Yorkshire Ambulance Service NHS
NHS Trust

An Aspirant Foundation Trust

# Risk, Safety and Clinical Quality Annual Report 2012-13

# 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 2012-13 – 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

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.

Risks can be identified on a daily basis throughout the Trust by any employee. In addition, risks are identified proactively by the Board and senior management team as part of the 5-year and annual business planning cycles.

YAS's systems of risk management for 2012-13 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 risk management, a number of specialist functions ensure the management of risk and safety in essential areas including Health and Safety, Information Governance 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* sets out Yorkshire Ambulance Service's (YAS's) approach to clinical quality. It focuses on the potential contribution of all YAS employees in delivering high quality care and supporting improvements in our services.

The strategy consists 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

A number of priority clinical and cultural issues were set as the priorities for 2012-13. These are areas where there is strong evidence to indicate that YAS can make a real difference to patient care.

# Section 2.0

# Risk and Safety

## 2.1 Risk Management

### 2.1.1 Delivery of work plan for 2012-13

The YAS Board Assurance Framework (BAF) documents the principal risks to YAS's strategic objectives. It records the details of the risk, the controls in place, the strength of those controls, any gaps in control and assurances on the controls. It is reviewed and updated on a monthly basis.

The YAS Corporate Risk Register (CRR) contains the detail of all extreme level business risks which have either escalated up from local business area and directorate level, or from gaps in control identified in the Board Assurance Framework.

The content of the BAF and CRR was extended to include risks with a consequence score of 4 (high) or 5 (catastrophic) in addition to risks rated 15 or above. This has strengthened our governance arrangements by bringing those risks considered to have a potentially high or catastrophic consequence, regardless of likelihood, to the attention of the Trust executive and the Board.

The Associate Director Risk & Safety continues to liaise with all executive directors on a quarterly basis to review the content of the risks for which they have lead responsibility.

Throughout 2012-13 the Trust Board and senior executive groups received risk and assurance reports providing them with an overview of current risks and information about changes to the risks themselves or the level of assurance. Heat maps were used as a tool to support clear understanding of the current situation.

The principal risks on the BAF and CRR were considered and reviewed at the Risk & Assurance Group, Trust Executive Group (TEG), and individually by Executive Directors.

### 2.1.2 Key achievements

One of the principal risks identified on the BAF in 2012-13 was: failure to learn from patient experience and adverse events due to inadequate data management systems for reporting and identifying learning opportunities.

During 2012-13 the Risk & Safety team successfully specified, procured and implemented a new incident management system to replace the existing PRISM system which was no longer fit for purpose. Datix was chosen as the new system, with specific modules for the management of risk, incidents and 4Cs (complaints, concerns, comments and compliments).

The new system was designed with input from operational staff and managers to ensure it could be used effectively in practice. Senior managers and those responsible for day to day complaints, incident and risk management were also closely involved to ensure that the data captured would provide effective management reports to support Trust governance systems.

The rollout process included training for all YAS staff on the new system.

### 2.1.3 Local risk management system

Key risks are identified and managed via the risk escalation and reporting procedure and captured on corporate or local risk registers as appropriate. Each risk is identified for action by the relevant directorate. For example the risk relating to use of safety harnesses on vehicles is being managed by the Operational Management Group and the Vehicle and Equipment Working Group with support from the Risk & Safety team.

It was identified that directorates and local business units needed to strengthen their arrangements for risk management, in particular the development and review of risk registers. Risk and Assurance Group members were tasked with actively engaging with the Risk & Safety team to complete a comprehensive review of local and directorate risk registers. The aim of the review was to ensure that current risk registers were in place for all directorates and within local business units and to identify existing good work at local level to take account of restructures within the Trust.

Staff and management changes meant that many of the nominated local risk leads had left the Trust or changed roles. A review of the nominated leads for each area was therefore undertaken. Where necessary new leads were identified and briefed on their responsibilities.

### 2.1.4 Looking ahead – priorities for 2013-14

The following priorities have been set for 2013-14:

- BAF maintenance. The April 2013-14 BAF identified 13 strategic risks. This was presented to the Audit Committee who agreed it provided effective assurance on the control of strategic risks.

- Recruitment to the key posts of Associate Director of Risk & Safety and Head of Safety.

- Development of Datix functionality. Datix will be rolled out to include the capture of risk registers. Those responsible for identifying and managing risks within corporate, PTS, A&E operations and NHS 111 will receive training from the Risk & Safety team.

- Management reports. A new reporting style has been developed and is being introduced to provide greater depth and clarity of information to support management and assurance functions. The new style has been widely welcomed at senior management and Board level.

- A mapping exercise has been completed to match information captured by Datix and the reporting fields required by the National Reporting and Learning

System (overseen by NHS England). The new mapping has been accepted and YAS data will be uploaded to the national database at least monthly.

- The Board and supporting committees have agreed changes to the Trust risk matrix which is used across risk and incident assessment. These changes will be introduced throughout 2013-14 and will increase the Trust risk appetite and ensure that higher level risks receive the proper attention and recognition.

- The documentation for serious incident investigation reports has been updated in line with guidance from NHS England. This has been introduced in 2012-13 and training sessions have been started and will continue for all staff who may be involved with, or may be asked to investigate an SI.

- Internal audit will carry out a risk maturity audit to give a baseline of the current position relating to the efficiency of current risk management arrangements across all levels of the Trust.

## 2.2 Information governance

YAS takes information governance very seriously, recognising the importance of reliable information, both in terms of the clinical management of individual patients and the efficient management of services and resources.

Information governance plays a key part in supporting clinical governance, service planning and performance management. It also gives assurance to the Trust and to individuals that information is dealt with legally, securely, efficiently and effectively, in order to deliver the best possible care and to meet the Trust's legal and good practice responsibilities.

The Senior Information Risk Owner during 2012-13 was Steve Page, Executive Director of Standards and Compliance.

The Caldicott Guardian during 2012-13 was Dr Alison Walker, Executive Medical Director.

### 2.2.1 Mandatory reporting

Serious incidents relating to information governance (assessed as Level 2 or above) must be reported to the Department of Health, Information Commissioner's Office and other regulators. This is done via a new electronic reporting tool which automatically assesses the severity level. The severity is assessed by the context, scale and sensitivity of the incident. In addition to mandatory reporting, information governance incidents are reporting within YAS through the Datix system and serious incidents are reported on the Strategic Executive Information System (STEIS).

YAS had no IG serious incidents in 2012-13.

The Trust did, however, have a small number of personal data-related incidents of a lower level of severity and these are shown in aggregate in the table below.

| Category | Nature of Incident | Total |
|---|---|---|
| V | Other | 1 |
| IV | Unauthorised disclosure | 1 |
| III | Insecure disposal of inadequately protected electronic equipment, devices or paper documents | 0 |
| II | Loss of inadequately protected electronic equipment, devices or paper documents from outside secured NHS premises | 2 |
| I | Loss of inadequately protected electronic equipment, devices or paper documents from secured NHS premises | 0 |

We take all incidents seriously and all incidents 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 to ensure that the organisation learns

from any incidents and puts supportive measures in place to prevent reoccurrence where required. All staff are encouraged to report incidents relating to the loss or disclosure of personal data.

### 2.2.3 Information Governance Toolkit

The IG Toolkit is a performance and improvement tool produced by the Department of Health (DH). It draws together the legal rules and central guidance and presents them in one place as a set of information governance requirements. The purpose of the assessment is to enable organisations to measure their compliance against the law and central guidance.

The IG Toolkit requirements include assessments to ensure that there are adequate skills, knowledge and experience within the organisation in relation to information quality and records management. It also ensures that there are procedures in place to ensure the accuracy of service-user information on all systems and in all records that support the provision of care.

Our attainment against the IG Toolkit assessment provides an indication of the quality of our data systems, standards and processes.

The Yorkshire Ambulance Service Information Governance (IG) Toolkit overall score for 2012-13 was 73% and was graded as satisfactory (green). This was an improvement on the 2011-12 score of 66%.

| **Initiative** | **Final Score End March 2013** | **Grade** |
|---|---|---|
| Information Governance Management | 86% | Satisfactory |
| Confidentiality and Data Protection Assurance | 70% | Satisfactory |
| Information Security Assurance | 71% | Satisfactory |
| Clinical Information Assurance | 75% | Satisfactory |
| Corporate Information Assurance | 66% | Satisfactory |
| **Overall** | **73%** | **Satisfactory** |

### 2.2.4 Delivery of 2012-13 workplan

An ambitious 2012-13 IG work plan was developed based on a risk assessment of YAS's current IG position and the requirements of the Department of Health's IG Toolkit.

Version 10 of the IG Toolkit was released in June 2012. This was assessed to identify the implications for YAS. There were no new requirements, however some additional information in the guidance and knowledge base sections was included.

East Coast Audit Consortium undertook an audit of 12 of the IG Toolkit requirements in November 2012. The audit reported significant assurance and the auditors agreed with the Trust's self-assessment of level 2 against all requirements audited.

All staff have responsibility for information governance and an ongoing, regular programme of staff communications was delivered to raise awareness of individual responsibilities and best practice. This builds on the annual information governance training which was provided for all staff through completion of a workbook. Trust-wide awareness-raising actions included regular information governance messages in the weekly Operational Update bulletin and via the Net-Consent system where staff receive messages when logging on to their computers.

The YAS Records Management Policy and Data Protection Policy were reviewed and updated.

Records for archived documents held by our records management storage company were checked and work done to ensure that records reaching the end of their required storage period were appropriately destroyed.

Spot checks were carried out to monitor staff practice against Trust policy. This included confidentiality audits and a staff questionnaire.

The Department of Health have enhanced their IG requirements for the Airwave digital radio system used by ambulance staff. YAS is continuing to work alongside other ambulance trusts to meet these new requirements.

### 2.2.5 Key achievements

The understanding and attention to information governance across YAS achieved a step change in 2012-13 under the leadership of the information governance manager appointed in July 2012.

An information governance working group was introduced and meets regularly. Membership includes the information asset owners (IAOs) who have formal responsibility for the management of Trust data systems. This group is responsible for managing IG-related risks at an operational level and help and support to the operational implementation of organisation-wide IG Toolkit requirements. The IG Work Plan is monitored by the IG Working Group.

The role of IAOs in managing information risk is essential and a workshop was held to build the knowledge understanding of nominated IAOs of the requirements of the role. Key objectives for IAOs focused on mapping and risk assessing transfers of personal data within YAS and to outside organisations. The need to strengthen the security of a number of transfers was identified and implementation plans were agreed.

### 2.2.6 Key risks

There are currently eight open information governance risks on the YAS risk register. All have established treatment plans or treatment plans are in development.

Two risks relate to failure to meet the 35 IG Toolkit requirements. Four risks relate to failure to adhere to records management standards, legal requirements and best practice. Two risks relate to confidential information in transit, paper based and electronic via email.

Treatment plans are in place for all these risks and work to strengthen controls continues through the information governance work programme for 2012-13.

### 2.2.7 Looking ahead – priorities for 2013-14

The IG Work Plan for 2013/14 was approved by the YAS Senior Management Group in March 2013.

The new IG Toolkit Version 11 has been released and work is currently on-going to maintain and improve the Trust's position. The aim is to move from compliance level 2 to compliance level 3 for as many requirements as possible by the end of March 2014. East Coast Internal Audit Consortium have been commissioned to provide assurance on our self-assessed scores for 2013-14.

Other key priorities are:

- strengthening and delivery of treatment plans relating to IG risks on the IG risk register
- ongoing review of IG policies, in particular to develop supporting guidance and communications to staff to aid implementation of policy
- continuing the programme of quarterly IAO information risk reviews
- supporting IAOs to develop and update mapping and risk assessment of person identifiable data flows.

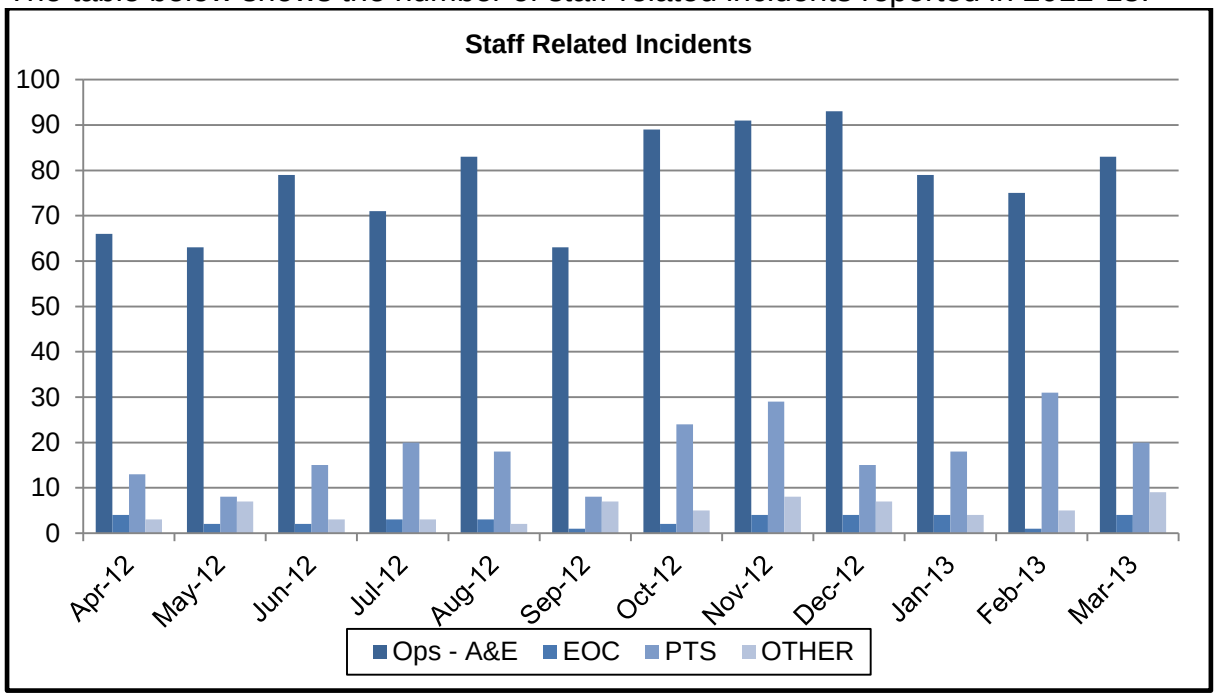
## 2.3 Health and safety

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

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

### 2.3.1 Incident reporting

The table below shows the number of staff-related incidents reported in 2012-13.




Health & Safety related incidents that fall into certain categories are required to be reported to the Health and Safety Executive under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR). The numbers of incidents reported under the RIDDOR requirements are shown in the table overleaf.

**Incidents reported in 2012-13 under RIDDOR**

| Incident Type | Apr 12 | May 12 | Jun 12 | Jul 12 | Aug 12 | Sep 12 | Oct 12 | Nov 12 | Dec 12 | Jan 13 | Feb 13 | Mar 13 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Hit by a moving, flying or falling object | 0 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 |
| Hit by something fixed or stationary | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 0 | 0 | 0 | 0 | 0 |
| Injured while handling, lifting or carrying | 3 | 0 | 1 | 3 | 1 | 1 | 2 | 4 | 4 | 2 | 3 | 1 |
| Slip, trip or fall on the same level | 1 | 1 | 0 | 1 | 2 | 1 | 1 | 2 | 3 | 2 | 0 | 1 |
| Fall from a height | 0 | 0 | 0 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Exposed to or in contact with a harmful substance | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 |
| Physically assaulted by a person | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 |
| Another kind of accident | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 1 | 1 | 0 | 0 |
| Total | **9** | **7** | **4** | **1** | **7** | **4** | **4** | **6** | **8** | **6** | **4** | **3** |

These figures show that the greatest harm to staff is 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 2012-13 workplan included focused work on moving and handling.

