Yorkshire Ambulance Service NHS
NHS Trust

An Aspirant Foundation Trust

Risk, Safety and Clinical Quality Annual Report 2013-14

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 2013-14; 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 2013-14 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.

Patient and staff safety are key priorities for YAS. The management, analysis and reporting of incidents and risk is a critical function of the Risk and Safety team. This management ensures that YAS continues to learn and develop a strong safety culture.

1.3 Introduction – Clinical Quality Strategy

High Quality Care for All (2008) remains a cornerstone for quality within the NHS since it clearly defined three key dimensions of quality:

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

More recently other national guidance has contributed to the wealth of evidence and information available regarding clinical quality. Specifically this last year, this has included the government response to the publication of the Mid Staffordshire NHS Foundation Trust Public Enquiry (Hard Truths DoH 2014). In addition both the Berwick Report (DoH 2013) and Cavendish Report (DoH 2013) have added to the enhanced focus on culture with NHS providers and the quality of clinical care and 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.

- Sustaining 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 clinical and cultural issues are identified as the annual priorities within the strategy. 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

1.2 Risk and Safety: systems, process and practice

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 12 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 2013-14 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 on a quarterly cycle at the Risk & Assurance Group, Trust Executive Group (TEG), and individually by Executive Directors. In addition principal risks are reviewed through the Board Committees and periodically in the Board. During 2013/14 the Board also reviewed the function of its committees to ensure rigorous scrutiny of key risks in the BAF and CRR and the effective flow of information on key risks between all Committees and the Board.

2.1.1 Delivery of work plan and key achievements for 2013-14

Thirteen strategic risks were identified through Board discussion. These were incorporated into a refreshed BAF, which was presented to the Audit Committee and subsequently to the Public Board for approval.

Recruitment to the key posts of Associate Director of Risk & Safety, Risk Manager and Head of Safety took place in order to strengthen the Quality and Risk team.

The Board and supporting committees have agreed changes to the Trust risk matrix which is used across risk and incident assessment. These changes were introduced throughout 2013-14 and ensured that higher level risks received an appropriate level of debate and analysis.

Through the Board Assurance Framework (BAF) review with Executive Directors and risk review presentations at relevant committees and groups, the Senior Management Team have received further education and development on how to effectively manage risk within their respective Directorates.

Following the successful procurement of the new risk management system (Datix) in 2012/13, the use of this has now been embedded across the Trust with increased reporting and a marked improvement in the quality of reports which are made available to the Board, supporting committees and across all Directorates at regional and local level. On-going training and development of the Datix database functionality is underway with a focus on how best to use the data to ensure we deliver a high quality service that is always learning.

All risk registers have now been transferred onto Datix and a process for managing these implemented in each Directorate. Live review of the CRR takes place in the Risk and Assurance Group meeting on a monthly basis.

Educational and training across the Trust, has been strengthened, through mandatory training and corporate induction. Both have been revised with the aim of promoting staff engagement with the processes and practice of risk management.

2.1.2 Local Risk Management

The Datix system enables effective reporting at local level. Within each business area, managers are acting as risk leads and are held accountable for the management of risk registers and delivery of associated actions.

Throughout 2013-14 the content of all local risk registers has been reviewed with the support of the Risk Manager. This has enabled robust and current risk registers to be uploaded onto Datix, and for local managers to be accountable for the delegated responsibilities associated with risk management.

2.1.3 Safety Alerts

The Central Alerting System (CAS) is a web-based cascading system for issuing patient safety alerts, important public health messages and other safety critical information and guidance to the NHS and others, including independent providers of health and social care.

Alerts available on the CAS website include safety alerts, CMO messages, drug alerts, Dear Doctor letters and Medical Device Alerts.
When a CAS Alert is issued, it is received into YAS by email to a distribution list that contains selected members of the Risk and Safety team, who then assign the alert to the appropriate manager for review.

The managers review the alert to ascertain where actions need to be taken and this is then forwarded to the appropriate manager to implement those actions required. Once all actions are completed information is then provided back on to the CAS system to close down the alert.

The following table shows the alerts assessed for relevance during 2013/14 and the status of those requiring response.

CAS Alerts 2013/14

Originated By	Relevant	Not relevant	Total	Response
DH Estates and Facilities	0	91	91	
MHRA Medical Device Alerts	0	82	82	
NHS England	3	6	9	1 completed 2 action ongoing
Total	**3**	**179**	**182**	

The alerts assessed as relevant and requiring action were:

- Addressing rising trends and outbreaks in carbapenemase-producing Enterobacteriaceae (CPE) (action complete)
- Improving medical device incident reporting and learning
- Improving medication error incident reporting and learning

The actions still in progress are near completion and are still within the target dates set.

2.1.4 Looking ahead - key priorities for 2014-15

The following priorities have been set for 2014-15:

- Continue to work with risk leads and operational management groups across the Trust to ensure risk management is further embedded at all levels of the organisation. This will include sustaining and developing a high standard of reporting which analyses themes and trends to enable managers to more readily identify actions required form improvement.

- Maintain and develop the BAF with Executive Directors to ensure key risks to strategic objectives are being managed and monitored appropriately.

- Continue to develop the functionality of the Datix risk management system to actively learn from adverse events arising and to capture progress against risks.

- Build internal capacity for robust incident investigation with in depth root cause analysis training being delivered to key managers across 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 Trust aims to ensure that all information it holds is processed in accordance with the Data Protection Act 1998, Freedom of Information Act 2000 and other related legislation.

The Senior Information Risk Owner during 2013-14 was Steve Page, Executive Director of Standards and Compliance.

The Caldicott Guardian during 2013-14 was Dr Julian Mark, Executive Medical Director.

The aim for 2013/14 was to move from compliance level 2 to compliance level 3 for as many requirements as possible by the end of March 2014 and this was achieved. East Coast Internal Audit Consortium were also commissioned to provide assurance on our self-assessed scores for 2013-14.

2.2.1 Mandatory reporting

Serious incidents relating to information governance (those 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 an electronic reporting tool which automatically assesses the severity level. The severity is assessed by the context, scale and sensitivity of the incident. Level 2 or above incidents are also required to be reported on the Strategic Executive Information System (STEIS). In addition to mandatory reporting, level 0 and level 1 information governance incidents are reported and investigated locally within YAS through the Datix system.

YAS had no IG serious incidents of level 2 or above in 2013/14 reportable to Department of Health, Information Commissioner's Office and other regulators.

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

SUMMARY OF OTHER PERSONAL DATA RELATED INCIDENTS IN 2013-14		
Category	**Breach Type**	**Total**
A	Corruption or inability to recover electronic data	
B	Disclosed in Error	6
C	Lost in Transit	
D	Lost or stolen hardware	
E	Lost or stolen paperwork	3
F	Non-secure Disposal – hardware	
G	Non-secure Disposal – paperwork	
H	Uploaded to website in error	
I	Technical security failing (including hacking)	
J	Unauthorised access/disclosure	2
K	Other	

During the past year there has been one incident involving a lapse of data security which was reported to commissioners as a serious incident. This related to inadvertent publication of some additional respondent details in a posting of patient survey results on the Trust website. Following consultation with the Information Commissioner's Office it was established that the information released represented minimal risk to any individual respondents and the necessary action to prevent recurrence was completed by the Trust.

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

2.2.2 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 2013-14 was 81% and was graded as satisfactory (green). This was an improvement on the 2012-3 score of 73%.

Initiative	March 2014 Self-Assessment Submission	Grade
Information Governance Management	100%	Satisfactory
Confidentiality and Data Protection Assurance	83%	Satisfactory
Information Security Assurance	82%	Satisfactory
Clinical Information Assurance	66%	Satisfactory
Corporate Information Assurance	66%	Satisfactory
Overall	**81%**	**Satisfactory**

2.2.3 Delivery of 2013-14 Work Plan and key achievements.

An ambitious IG work plan was developed for 2013-14 based on a risk assessment of YAS's current IG position and the requirements of the Department of Health's IG Toolkit (version 11 published June 2013).

The Work Plan is monitored by the Information Governance Working Group and in addition in-year assurances of progress against the work plan are presented to the Quality Committee.

As part of the 2013/14 Internal Audit plan for the Trust, a review of the Trust's evidence in support of the IG Toolkit has been undertaken. The main objective of the review was to ensure that valid evidence supported the Trust's IG self-assessment for 2013/14 and that the scores assigned were appropriate and justified. Internal Audit provided the Trust with significant assurance in respect of the evidence in place to support the self-assessed scores and the systems in place for managing the Toolkit submission.

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 the Statutory and Mandatory Training Workbook 2013 - 2015. Trust-wide awareness-raising actions included regular

information governance messages in the weekly Operational Update bulletin, the Net-Consent system where staff receive messages when logging on to their computers and via poster materials.

The following IG related policies were reviewed and updated within 2013/14: IG Policy, IG Strategy, Data Protection Policy and Associated Procedures, Data Quality Policy, ICT Security Policy and Associated Procedures, Internet Policy and Procedure, Email Policy, Records Management Policy.

Spot checks were carried out to monitor staff information governance practice against Trust policy. This included confidentiality audits undertaken on all Trust premises and a staff questionnaire.

Positive progress has been made during 2013/14 to reduce the risks relating to confidential paper-based records held and stored at some of the more remote sites across the Trusts estate. This work has included archiving and destruction of paper based records in Rotherham and Malton. A records amnesty during the year has helped to prompt station staff to seek advice around the destruction and archiving of historical paper based records. The Inspections for Improvement process has also highlighted records requiring destruction/archive. However there remains a significant archiving and destruction exercise to be carried out from Doncaster Ambulance Station storage facility. Arrangements to undertake this exercise are currently underway.

