamentary and Health Services Ombudsman. Fourteen cases were closed with no further action, two were upheld or partly upheld and five remain ongoing.

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

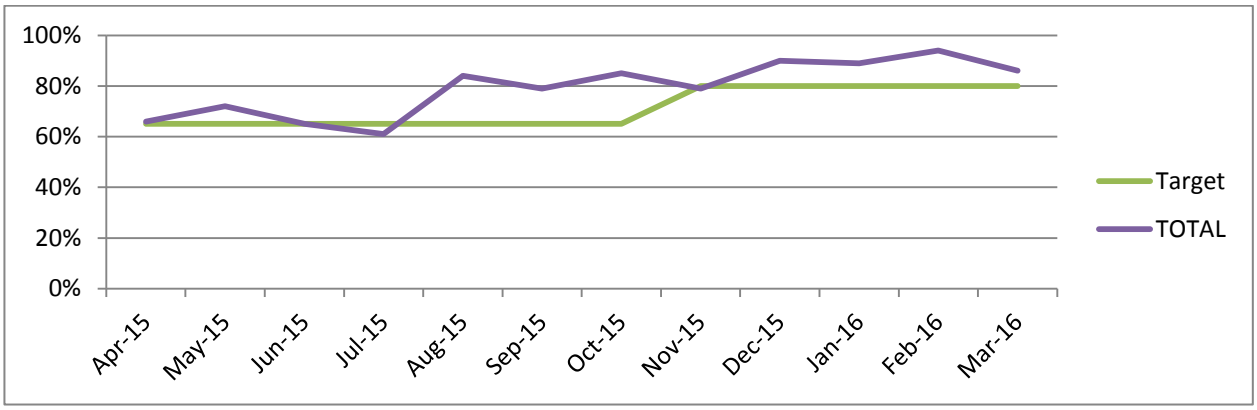
3.3.5 Number of Complaints Received 2013-16 (Trend)



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 (Q3 2015-16)

A&E/EOC complaints received/Activity

▪ SCAS	0.25%	WMAS	0.10%
▪ NEAS	0.21%	NWAS	0.09%
▪ EMAS	0.20%	SWAST	0.09%
▪ YAS	0.11%	EEAST	0.08%
▪ SECAmb	0.10%	LAS	0.06%

3.3.9 Developments for 2016-17 (Patient Relations)

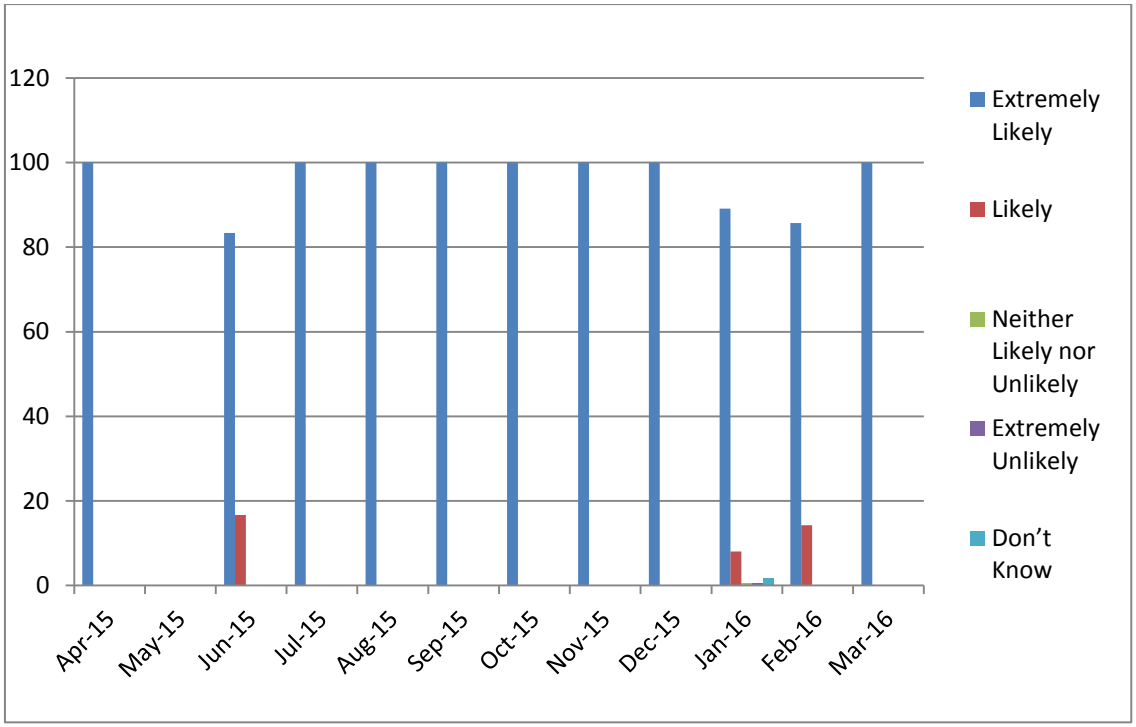
- Design and implementation of a case peer review process
- Work with Local Care Direct to streamline complaint handling in relation to the West Yorkshire Urgent Care Service.
- Implement the new Remedies and Redress Policy
- Act as a pilot Trust for the Department of Health's complainant satisfaction survey development
- Further improve the quality of individual compliant response