### 2.3.2 Delivery of work plan for 2012-13

### RIDDOR Reporting

The Risk & Safety Team undertook a comprehensive review of the *Incident and Serious Incident Reporting Policy*. This specifically included the process for reporting RIDDOR incidents. The review has resulted in improved and streamlined internal reporting processes to enable YAS to report consistently within the specified timescales.

### Health & Safety Training

Training materials and provision were reviewed for new starters, existing staff and managers. The health, safety and risk topics, including health & safety in the workplace, fire safety and prevention, waste management and safer manual handling which are included in the YAS statutory and mandatory workbook are a key route for reaching all staff.

On a three year rotational basis all operational staff receive tutor-led moving and handling and conflict resolution training programmes. Our achievement for 2012-13

was 81% of staff being up to date with moving and handling training and 86% being up to date for conflict resolution. This exceeded our target for conflict resolution training within our training needs analysis of 85%.

## Moving and Handling – Bariatric Patients

A review was undertaken during 2012-13 to consider the provision of transport for bariatric patients. The review considered the movement of bariatric patients from their home or location of an incident to the ambulance and discharge into the receiving healthcare facility. At the end of 2012-13 YAS had has 112 vehicles with the capability of transporting bariatric patients, and an additional five incident support vehicles with the ability to transport specialist equipment to both pre-planned and emergency incidents involving bariatric patients. The group started to develop a deployment plan for the incident support vehicles and this work is still underway.

In 2011 the Health & Safety Committee established a working group to review the current carry chairs used by the Trust.

In February 2012 controlled trials were undertaken at Doncaster Training school and the Ferno Compact 2 Track carry chair was put forward for consideration. The chair was then put out for trial in an operational environment. A decision to purchase the chair was made in October 2012 and funding is incorporated into the 2013/2014 capital plan. All newly purchased A&E and PTS vehicle now come with the new track chair.

## Equipment Bags

Work with Loughborough University and a number of equipment bag manufacturers, to design and develop a purpose made equipment bag has now been completed. The aim of the review was to provide staff with equipment bags that are lighter and more ergonomic than the current issue.

A procurement process for the bag was started in December 2012 and two bags were selected for operational trials. The trials finished on 15 February 2013. The new bag will be introduced across the Trust in 2013-14.

## Stress Management & Employee Wellbeing

YAS recognises that the management of stress is integral to our responsibility for the physical, mental health and wellbeing of our employees at work. During 2012-13 we:

- Reviewed and developed of a range of health and welfare-related procedural documents working with the Directorate of Workforce and Strategy.

- Established a Workplace Health Group. This is a staff welfare group with a focus on stress management, musculo-skeletal injuries and providing information. This group developed a stress action plan which was accepted by our Health & Safety Executive (HSE) Inspector, who confirmed that she was satisfied with the arrangements in place.

- The Trust carries out an annual stress survey, in accordance with the process suggested by the HSE. The survey is designed to assess the levels of stress in the Trust and to drill down into the root causes of stress.

### Occupational Health

Occupational health providers assess staff members who may be suffering from illness caused by harmful stress at work. The Health and Safety Manager formed closer links with the YAS occupational health providers, further to a recommendation from our HSE inspector, and attends their quarterly meetings.

### Health Surveillance and Hand-Arm Vibration

The Health & Safety Manager completed a comprehensive review of the health surveillance processes for Fleet staff. The aim of the review was to make health surveillance more specific to individual roles and duly consider the various levels of exposure to hazards.

A task and finish group was established to identify the specific requirements for the Fleet Department and to establish a consistent approach to health surveillance across the Trust. The group produced an action plan addressing the four main health hazards to which Fleet staff are exposed:

- Vibration
- Noise
- Hazardous substances – solids
- Hazardous substances – airborne.

This included completion of hand-arm risk assessments for each member of Fleet staff using power tools.

The issue of health surveillance for the Fleet Department and specifically the lack of HAVS risk assessments were raised as a query by the HSE Inspector in 2011. During 2012 our inspector confirmed that she was satisfied with the Trust's work and progress on this issue.

### 2.3.3 Key risks

A full review of health and safety premise inspections and risk assessments was undertaken and found to require improvement.

Managers working with the Risk & Safety Team conduct a significant number of risk assessments however a consistent process of planned proactive risk assessments is not yet fully embedded across the Trust.

There were limitations in the reporting functionality of the PRISM data management system relating to the recording and reporting of health and safety information. The new Datix system will allow for the capture and reporting of more reliable health and safety statistics.

At the August 2012 H&S Committee a risk was raised regarding the work of union health and safety representatives and non-compliance with the Safety Representatives and Safety Committee Regulations 1977. A number of representatives were finding it difficult to gain release to attend health and safety meetings and carry out their role effectively. Union representatives for each operational CBU have now been nominated and meet on a monthly basis with the Risk and Safety Team to discuss issues.

### 2.3.4 Looking ahead – priorities for 2013-14

A new inspection programme for 2013-14 has been designed and is being introduced – known as Inspections for Improvement. This combines previous assessments for compliance with individual quality and safety requirements into one process.

A team of YAS staff carry out the inspections following a specially designed risk assessment workbook. Each team includes a management lead, support staff and an operational/clinical representative. The workbook ensures that the checks carried out monitor compliance with Care Quality Commission standards, health and safety, information governance and security requirements. A schedule of visits has been agreed for 2013-14. After each visit feedback and any necessary actions are communicated to the relevant management team and an analysis of themes and issues from the inspection programme will be reported to the Health and Safety Committee.

Other priorities include:

- Further review and development of health and safety training for staff and managers
- Develop a standardised risk assessment process, building on learning from existing areas of best practice within YAS.

## 2.4 Security

### 2.4.1 Delivery of work plan for 2012-13

Ambulance services face a particular security challenge due to the need to operate a large number of small sites, many of which may be unstaffed for periods of the day, and where access and egress must be achieved quickly.

A key objective for the year was to develop a five year plan to improve access control and use of CCTV on Trust sites. All the proposed security improvements within this five year plan will link to the Estates Management Plan and will be supported through the work plan for the YAS Local Security Management Specialists (LSMS).

At the end of 2012-13 22 ambulance stations and nine strategic premises across YAS had lockdown procedures in place with full access control and CCTV.

110 frontline A&E vehicles currently have CCTV systems installed that record continually in the cab of the vehicle (road facing). Staff can also activate the camera within the saloon of the vehicle to start recording if they are concerned about their personal safety. Saloon cameras only record when activated. CCTV footage can be requested by the police or other agencies following incidents involving our vehicles. Under the Trust procedure for the retrieval of CCTV data, only an accredited LSMS can collect, download and view images from the encrypted data files.

### 2.4.2 Security incidents – reporting and action taken

The following numbers of security incidents were reported in 2012-13:

| Incident type | Number |
|---|---|
| Physical assault on staff by patient/relative or public | 59 |
| Threats of physical violence and verbal abuse by patient/relative or public | 122 |
| Thefts of trust property | 32 |
| Incidents of criminal damage to trust property ie vehicles, equipment and premises | 10 |

NHS trusts are required to report incidents of violence, abuse and thefts of trust property to NHS Protect, the national agency responsible for protecting NHS staff and resources from crime.

YAS reported 355 security incidents to NHS Protect via the Security Incident Reporting System (SIRS) form for 2012-13.

### Prosecution of offenders

YAS has a policy of zero tolerance relating to anyone who is violent or abusive towards a member of staff.

The LSMS contacts members of staff reporting an incident of physical or verbal abuse either direct or through their manager and offers them advice and guidance on what action can be taken. This approach has resulted in outcomes including custodial sentences, community orders, fines and cautions.

### 2.4.3 Key risks

The current policies and processes relating to security and the retrieval of CCTV data require review.

### 2.4.4 Looking ahead – priorities for 2013-14

There will be a focus on security management training, particularly seeking to reach any clinical supervisors who were not trained in 2012-13. Particular attention will be paid to the implementation of a new directive from NHS Protect relating to the delivery of Conflict Resolution Training. The YAS education department have reviewed current provision against the new directive and confirmed that current provision meets the new requirements in terms of content and contact time.

The LSMS will continue to contribute to the Inspections for Improvement process to ensure that any security risks are identified, escalated as necessary and that mitigation plans are put in place.

Development of Policies will continue to ensure that they are concise and are not overly constraining with particular emphasis on Security and retrieval of CCTV data cards from vehicles.

The process of reporting security incidents is now via a new electronic system, the Security Incident Reporting System (SIRS). Manual upload to this system was a time consuming process for the LSMS so the new YAS Datix system has been designed to allow automatic production of SIRS reports for checking and monthly upload. YAS is one of only 11 NHS trusts (three of which are ambulance trusts) that have embedded this reporting system within Datix.

## 2.5 Infection prevention and control

### 2.5.1 Report from the Director of Infection Prevention Control

In 2012-13 the YAS Director of Infection Prevention and Control was 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 Essential Standards of Quality & Safety. This means 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 good hand-washing techniques and carry alcohol gel bottles on their person.

**Vehicle cleanliness**: vehicles should be clean inside and out and any damage to stretchers or upholstery reported and repaired.

**Vehicle deep cleaning**: vehicles should receive regular deep cleans in accordance with the agreed deep cleaning schedule.

**Premises cleanliness**: stations and other sites should be clean and have appropriate cleaning materials available and stored appropriately.

### 2.5.2 Delivery of work plan for 2012-13

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

The seven work plan high level priorities for 2012-13 were to:

- remain compliant with the Care Quality Commission standards and the Health & Social Care Act (2008)
- effectively manage the risks associated with IPC across the Trust
- review, develop and approve YAS IPC procedural documents
- complete a programme of audits to meet the requirements of the Health & Social Care Act (2008)
- manage and facilitate a range of education and development initiatives
- maintain and improve the IPC resources necessary to meet the requirements of the Health & Social Care Act (2008).

### 2.5.3 Compliance with CQC standards

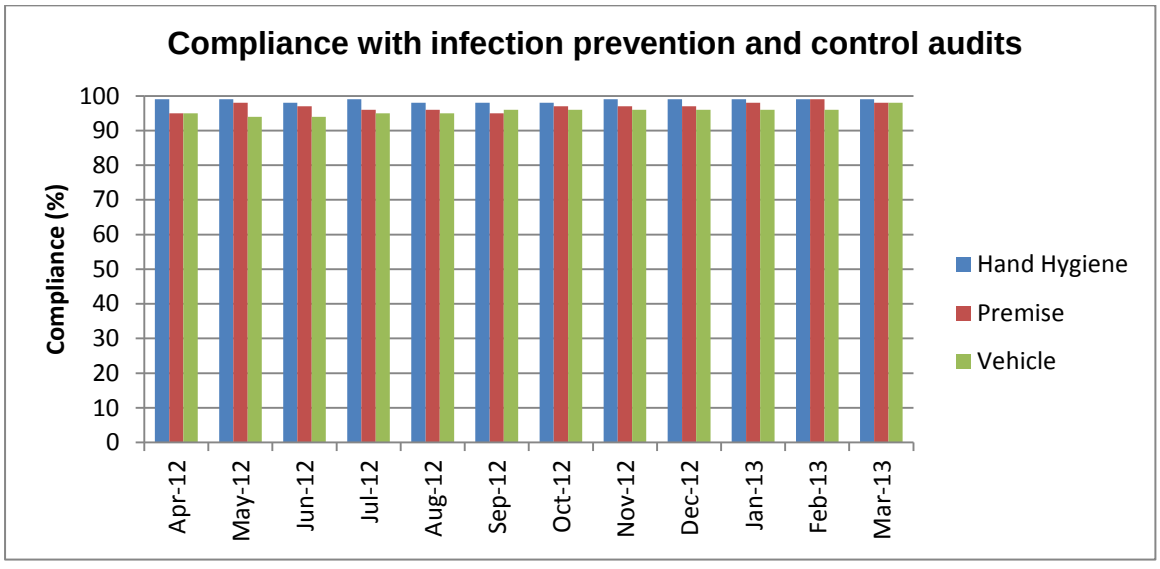
During 2012-13 YAS maintained compliance with the requirements of the *CQC Essential Standards of Quality & Safety* – outcome 8: cleanliness and infection control.

### 2.5.4 IPC audit

The clinical audits for hand hygiene, vehicle cleanliness and estates were carried out monthly in each clinical business unit and are reported to the Trust Board monthly via the Integrated Performance Report. Audit compliance across all areas has improved over the year, with the majority of business and practice areas achieving compliance. Where areas were found to be non-compliant targeted action was taken by the YAS IPC nurse.

The methodological approach of observational audit by the YAS IPC nurse meant that any issues could be addressed in real-time. In addition to this, objective assurance was gained through premises inspections. There is growing evidence that IPC audits are communicated through to station level and are visible on notice boards. The inspection teams have also observed an improvement in general housekeeping issues. Examples include the appropriate storage of clean linen, better stock control of consumables and the availability of hand gels for individuals.

**IPC Audit Results 2012-13**



### 2.5.5 Vehicle deep cleaning

All YAS operational vehicles should receive regular deep cleans in accordance with the agreed deep cleaning schedule – this is a maximum of 35 days. Our target is to achieve 95% compliance with the agreed schedule. This was achieved for every month in 2012-13.

| Month | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | **Total** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **% vehicles deep cleaned within scheduled period** | 97.26 | 98.40 | 97.80 | 98.30 | 97.00 | 95.90 | 97.20 | 97.10 | 97.20 | 95.20 | 97.40 | 97.20 | **97.16** |

### 2.5.5 IPC training

The proportion of YAS staff compliant with IP&C training continued to increase in 2012-13 and at year end was at 92%.

IP&C training is provided at the time of appointment to the Trust through corporate and local induction. Refresher training is provided either through a statutory and mandatory workbook or through two-yearly tutor-led programmes for operational staff. The content of the supporting training materials was updated during 2012-13.

### 2.5.6 Occupational exposure

Occupational exposure incidents and near misses continued to be reviewed by the Risk and Safety team prior to allocation to a local manager for action. In the event of an IPC issue, the Infection Prevention & Control Nurse was informed to review and offer advice to the individual affected and the manager assigned to resolve the incident. Where an incident was identified as an occupational exposure incident the member of staff was advised to attend an occupational health appointment for assessment and to arrange any further support required.

### 2.5.7 Key risks

A consistent finding from IPC audits was the need to repair damage to upholstery, predominantly in PTS vehicles. Work is ongoing in the PTS and Fleet departments to ensure that upholstery repairs are made.

There is a risk that good practice standards for uniform use of disposable gloves are not being followed in practice, e.g. wearing rings, bracelets. IPC good practice reminders have been publicised through the weekly Operational Update staff bulletin throughout the year.

There is work required with colleagues in acute hospitals to ensure that staff who are subject to an occupational health exposure receive appropriate support. A blood sample is taken from both the member of staff and the patient but YAS is experiencing difficulty in some areas to retrieve the patient's blood results. Work is

ongoing with occupational health to develop the process, including arrangements for obtaining patient consent, for YAS to routinely have access to blood results.

### 2.5.8 Next steps for 2013-14

A restructure in the Standards and Compliance Directorate has incorporated the role of IPC nurse into the responsibilities of the Head of Safety.