Work continues to improve the quality of the records held on the CINTAS 'FileTrack' tracking system relating to the contents descriptions and destruction dates of boxes of archived paper-based records held by the Trusts document storage company CINTAS.

A number of ICT software, hardware and technical implements have been progressed by the Trust during 2013/14. These initiatives, which are detailed below, positively contribute to the Trusts assurances around information security.

- The Thin Client rollout (to replace PCs) which has reduced the amount of, or in some cases eliminated, electronic information being stored locally on desktop computers at a significant number of sites across the YAS estate.
- The implementation of Windows 7 throughout the Trust. This has been a necessary roll out for the Trust in order to move away from Windows XP operating systems which will no longer receive security updates from Microsoft from 8th April 2014 onwards.
- Use Microsoft Bit locker on Trust supported laptops in place of McAfee Safeboot. This both reduces the Trusts reliance on 3rd party security products and enables storage of the recovery key in Active Directory.
- Implementation of a new group policy feature of Windows 7 to deny access to all Windows Portable Devices (WPD) such as mobile phones which now show up as portable devices in Windows Explorer rather than drive letters.
- Implementation of DVD device control to prevent the unauthorised writing of electronic data to disk. Specific business functions within the Trust with a requirement to 'write' to disk, have been white listed.

2.2.5 Key risks

The most significant risk relates to records management. With the progression of paperless working alongside new technologies and devices different information governance challenges and risks arise. The Trusts risk management procedures, role of the Information Asset Owner and general understanding of IG by all staff will therefore continue to be critical in the management of information governance and information risk.

2.2.6 Looking ahead – priorities for 2014/15

The IG Work Plan for 2014/15 was approved by the Senior Management Group in April 2014.

Priority work areas are detailed below:

- IG Toolkit (version 12) work areas and performance update in July 2014.
- Progression of treatment plans relating to IG risks on the Standards and Compliance risk register.
- Supporting guidance development and communications to staff to aid implementation of policy.
- Supporting IG assessment (including privacy impact assessment) of new processes and systems.
- Quarterly Information Asset Owner reviews, identification and management of information risk.

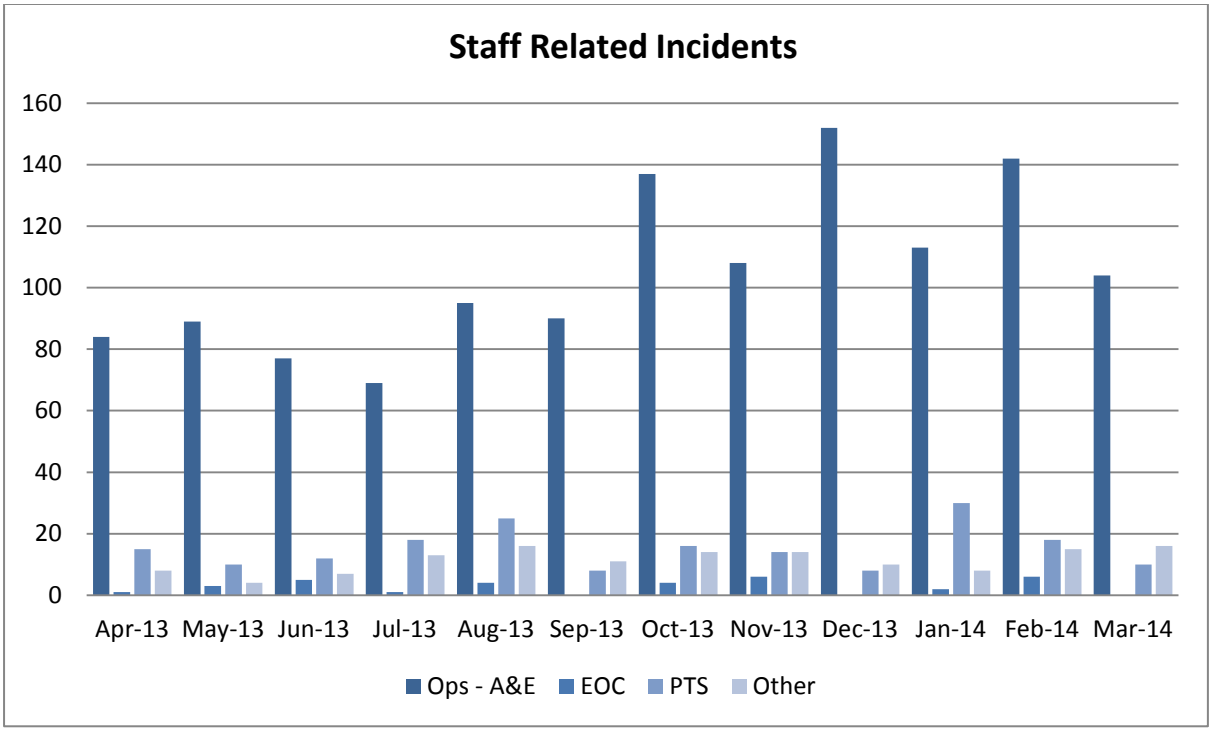
2.3 Health and safety

YAS is committed to ensuring the health, safety and welfare of all our staff and all those people who are affected by our services. We have a health and safety policy and procedures to meet our legal responsibilities under the Health and Safety at Work Act and associated legislation. We also take account of all NHS requirements and guidelines.

Working together with all staff and with our designated staff-side safety representatives, 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 2013-14.



Reported staff incidents have increased over the last 2 quarters of 2013-14 and are higher than levels reported in the same quarters during 2012-13. This is likely to be related to increased awareness of the requirement to report and is indicative of an increasingly safety conscious culture.

Although staff incident numbers have increased in the latter part of the year, analysis of the types of harm occurring across all incidents shows that the proportion of those resulting in “negligible harm” i.e. no harm or minor harm, has increased over the year from 90% in Q2 to 96% in Q4. Therefore, there are indications that the level of harm being experienced through incidents is reducing.

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 below.

Incidents reported in 2013-14 under RIDDOR

Incident Type	Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sep 13	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14	Total
Hit by a moving, flying or falling object	1	2	0	0	0	0	0	0	0	0	0	0	3
Hit by something fixed or stationary	0	1	0	0	0	0	0	0	0	0	0	0	1
Injured while handling, lifting or carrying	1	3	0	2	1	5	7	2	2	3	3	1	30
Slip, trip or fall on the same level	1	1	0	0	1	1	2	3	3	1	2	2	17
Fall from a height	0	0	0	0	0	0	0	0	0	0	0	0	0
Exposed to or in contact with a harmful substance	1	0	1	1	0	0	0	0	0	0	1	0	4
Physically assaulted by a person	1	0	1	0	1	0	0	0	0	0	0	1	4
Another kind of accident	1	0	0	2	3	0	0	3	3	0	0	0	12
Total	**6**	**7**	**2**	**5**	**6**	**6**	**9**	**8**	**8**	**4**	**6**	**4**	**71**

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. There were also 4 incidents in which first responders were exposed to asbestos.

Addressing these areas of harm is a priority for the Trust and the 2013-14 work-plan included focused work on moving and handling, improved slip and trips guidance and operational asbestos awareness and action cards.

The following chart shows data collected by the National Ambulance Risk and Safety Forum and displays benchmarking data that is available.

RIDDOR Benchmarking Data

April 13 - March 14

	EofE	LAS	NWAS	SAS	SCAS	SECAS	SWAS	WMAS	YAS
A&E Inc Air Ambulance	157	43	228	68	79	80	124	78	112
PTS	6		14	34	3	17	7	7	9
GP Out of Hours									
Other	1			4	3	2	5	1	4
Total	164	43	242	106	85	99	136	86	125

2.3.2 Delivery of work plan for 2013-14 and key achievements

Incident reporting

The Trust moved from its existing accident reporting and recording system (Prism) to Datix. This brings much improved ability to interrogate data and produce reports including live dashboards. This allows the Trust to monitor incidents more closely and better determine their causes and plan subsequent required actions.

RIDDOR 2013

The Risk & Safety Team have continued to report RIDDOR incidents where they meet the revised regulations as published in the government's Lofstedt Review.

Risk Assessment

Awareness raising and the development of procedures and simple templates have contributed to the improvement of management risk assessments. Systems have been developed via the Intranet to record and monitor these assessments.

Dynamic Risk Assessment

The need to improve policy and training on DRA has been recognised and awareness raising sessions on the national decision making tool, best practice and the development of protocols have been initiated during 2013/14.

Operational Risks

Risk assessment for rare high risk events encountered when responding to incidents such as asbestos, chemicals, confined spaces, railways, live electricity, water, mud and ice, has progressed on a national level, with YAS leadership. Standard operating procedures and risk cards are being developed to be carried on all front line vehicles. The asbestos risk assessment has been completed in 2013/14.