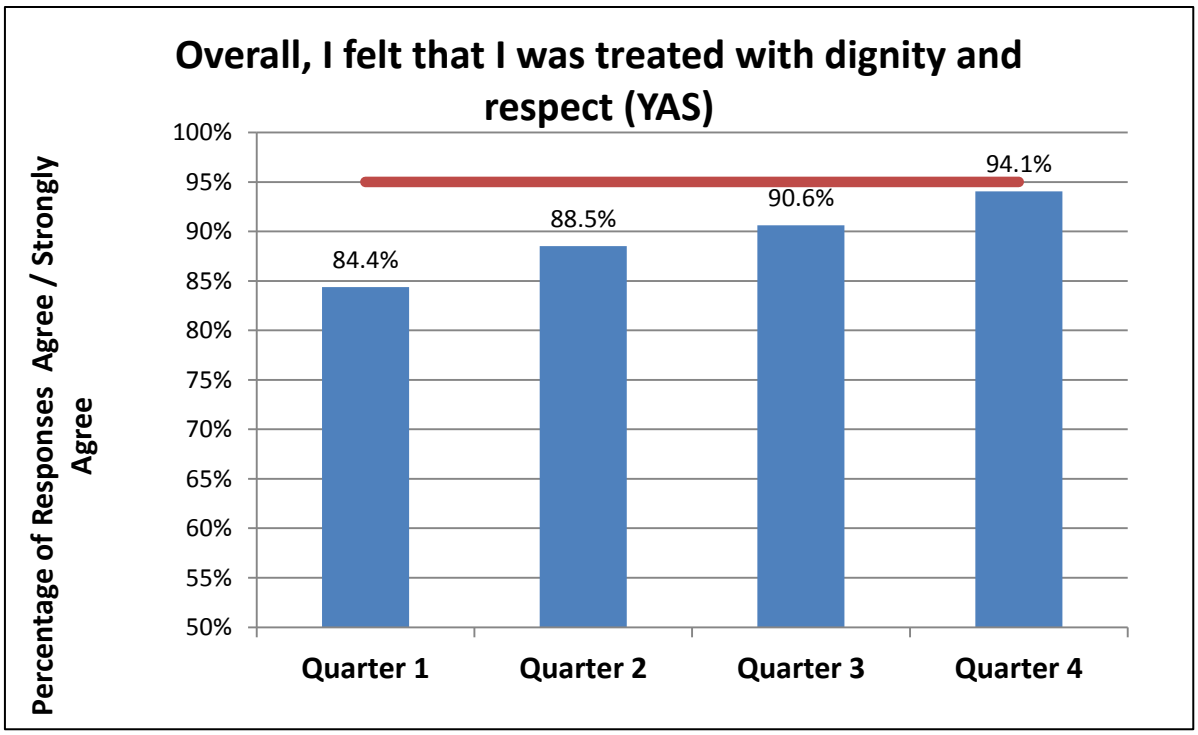
3.3.10 Patient Experience Surveys

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.

3.3.11 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?

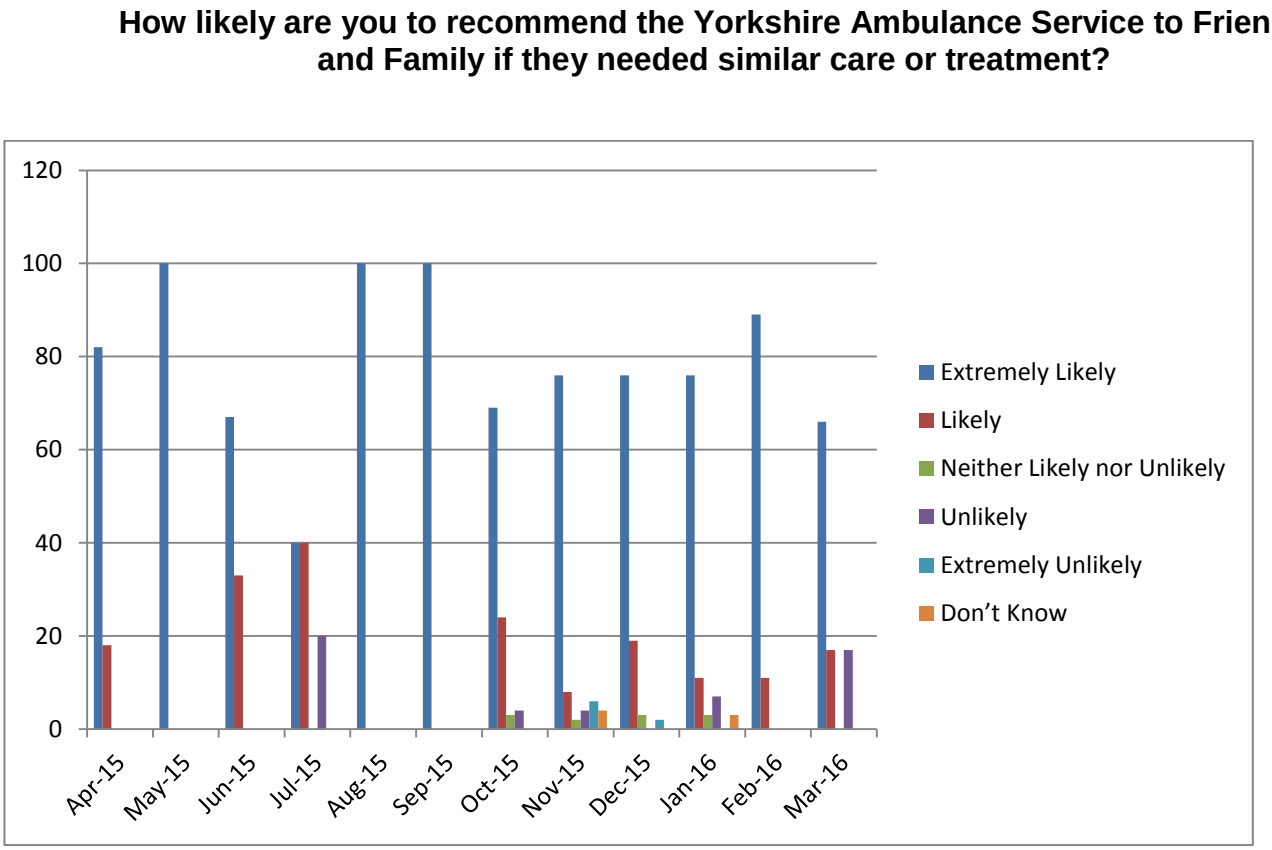




A&E: Themes and Trends from Narrative Feedback

- Service users acknowledge and appreciate the dignity and respect afforded to them during YAS care
- 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