The Head of Safety started in post in July 2013 with initial priorities of updating the 2013-14 IPC work plan to take into account recent recommendations relating to occupational health and reviewing all IPC policies and procedures.

The new 2013-14 workplan includes:

- reviewing existing Trust processes for IPC audit, including hand hygiene, premises cleanliness, vehicle cleanliness and canulation
- reviewing the procedure for deep cleaning vehicles and the assessment of this process via the Inspections for Improvement programme
- review information for staff on the Trust intranet and public information on the Trust website
- reviewing IPC training for all YAS staff and contractors
- developing arrangements with the YAS Occupational Health providers to ensure IPC is advice 24 hours a day, seven days a week
- reviewing all YAS IPC procedural documents to ensure that they are clear and accessible to frontline staff
- benchmarking YAS IPC systems and processes with other ambulance services.

# Section 3.0
# Clinical Quality

## 3.1 Patient Safety

### 3.1.1 Incident reporting

Yorkshire Ambulance Service encourages staff to report patient safety incidents. During 2012-13 we have aimed to increase the numbers of incidents reported whilst seeing a reduction in the numbers of incidents resulting in severe harm or death.

Staff are encouraged to report all incidents, 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.

Operational managers have been supported to investigate and resolve issues occurring in their local areas and escalate when serious issues have arisen.

The Incident Review Group, chaired by an executive 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 the same things happening again.

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.

### 3.1.2 Number of Adverse Incidents for 2012-13

| New incidents reported | Apr 12 | May 12 | Jun 12 | Jul 12 | Aug 12 | Sep 12 | Oct 12 | Nov 12 | Dec 12 | Jan 13 | Feb 13 | Mar 13 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **A&E Operations** | 319 | 360 | 365 | 373 | 332 | 337 | 378 | 342 | 357 | 335 | 319 | 325 |
| **Emergency Operations Centres** | 30 | 28 | 23 | 52 | 48 | 30 | 36 | 30 | 46 | 40 | 13 | 18 |
| **Patient Transport Service** | 66 | 79 | 67 | 72 | 69 | 50 | 69 | 69 | 61 | 71 | 96 | 72 |
| **Other** | 17 | 24 | 13 | 21 | 35 | 17 | 14 | 15 | 18 | 19 | 16 | 30 |
| **Total** | **432** | **491** | **468** | **518** | **484** | **434** | **497** | **456** | **482** | **465** | **444** | **445** |

These figures equate to:

- one adverse incident relating to A&E operations reported for every 189 emergency incidents
- one adverse incident relating to the Emergency Operations Centre reported for every 1,818 emergency incidents
- one adverse incident relating to PTS reported for every 2,760 patient journeys.

### 3.1.3 Adverse Incidents Relating to Patient Care

| Patient-related incidents | Apr 12 | May 12 | Jun 12 | Jul 12 | Aug 12 | Sep 12 | Oct 12 | Nov 12 | Dec 12 | Jan 13 | Feb 13 | Mar 13 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **A&E Operations** | 29 | 47 | 38 | 34 | 31 | 56 | 44 | 48 | 40 | 54 | 35 | 54 |
| **Emergency Operations Centres** | 0 | 0 | 1 | 1 | 0 | 0 | 1 | 1 | 3 | 2 | 2 | 7 |
| **Patient Transport Service** | 22 | 30 | 29 | 27 | 24 | 18 | 17 | 14 | 24 | 22 | 21 | 21 |
| **Other** | 1 | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 1 | 1 | 1 | 2 |
| **Total** | **52** | **78** | **68** | **63** | **55** | **74** | **62** | **63** | **68** | **79** | **59** | **84** |

The unpredictable nature of the work carried out by A&E operations staff and the difficult circumstances in which they sometimes provide care means that a higher number of incidents have occurred in this area. A significant number of these incidents relate to care pathways or care planning issues. YAS have worked in partnership with our commissioners, acute, community and social care providers to minimise these incidents.

Within PTS the highest numbers of incidents relate to slips, trips, falls and injuries sustained whilst being transported on a vehicle. We has analysed these incidents, through our Patient Safety Thermometer tool, to understand more about the causes of harm to patients and put in place actions which will minimise this harm.

### 3.1.4 Serious Incidents

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. These are the main categories, but there may also be other causes.

| Serious incidents | Apr 12 | May 12 | Jun 12 | Jul 12 | Aug 12 | Sep 12 | Oct 12 | Nov 12 | Dec 12 | Jan 13 | Feb 13 | Mar 13 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **A&E Operations** | 1 | 0 | 0 | 1 | 0 | 0 | 1 | 1 | 3 | 2 | 4 | 1 |
| **Emergency Operations Centres** | 2 | 1 | 2 | 3 | 2 | 0 | 0 | 0 | 1 | 3 | 2 | 2 |
| **Patient Transport Service** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 0 | 0 | 0 | 1 |
| **Other** | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 1 |
| **Total** | **3** | **1** | **2** | **4** | **2** | **0** | **2** | **3** | **4** | **5** | **6** | **5** |

In July 2012 a review of SIs in the emergency operations centres was carried out to understand common themes and make recommendations to reduce the risk of

further SIs occurring. A task and finish group was established to deliver the action plan based on the findings of the review.

This was implemented and will continue to be monitored closely.

### 3.1.5 NHS Staff Survey Results - Reporting of Errors, Near Misses and Incidents

| | 2011 percentage for YAS | 2012 percentage for YAS | National average for ambulance trusts 2012 |
|---|---|---|---|
| **Staff saying they or a colleague reported an error that could hurt staff** (the higher the better) | 84% | 78% | 81% |
| **Staff saying they or a colleague reported an error that could hurt patients** (the higher the better) | 84% | | |
| **The fairness of incident reporting procedures** (score out of 5.0 - the lower the better) | n/a | 3.08 | 3.33 |

### 3.1.6 Delivery of work plan for 2012-13

#### Safety Thermometer

Patient safety continues to be a high priority and we have been working, as part of our Commissioning for Quality and Innovation (CQUIN) programme, to develop a Safety Thermometer tool which is relevant for ambulance services. The Safety Thermometer has been developed in hospitals to measure the prevalence of harm to patients as a proportion of all patients seen. We want to learn from the best practice developed in the acute sector and identify where we can reduce harm in the ambulance service.

During 2012-13 we analysed incident data to identify the main areas where harm may occur to patients. This showed three categories where we can reduce the risk of harm to patients. These relate to preventing falls and injury to patients who are in our care and correct coding of 999 calls.

During analysis of the incident data management system falls were highlighted as an area of harm for YAS. YAS then went onto identify other harms that occurred during the year. These were benchmarked against indicators being gathered nationally as part of the work-stream being progressed through the national Quality Governance & Risk Directors (QGaRD)
Three harms were identified:

- Falls
- Injury to patients (not from falling)

- Harm arising from delayed response to calls coded green (non life-threatening) in our emergency operations centre.

- **Falls whilst in YAS care**

YAS has a zero tolerance approach to patients falling whilst in our care. Although the percentage of patients who fall is minimal compared to the number of patients conveyed without incident, every fall is subject to a detailed investigation and results in an action plan.

All serious untoward incidents that have involved a fall whilst in receipt of care were reviewed by the Risk and Safety team. An emerging theme included a lack of adequate harness systems on ambulance vehicles. This learning has been shared across YAS and an audit of harness availability has been completed to ensure the correct equipment is available at all times. Lessons learnt from these incidents have been shared via the Operational Update staff bulletin.

It was apparent from the data that most falls occurred on Patient Transport Service (PTS) journeys rather than A&E journeys. The majority of falls occurred when the patient was moved to or from the vehicle or whilst on board. Further analysis identified that improvements were required around the PTS booking process, patient risk assessments and the allocation of correct vehicles.

- **Injuries to patients (not falls)**

Analysis of data during 2012-13 showed that most injuries take place whilst the patient is on the vehicle. Examples included:

- cuts/skin tears caused by direct contact with the vehicle
- cuts/skin tears caused by direct contact with the vehicle equipment
- patients not being properly secured on the vehicle.

Further review will be carried out in 2013-14 to determine how these incidents can be reduced.

- **Green coded calls which subsequently code as red**

Our 2012-13 CQUIN target required us to analyse our data about safety in our emergency operations centre and A&E operations to identify three areas of harm. The data indicated that harm was occurring to patients whose calls were initially coded as Green (not life-threatening) but subsequently upgraded to Red (life-threatening).

Work was done to understand this data set and to look at whether it could be developed into a harm reduction programme as part of the Safety Thermometer programme. Note: it is unlikely that this potential harm will be developed during 2013-14 due to the complexity of issues associated with this data set. An alternative harm is currently being considered for the safety thermometer programme, although work will continue between the clinical directorate and emergency operations centre to understand the reasons for upgrading codes and identify any learning.

- **Reducing levels of harm**

During 2012-13 multidisciplinary working groups were established to review the data sets relating to falls and other injuries and to develop action plans to achieve reductions in the levels of harm seen in future.

### 3.1.7 Key achievements

The actions delivered as a result of the Safety Thermometer programme are:

- **Changing the booking process for PTS patients**

A change to the booking process was agreed and will be introduced in 2013-14. A falls risk assessment will be carried out using two questions which have a strong evidence base for identifying those patients most at risk of falling:
Question 1 “have you fallen in the last 6 months?”
Question 2 “are you afraid of falling?”

Communicating the responses to these questions will ensure frontline PTS staff are more aware of the needs of their patients.

- **Availability of safety belts and harnesses**

An audit of all YAS vehicles and equipment indicated that some vehicles were not equipped with four point harnesses as required by Trust policy. Once the gaps in provision were known the missing harnesses were ordered and replaced as an immediate priority. Looking to the future, the YAS Equipment Procurement Group was tasked with reviewing the type of harness used to ensure that it offers the maximum safety and ease of use.

- **Collaboration with other ambulance services**

The YAS Associate Director of Quality is working collaboratively with safety colleagues other ambulance trusts to share learning on patient safety. Learning from their work may suggest possible areas of harm for YAS to include in the Safety Thermometer programme.

### 3.1.8 Next steps for 2013-14

The patient safety thermometer work-stream is part of the *Right Care* Project Group which has a remit on urgent care and harm free care.

The *Right Care* Project Group is part of the YAS Service Transformation Programme which is delivering the priorities and necessary major change programmes within our five year Integrated Business Plan.

The plan for 2013-14 includes:

- using the Patient Safety Thermometer to monitor, report and make interventions to reduce the level and risk of harm occurring in the two of the three identified areas

- developing a third source of harm to include in the Patient Safety Thermometer programme . Areas being considered relate to assessment of spinal injuries and medication errors.

- continually analysing and reporting incident and complaint data to track levels of harm and identify causal factors.

- reviewing levels of harm resulting from changes to the PTS booking system

- reporting the results of work on patient safety to YAS leaders, managers and staff in order to achieve engagement with the patient safety agenda and specifically the Safety Thermometer programme.

- working alongside other ambulance services further develop the Safety Thermometer programme, agree national data definitions and learn from patient safety programmes which have achieved success in other services

- review of YAS moving and handling training provision.

## 3.2 Medicines Management

### 3.2.1 Introduction

Medicines management includes the purchasing, procurement, safe storage and handling, guidelines and prescribing, 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.

### 3.2.2 Background

In 2011 YAS introduced a new and very different controlled drug procedure. The aim for 2012-13 was to evaluate the new process and review it.

During this time new guidance was published specifically around the safe and secure management of controlled drugs in the ambulance sector. Prior to this there was very little published information around controlled drugs in the ambulance service. Any information relating to the management of controlled drugs stood firmly in the hospital and primary care setting and could not be directly transferred into an ambulance service.

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)
- Joint Royal College Ambulance Liaison Committee (JRCALC) guidelines for drug administration.

The JRCALC guidelines set out the list of drugs which may be used by any qualified, registered and 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 JRCALC list when specifically indicated by a patient's condition.

### 3.2.3 Medicines Management Workplan

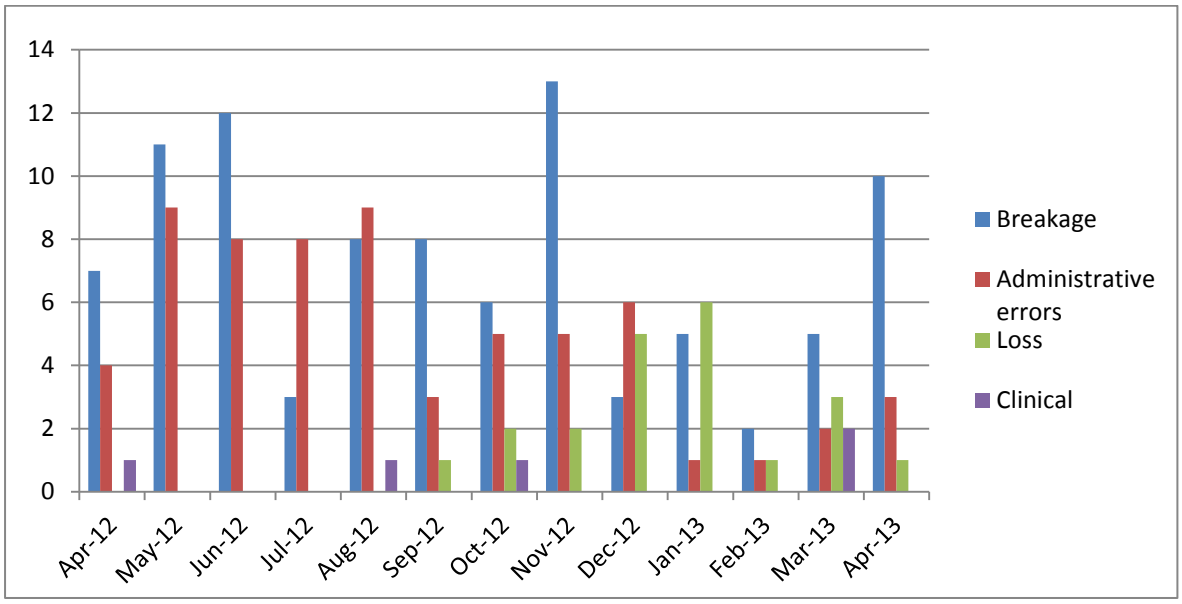
The following items were delivered as part of the Medicines Management workplan.

#### Review of Adverse Incidents Relating to Medication

| | Apr 2012 | May 2012 | Jun 2012 | Jul 2012 | Aug 2012 | Sep 2012 | Oct 2012 | Nov 2012 | Dec 2012 | Jan 2013 | Feb 2013 | Mar 2013 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Medication incidents** | 31 | 43 | 42 | 23 | 42 | 33 | 30 | 40 | 35 | 23 | 14 | 31 |

All medication incidents were reviewed by the Medicines Management Group to ensure that any appropriate action was taken to reduce reoccurrence.

#### Monitoring Usage of Controlled Drugs




The above chart shows controlled drug incidents for 2012-13. One of the main aims was to closely monitor the safe and secure handling of controlled drugs after the adoption of the revised procedure to give assurance to the Trust Board that the procedure was robust.

At the beginning of the year the group identified the high numbers of breakages of morphine and after investigation of the incidents it was determined that the majority of the breakages occurred on whilst removing them from the safe. To reduce breakages new larger ampoule boxes were procured. It was agreed that information about controlled drugs should be collated and nationally benchmarked against the other ambulance services.