Display Screen Equipment (DSE)

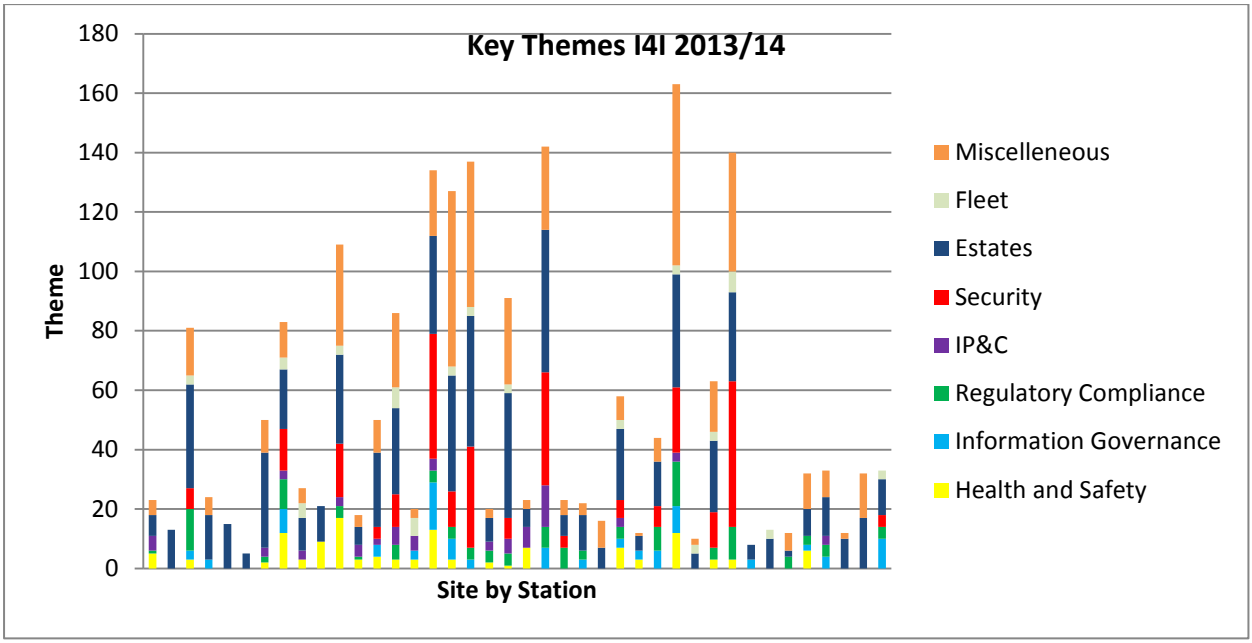
New guidance was produced in January 2014 to reduce the risk to staff when using DSE. The procedures necessary to enable the guidance to operate are currently being implemented.

Inspections for Improvement (i4i)

The process was refreshed and is now a more multi-disciplined inspection for improvement of all premises. This now includes all statutory elements including health and safety, Infection prevention & Control and Information Governance as well as an engagement opportunity. Follow up action is agreed with local management teams to

address any specific issues arising and broader themes are used to inform the Trust level work plans.

Key themes identified are detailed in the graph below.



Health & Safety Policy and Associated Guidance

The Health & Safety policy is under significant review and improved guidance is being developed for staff, including slips trips and falls, DSE, equipment, COSHH and PPE, work at height and electricity.
This is due to be completed summer 2014.

Moving and Handling

Manual handling continues to be a major cause of sickness absence.
A review of the Trust requirements for manual handling is underway. A task and finish group has been established under the direction of the Health and Safety Committee to progress recommendations associated with equipment, training and other aspects of moving and handling practice.

The new equipment bag, selected with the assistance of Loughborough University, was purchased and rollout has been completed. There are real benefits to staff safety that have been identified from the purchase and use of this equipment. In the first 6 months of use there was a 64% reduction in response bag related incidents.

A number of new carry chairs have been introduced in 2013/14. Continued roll out and training for the new carry chairs remains a priority and will continue into 2014/15. This will significantly reduce the manual handling element when moving patients down stairs.

Occupational Health

A new single provider was commissioned. The new service includes a single point of access for sickness reporting and improved staff welfare services including physiotherapy referrals for staff with musculoskeletal injuries.

Involvement with HSE

The Trust has worked with the HSE over the past year to strengthen process and practise for staff who suffer a needle stick injury and to strengthen safety for patients travelling with PTS. All the related actions in association with the two specific cases in relation to these issues have been completed.

2.3.3 Key risks

Health and safety, and specifically risk assessment policy, have been reviewed and strengthened during 2013/14. Implementing the revised policies and improving risk assessment process and practice are a priority action for 2014/15.

A performance dashboard has been developed to monitor and report the process and completion of accident investigations by managers.

The functionality of Datix has enabled improvements in reporting, management and analysis of health and safety incidents. Datix is now programmed to direct managers through concise steps to better manage incidents through a series of questions and triggers. This will ensure greater consistency in investigations which will subsequently lead to improved analysis and opportunity for learning.

2.3.4 Looking ahead – priorities for 2014-15

Priorities for the coming year include:

- The implementation of more effective and concise policy and procedures for general day to day health and safety practices with the introduction of the improved policy and guidance.

- Improved dynamic risk assessment and enhanced staff awareness and training materials relating to best practise will be utilised to ensure the safety of all responders.

- Further work to reduce risks associated with moving and handling. A reduction in moving and handling injuries/absences is expected to be realised during 2014/15. This will be due to improved assessments, training and use of mechanical aids including tail lifts and loading ramps/winches, impact of the compact 2 track chair and new equipment bag introduced in 2013/14, utilisation of the incident support vehicles (bariatric equipment) and associated equipment, and planned implementation of lighter defibrillator and ECG monitoring kit for single responders.

- Implementation of new operational risk procedures for example, in relation to responding in confined spaces, ICE (chemical), water, incidents with electricity involvement.

2.4 Security

2.4.1 Delivery of work plan and key achievements for 2013-14

In 2013/14 the designated Security Director for the Trust was the Executive Director of Standards and Compliance.

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 2013-14 25 ambulance stations and nine strategic premises across YAS had lockdown procedures in place with full access control and CCTV.

In addition, work was completed to install a Controlled Drugs (CD) room at the new premises of the Air Ambulance at Nostell Priory, Wakefield; and the new HART building at Manor Mill Lane, Leeds has been provided with access control and CCTV.

186 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 table below indicates the number of security incidents reported 2013/14. These incidents all fall into the national Security Incident Reporting System (SIRS) categories and have therefore been uploaded onto the SIRS database at NHS Protect.

Incident type	Number
Physical assault on staff by patient/relative or public	104
Threats of physical violence and verbal abuse by patient/relative or public	162
Thefts of trust property	10
Incidents of criminal damage to trust property ie vehicles, equipment and premises	6

In addition, in 2013/14 the following number and types of incidents were reported via the Trust incident reporting system DATIX which are not required to be reported to SIR's:

194 Security Incidents

449 Violence & Aggression Incidents.

Staff physical assaults and verbal abuse.

The work which has been undertaken by the data flagging group has had an effect on reducing the impact of violence and aggression from patients with challenging behaviour. Addresses are flagged and crews are warned of potential dangers prior to their arrival, when attending these patients, staff awareness combined with Conflict Resolution Training (CRT) is helping to reduce the risk of staff exposure to assaults.

Work that is being done by the frequent caller manager, the LSMS and external agencies, e.g. Police, GP's and probation services. This multi-agency group is having a very positive effect using alternative treatment plans/pathways for frequent callers with violent and or aggressive tendencies. These plans will reduce the frequency of attendances by ambulance to these type of patient significantly and our staff that do attend will be supported fully by police to ensure their safety.

Security of Trust Assets

The installation of cctv on trust premises and vehicles appears to be having a very positive effect in reducing thefts and anti-social behaviour on and near trust property and vehicles. Thefts from stations with CCTV and access control, and from vehicles, has reduced significantly over the last 5 years, despite a national trend in thefts from non-domestic premises, which have been targeted for scrap metal, fuel, medical gases. It's worth noting that the station CCTV is also having a positive impact on the local community that live in very close proximity to ambulance station. feedback from police officers have said that CCTV recovered from ambulance stations has resulted in several prosecutions of offenders for incidents which have occurred in the local areas.

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 as detailed in the table below.

Sanction	Number
Community service order	17
Custodial sentence	5
Fines	31
Internal sanction, data flag/warning letter issued	62
Police cautions	15
Suspended prison sentence	16
Verbal Police warning	30
Total	177

Self Review Tool (SRT) NHS PROTECT

In June 2013, all NHS trusts were asked to complete the new NHS Protect self-review tool kit for security management. The tool kit enabled the organisation to assess itself against the new NHS security management standards and the findings from this self-review has informed the work required in the trust's security management annual work plan.

The SRT audit was conducted in January 2014 against standard 4 "Hold to Account".

The evidence highlighted full compliance with the exception of one element which was graded as “amber”. This has been incorporated into the 2014/15 work-plan for reaudit in November 2014 when full submission is due again to NHS Protect.

2.4.3 Key risks

The CCTV policy has been reviewed and approved through the Trust governance processes.

2.4.4 Looking ahead – priorities for 2014-15

There will be a focus on security management training, particularly seeking to reach any clinical supervisors who were not trained in 2013-14. 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 from vehicles.

The process of reporting security incidents is now via a new electronic system, the Security Incident Reporting System (SIRS). This function is now fully operational since the YAS Datix system has been designed to allow automatic production of SIRS reports for checking and monthly upload. The trust will continue to self-assess annually against the new NHS security standards involved in 2013/14 and will review this assessment via Quality Committee prior to admission to NHS Protect.

2.5 Infection prevention and control

2.5.1 Report from the Director of Infection Prevention Control

In 2013-14 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 2013-14

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

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 commenced in July 2013 with initial priorities of updating the 2013-14 Infection Prevention and Control work plan to take into account recent recommendations relating to occupational health and reviewing all IPC policies and procedures.

Progress with the 2013-14 work-plan included:

- reviewing existing Trust processes for IPC audit, including hand hygiene, premises cleanliness, vehicle cleanliness and cannulation

- review of the procedure for deep cleaning vehicles and the assessment of this process via the Inspections for Improvement programme

- developed arrangements with the YAS Occupational Health providers to ensure IPC advice is available 24 hours a day, seven days a week

- review of all YAS IPC procedural documents to ensure that they are clear and accessible to frontline staff

- benchmarked YAS IPC systems and processes with other ambulance services was undertaken.

2.5.3 Compliance with CQC standards

During 2013-14 YAS maintained compliance with the requirements of the *CQC Essential Standards of Quality & Safety* – outcome 8: cleanliness and infection control.