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
- Some patients find the booking process difficult regarding the questions which are asked to check eligibility and sometimes experience difficulty getting through.

Patient Survey Narrative

I was in complete agony at the time so I unfortunately cannot remember the names of the first responder and 2 ambulance staff that came to attend me, but all 3 were fantastic, I cannot find one single fault with anything that they did. I would like to hope that I will never be in need of ringing 999 and getting an ambulance in to A+E ever again, but if it had to come to that, I would feel like I was in safe hands if the staff were 50% as good as the ones that dealt with me that evening.

My ambulance was re-routed on way to me, and then brought back later, meaning a wait time of over an hour. No explanation was ever given to me.

The Patient Transport Service overall is very good, the only thing I would like to mention is sometimes you are kept waiting a long time for your transport home. Sometimes I had to wait for 2½ hours but I understand you are very busy.

I do get a little fed up when booking an appointment to have to answer the third degree question on why you need to use PTS which resulted in slight row including my GP and almost my MP

The paramedic and ambulance crew were brilliant. I would really recommend these particular men for their care, respect and efficiency. Thank you.

Considering the financial pressure the NHS is under, I do not know how you managed to get a such a superb team of drivers, employers and volunteers alike. Using the transport system made my visit to St James for radio therapy trouble free. Thank you!

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.

A focus group has looked at initiatives to improve the communication skills of our Accident and Emergency staff and this work is ongoing into 2016-17. The way we process and feed back to staff from compliments we receive has been redesigned as part of this work to assist in changing culture.

Significant work on redesign of services is beginning to impact on the volume of complaints received in respect of Emergency Ambulance response times.

Work has commenced on several initiatives in the Patient Transport Service to improve timeliness and efficiency of the service. This includes implementation of auto-planning and review of specialist service resourcing and increased management capacity.

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

- Our Patient Transport Service requests that patients are ready to be collected 2 hours prior to their hospital appointment time. It was highlighted through a complaint that this was unreasonable for patients who have appointments schedules outside of core hours, i.e. the patient would need to be ready to be collected at 5.30 am for a 7.30am appointment. As a result of the complaint, in future such patients will be asked to be ready 1 hour in advance of their appointment.
- A complaint investigation found that a patient's journey to their hospital appointment had been aborted as a result of incorrect address details. As a result a new procedure has been introduced for better communication between drivers and Patient Transport Service Control to make contact with the relevant hospital department to attempt to clarify address details at the time where there is reason to suspect these are incorrect.
- An incorrect access code to a defibrillator was given to a 999 caller. As a result of this, the process around registering and auditing defibrillator details has been strengthened.
- A small number of complaints from people with Addisons disease, who feel that their condition is not appropriately considered when they require our emergency services, has led to discussions between YAS and the International Academy of Emergency Medical Dispatch who are looking to develop local protocols which will take into account this condition in how calls are handled and responded to.
- The West Yorkshire Urgent Care service reviewed its policy on closing calls following a complaint in which a call was prematurely closed.
- Following a complaint to NHS 111, in which a case of testicular torsion was missed, NHS Pathways have reviewed and changed the triage tool for acute scrotal pain.
- Following a number of complaints, improvements have been made to the comfort call processes of both NHS 111 and West Yorkshire Urgent Care.

3.3.13 Patient Stories

Throughout 2015-16, 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. Through discussion with patients and families what 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 2015-16:

- A lady who experienced problems taking her oxygen with her on our Patient Transport service to hospital appointments
- A lady with sepsis who had received an ambulance response following her husband's call to NHS 111
- A care home's experience of Ambulance staff's treatment of a patient with dementia

Learning for service improvements often arises from patient stories. In respect of the lady who experienced problems taking her oxygen with her on our Patient Transport, a new procedure was developed to enable this to be accommodated for all patients who need this in the future.

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

The Trust continues to work to the Duty of Candour; being open with patients and/or their families when something has gone wrong and moderate or above harm has been sustained. Since the review of the process in December 2015 which was implemented in January 2016 the Trust has seen an improvement in the engagement from patients and their families and positive feedback has been received; with specific feedback around the professionalism of the organisation in the management of these cases and an appreciation of the openness and honesty displayed by the Trust when things have gone wrong. The reviewed process included providing more information in initial contact and applying a flexible approach to the method of contact; both of which have been well received.

Monthly, quarterly, bi-annual and annual audits are also underway to ensure the system is robust in identifying the cases that meet the criteria of Duty of Candour and to ensure all of these have had a consistent approach applied.

These figures are reported within the Quality, Governance and Performance Assurance Directorate dashboard which is reviewed monthly. In Quarter 1 16-17 these audits have been returned 100% compliant each month which meets the KPI set for performance under Duty of Candour.

All cases are captured on the Datix system including any lessons learned from the Duty of Candour process which is reviewed to inform any amendments to the current ways of working.