YAS is required to have a representative at the West Yorkshire Controlled Drug Local Intelligence Network (CDLIN). This role is fulfilled by our Trust Pharmacist

who also expanded her attendance to include the North Yorkshire CDLIN. On a quarterly basis incident reports are sent to both these LINs who disseminate the information to the other LINS in the Yorkshire area. Any serious incidents are verbally reported at the meetings.

### Review of Morphine

The controlled drug standards operating procedure was reviewed in January 2012. Initially a number of small changes were made, but an incident in February lead to a full review of the procedure. The increase in administrative errors also highlighted the need for specifically designed controlled stationary. Significant work was undertaken to review current practice, identify any gaps in meeting legislative requirements and best practice guidelines and strengthen policies and procedures. A strengthened audit procedure was also implemented to monitor practice.

### Review of Patient Group Directions

All PGDs currently in use by YAS clinicians were reviewed to ensure that they were fit for purpose and in line with all necessary national guidelines and legislation. It was identified that a number of PGDs were rarely used and these were discontinued.

### Introduction of New Patient Group Directions

Two new PGDs were introduced for paramedics: tranexamic acid for severe trauma, and prednisolone for asthma. Use of tranexamic acid is currently being audited by the Yorkshire Air Ambulance (YAA) and Hazardous Area Response Team.

New legislation by the home office allows the carriage and administration of ketamine by paramedics. The MMG produced PGDs for ketamine, midazolam and flumazenil (adhering to the Medicines and Healthcare Produces Regulatory Agency alert surrounding the use of midazolam). Paramedics working within YAA and the YAS Hazardous Area Response Team were trained on the administration of these medicines and an audit of their use was undertaken. YAS is now working with the National Ambulance Resilience Unit (NARU) to produce national PGDs for these medicines.

## 3.2.4 Management of key risks

- **Risk of administrative errors due to inadequate controlled stationary**

  The vehicle and station controlled drug books did not support ambulance service ways of working. This led to administrative errors that required extensive investigation with the risk of unidentified loss of morphine.

  Mitigation: bespoke books were designed to support ambulance service practice.

- **Risk of handover of morphine on the vehicle**

  A serious incident in February 2013 involved the loss of morphine. At the time, the controlled drug standard operating procedure allowed clinicians to hand over responsibility for morphine whilst it remained in the vehicle – ie without booking back into the station safe. This was designed to support swift turnaround times at the beginning/end of shifts. The standard operating procedure clearly stated that the clinicians must visibly check the morphine and sign to take responsibility, but this was not routinely followed in practice.

  Mitigation: the controlled drug standard operating procedure was revised to make it mandatory to replace morphine in the station safe at the end of every shift.

- **Risk of *c.difficille* after administration of cephalosporin antibiotics**

  MMG highlighted that YAS procedures for use of cefalosporins led a risk to patients arising from increased risk of contracting *c.difficile*.

  Mitigation: the YAS pharmacist worked with a consultant microbiologist to produce new PGDs for antibiotics. This encouraged use of cephalexin which is a cost effective alternative and less likely to lead to a patient contracting *c.difficile*.

- **Risk of harm to patients from inappropriate administration of ketamine, midazolam or flumazenil**

  Mitigation: YAA and HART report their usage of ketamine, midazolam and flumazenil to the MMG on a monthly basis, including dosages, indications and outcomes.

### 3.2.5 Next steps for 2013-14

The priorities for 2012-13 are:

- Revised controlled drug standard operating procedure presented to Clinical Governance Group and Senior Management Team for formal approval.

- Revised audit procedure for controlled drugs implemented.

- Controlled drugs books to be introduced on all stations and vehicles. Example pages will be included in the controlled drug standard operating procedure to promote correct record keeping. Clinical Supervisors will receive training in the standard operating procedure and use of the new books and they will be responsible for training staff in their areas.

- Roll out the new PGDs to all emergency care practitioners (ECPs). A training programme has been set up for all ECPs to attend by the end of October 2013.

- Continue working with NARU to develop national PGDs for ketamine, midazolam and flumazenil

- Implement an audit of all prescription-only medicines carried on YAS vehicles and develop systems for ensuring medicines are tracked.

## 3.3 Safeguarding

### 3.3.1 Introduction

YAS staff working at all levels, and in all types of role, clearly understand that protecting children and vulnerable adults from harm is everyone's responsibility. The measures set out in YAS's policies and procedures for safeguarding children and vulnerable adults ensure that whenever an individual has concerns that someone is suffering or at risk of significant harm then they can report their concerns for further investigation.

The number of referrals to specialist services for protecting vulnerable adults and children that are made by our staff indicates the effectiveness of our safeguarding training. Staff are given information to help them identify warning signs of abuse or neglect and to report this via our Clinical Hub, to social care. We have strong partnerships with the other organisations across Yorkshire and the Humber who are involved in safeguarding.

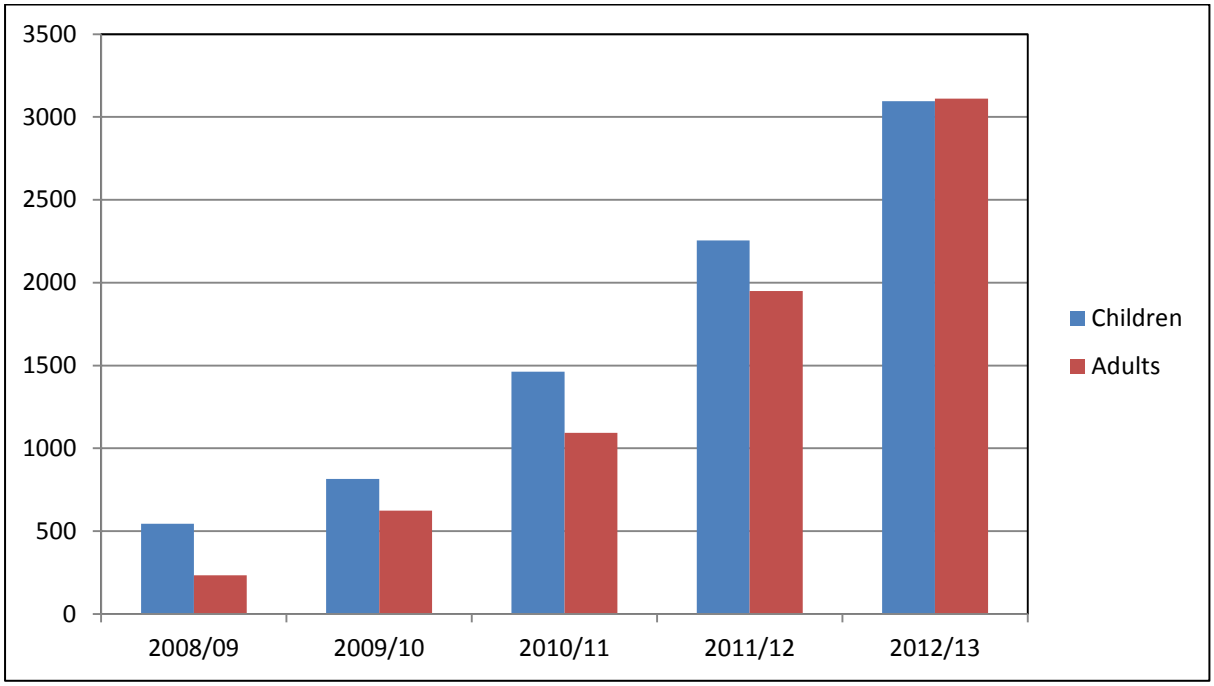
### 3.3.2 Delivery of 2012-13 Workplan

The safeguarding 2012-13 workplan included:

- increasing the number of adult and child referrals made by YAS staff to social care.
- ensuring that all necessary staff receive safeguarding training at the correct level for their role.
- reducing the number of under two year olds who are not taken to hospital after attendance by YAS clinicians.
- completing child death reports as required by Child Death Overview Panels
- contributing to serious case reviews, domestic homicide reviews and safeguarding lessons learned reviews where the person involved was attended by YAS clinicians.

Achievement of these objectives is shown in the information provided overleaf.

## Numbers of adult and child referrals to social care

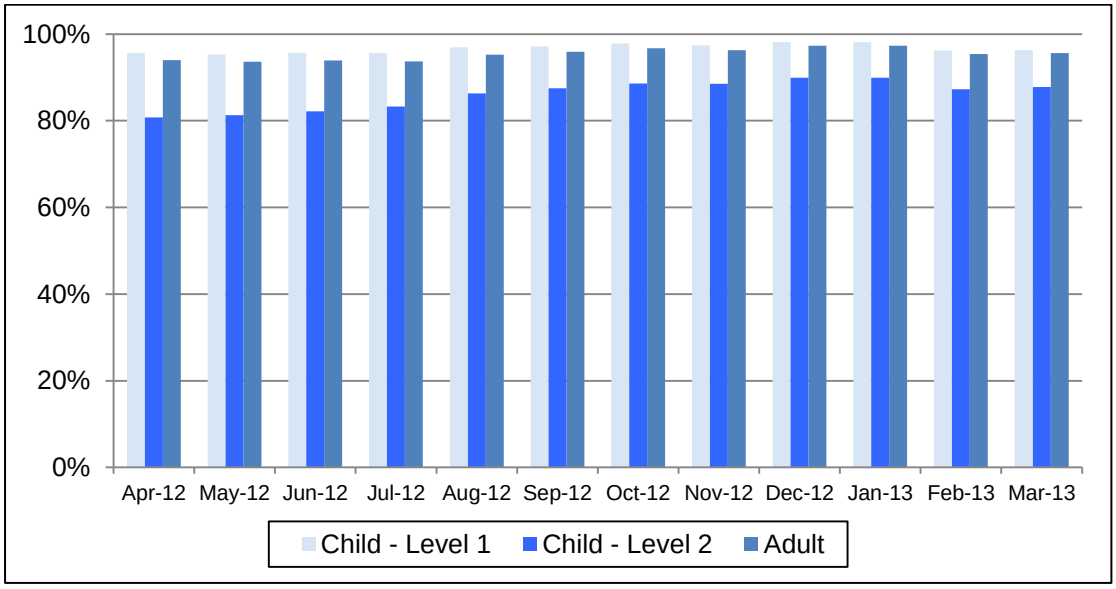



YAS staff made a total of 6206 referrals to social care in 2012-13. This compares to 4204 in 2011-12 and 2556 in 2010-11.

Proportion of YAS A&E incidents resulted in a safeguarding referral: 0.18%

## Compliance with safeguarding training requirements

The proportion of eligible staff who have received safeguarding training at the appropriate level is shown below.



Where relevant to their role, new members of staff must complete level two safeguarding children within three months of joining YAS. This is a requirement of our commissioners and was delivered for 2012-13 and required a specific focus on training for new staff joining the NHS111 service.

During 2012-13 the safeguarding element of the YAS Corporate Induction increased from 30 to 60 minutes. This enabled all new staff to receive training relating to the Mental Health Act (MHA) and Mental Capacity Act (MCA).

YAS is aware that on rare occasions, staff attending incidents find it challenging to follow the requirements of the MCA/MHA when working in partnership with other agencies and professionals with differing opinions. YAS will complete an awareness raising campaign during 2013-14 to assist staff to deal with such incidents. Information has been provided by YAS for General Practitioners when making transport bookings for patients with mental health conditions and/or impaired mental capacity.

## Conveyance of under-twos

In accordance with guidance from the Royal College of Paediatrics and Child Health in 2009 our YAS policy is that all patients under two years old who are attended by a YAS clinician must be conveyed to hospital for further assessment.

During 2012-13 the YAS Clinical Governance Group received regular reports on non-conveyance rates which appeared to show that approximately 5% of YAS patients under two were not being conveyed. This was logged as a risk and further work undertaken by the YAS clinical managers to understand the reasons for this level of non-conveyance.

## 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.

In 2012-13 YAS provided 108 reports to CDOPs.

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

In 2012-13 YAS contributed to:

- three domestic homicide reviews
- eight child serious case reviews
- four adult serious case reviews.

Lessons learned for YAS included:

- enhancing the information provided during safeguarding training regarding the risks associated with non-conveyance of mental health patients

- improving welfare and support for staff who have attended a child death. A post incident care process is now in place to ensure that all staff attending traumatic incidents receive support from a clinical supervisor as soon as possible after they are stood down from the incident.

### 3.3.3 Key Achievements

**National-level working**

The YAS Head of Safeguarding currently chairs the National Ambulance Safeguarding Group (NASG).

YAS has developed a safeguarding self- assessment tool, which has been adopted for peer review of safeguarding processes in other ambulance trusts. Peer reviews will be completed and reported to the Ambulance Quality Governance and Risk Directors (QGARD) group at quarterly meetings.

The NASG are also developing a national ambulance specific distance learning workbook for safeguarding adults to level 3. This will be circulated to all relevant staff when completed to assist with advancing compliance levels.

During 2012/13 the YAS Head of Safeguarding represented NASG as a member of the Department for Education advisory group for the review of *Working Together to Safeguard Children* national guidance.

**Adult social care referrals – pilot project**

It was identified that many adult safeguarding referrals being made by YAS staff were not related to cases of abuse or neglect but where the attending staff identified a need for social care support. In 2012-13 the YAS named professional for safeguarding adults established a pilot project in the Leeds area where staff can contact social care directly to notify them of a patient who may require support. A social care professional will then contact the patient to arrange an assessment.

### 3.3.4 Key Risks

The main YAS safeguarding risk relates to the number of patients under two years old not conveyed to hospital. During 2012-13 work commenced with the YAS clinical managers to review each case included in the figures and check the decision-making of the clinicians involved. This work indicated that approximately 50% of cases reported in the period reviewed (June 2013) should not have been included in the figures. Learning from this review will be used to further develop the reporting of this data and the action plan to reduce non-conveyance.

### 3.3.5 Workplan for 2013-14

During 2013-14 the safeguarding team will continue with their work to increase safeguarding referrals and ensure all staff receive the appropriate level of training.

In 2012-13 YAS will be required to deliver a Workshop to Raise Awareness of Prevent to all staff. This is a mandatory requirement of the Department of Health's implementation of the 'Prevent' element of the Government's counter-terrorism strategy. This specified in the 2013-14 NHS contract and requires two hours of face-to-face training for every member of staff to be delivered by an approved trainer.

The YAS safeguarding team will be developing the necessary policies and procedures to support the Prevent workstream and ensuring that plans are put in place for the necessary training.

## 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

### 3.4.2 New Clinical Guidelines

The Clinical Directorate interprets and develops implementation plans for new guidelines eg from the National Institute for Health and Care Excellence (NICE) and Joint Royal College Ambulance Liaison Committee (JRCALC). Each guideline is reviewed 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 provides the Trust Board with assurance regarding the care delivered to our patients.

### 3.4.3 Clinical Quality Monitoring

All Ambulance services report against two sets of clinical quality standards. These are the Clinical Performance Indicators (CPI) and the Ambulance Clinical Quality Indicators (ACQIs).

YAS's objective for 2012-13 was to achieve improvement initiatives in all CPIs and ACQIs.