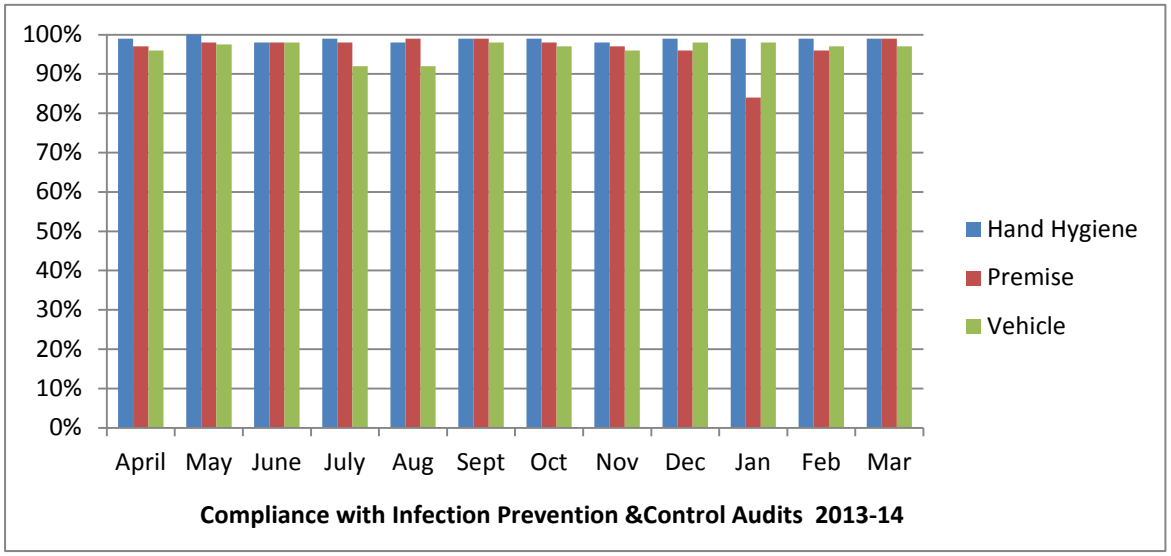
2.5.4 IPC audit

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 Risk and Safety team. Additional validation audits have been completed on a quarterly basis across each CBU.

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 that form part of the Inspections for Improvement programme.

There is growing evidence that IPC audits are communicated through to station level and are visible on notice boards. The Risk and Safety team have altered the reporting format for audits to make it more visually attractive and informative.

Infection Prevention and Control monthly audit compliance 2013-14



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 2013-14.

Vehicle cleaning	Apr-13	May-13	June-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
% of vehicles cleaned within specific time period*	97	99	98.	98	98	98	98	98	98	100	100	99

2.5.5 IPC training

The proportion of YAS staff compliant with IP&C training continued to increase in 2013-14 and at year end was at 96%.

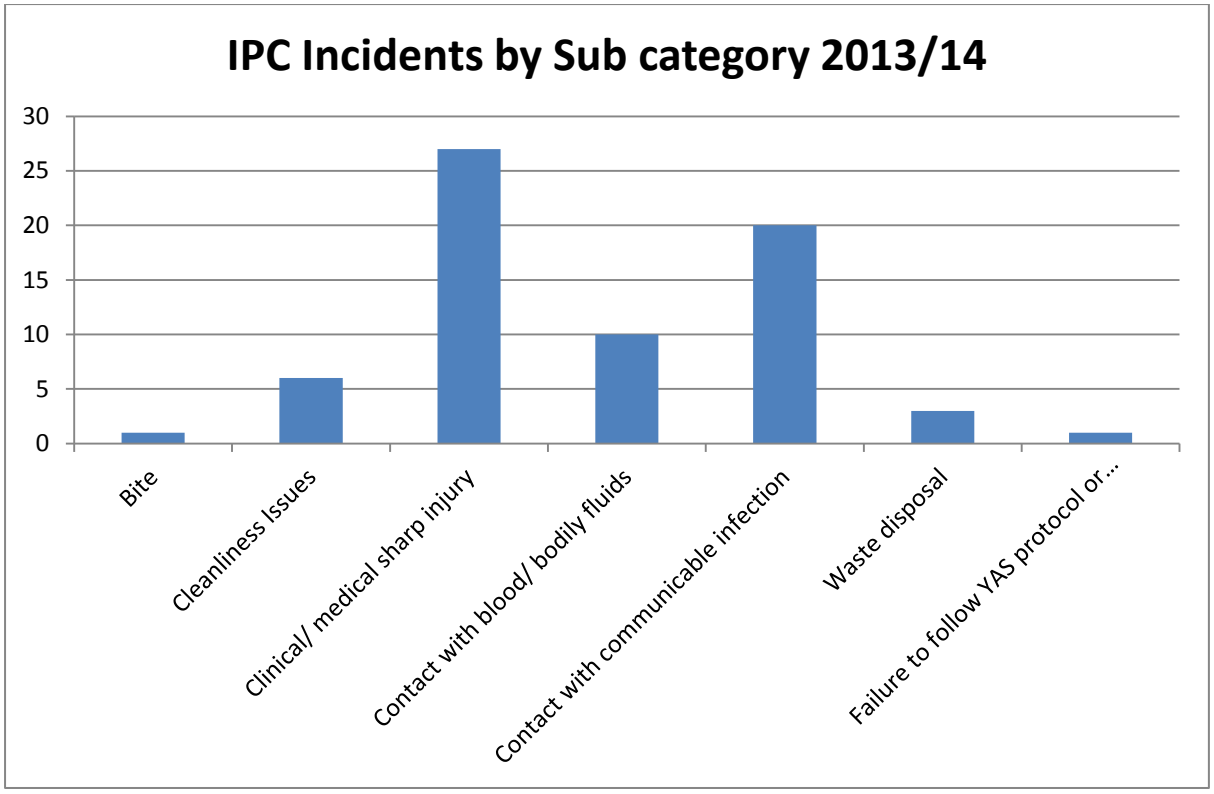
IP&C training is provided at the time of appointment to the Trust through corporate and local induction. Refresher training is provided either through a statutory and mandatory workbook or through two-yearly tutor-led programmes for operational staff.

2.5.6 Occupational exposure

Occupational exposure incidents remain the highest reported incident category for infection prevention and control. Each incident and near misses involving exposure is 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 is 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.

Collaborative work has been undertaken to ensure colleagues in acute hospitals give appropriate support to YAS staff who are subject to an occupational health exposure. In line with learning from incidents, the Occupational Exposure Policy has been reviewed and simplified.



2.5.7 Key risks

A consistent finding from IPC audits was the need to repair damage to upholstery, predominantly in PTS vehicles. The Fleet department have commissioned a local provider to make new chair covers for all makes of chairs used across YAS. During routine fleet inspection the damaged chair covers can then be replaced without delay. This action has led to a reduction in the number of PTS vehicles being noted as having damaged and torn upholstery.

During the hand hygiene validation audits, it became evident that staff were not always adhering to the dress code in relation to wearing items such as rings with stones, bracelets and non-washable watches. IPC good practice reminders have been publicised through the weekly Operational Update staff bulletin throughout the year; with specific updates sent in response to MHRA patient safety bulletins such as the recent publication on carbarpenamase producing enteriobacteriae. In addition, managers have been encouraged and supported to challenge staff who do not comply with best practice uniform standards.

2.5.8 Next steps for 2014-15

- Refresh the information for staff on the Trust intranet and public information on the Trust website

- Refresh of IPC training for all YAS staff and contractors

- Maintaining robust IPC procedural documents to ensure that they are clear and accessible to frontline staff, and current with published research and best practice guidance.

- Further benchmarking YAS IPC systems and processes with other ambulance services.

- An Infection Prevention and Control road show campaign to include the 5 moments of hand hygiene, safer sharps practice, asepsis during insertion of cannula, standard precautions and decontamination processes.

Section 3.0
Clinical Quality

3.1 Patient Safety

3.1.1 Incident reporting

Yorkshire Ambulance Service actively encourages staff to report patient safety incidents and near misses. During 2013-14 there has been an increase overall of the numbers of incidents reported. A positive safety culture is indicated by high overall incident reporting levels but with few serious incidents and this continues to be a high priority for the Trust. Plans for 2014/15 include further development of our learning from incidents, near misses and issue/concerns reporting.

Staff are encouraged to report all incidents, near misses and issues/concerns, 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 the Executive Medical Director and attended by our clinicians at director and associate director level, has reviewed themes and trends across incidents, complaints, claims, coroners' inquiries and safeguarding cases and identifies what can be learnt for the future to reduce the risk of re-occurrence.