3.3.16 Work Plan 2016-17

The Patient Experience and Patient Relations Work plan for 2016-17 is reflective of the Clinical Quality Strategy priorities and contract requirements. The work plan focuses on;

- Introduction of a complaint peer review process
- Maintaining and strengthening responses to 4Cs
- Developing a critical friend's network that would ensure integration of patient and public views in service developments across the organisation.
- Targeted engagement with specific patient groups
- Improving accessibility of information for patients

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 YAS 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 regional 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 Precautious Primary Coronary Angioplasty for STEMI (PPCI
- Maternity
- Referral to Hyper-acute stroke services
- Suspected Fractured Neck of Femur
- Major Trauma
- Vascular emergencies
- Gastric Intestinal (GI) emergencies

The monitoring of individual pathways is undertaken by the clinical manager (quality) supported by the information generated by; DATIX, service to service condition specific feedback, staff feedback and complaints. The clinical manager also reviews a number of outcome based pathways e.g. numbers of patients taken direct by YAS for PPCI. In 2015/16 00000 were reported as having PPCI of these YAS identified and transported (%) direct for specialist care.

In addition YAS has produced a guide to Urgent Care services across the region which includes; 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.

3.4.4 Clinical Quality Monitoring

All Ambulance services report against two sets of clinical quality standards. These are the Clinical Performance Indicators (CPI); approved by the National Ambulance Service Medical Directors (NASMeD) and 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.

YAS's objective for 2015-16 was to achieve improvement initiatives in all CPIs and ACQIs and this was achieved, the introduction of a new Patient Care Record PCR in 2015 aimed to support staff in the recording and collection of the CPI data.

The ACQIs are collected monthly producing national data the results, the CPI's are collected in 6 monthly cycles and support local initiatives to improve care. The data is collected from patient care records and shows how many patients received all the correct assessments and treatments for their condition. The full set of agreed actions that should be carried out for each patient with a particular condition is known as a care bundle.

CPIs include data for established and pilot care bundles. They are directed at providing a platform for each trust to identify local areas for clinical improvement with a national overview allowing comparison between services.

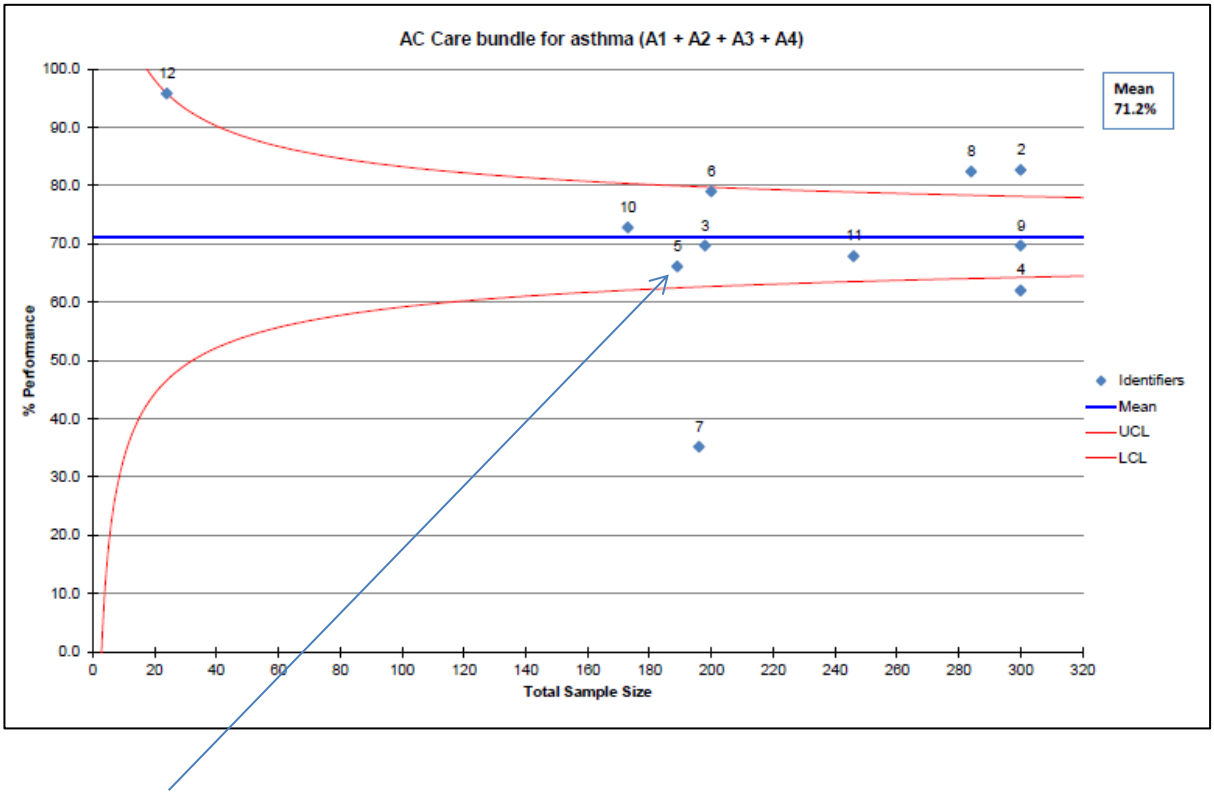
CPI cycles fifteen and sixteen were reported in 2015-16, a new pilot CPI for mental health explored deliberate self-harm.