CPI s were agreed for all English ambulance services through the National Association of Ambulance Service Chief Executives and its supporting clinical subgroups. The CPIs are collected monthly for local improvement and national data is reported in cycles. The data is collected from patient report forms 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 nine and ten were reported in 2012-13. The included the following clinical care conditions:

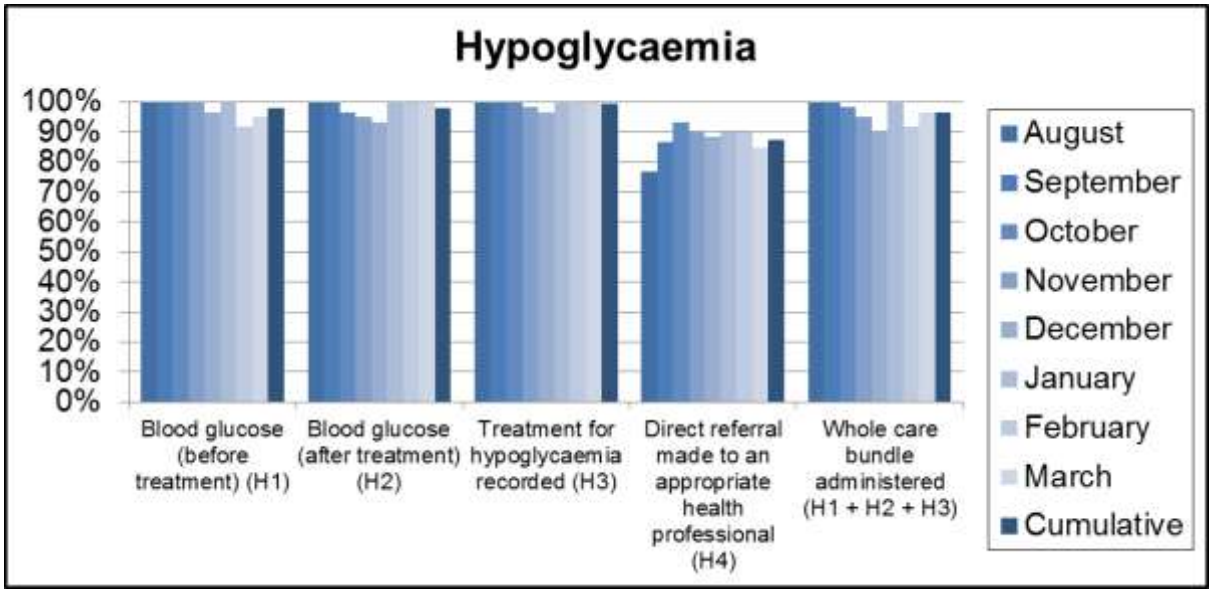
- Hypoglycaemia
- Asthma
- Below knee fracture (trauma)
- Febrile convulsion (paediatric care).

## Hypoglycaemia

The hypoglycaemia care bundle includes:

- Blood glucose checked (before treatment) (H1)
- Blood glucose checked (after treatment) (H2)
- Record treatment for hypoglycaemia (H3)
- Direct referral made to an appropriate health professional (H4)
- Whole care bundle administered (H1 + H2 + H3).

### Hypoglycaemia YAS CPI results 2012-13




At March 2013 YAS was achieving 1.2% above the national average performance for this CPI.

## Diabetes

YAS are amongst the top ambulance trusts when referring diabetic patients to health care professionals this is seen as essential element of care and is targeted towards improving outcomes for patients.

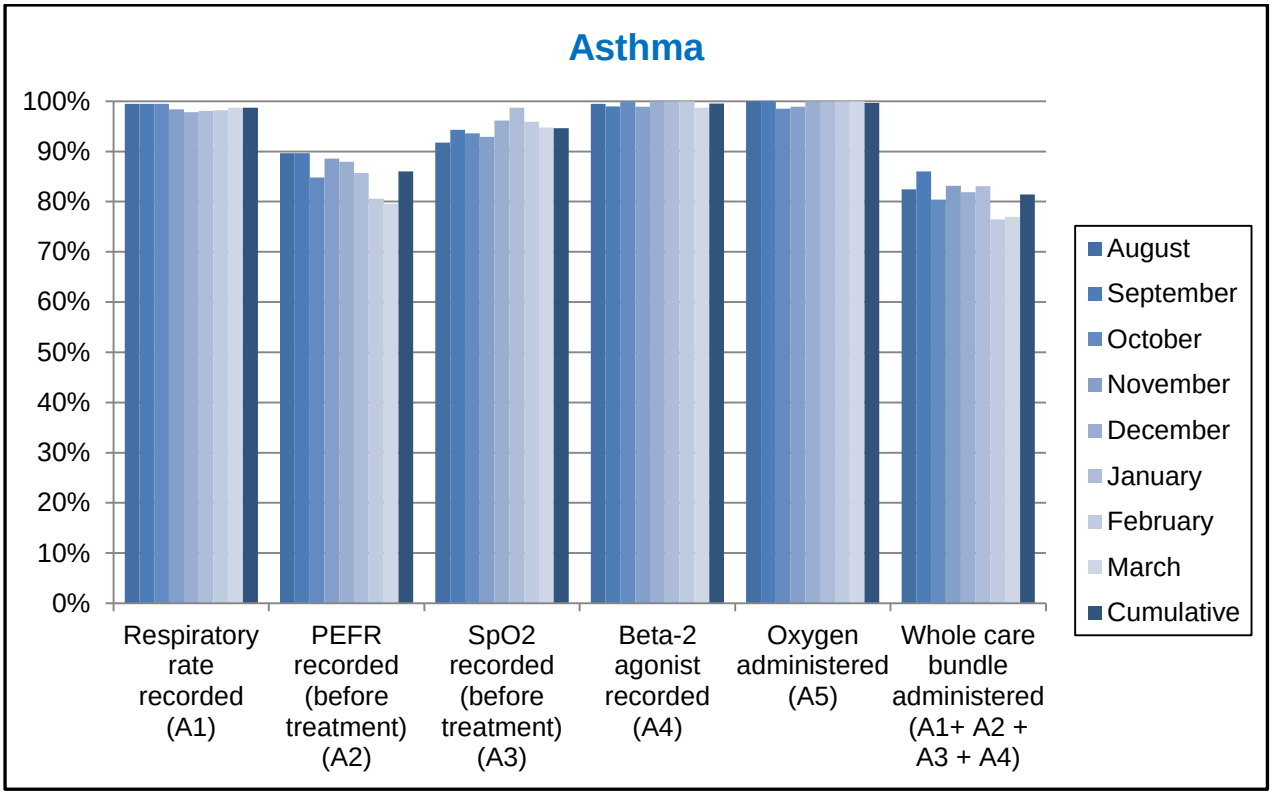
## Asthma

Asthma care bundle includes:

- Respiratory rate recorded (A1),
- Peak expiratory flow rate (PEFR) recorded (before treatment) (A2)
- Oxygen saturation (SpO2) recorded (before treatment) (A3)

- Beta-2 agonist recorded (A4)
- Oxygen administered (A5)
- Whole care bundle administered (A1+ A2 + A3 + A4)

### Asthma YAS CPI results



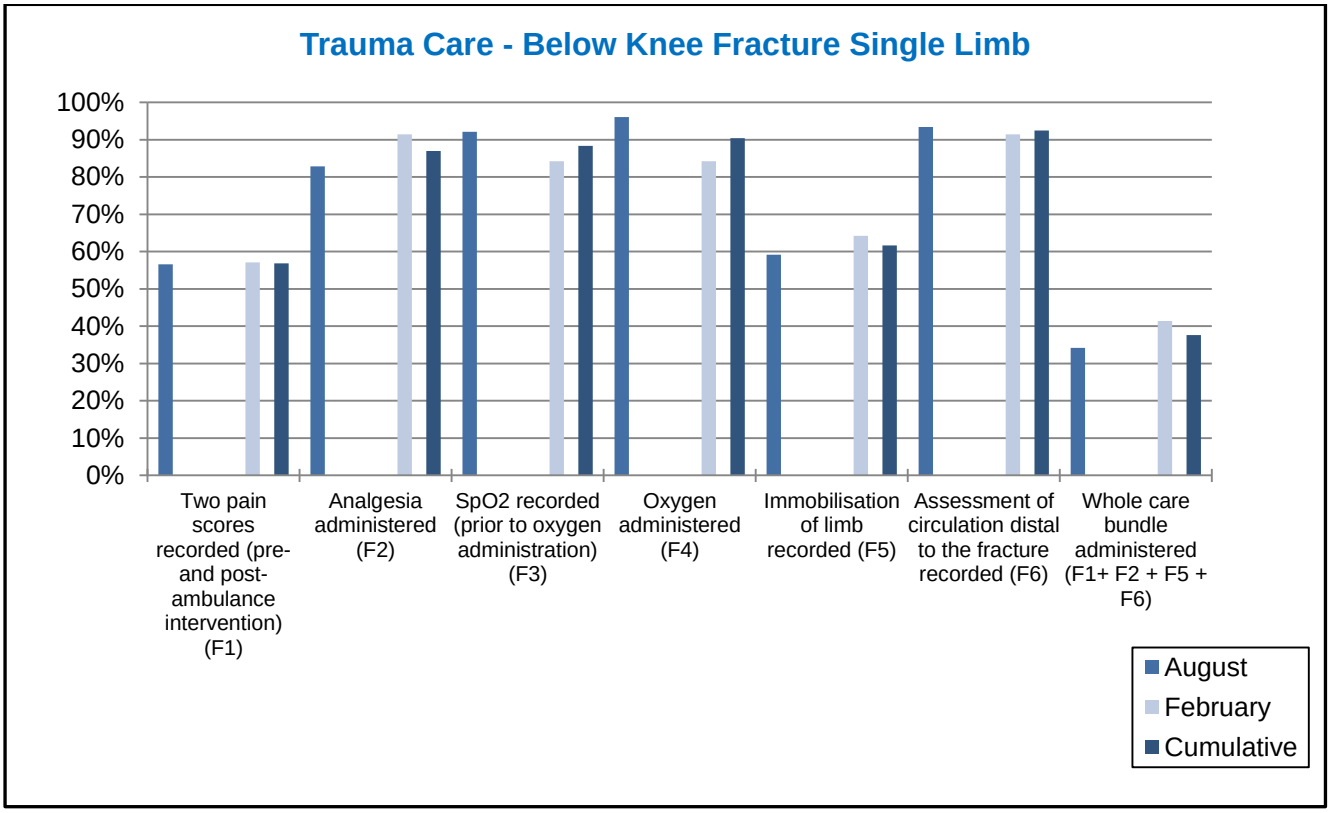

The improved recording of PEFR over the year has resulted in an improved performance for this care bundle. YAS clinical communications clearly promoted the rational for pre-treatment PEFR recording for asthma patients in terms of the benefits for their ongoing care once at hospital. This has been effective, with YAS achieving 1.5% above the national mean for this care bundle.

### Below Knee Fracture

The Trauma Care CPI focuses on care provided to patients suffering a below-knee fracture of one leg. The care bundle includes:

- two pain scores recorded (pre- and post- ambulance intervention) (F1)
- analgesia administered (F2)
- SpO2 recorded (prior to oxygen administration) (F3)
- Oxygen administered (F4)
- Immobilisation of limb recorded (F5)
- Assessment of circulation distal to the fracture recorded (F6)
- Whole care bundle administered (F1+ F2 + F5 + F6)

## Below Knee Fracture YAS CPI results



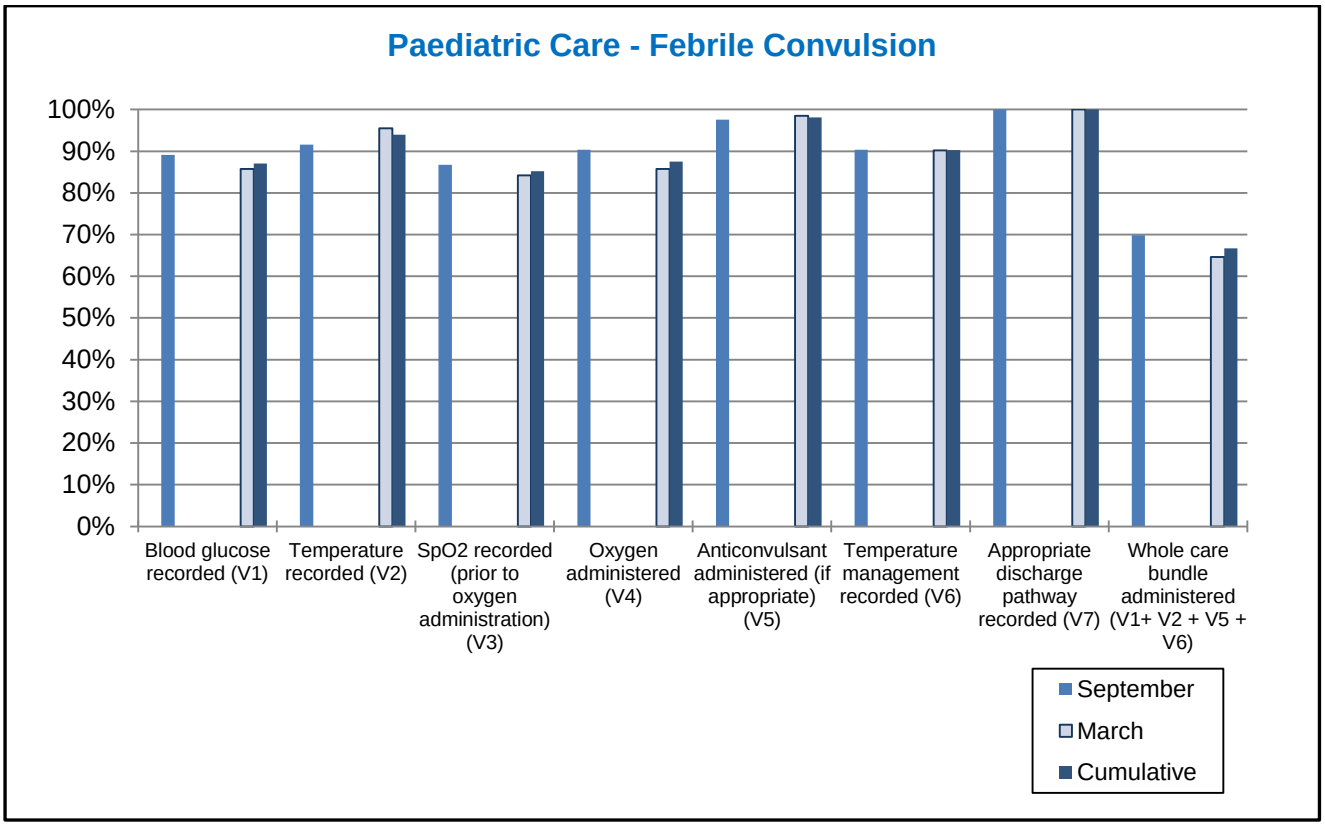

As this was a pilot CPI in 2012-13 there were two cycle data collection periods: August 2012 and February 2013. The care provided to 146 patients was audited and the results highlighted an improvement of 7.2% between the two periods. However, this is still below the national performance of 43% for the care bundle. Like all ambulance trusts YAS is working to improve the recording of pain scores and promote appropriate limb immobilisation.

## Febrile Convulsion - Paediatric Care

The febrile convulsion care bundle includes:

- Blood glucose recorded (V1)
- Temperature recorded (V2)
- SpO2 recorded (prior to oxygen administration) (V3)
- Oxygen administered (V4)
- Anticonvulsant administered (if appropriate) (V5)
- Temperature management recorded (V6)
- Appropriate discharge pathway recorded (V7)
- Whole care bundle administered (V1+ V2 + V5 + V6)

### Febrile Convulsion YAS CPI results




Performance from cycles nine and ten highlight mixed results with some areas improving more than others. YAS results were 7.7 % above the national mean for cycle ten performance. Areas for improvement are blood glucose recording and oxygen saturation recording. Both these require further emphasis to clinical staff to ensure overall improvement in this care bundle.