3.1.2 Number of Adverse Incidents for 2013-14

New Incidents Reported	Ops - A&E	EOC	PTS	111	Other	TOTALS
Apr-13	267	6	68	41	13	395
May-13	286	9	50	26	16	387
Jun-13	203	9	54	12	20	298
Jul-13	249	13	72	24	32	390
Aug-13	244	5	82	22	32	385
Sep-13	222	4	38	8	21	293
Oct-13	301	9	67	15	28	420
Nov-13	261	18	72	17	21	389
Dec-13	316	6	61	16	21	420
Jan-14	282	10	84	19	21	416
Feb-14	296	9	70	23	22	420
Mar-14	265	9	65	18	23	380

These figures equate to:

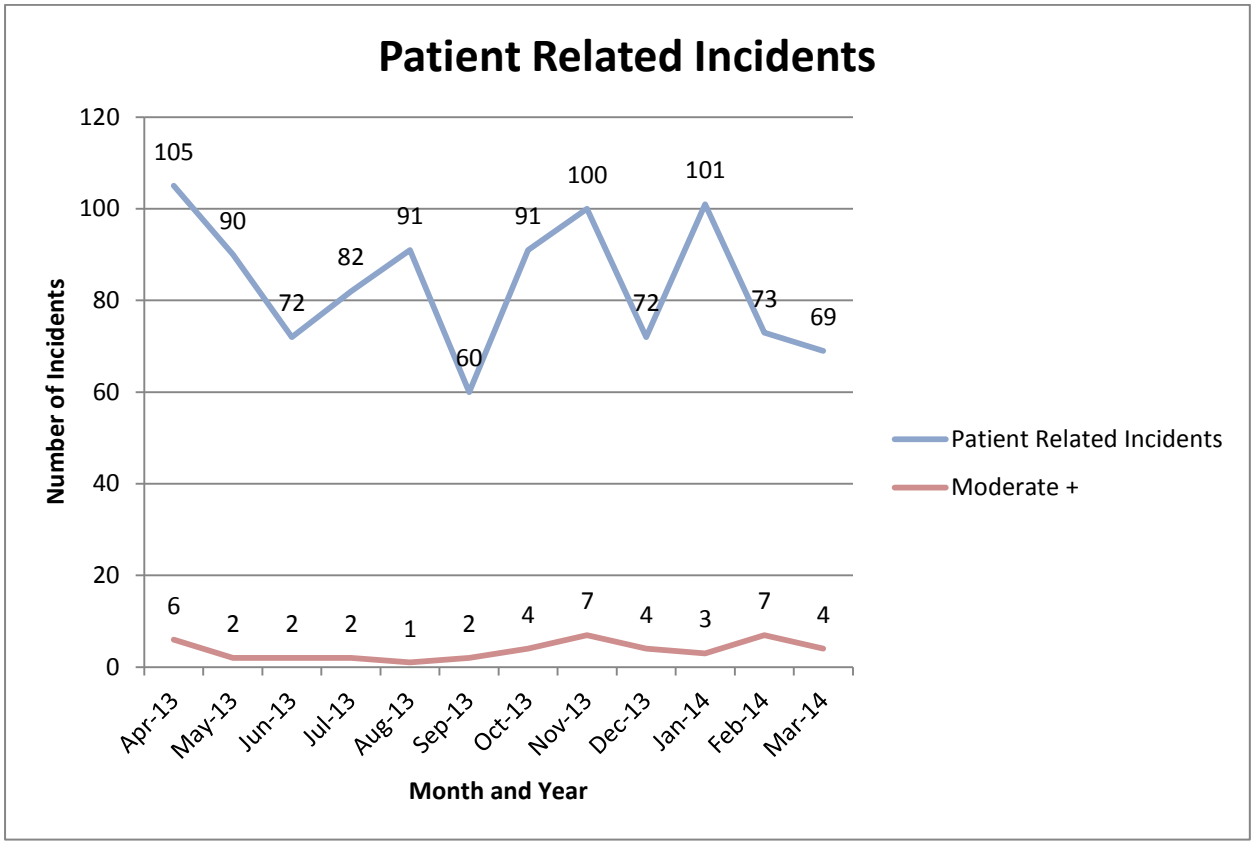
- one adverse incident relating to A&E operations reported for every 189 emergency incidents
- one adverse incident relating to the Emergency Operations Centre reported for every 1,818 emergency calls

- one adverse incident relating to PTS reported for every 2,760 patient journeys.

3.1.3 Adverse Incidents Relating to Patient Care 2013/14

Patient Related Incidents (13-14)	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Ops - A&E	46	52	34	40	41	35	49	50	40	58	36	30
EOC	3	3	3	8	0	3	4	12	3	5	3	4
PTS	22	10	20	17	26	11	21	19	14	25	15	17
111	33	22	9	15	19	5	10	12	12	13	17	16
Medical Ops	0	0	4	1	5	5	7	6	3	0	0	0
Other	1	3	2	1	0	1	0	1	0	0	2	2
TOTALS	105	90	72	82	91	60	91	100	72	101	73	69

The chart below identifies the level of moderate and above harm in comparison to the number of patient related incidents reported throughout 13-14.



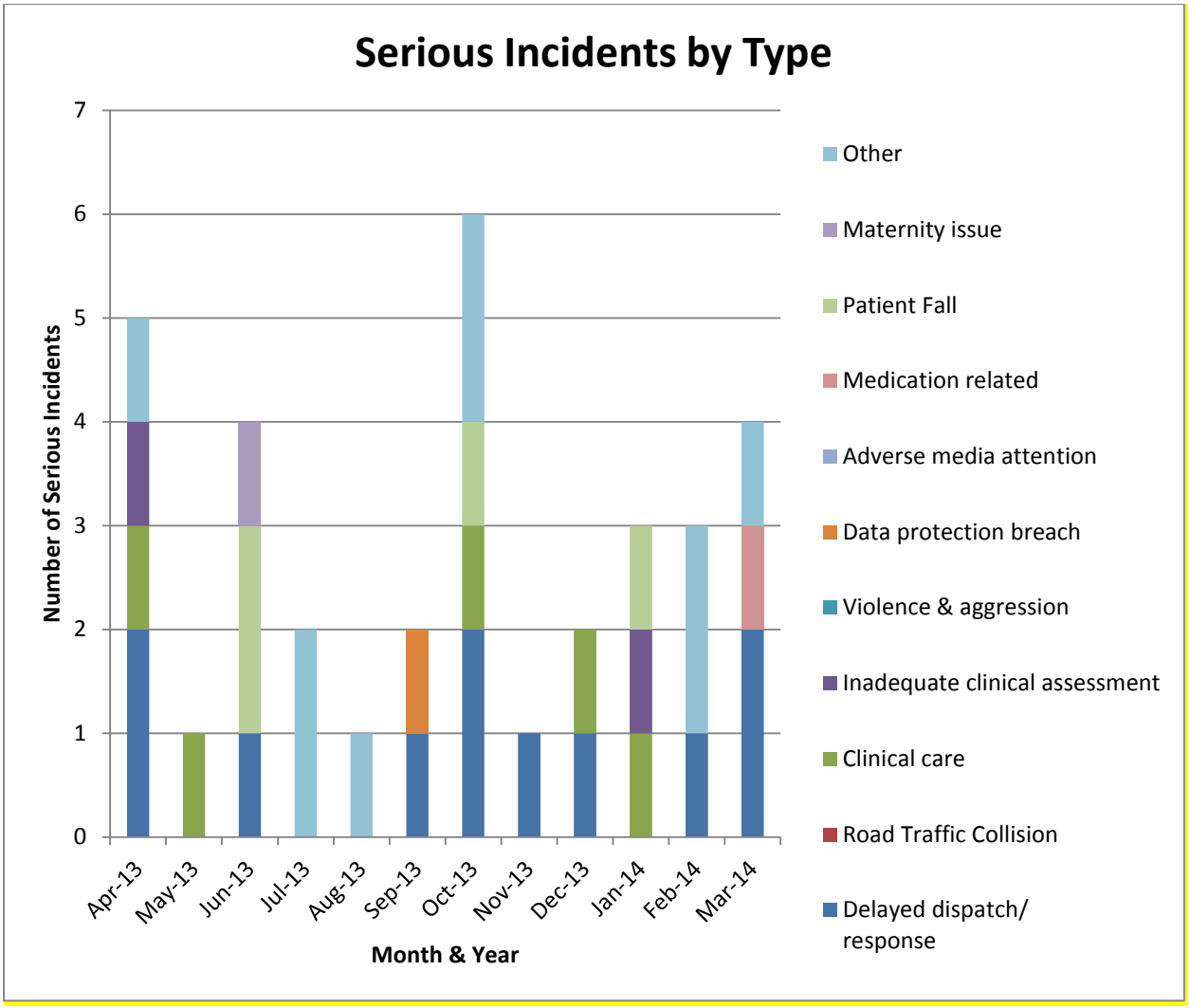
The unpredictable nature of the work carried out by A&E operations staff and the difficult circumstances in which they sometimes provide care means that a higher number of incidents have occurred in this area. A significant number of these incidents relate to care pathways or care planning issues. YAS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

Within PTS the highest numbers of incidents relate to slips, trips, falls and injuries sustained whilst being transported on a vehicle. We have 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	Ops - A&E	EOC	PTS	111	OTHER	TOTALS
Apr-13	1	1	1	2	0	5
May-13	1	0	0	0	0	1
Jun-13	1	0	2	1	0	4
Jul-13	0	1	0	1	0	2
Aug-13	1	0	0	0	0	1
Sep-13	1	0	0	0	1	2
Oct-13	1	2	2	1	0	6
Nov-13	0	0	0	1	0	1
Dec-13	1	1	0	0	0	2
Jan-14	2	0	1	0	0	3
Feb-14	2	0	0	1	0	3
Mar-14	1	0	0	1	2	4



In September 2013 a review of SIs in the Patient Transport Service related in particular to falls 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 has been undertaken by the PTS representatives and Risk and Safety members within the Safety Thermometer Steering group.

Being Open

The “Being Open” process is a set of principles that Health care providers should use when communicating with patients, their families and carers following a patient safety incident in which a patient has been harmed. Through the Serious Incident process, an investigation is instigated in order to review care and service issues, causational factors and actions to take in order to reduce the risk of the incident reoccurring. The Being Open process enables Yorkshire Ambulance Service to share the report with patents and their families to discuss the investigation findings, actions to be taken and answer any questions they may have. The Being Open process for serious incidents is co-ordinated through the Standards and Compliance Directorate.
From April 2013 to March 2014, number of Being Open cases that were logged and processed: 39

3.1.5 Improving patient safety - Delivery of work plan for 2013-14

Safety Thermometer

Improving 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 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)
- Medicine errors

- **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 the vehicle was moving. Further analysis identified that improvements were required around the PTS booking process, patient risk assessments and the allocation of correct vehicles and these issues have been addressed.