- Asthma
- Single limb fracture (trauma)
- Febrile convulsion (paediatric care)
- Falls in older people (pilot 2)
- Mental Health - deliberate self-harm Pilot 1*

Asthma YAS CPI results

Asthma care bundle includes:

- A1 Respiratory rate recorded
- A2 Peak expiratory flow rate (PEFR) recorded (before treatment)
- A3 Oxygen saturation (SpO2) recorded (before treatment)
- A4 Beta-2 agonist recorded
- A5 Oxygen administered
- AC Care Bundle (A1+ A2 + A3 + A4)



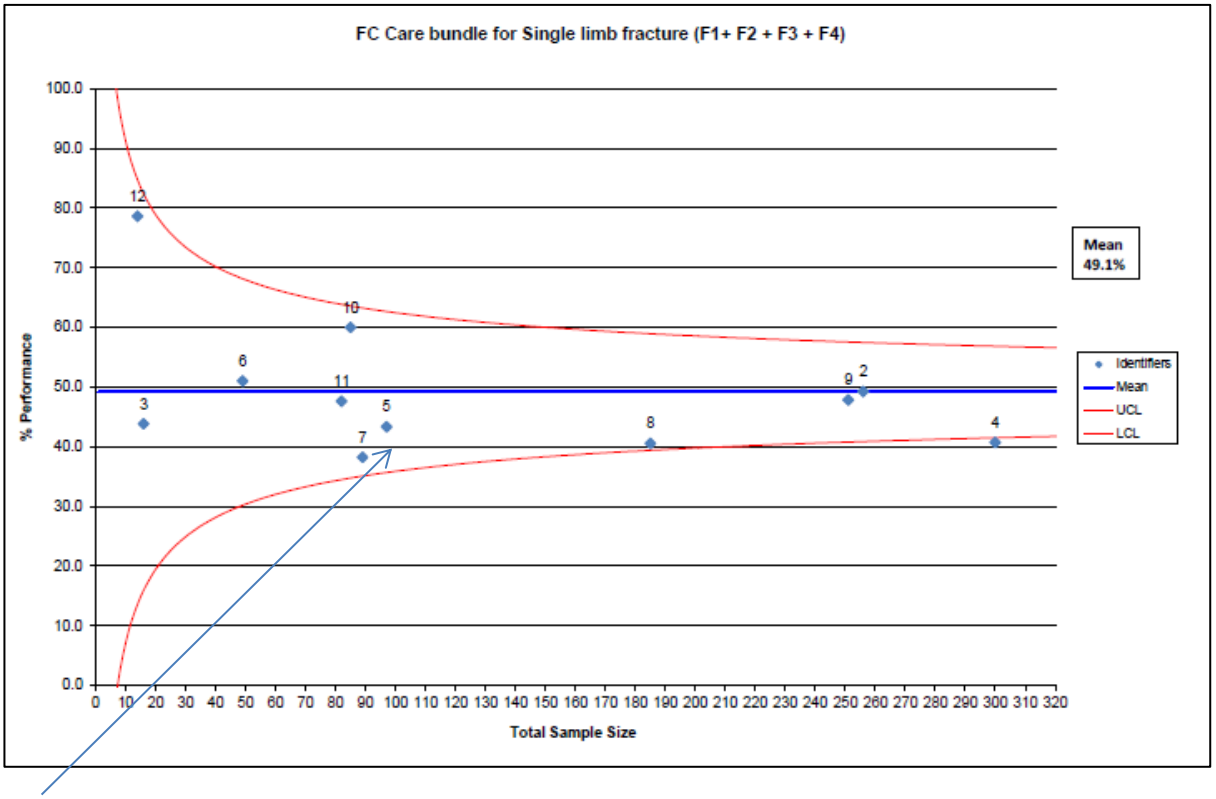
YAS = Trust number 5

YAS has sustained the individual indicators A1-A5 in this care bundle for the Asthma CPI. However the work to promote and improve the (A2) PEFR recording before treatment needs to continue. The measure of PEFR is important in the assessment of the severity of the condition prior to any intervention, it is used in the ongoing management of the patients providing essential information for medical teams regarding ongoing care e.g. admission or discharge home. The use of reminders, a new PCR design as well as posters and a review of training and education information will target this element of the care bundle. Clinical manager supports the local operational teams in making the improvements required.

Single Limb Fracture (Trauma) CPI results

Single Limb Fracture CPI consists of

- F1 Two pain scores recorded (before and after treatment)
- F2 Analgesia administered
- F3 Immobilisation of limb recorded
- F4 Assessment of circulation distal to fracture recorded
- FC Care Bundle (F1 + F2 + F3 + F4)