### 3.4.4 Ambulance Clinical Quality Indicators (ACQI)

A national review is underway following a recommendation from the National Ambulance Service Medical Directors (NASMED) Group. Currently the guidance for ACQIs allows a number of local definitions. This challenges the basis that ambulance trust ACQI results can be fairly benchmarked.

Nevertheless, ACQIs remain highly valuable within local services to support promotion and monitoring of reporting, documentation and high quality care delivery by all clinicians.

The first full year of national ACQI data was reported in August 2013. Over this first year YAS implemented a number of initiatives focused on addressing data quality, patient report form (PRF) completion, communication of care bundle elements, and a review of data collection methods.

The four ACQIs are:

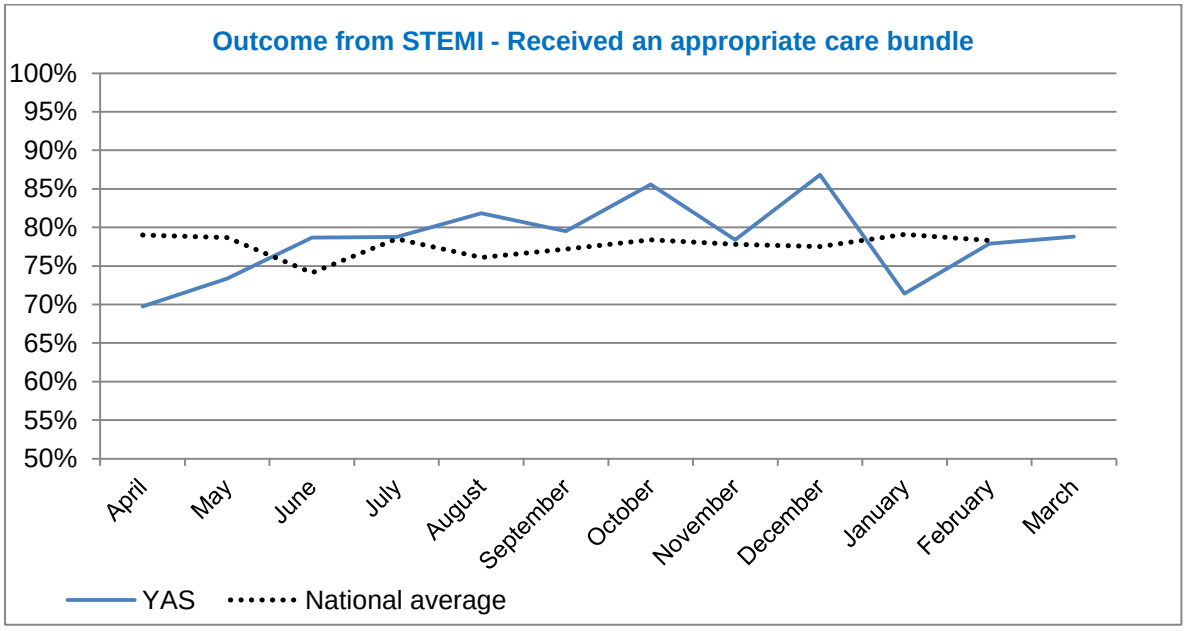
- Outcome from acute ST-Elevation Myocardial Infarction (STEMI)
- Outcome from cardiac arrest: return of spontaneous circulation (ROSC
- Outcome from cardiac arrest: survival to discharge
- Outcome from acute stroke

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):

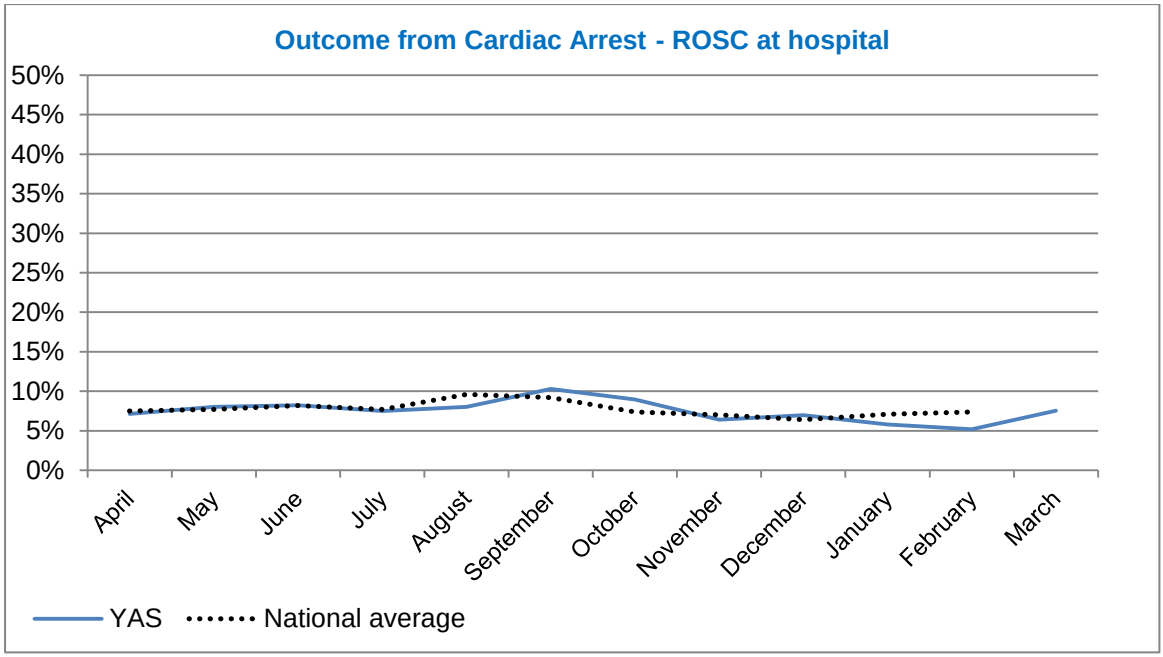
- Call for help to inflation of balloon (part of primary angioplasty procedure carried out in specialist hospital unit) time to be under 150 minutes. Note: validated report not available until September 2013.

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

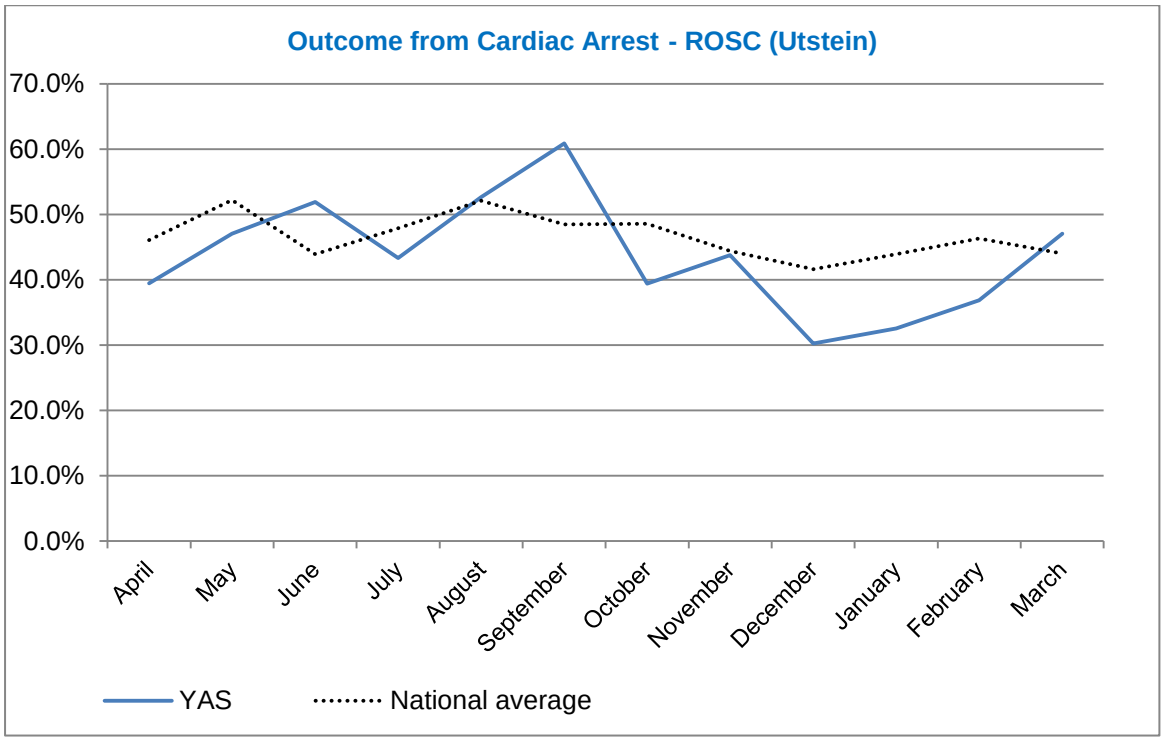


## Outcome from cardiac arrest: return of spontaneous circulation (ROSC):

- number of patients for whom ROSC is achieved compared to the number where cardiopulmonary resuscitation was commenced

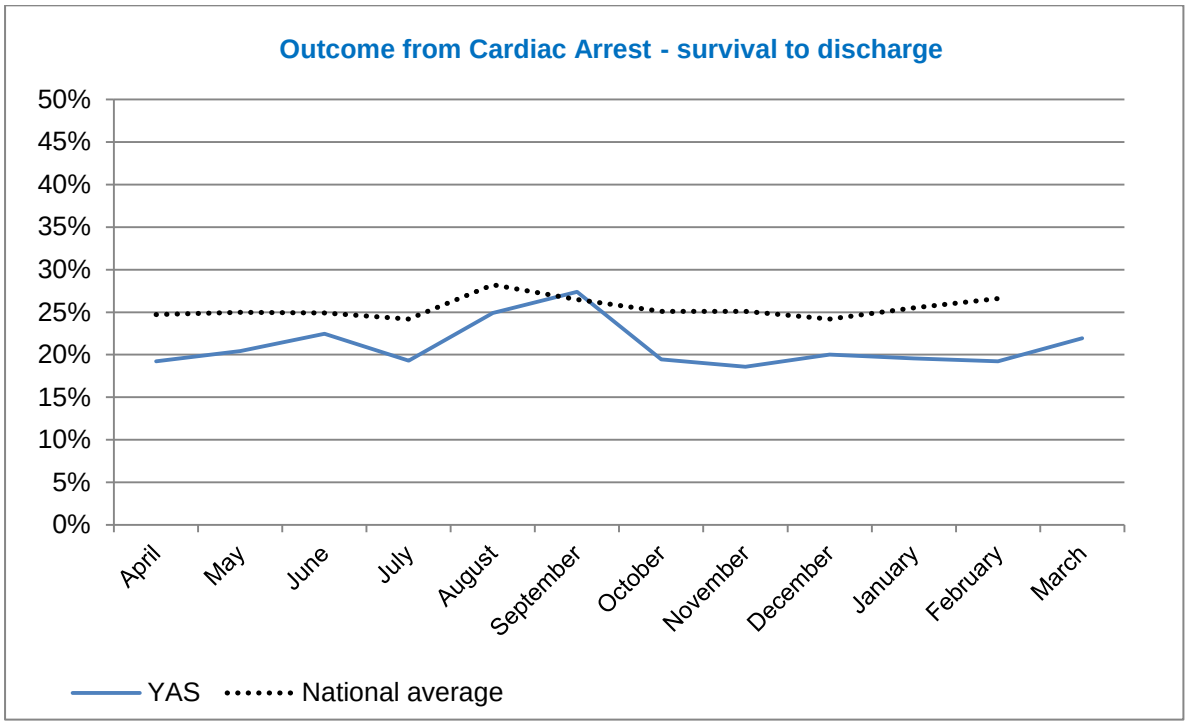



- number of patients in Utstein group (where ventricular fibrillation – VF, or ventricular tachycardia – VT is recorded) for whom ROSC is achieved compared to the number where cardiopulmonary resuscitation was commenced

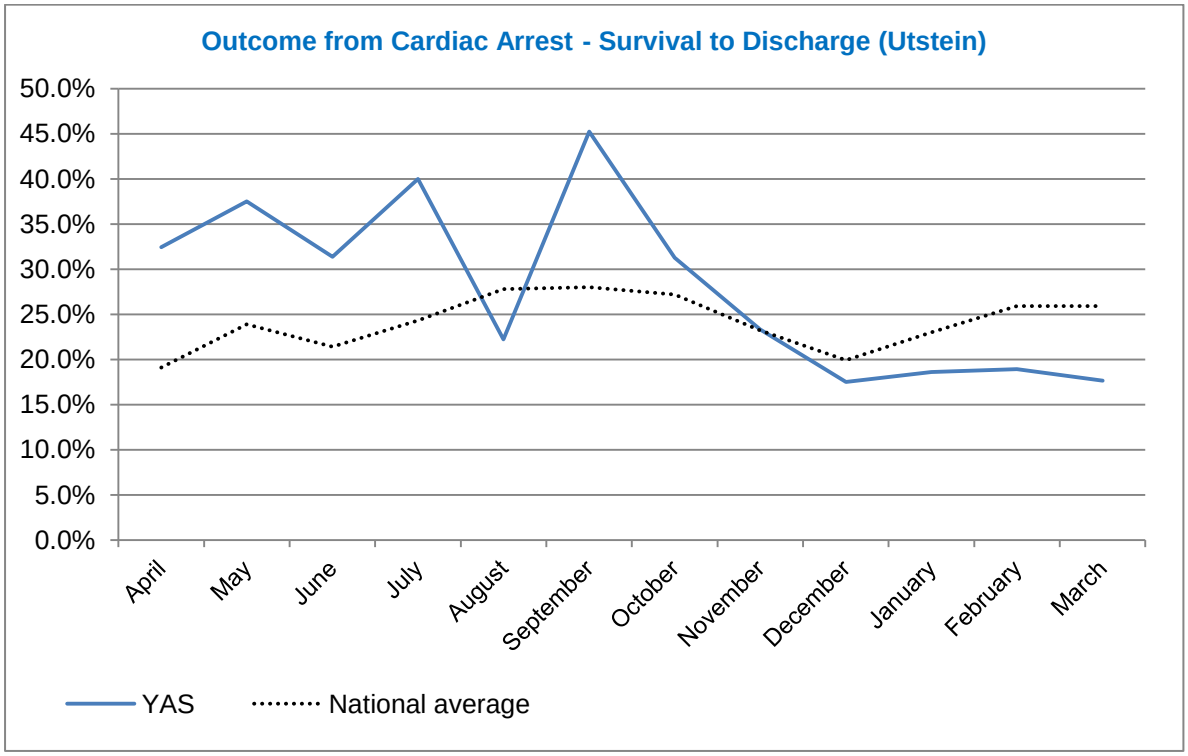



## Outcome from cardiac arrest: survival to discharge:

- the number of patients who survived to discharge from hospital compared to the number for whom resuscitation was attempted.