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

Analysis of data during 2013-14 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.

Additional guidance has been issued to staff based on analysis of incidents to date. Further review will be carried out in 2014-15 to determine how these incidents can be reduced.

- **Medicine errors**

Medicine related errors, which includes administration of incorrect dose and/or incorrect drug, is the only category of incidents in which harm had shown an increase part way through the year. This may have been due to stricter auditing of drugs discrepancies and therefore an increased awareness of staff in their need to report drug these discrepancies via Datix. However in the last quarter of the year, in particular February and March reported medicine errors fell significantly.

The new Controlled Drug standard operating procedure revisions were put in place during Q3 and the effectiveness of this change been noted within Q4 reported incident results.

It is intended that these measures will reduce patient safety incidents by encouraging staff to consider the wider impact of drug stocks thereby making sure vehicles are handed over with medication in stock and in date.

All incidents are reviewed by the medicines management group for human factors these are then feedback into the SOP's and training sessions. Actions have been completed in collaboration with the Medicines Management group to improve checking of medicines, storage of medicines and audit of clinical practice.

Further work on medicines management is underway via the medicines management group which meets on a monthly basis. The Datix system is used to highlight possible themes and trends to ensure they are sighted on where medication errors occur and if there are any emerging patterns that relate to geographical areas or specific staff.

- **Reducing levels of harm**

During 2013-14 multidisciplinary Patient Safety Steering Group was 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. The membership includes the YAS expert patient.

A considerable amount of work was undertaken in relation to falls following a number of incidents in both the A&E and PTS services occurring as a result of patients not being adequately secured. A full audit was undertaken to assess the provision of harnesses on vehicles and a considerable amount replaced to ensure patient safety. A re-audit was undertaken in June 2014 to ensure adequate provision was in place and there has been a significant reduction in these incidents during 14-15.

During Q4 13-14 the Risk & Safety Team worked closely with the Clinical Directorate to incorporate key lessons learned from clinical SIs into update training for 14-15. This included reference to treatment of sepsis patients, recognising the critically ill patient and the importance of conducting a thorough clinical assessment. This work has continued through into 14-15 with immobilisation of patients included within clinical updates also, following a trend identified in incident and SI reporting.

3.1.6 Key achievements

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

Improvements completed within 2013-14

- Further communication with staff regarding requirement for open and honest incident reporting has been achieved.
- The patient leaflets and poster raising awareness about self-reporting of falls is available at patient reception centres.
- The public and patient involvement forum for moving and handling experiences within YAS was held in Hull during February 2014.
- Safety Thermometer Dashboard was launched 'live' on the intranet and is sustained by weekly performance emails and monthly newsletters for frontline staff.
- The Safety Thermometer PTS Roadshow; a campaign to increase staff awareness about patient safety was completed in February and March.
- PTS Safety Champion recruitment and involvement has been completed via the team leaders and Locality Managers.
- Datix reporting shows increasing awareness of patient harms and from early 2014/15 there has been an increase in levels of reporting per se – in particular for near misses and issues/concerns.
- Triangulation with claims and complaints data to enhance reporting and learning is evident and all safety issues are reported to the clinical governance group.
- The safety thermometer steering group has been focused on the most effective interventions to reduce harms and ensures continued implementation.

3.1.7 Next steps for 2014-15

The plan for 2014-15 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

- 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.

During 2013/14 the Accountable Officer for Controlled Drugs has been the Executive Medical Director.

3.2.2 Background

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

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

- National Institute for Health and Care Excellence (NICE)
- Quality, innovation, productivity and prevention programme (QIPP)
- Joint Royal College Ambulance Liaison Committee (JRCALC) guidelines for drug administration.
- Care Quality Commission (CQC)

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

The CQC highlighted a minor concern and noted a number of recommendations for Outcome 9 (Management of Medicines) at the last inspection and these have been addressed. A follow up visit found the Trust to be fully compliant.

3.2.3 Medicines Management Work plan

The new Management of Controlled Drugs Standard Operating Procedure has been implemented during December 2013, and the revised station and vehicle books are now in place. The policy requires that all Controlled Drugs are removed from the vehicle at the end of shift and signed back into the station safe. The station safe is required to be checked every 24 hours by a Clinical Supervisor or a nominated Paramedic.

Detailed assurance reports will be presented to Medicines Management Group on a rolling basis. The report will contain the monthly morphine station audit, the monthly vehicle morphine spot checks, and audit of the 24 hour station checks

The law surrounding the supply of morphine to Yorkshire Ambulance Service has changed. This means that the current providers will have to apply for licences to continue this supply. To mitigate this risk, we are moving to an internal logistics solution for the supply of morphine through the provision of Hub Morphine stores. Hull and East Riding CBU has gone live with the new supply chain. Further CBUs will go live this year.

The latest NPSA safety alert described the integration of local and national systems for reporting and learning from patient safety incidents involving medication errors. Specific actions which YAS is already compliant with include;

- Strengthened clinical governance arrangement for medication incident reporting.

- Identification of a Medication Safety Officer to be a member of the new National Medication Safety Network.

- Identification of a multidisciplinary group within the organisation to regularly review medication incident reports.

Ketamine and Midazolam have been in use by Yorkshire Air Ambulance, and Hazardous Area Response Team Paramedics since February 2013. An audit has been completed into the safety and frequency of use. Ketamine has been used on 45 occasions since launch without any reported patient safety incidents. Ketamine has proved to be a safe and effective analgesia for trauma patients.

A gap in the provision of care for Post-partum Haemorrhage has been identified and Misoprostol will be introduced in 2014/15 to provide front line clinicians with treatment modalities for this potentially life threatening condition.

Review of Adverse Incidents Relating to Medication

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

- Accidental administration of the wrong medication

  The most common are mistaking Paracetamol with Aspirin, 0.9% Saline with 10% Glucose, and Salbutamol with Atrovent. Work is underway to improve the labelling of medicines and crew awareness of checking medicines.

- Missing or out of date medicines

  There are a number of incidents of clinicians at scene finding drugs are missing or out of date, and they are unable to provide treatment for the patient. The issue is also identified and reported during the monthly audits.

Monitoring Usage of Controlled Drugs

The introduction of the Data Warehouse has allowed for greater transparency and ease of accessing individual morphine usage. Monthly reports are reviewed for outlying users of morphine, and Patient Review Forms reviewed.

The MMG monitors all Morphine breakages and losses, whilst breakages remain high YAS are not an outlier compared with other Ambulance Trusts.

Review of Patient Group Directions

A full review of Patient Group Directives has taken place and through Clinical Audit of antibiotics, a revised and refreshed set of PGDs has been agreed for use by Emergency Care Practitioners. Front line clinicians and expert Microbiologists have reviewed and agreed the final documents. These will restrict the number of antibiotics in use, and bring the management of Urinary Tract Infections in line with NICE guidance.

Introduction of New Patient Group Directions

A new PGD has been introduced for use by Clinical Supervisors trained in The Red Arrest Team response for cardiac arrests. The use of small doses of adrenaline in patients post cardiac arrest can help improve their survival to discharge by maintaining brain and vital organ perfusion.

3.2.4 Management of key risks

- The minor concerns arising from the inspection of CQC Outcome 9 have been addressed and YAS are now fully compliant with CQC recommendations.

- The risk to supply of morphine has now been mitigated through the move to internal logistics and hub stations. This risk has now been reduced to acceptable levels.

- A new risk has emerged regarding the temperature at which ambulance medicines are stored, both in stations and out in vehicles. YAS have expressed interests in joining a national audit to monitor medicines storage temperature. This will provide data to allow improved risk assessment.

3.2.5 Next steps for 2014-15

- Complete the regional rollout of the internal logistics of morphine supply, through the identification of hub stations in each area and training of local managers

- Complete and review the pilot of iv Paracetamol for the management of moderate to severe pain.

Develop and roll out the use of Misoprostol for the management of Primary Post-Partum Haemorrhage

3.3 Safeguarding

3.3.1 Introduction

In 2013/14 the designated Executive lead for safeguarding has been the Executive Director of Standards and Compliance.