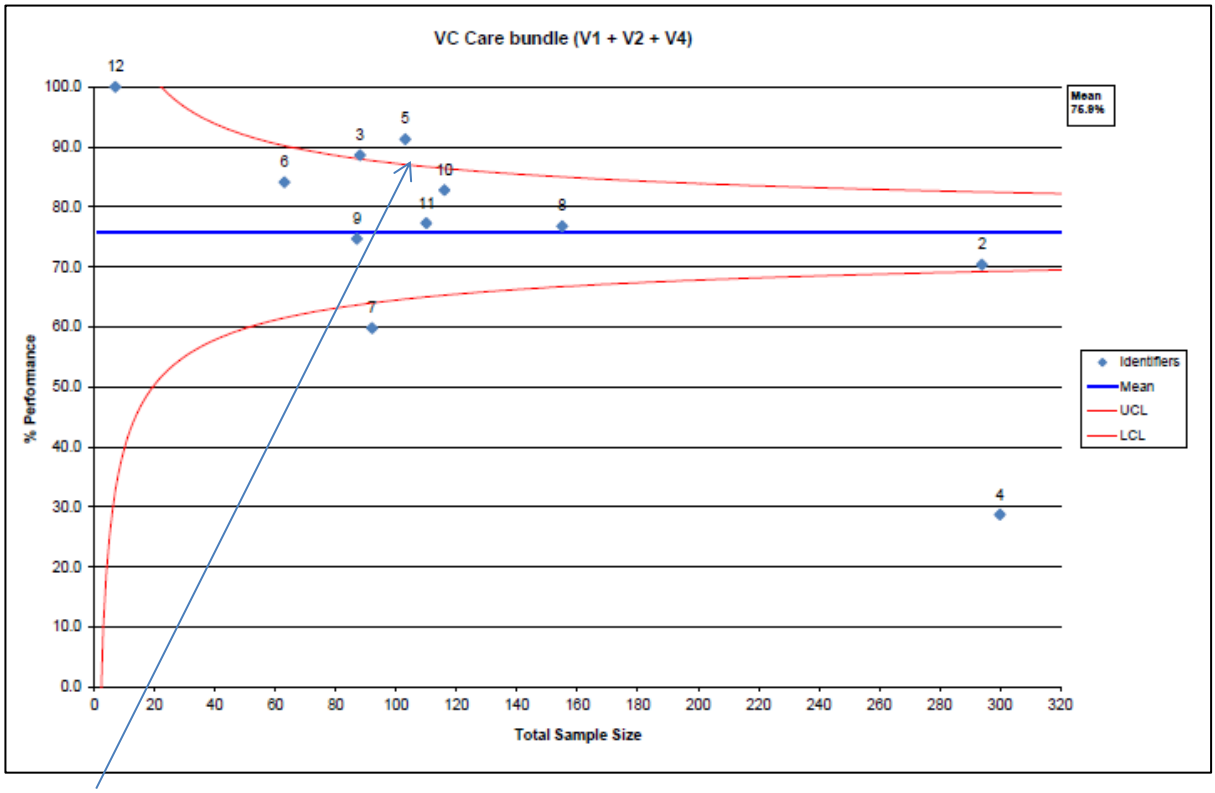
YAS = Trust number 5

Compliance to the Single limb fracture care bundle remained below the national average the documenting of splint use as well as two pain scores was an issue. These are important interventions to ensure the patient is comfortable and the injured limb is secure during transport. YAS are improving in all elements of this care bundle, with focused work on assessing, scoring and recording pain. The introduction of a new PCR also aids better completion as well as the capture of a larger sample size.

Febrile Convulsion CPI results

Febrile Convulsion CPI consists of;

- V1 Blood Glucose recorded
- V2 SpO2 recorded before oxygen administration
- V3 Administration of anticonvulsant if appropriate
- V4 Temperature management recorded
- V5 Appropriate discharge pathway recorded
- VC Care Bundle (V1 + V2 + V4)



YAS = Trust number 5

Trust compliance with this CPI remains high with YAS are the highest performing Trust this care bundle with CPD sessions and information from Q and A resulting in the excellent recording of all elements.

There are 2 pilot CPI

Elderly Falls CPI (pilot 2) the care bundle for falls in older people is made up of

- E1 Primary observations recorded
- E2 Recorded assessment of the cause of the fall
- E3 Recent history of falls documented
- E4 12 lead ECG assessment
- E5 Recorded assessment of mobility

- E6 Direct referral to an appropriate health professional

This pilot phase continues to support the process of data collection, the compliance nationally is poor these cycles are not refined enough to enable services to compare. However, YAS use the initial data to make and monitor improvements the results highlighted no single one element all elements require improvement. National discussion around the current care bundle is also progressing due to the number of exceptions reported by ambulance trusts.

Mental Health deliberate Self-Harm CPI (pilot1)

The care bundle for Mental Health: Self Harm is made up of seven criteria:

SH1 Mental state of patient recorded
SH2 Evidence of use of drugs and/or alcohol recorded
SH3 Exact nature of injury
SH4 Has a clinical assessment been completed?
SH5 History of events leading to today's self-harm episode recorded
SH6 Has there been an assessment of mental capacity?
SH7 Information relating to social/family support network or (NoK) recorded?

The aim of this care bundle is to focus on ensuring that those patients with deliberate self-harm have a fully documented assessment focused on presentation and family and social support. The first pilot aims to test data collection methods, YAS as part of the new paper PCR design was able to collect a number of elements electronically form verify. In addition a number of CPD sessions on the assessment of those with DSH and mental health problems supported this excellent result.

3.4.5 Ambulance Clinical Quality Indicators (ACQI)

The ACQIs are:

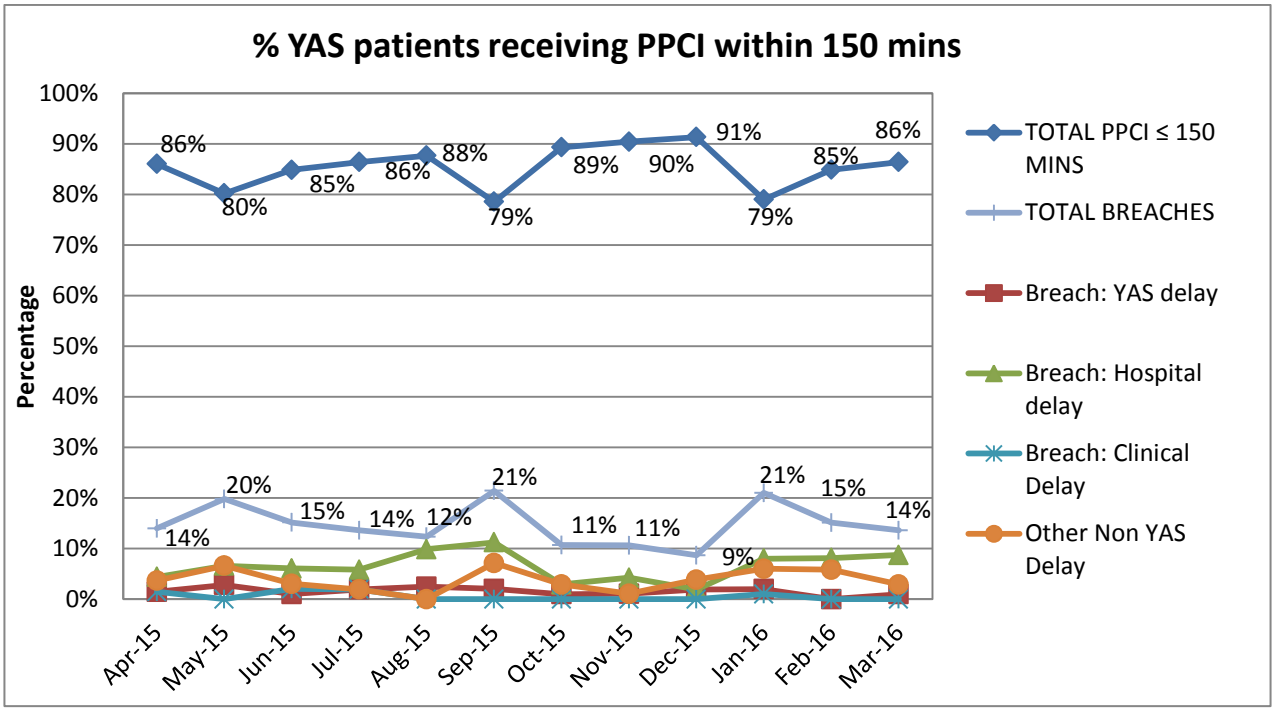
- Outcome from acute ST-Elevation Myocardial Infarction (STEMI)
- Outcome from cardiac arrest: return of spontaneous circulation (ROSC – Utstein group)
- Outcome from cardiac arrest: survival to discharge – (Utstein group)
- Outcome from acute stroke
- Stroke 60
- ST-Elevation Myocardial Infarction 150

The following graphs show YAS's performance against the four ACQIs compared to the national average for all ambulance services.

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

- Call for help to inflation of balloon (part of primary angioplasty procedure carried out in specialist hospital unit) time to be under 150 minutes.
- STEMI care bundle: aspirin administered, GTN administered, analgesia administered and two pain scores recorded (pre- and post- analgesia).

YAS has demonstrated an improvement across both indicators, with the STEMI care bundle increasing from 82.8% in 2013/14 83.5% in 2014/15. The STEMI 150 performance also remains high at 86.27% of STEMI patients referred direct by YAS to a heart centre. With 85.4% receiving PPCI within 150 minutes of calling 999 (see chart below).



The referral of patients with STEMI by our practitioners for PPCI is consistently high. However it is beyond our control when one or more centres have a capacity issue requiring the patient to be transferred to the local DGH. In addition patients who have had a cardiac arrest may also require advanced airway management, this is often not available at the cardiac centres. These factors can impact on the numbers taken by ambulance directly to PPCI.

Outcome from Cardiac Arrest: Return of Spontaneous Circulation (ROSC):

- Number of patients for whom ROSC is achieved compared to the number where cardiopulmonary resuscitation was commenced
- Number of patients in Utstein group (where ventricular fibrillation – VF, or ventricular tachycardia – VT is recorded) for whom ROSC is achieved compared to the number where cardiopulmonary resuscitation was commenced

Outcome from Cardiac Arrest: Survival to Discharge:

- The number of patients who survived to discharge from hospital compared to the number for whom resuscitation was attempted.
- The number of patient in the Utstein group (where ventricular fibrillation – VF, or ventricular tachycardia – VT is recorded) who survived to discharge from hospital compared to the number for whom resuscitation was attempted.

Outcome from Cardiac Arrest – Summary

	2014/15	2015/16
ROSC	22.9%	26.37%
ROSC Utstein	51.5%	57.14%
Survival to Discharge	10.6%	8.82%
STD Utstein	40.2%	37.05%

Please note this data is not directly comparable it will change as yearend full figures are not yet available

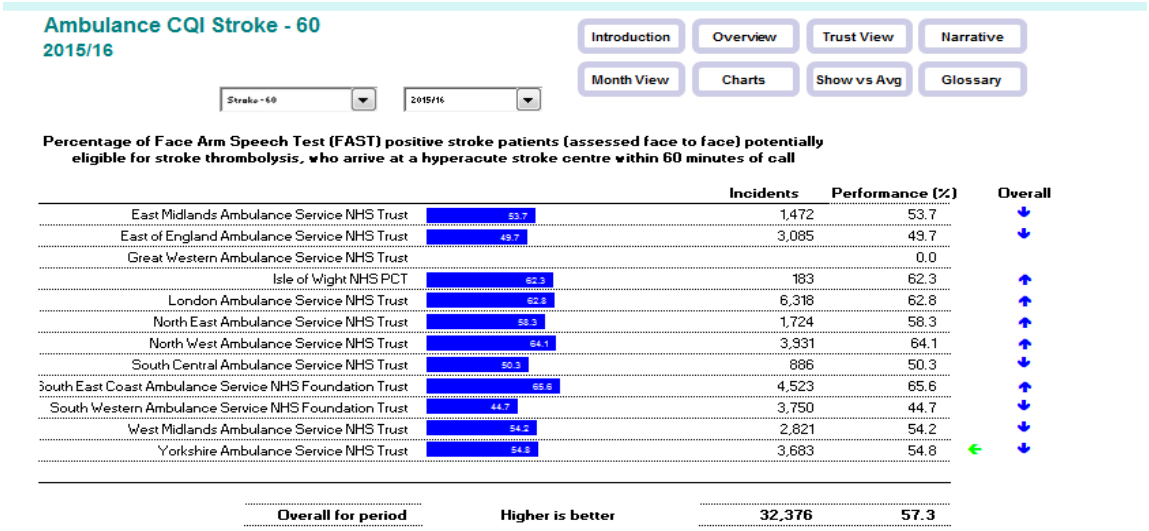
There have been improvements across all outcome indicators for cardiac arrest from last year. A great deal of work emphasising the benefits of early chest compressions (BLS) both to the public, restart a heart, with our call centres both 999 and 111 and our clinicians has delivered these life-saving achievements. Investing in the early identification of arrest as well as improving the skills and numbers of staff who attend a cardiac arrest is improving the patients likelihood of surviving a cardiac arrest out of hospital.