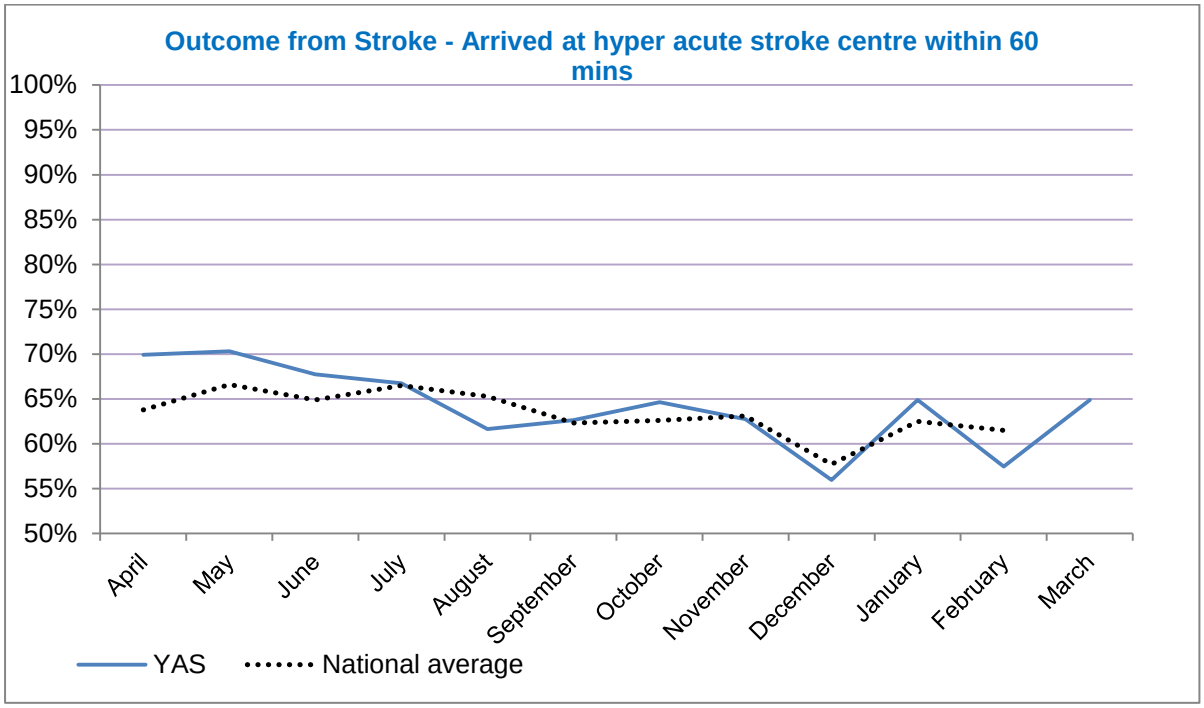


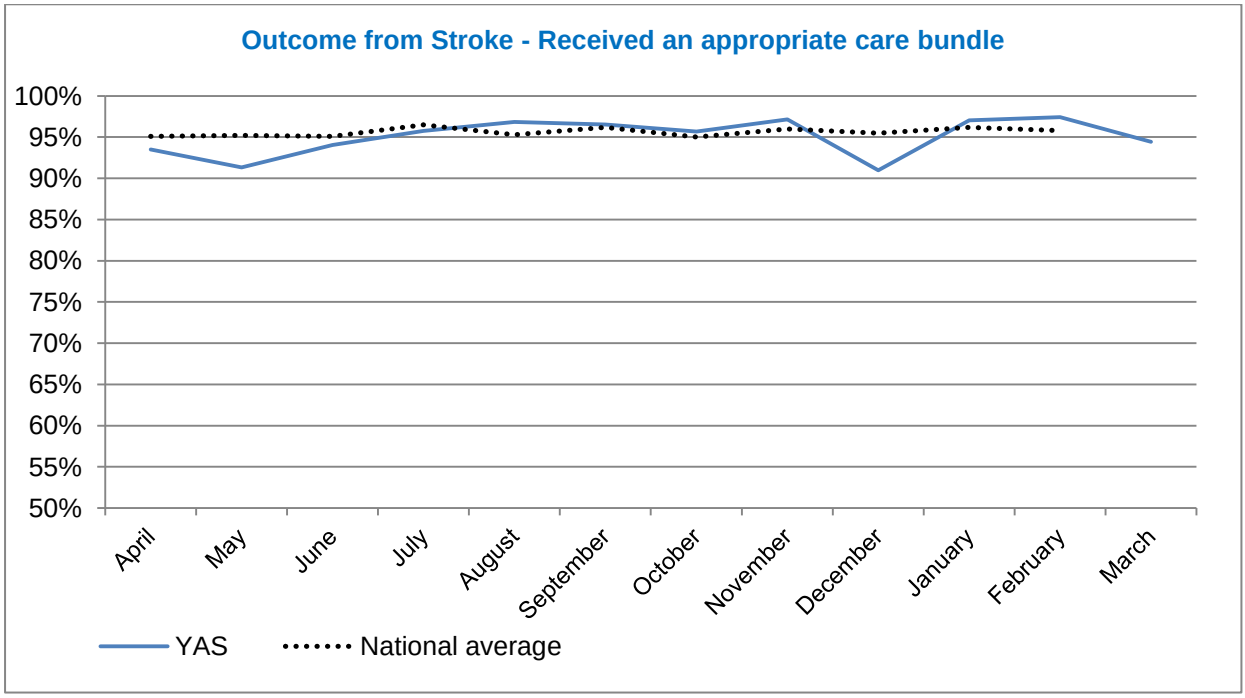

- the number of patient in the Utstein group (where ventricular fibrillation – VF, or ventricular tachycardia – VT is recorded) who survived to discharge from hospital compared to the number for whom resuscitation was attempted.



## Outcome from 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.



In summary, the ACQI data highlights reduced performance at times of operational pressure. The overall fall in performance over December for all care bundle elements requires further analysis.

The need for a whole service focus on the recording and management of pain is evident.

### 3.4.5 Next steps for 2013-14

- Further data analysis is required to inform specific recommendations to local clinical teams about how they can improve clinical quality for their patients.

- A review will be undertaken of the outcome of a pilot project in Hull focusing on achieving best possible outcomes for patients suffering cardiac arrest. Once validated data is available this will be analysed to inform Trust-wide recommendations for clinical practice.

- The Clinical Effectiveness Team will continue to make recommendations, provide feedback on clinical developments and share best practice throughout locality operations teams.

- An audit of stroke patients carried out by a member of YAS operations staff in Wakefield highlighted that, although performance against the stroke ACQI was used to compare ambulance services, the technical guidance allowed local variation in the criteria used to select patients. In 2012-13 YAS will provide data to NASMED to influence development of the technical guidance for ACQIs and improve the ability to benchmark between ambulance services.

- A priority for 2012-13 is to build understanding of the factors influencing ACQIs and CPIs with the Trust Board and commissioners to support effective scrutiny of reported results.

## 3.5 Patient Experience

Patient experience is seen as an important priority at YAS, monitored and reported at local and Trust-wide level. Local operational managers are engaged in work to investigate individual issues raised and act on themes and trends.

YAS has an Expert Patient who provides a patient voice at Clinical Governance Group, Quality Committee and the Trust Board. She promotes best practice in relation to patient engagement and links YAS into local groups representing patients and the public.

### 3.5.1 Complaints, concerns, comments and compliments

Our staff work very hard to get the job right first time. But, as in any complex service, mistakes can happen and problems occasionally occur. When people tell us about their experiences we listen, we find out what has happened and we 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.

#### Number of complaints, concerns, comments and compliments received

#### A&E

| Complaints, concerns and comments | Apr 2012 | May 2012 | Jun 2012 | Jul 2012 | Aug 2012 | Sep 2012 | Oct 2012 | Nov 2012 | Dec 2012 | Jan 2013 | Feb 2013 | Mar 2013 | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Attitude and Conduct | 10 | 5 | 15 | 13 | 14 | 12 | 17 | 12 | 13 | 11 | 9 | 15 | **122** |
| Clinical Care | 28 | 21 | 15 | 25 | 14 | 14 | 8 | 21 | 12 | 20 | 21 | 8 | **178** |
| Driving and Sirens | 1 | 4 | 10 | 10 | 7 | 3 | 3 | 6 | 10 | 8 | 8 | 3 | **62** |
| Call Management and Response | 33 | 22 | 26 | 26 | 30 | 25 | 35 | 33 | 23 | 27 | 21 | 20 | **280** |
| Other | 2 | 4 | 11 | 10 | 8 | 11 | 11 | 7 | 9 | 8 | 20 | 9 | **81** |
| **Total negative** | **74** | **56** | **77** | **84** | **73** | **65** | **74** | **79** | **67** | **74** | **79** | **55** | **723** |
| **Compliments** | 10 | 0 | 26 | 154 | 47 | 32 | 78 | 19 | 65 | 2 | 19 | 0 | **433** |

## PTS

| Complaints, concerns and comments | Apr 2012 | May 2012 | Jun 2012 | Jul 2012 | Aug 2012 | Sep 2012 | Oct 2012 | Nov 2012 | Dec 2012 | Jan 2013 | Feb 2013 | Mar 2013 | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Attitude and Conduct | 3 | 4 | 6 | 2 | 3 | 7 | 6 | 8 | 2 | 6 | 4 | 6 | **51** |
| Clinical Care | 3 | 8 | 7 | 4 | 4 | 4 | 3 | 9 | 5 | 6 | 4 | 3 | **57** |
| Driving and Sirens | 3 | 3 | 2 | 8 | 2 | 3 | 4 | 4 | 2 | 4 | 1 | 1 | **35** |
| Call Management | 9 | 5 | 6 | 3 | 6 | 3 | 3 | 2 | 3 | 1 | 2 | 0 | **43** |
| Response | 27 | 40 | 28 | 28 | 37 | 51 | 63 | 36 | 34 | 29 | 39 | 33 | **373** |
| Other | 8 | 7 | 2 | 2 | 4 | 6 | 5 | 7 | 6 | 8 | 3 | 7 | **55** |
| **Total negative** | **53** | **67** | **51** | **47** | **56** | **74** | **84** | **66** | **52** | **54** | **53** | **50** | **604** |
| **Compliments** | 1 | 0 | 0 | 11 | 7 | 4 | 16 | 1 | 6 | 1 | 0 | 4 | **47** |

### 3.5.2 Number of formal complaints

YAS is committed to the principles of 'Making Experiences Count, DH 2009. This encourages organisations to ensure that they handle expressions of dissatisfaction with their services in a way that is proportionate to the issues raised and in line with the wishes of the person putting forward these views.

In practice, this means guiding the person making contact with YAS through the complaints/concerns process to help them achieve the outcome they want in a timely manner and to ensure that the issues raised are managed at the appropriate level in the Trust.

**Complaint**: an expression of dissatisfaction with any aspect of the service provided to a patient and/or their carer(s)/family which requires the Trust to provide a formal response in line with the NHS Complaints Regulations 2009.

**Concern**: where a patient/carer/member of the public wishes to make YAS aware of an issue, event or incident and receive feedback (often informal – eg verbal or short email) but where they do not wish this to be recorded as a formal complaint.

**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.

Of the issues reported above, 257 were handled as formal complaints.

### 3.5.3 Referrals to the Parliamentary and Health Service Ombudsman

In 2012-13 seven people referred their complaints to the Parliamentary & Health Services Ombudsman. Five cases were closed with no further action, one was upheld and one remains ongoing.

### 3.5.4 Learning from complaints, concerns, comments and compliments

Learning from complaints, concerns and comments is very important. We report themes, trends and lessons learned to our fortnightly Incident Review Group and monthly Clinical Governance Group. Examples of lessons learned and actions taken in 2012-13 are:

- Patients waiting for PTS journeys at the Pinderfields reception centre expressed concern about the temperature of the waiting area. We negotiated with the hospital to take steps to reduce draughts through entrance doors.

- Feedback suggests that people calling 999 expect an immediate ambulance response and do not expect to have their call sent for telephone triage. We are working to raise awareness of how the ambulance service works through our public communications campaign.

- Information from complaints and concerns indicated that we did not have consistent guidance for A&E staff on how to safely secure babies and young children for travel to hospital. A piece of work is being done by our Fleet department, working with the Health and Safety Committee to look at best practice from other services and current equipment provision.

- A number of staff attitude complaints arose where clinicians had made a safeguarding referral. We found that clinicians had focused on obtaining key information about the patient/child's safety in line with their training. In doing so they had not seen how this would be perceived. A new section on patient experience was developed to be included in safeguarding training which includes examples of learning from experience and a reminder of the Trust's Dignity and Respect Code.

- Survey feedback indicates that staff are valued extremely highly by members of the public. Positive comments from surveys and examples of compliment letters received are included in local and Trust-wide communications to share learning and recognise good service. This is seen as increasingly important within Yorkshire Ambulance Service as a key part of developing a culture of patient-centred care.

Comparison with 2011-12 shows an overall reduction in negative feedback received. The main reason for this reduction has been improvements by PTS in minimising long waits and delays for patient travel. The exception to this improvement was in September and October 2012 when demand was higher than expected commissioned levels, and PTS vacancies in North and West Yorkshire contributed to longer waits.

### 3.5.5 Patient Experience Survey – A&E

In September 2012 we revised our A&E patient experience survey to make it shorter, simpler to complete and more focused on the things that matter to patients.

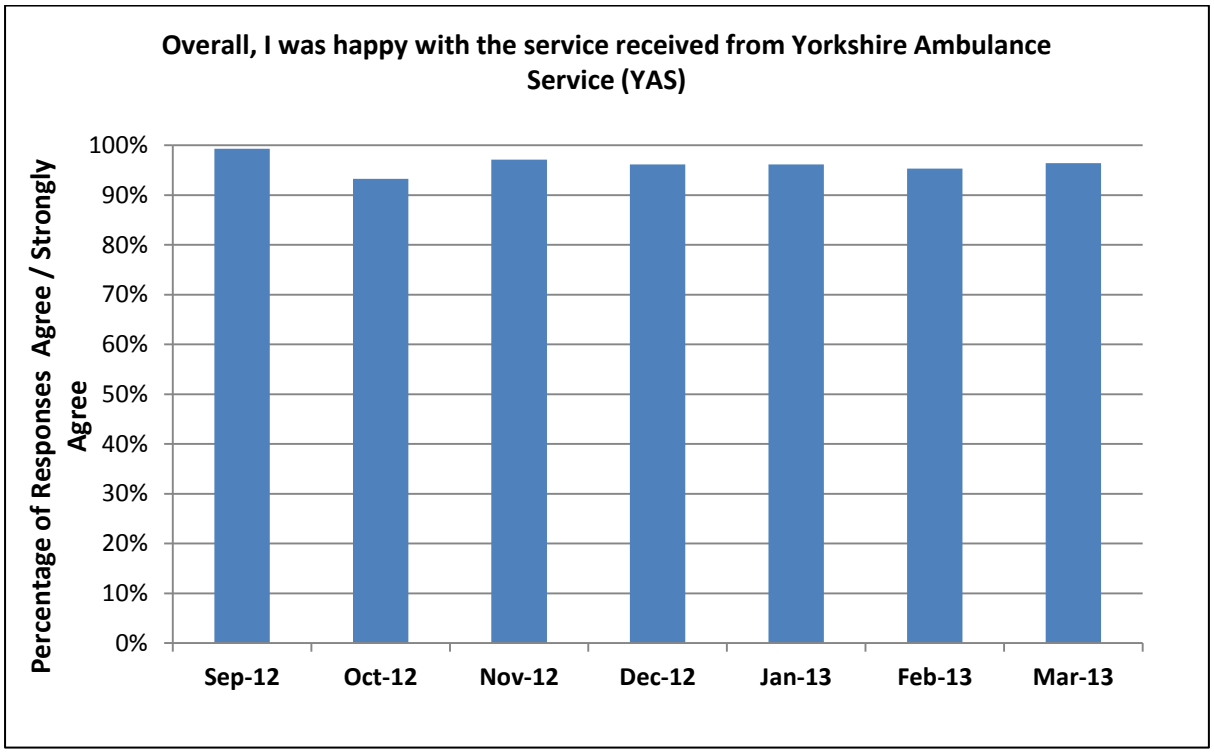
We also introduced the Friends and Family Test, which asks service-users whether they would recommend our service to friends and family. This test is being introduced by all acute trusts from April 2013 and ambulance trusts have agreed to use the same question to allow us to compare results. When we introduced the test we started using a 1 to 10 scale. In November 2012 we changed to a descriptive scale. This seems to have had an impact on the scores.