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 2013-14 work-plan

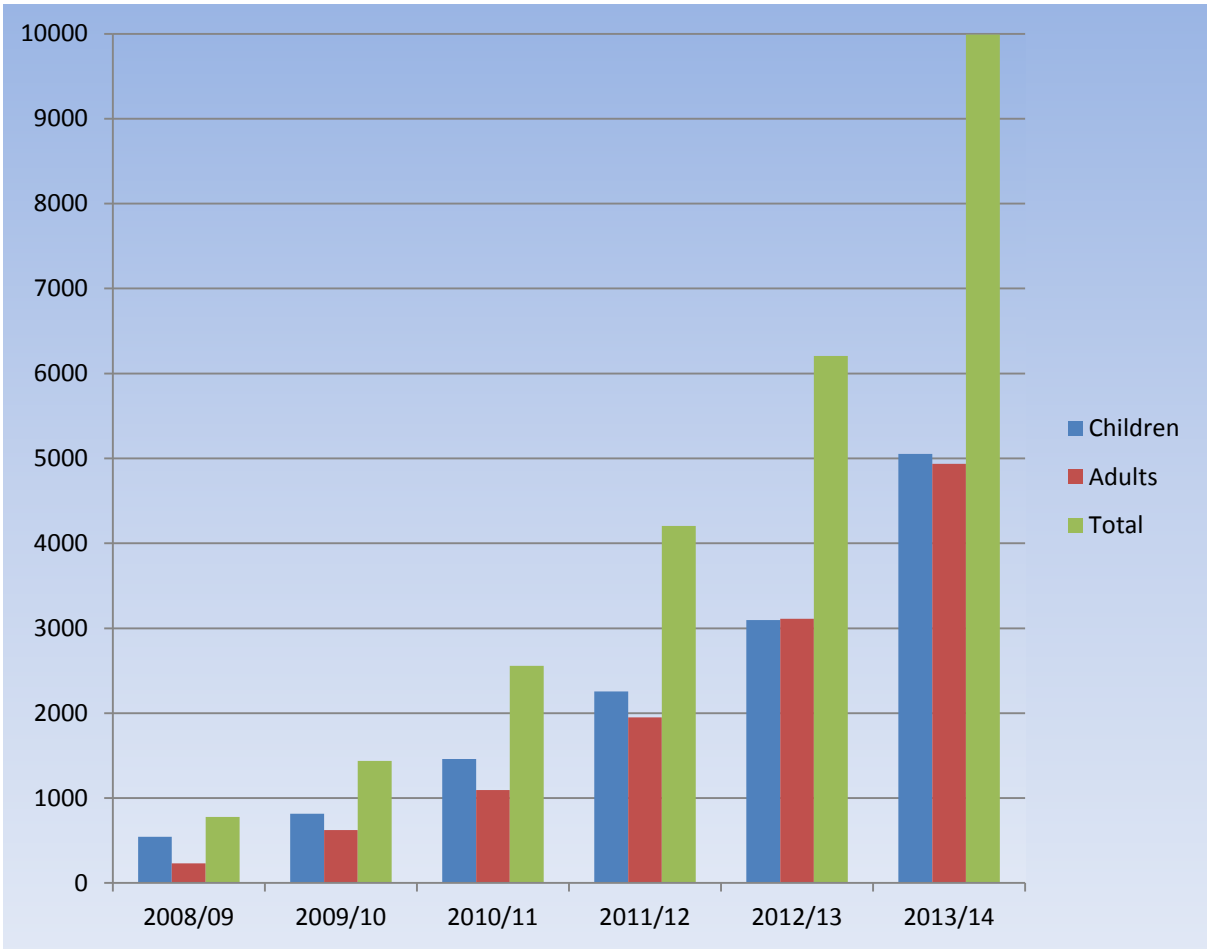
The safeguarding 2013-14 work-plan included:

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

- 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 work-stream and ensuring that plans are put in place for the necessary training.

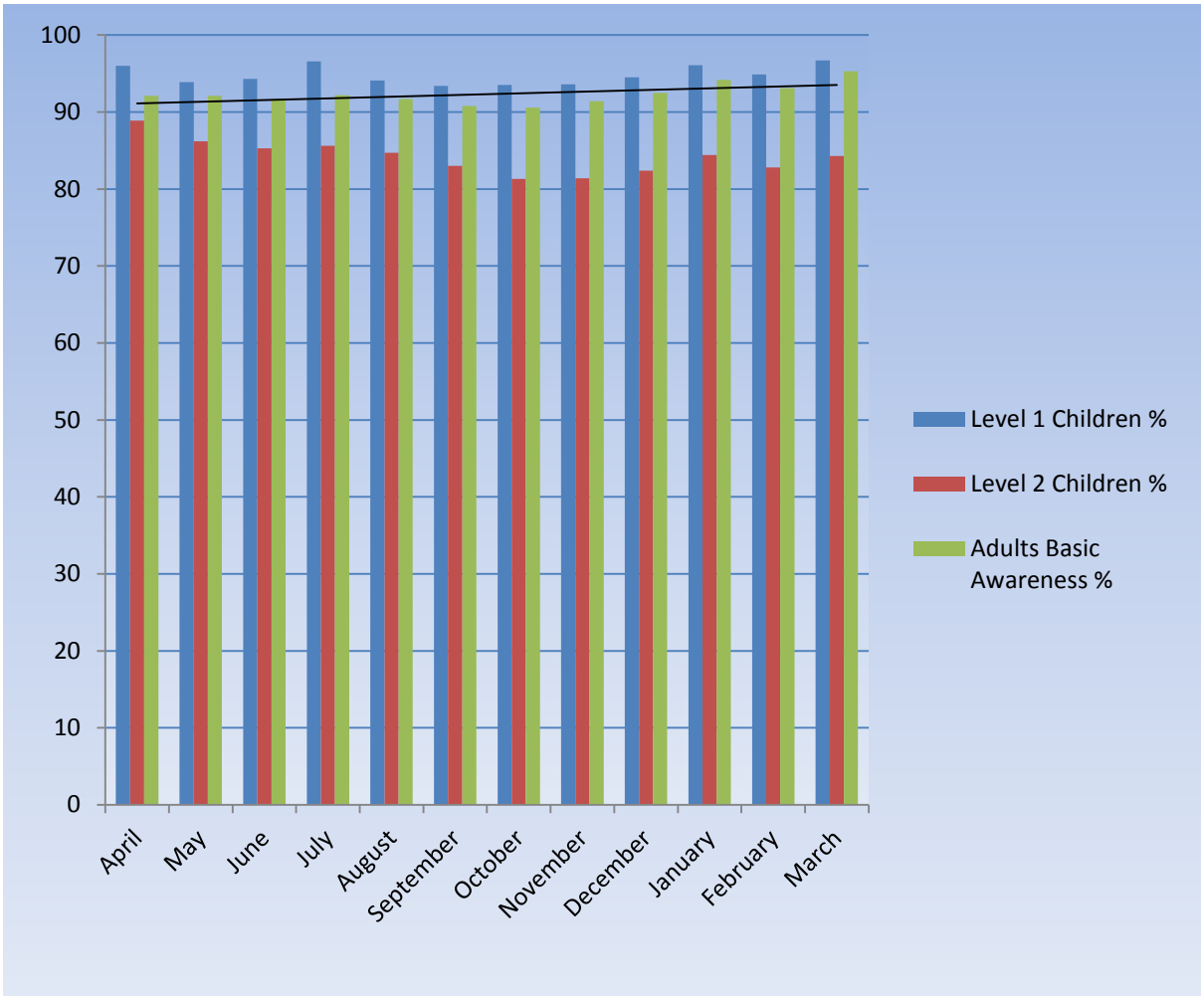
Numbers of adult and child referrals to social care



YAS staff made a total of 9990 referrals to social care in 2013-14. This compares to 4204 in 2011/12 and 6206 in 2012/13. It is clear that the referral rate is increasing year on year due to the sustained education and training and awareness campaigns run by the Safeguarding team.

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 2013-14.

Safeguarding remains a key element of Corporate Induction. The increased time allocation for this has meant that the training has been refreshed to include 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 completed 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 (RCPCH 2009), YAS has a policy and procedure in place for the management of conveyance and non-conveyance of patients under 2 years of age.

The limitations of information sharing, paediatric assessment skills and families individual circumstances can impact on the ability of YAS clinicians to reduce rates of non-conveyance for children under 2. The important element is that the risk for children is reduced as much as possible through referral processes should the child not be conveyed. The Safeguarding team continue to work with operational staff and the clinical directorate to raise awareness and resolve specific local issues.

A draft non-conveyance referral pathway for children via the 111 call centre has been developed and will be submitted at the Senior Management Group for approval during 2014/15.

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 2013-14 YAS provided 129 reports to CDOPs (108 in 2012/13). YAS have not received any recommendations following involvement in CDOP processes across the region and surrounding areas in 2013/14.

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

In 2013/14 YAS contributed to:

- Six domestic homicide reviews
- Four child serious case reviews
- One adult serious case review
- Two lessons learned reviews

Lessons learned for YAS included:

- enhancing the information sharing process and raising awareness of domestic abuse management.

- improvements in education and training and procedural documents.

3.3.3 Key Achievements

National-level working

The NASG held quarterly meetings at London Ambulance Service (LAS) throughout 2013/14. The group provides peer support, group supervision and the opportunity for benchmarking, sharing practice and lessons learned.

YAS developed a bespoke safeguarding self- assessment tool, which was used to peer review safeguarding processes in all other ambulance trusts in England and Wales

during 2013/14. Peer reviews have been completed and progress reported to the Ambulance Quality Governance and Risk Directors (QGARD) group at quarterly meetings. YAS were reviewed by a team from NEAS on 19/06/13 with positive feedback from the review team. A thematic analysis will be provided to QGARD during 2014/15 to highlight relevant issues for safeguarding in the ambulance sector.

The NASG also developed a national ambulance specific distance learning workbook for safeguarding adults to level 3 during 2013/14. This will be circulated to all relevant UK ambulance staff when completed to assist with advancing knowledge and compliance levels.

During 2013/14 the YAS Head of Safeguarding stepped down as the chair of NASG after establishing and chairing the group since 2009.

3.3.4 Key Risks

In 2013-14, the main risk relating to YAS safeguarding was based on the possible Breach of NHS Standard Contract 2013/14 (The Prevent Strategy) leading to compliance and reputational loss.

Prevent is 1 of the 4 elements of CONTEST, the government's counter-terrorism strategy. It aims to stop people becoming terrorists or supporting terrorism.

The Prevent strategy:

- responds to the ideological challenge we face from terrorism and aspects of extremism, and the threat we face from those who promote these views
- provides practical help to prevent people from being drawn into terrorism and ensure they are given appropriate advice and support
- works with a wide range of sectors (including education, criminal justice, faith, charities, online and health) where there are risks of radicalisation that we need to deal with

In order to manage this risk, YAS trained a number of approved "HealthWRAP" Facilitators to deliver the Prevent training to relevant staff. As of the 13th August 2014, the Risk Register scoring provides assurance of adequate measures in place to mitigate this potential risk and training for all staff has been included in the training plan for all staff from April 2014.

3.3.5 Looking ahead 2014/15

During 2014-15 the safeguarding team will continue with their work to increase safeguarding referrals and ensure all staff receives the appropriate level of training.