There have been improvements across all outcome indicators for cardiac arrest from last year.

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.

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. Only 12% of the population are legible, it is important that a late presentation is not the only factor in exclusion from the therapy group.



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 and 16 January 2015. All service areas of YAS were inspected, with the exception of NHS 111. The Trust commented on the factual accuracy of the draft report and received a final draft ahead of the Quality Summit. The report was published in September 2015 and implementation of the action plan continued throughout 2015-16

The publication of the report included the ratings as below:

	SAFE	EFFECTIVE	CARING	RESPONSIVE	WELL LED	OVERALL
Emergency and urgent care	**Requires improvement**	**Requires improvement**	**Good**	**Requires improvement**	**Requires improvement**	**Requires improvement**
PTS	**Requires improvement**	**Requires improvement**	**Good**	**Requires improvement**	**Requires improvement**	**Requires improvement**
EOC	**Requires improvement**	**Requires improvement**	**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**

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

The Trust must:

- Ensure all ambulances and equipment are appropriately cleaned and infection control procedures are followed
- Ensure that equipment and medical supplies are checked and fit for purpose
- All staff are up to date with their mandatory training

The Trust should:

- Ensure all staff receives an appraisal and are supported in their professional development. This must include support to maintain the skills and knowledge required for their job role.
- Ensure risk management and incident reporting processes are effectively embedded across all regions and the quality of identifying, reporting and learning from risks is consistent. The trust should also ensure staff are supported and encouraged to report incidents and providing feedback to staff on the outcomes of investigations.
- Ensure all ambulance stations are secure at all times.
- Review the provision and availability of equipment for use with bariatric patients and staff are trained to use the equipment.
- Review the safe management of medication to ensure that there is clear system for the storage and disposal of out of date medication. The trust should also ensure oxygen cylinders are securely stored at all times.
- Ensure records are securely stored at all times.
- Ensure consistent processes are in place for the servicing and maintenance of equipment and vehicle fleet.

- Ensure all staff have received training in the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.
- Ensure performance targets in relation to patient journey times and access to booking systems continue to be monitored and improve.
- There are appropriate translation services available for staff to use to meet the needs of people who use services.

The Trust was aware of most of the issues in advance of the inspection and in the majority of cases action was already underway to address these.

The action plan the address the key issues has been actively managed by the Trust Executive Group. A mock inspection to provide further objective assurance on progress since the 2015 inspection took place in May 2016, in anticipation of a formal re-inspection later in 2016.

4.2 Quality, Governance and Performance Assurance Directorate

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

The Quality, Governance and Performance Assurance Directorate redefined key roles and responsibilities and increased the support and expertise provided in areas including incident reporting, information governance and infection prevention and control.

The Directorate structure was also reviewed to accommodate a new performance assurance role from April 2016.

4.3 Quality reporting

Information about quality and safety is reported to Trust Board via the monthly Integrated Performance Report (IPR) and in locality dashboards. This provides 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 Trust Board and Quality Committee which has the lead committee role for scrutinising all aspects of quality and safety. Locality-level scrutiny of risk, safety and quality is via the five Locality Operational Management Groups and the Patient Transport Service management group.

4.4 Internal audit

During 2015-16 the YAS Internal Audit programme included a focus on key aspects of quality and safety. The results of internal audits carried out into aspects of risk, safety and clinical quality in 2015-16 were:

Audit subject	Outcome
Compliance with health and safety Requirements	Significant assurance
Risk Management Framework	Significant assurance
Clinical Quality Strategy	Significant assurance
IG TOOLKIT	Significant assurance
Health and Safety – Moving and Handling	Significant assurance
CQC Standards	Significant assurance
Quality Accounts and Strategy	Significant assurance

4.5 External scrutiny

An internal audit review of the effectiveness of the Board, Committees and Executive Management Groups was undertaken in 2015-16, using the national 'well led' framework. This identified a number of partial refinements to further strengthen quality reporting and performance assurance and these will be implemented in 2016-17.

The NHS Trust Development Agency (NHS TDA) visited the Trust in 2015 to review progress with the Infection Prevention and Control actions that were identified during the CQC inspection. Representatives from the NHS TDA deemed HART to be compliant with the Health Care Act with all actions recommended within the CQC inspection report completed. This team also reviewed the systems and processes utilised to ensure safe practice in relation to Infection Prevention and Control practices across the wider Trust and found positive assurance with these processes.

Section 6.0

Looking ahead to 2016-17

6.0 Looking Ahead to 2016-17

The 2016-17 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. These will continue to progress the delivery of Clinical Quality Strategy and high quality patient care.