We monitor the results by geographic area and the results are reviewed by local teams as part of routine performance monitoring alongside measures of operational and financial performance.

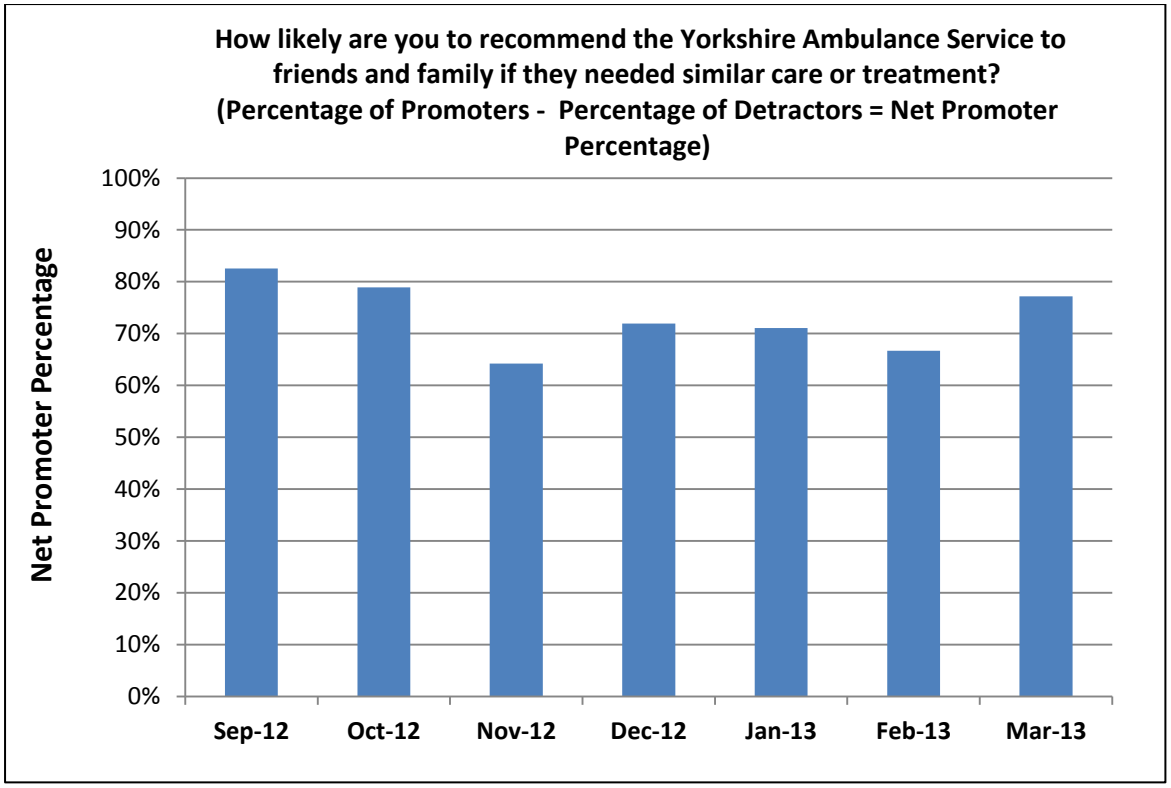
We also monitor the narrative comments that are made and these provide an important insight into factors affecting patient experience. Some of the comments are published throughout this document.

Survey feedback highlighted that YAS received regular complaints and negative feedback showing that callers did not understand a statement when their call was triaged by Emergency Operations Centre (EOC) call takers. This was a common theme to lessons from complaints and concerns. A revised statement was tested and subsequently implemented to help patients better understand why their call had been triaged.

### 3.5.6 A&E Survey Results




| | Sep 2012 | Oct 2012 | Nov 2012 | Dec 2012 | Jan 2013 | Feb 2013 | Mar 2013 | Year average |
|---|---|---|---|---|---|---|---|---|
| **Agree/Strongly Agree** | 99.4% | 93.3% | 97.1% | 96.2% | 96.2% | 95.3% | 96.4% | 96.1% |




| | Sep 2012 | Oct 2012 | Nov 2012 | Dec 2012 | Jan 2013 | Feb 2013 | Mar 2013 | Year Average |
|---|---|---|---|---|---|---|---|---|
| **Net promoter percentage** | 82.6% | 78.9% | 64.2% | 71.9% | 71.1% | 66.5% | 77.2% | 73.2% |

### 3.5.7 Patient Experience Survey – PTS

We undertook patient relations surveys across all areas of Yorkshire in October 2012 and have been continued in South Yorkshire every month. Results for four key questions are shown below. From April 2013 we will be conducting monthly surveys in all areas.

Narrative feedback showed six key themes which we will be using to inform our service improvement plans in the year ahead:

- Long waits for transport home have a negative impact on patient's experience of PTS.
- Some patients have welfare concerns about missing meal times, missing scheduled carer visits and access to toilet facilities.
- The friendship and caring attitude of staff makes a positive difference to patients' care experiences.
- When delays occur, patients want to be kept up-to-date with what is happening and how long they may have to wait.
- Some patients find the vehicles uncomfortable.
- Some patients explained the impact on their care experience from not being eligible to have the support of an escort during their journey.

### 3.5.8 Patient Stories

Patient stories 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 are via film, narrative or voice recording.

Patient stories are used in A&E and PTS training and considered a powerful learning tool. They are also shared with operational management teams and the Trust Board to demonstrate the importance of these patients and being empowered to deliver a caring and dignified service.

Examples of patient stories undertaken during 2012-13:

- Dementia - a nursing home manager talking about YAS involvement in the care of residents.
- Stroke - a service-user living in a rural location who had cause to use the A&E service when they experienced a stroke
- Bariatric - a service user who has used the A&E service and is a regular user of PTS.
- Drug & alcohol misuse - an individual's personal account of their experiences after calling 999 and being referred via a pilot alcohol pathway.
- Disability – the experiences of a young adult who has multiple complex health needs (including cerebral palsy and blindness) and his family and how YAS helped them put arrangements in place to ensure that this patient's needs would be met in an emergency.

### 3.5.9 Dementia and Learning Disability Survey

In partnership with Rotherham Learning Disabilities Services and Speak up Self Advocacy, specific surveys were designed for patients with Dementia and learning disabilities across both A&E and PTS. Over 126 responses were received in the first wave of this survey.

Most feedback was received about PTS. Key themes and learning were:

- 21% of carers of patients with Dementia responded that patients did not arrive on time for their appointment.
- Patients had concerns about whether they would be allowed to travel with a carer as an escort when using PTS. Whilst commissioners must continue to employ the eligibility criteria to both patients and escorts, the possibility of having to travel alone if escorts are withdrawn is causing anxiety amongst patients, family members and carers.
- Positive feedback about the care, respect and friendship of YAS staff.
- Patients and carers felt that drivers did not fully understand the patient's condition. To build awareness within YAS all our staff receive training on learning disabilities and dementia as part of their basic training and we started

to work on new training materials which provide a greater depth of understanding for all staff. We also held a 'dementia awareness week' where communication to all our staff about dementia was made a Trust-wide priority.

### 3.5.10 Young People's Survey and Carers of Under-twos Survey

Since starting the YAS survey programme in June 2011 the response rate from young people has been low. Therefore a young people's survey was developed for ages 11-18 year olds in partnership with Sheffield Futures Young People's Advisory Team.

The 11-18 year old survey was designed so that it could be completed by both those who had experienced using the Yorkshire Ambulance Service and those who hadn't.

In addition, a survey has been undertaken to better understand the experience of carers of children under two years old who are attended by our A&E clinicians. YAS policy is to take all children under two to hospital for further assessment but this does not happen on every occasion.

These surveys were publicised via hospital paediatric departments and the Yorkshire forums of the 'Netmums' website. Paper copies of the survey were also made available in visitor waiting rooms and on hospital wards. In addition the commercial training department distributed surveys. A group of young people who wished to comment on health services were also encouraged to complete the survey aimed at 11-18 year olds. The 'Youth Parliament' was formed by Airedale NHS Foundation Trust. The surveys were also available to complete via the YAS website.

Despite the advertising, we received low response numbers from this work. This meant that the quantitative data could not be used to draw significant conclusions. Nevertheless the narrative comments were analysed and following learning points identified:

- Parents and carers of under two year-olds told us about the positive impact of a caring and reassuring response from YAS staff and how they were able to communicate effectively with their children.
- Through the survey we were made aware that Eureka children's museum in Halifax had an exhibit simulating what happens when 999 is called. This was felt to help young people understand when and how to call an ambulance.

### 3.5.11 Residents of Rural Areas Survey

A postal survey of rural patients residing in Calderdale, Wakefield, East Riding and North Yorkshire was undertaken during Quarter 1 of 2012-13. A further survey of rural patients residing in the same areas was undertaken during Quarter 3. The results are currently being analysed and will form part of the report for the commissioners as part of the CQUIN report for quarter four.

Overall feedback showed great appreciation for YAS services however there was some indication that service users were unclear about what to expect when they called 999. YAS worked with East Riding Local Involvement Network to host an

event to raise awareness of what happens when you call 999. The event also included sessions on how to undertake cardiopulmonary resuscitation.

### 3.5.12 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 will use this resource as another channel to listen and respond to online service user feedback.

### 3.5.13 Dignity and Respect

The YAS Dignity & Respect Campaign was launched during 2011 to raise awareness of the need to treat patients and service users with dignity and respect. The YAS Dignity Code contains six points of important ways in which dignity can be assured; these were developed with staff and patients. YAS currently have over 20 Dignity Champions across the Trust.

Service user feedback regarding dignity and respect is included in training on a regular basis.

YAS celebrated Dignity in Action day on Friday 1 February 2013 by actively demonstrating support and encouraging staff to promote dignity and respect. Information of the YAS Dignity and Respect campaign is available via the YAS intranet. This includes a message board on which staff can post their views and experiences.

### 3.5.14 Workplan 2013-14

The Patient Experience Workplan for 2013-14 includes:

- development of national benchmarking via National Ambulance Patient Experience Group
- introduction of consistent monthly surveying across A&E, PTS and NHS111
- development of Patient Experience section of YAS website to include “you said we did” information and better signposting to ways for people to tell YAS about their experiences and get an answer
- supporting the development of the dignity and respect and customer care elements of YAS induction and training
- a review of the effectiveness of the YAS complaints management system from a complainant perspective.

### National Ambulance Patient Experience Ambulance Survey – Hear & Treat

This has been commissioned nationally via the Department of Health. It is being carried out by the Care Quality Commission (CQC), working with the Picker Institute.

YAS will be supporting the development and implementation of the survey via the National Ambulance Patient Experience Group.

## Building Relationships with Healthwatch

Throughout 2012-13 the Head of Quality and Patient Experience has continued to co-ordinate YAS's engagement with LINks. This has been primarily via the Yorkshire-wide LINk Ambulance Group.

When specific local issues are raised with YAS these are responded to directly, involving the relevant local operations teams from A&E and/or PTS.

In August 2012 East Riding of Yorkshire LINk published its Hospital Discharge report which contained a number of recommendations for YAS – in particular that YAS should develop a specific hospital discharge policy within PTS. YAS responded to the recommendations and offered the opportunity for LINk members to engage directly with the local PTS team.

From April 2013 LINks were replaced by Local Healthwatch. YAS has 13 local Healthwatch organisations within Yorkshire and early engagement with each Local Healthwatch is planned, including an engagement event on 27 June 2013.

# Section 4.0

# Assurance on Risk, Safety & Clinical Quality

# 4.0 Assurance on Risk, Safety and Clinical Quality

## 4.1 Standards and Compliance Directorate

This report demonstrates the progress in terms of our systems of risk management, safety and quality that we have achieved at all levels of the Trust in 2012-13. The support provided by corporate teams has strengthened and developed significantly, as has the interface between corporate functions and local, frontline operations. The restructuring of the Standards & Compliance 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.

## 4.2 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 sub-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. From 2013-14 separate quality management arrangements are also in place for the NHS 111 service.

Formal quality monitoring is supplemented by regular frontline visits via the Listening Watch programme. This is an annual programme which covers all geographic areas, frontline services and support services. It gives directors and other senior managers the opportunity to hear directly from staff about a wide range of issues and to discuss safety and quality-related issues. Non-executive directors also undertake regular visits to frontline and corporate functions. After every visit, senior staff record their learning and a six-monthly report is presented to the Trust Senior Management Group. Key issues are discussed and actions agreed and, wherever possible, feedback is provided to staff on actions taken by the directors and other senior managers as a result of their visits.

## 4.2 Internal audit

During 2012-13 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 2012-13 were:

| Audit subject | Outcome |
|---|---|
| Quality Accounts and Strategy | Significant assurance |
| Lessons Learned from serious incidents | Significant assurance |
| CQC standards self-assessment | Significant assurance |
| Information governance | Significant assurance |
| Clinical records management | Significant assurance |
| Clinical audit | Action plan is in place |

The recommendations of the audit of the YAS clinical audit function were published in January 2013 and an action plan was put in place to address the risks and issues highlighted. Audit committee received a further assurance report in April 2013 highlighting the following progress:

- new, structured clinical audit programme for 2013-14 to prioritise resources for planned audits
- agreement of a long-term clinical audit plan and business case by the Trust Executive Group to increase YAS's capacity to conduct audits recommended by NICE and support individual clinicians condition local audits
- joint programme with the YAS IT department to improve scanning and verification software.

## 4.2 External scrutiny

Throughout 2012-13 YAS continued to move through the process of external scrutiny of arrangements for risk, safety and quality governance which is required as part of our Foundation Trust application. This was initially overseen by Yorkshire and the Humber Strategic Health Authority, until this responsibility transferred to the Trust Delivery Authority under the new NHS structures.

Deloitte were commissioned to carry out a review of our quality governance arrangements and provided us with an assessment of our current position and key areas to be addressed. The most recent review was reported in February 2013 and assessed the Trust as being within the required quality governance rating for Foundation Trusts. Priorities highlighted were addressed through in-year actions and/or 2013-14 workplans.

# Section 5.0

# Looking ahead to 2013-14

## 5.0 Looking Ahead to 2013-14

The 2013-14 workplans detailed in this report all 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. In addition they link into an overarching strategic context of achieving compliance with CQC and Foundation Trust requirements. This includes a full review of the learning from the Public Inquiry into Mid-Staffordshire NHS Foundation Trust and targeted actions to address its implications for YAS.

The work established in 2012-13 to foster cross-departmental working relationships between the Standards & Compliance, Clinical and other directorates will continue. Together, we will continue to build and embed risk, safety and clinical quality management arrangements at all levels within our core operational departments of A&E, emergency operations centres, Patient Transport Service and NHS 111.

During 2013-14 we will continue to build effective clinical leadership and the engagement of all YAS employees with an emphasis on patient centred professionalism and the contribution made by every individual employee to delivering safe, high quality care.