The YAS safeguarding team will continue to develop the necessary policies and procedures to support the Prevent work stream and to monitor delivery of the agreed 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 through national performance indicators and local audit processes

3.4.2 New Clinical Guidelines

The Clinical Directorate interprets and develops implementation plans for new guidelines e.g. from the National Institute for Health and Care Excellence (NICE) and 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, combined with the results of clinical audit, provides the Trust Board with assurance regarding the care delivered to our patients.

3.4.3 Pathway monitoring and Development

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

- STEMI and Cardiac
- Maternity
- Suspected Stroke
- Suspected Neck of Femur
- Major Trauma

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

3.4.4 Clinical Quality Monitoring

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

YAS's objective for 2013-14 was to achieve improvement initiatives in all CPIs and ACQIs and this was achieved.

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.

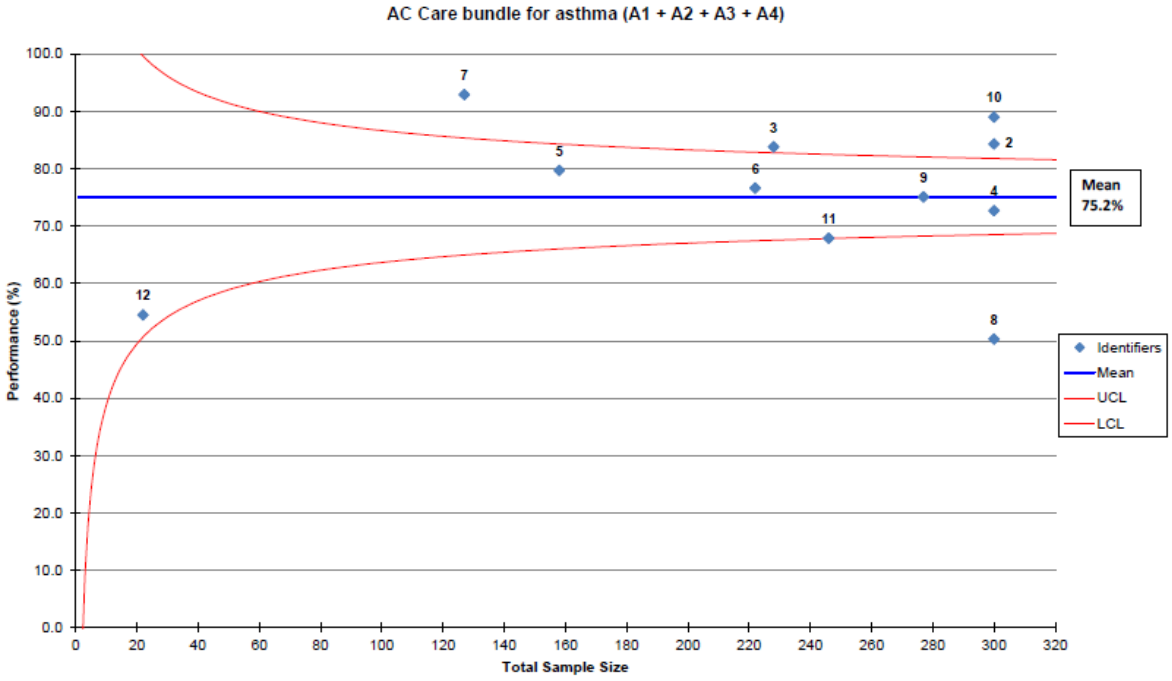
CPI cycles eleven and twelve were reported in 2013-14. This included the following four clinical care conditions:

- Asthma
- Single Limb fracture (trauma)
- Febrile convulsion (paediatric care).
- Hypoglycaemia

Asthma YAS CPI results

Asthma care bundle includes:

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



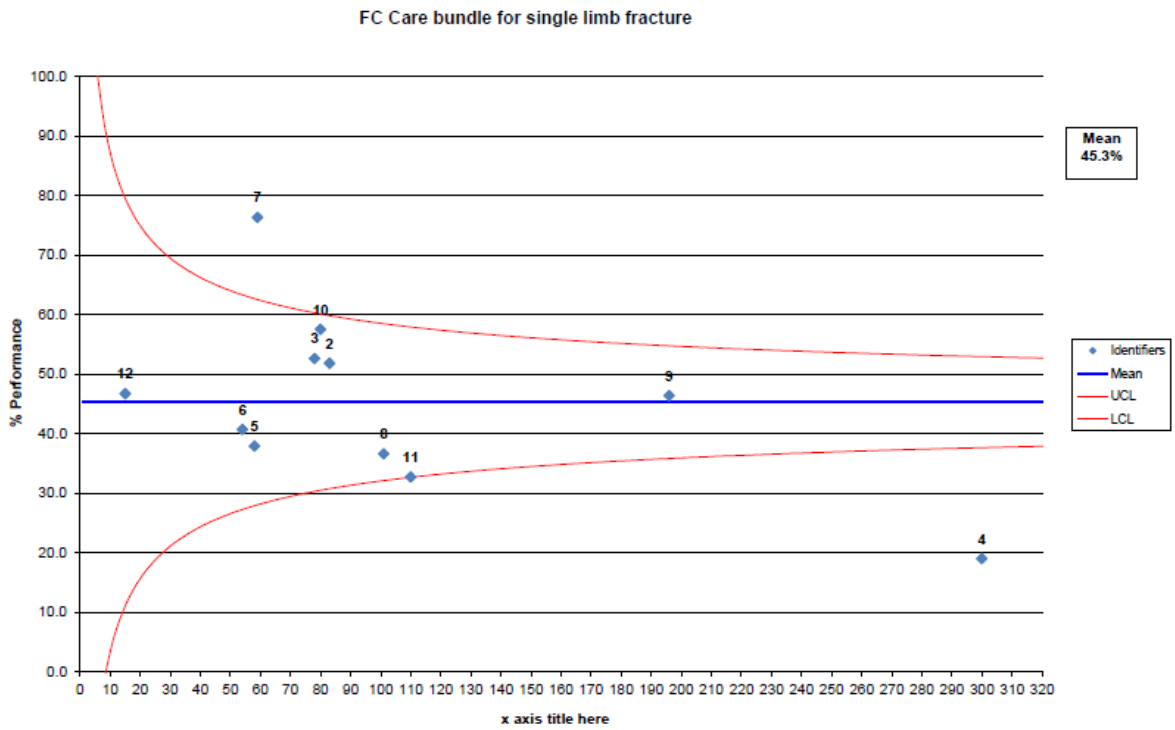
YAS = Trust number 5

YAS has continued to improve in all individual indicators A1-A5 and in the care bundle for the Asthma CPI. Further work needs to be undertaken to improve PEFR recording before treatment although YAS still continues to perform above the national average.

Single Limb Fracture (Trauma) CPI results

Single Limb Fracture CPI consists of

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



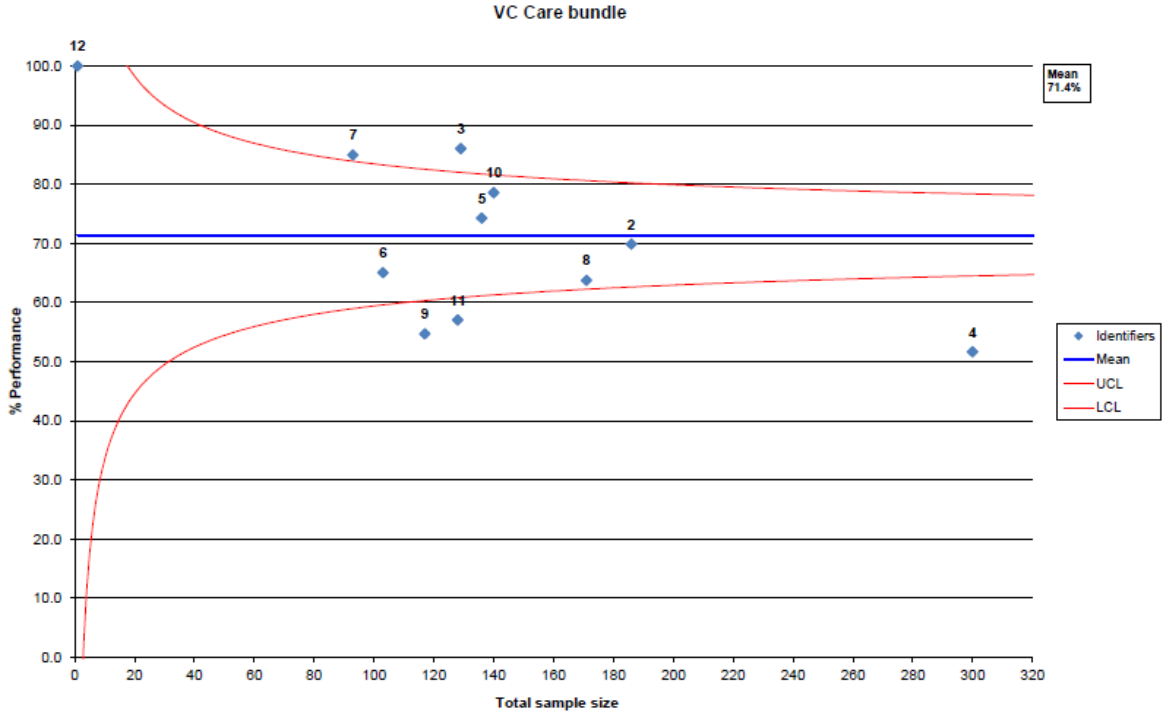
YAS = Trust number 5

Compliance to the Single Limb fracture remains poor. Sample size is low when compared with other CPIs and demonstrates difficulties capturing this group of patients. Knowledge and management of single limb fractures needs to improve and possible demonstrates a recording issue. Further work at locality level will be undertaken

Febrile Convulsion CPI results

Febrile Convulsion CPI consists of;

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



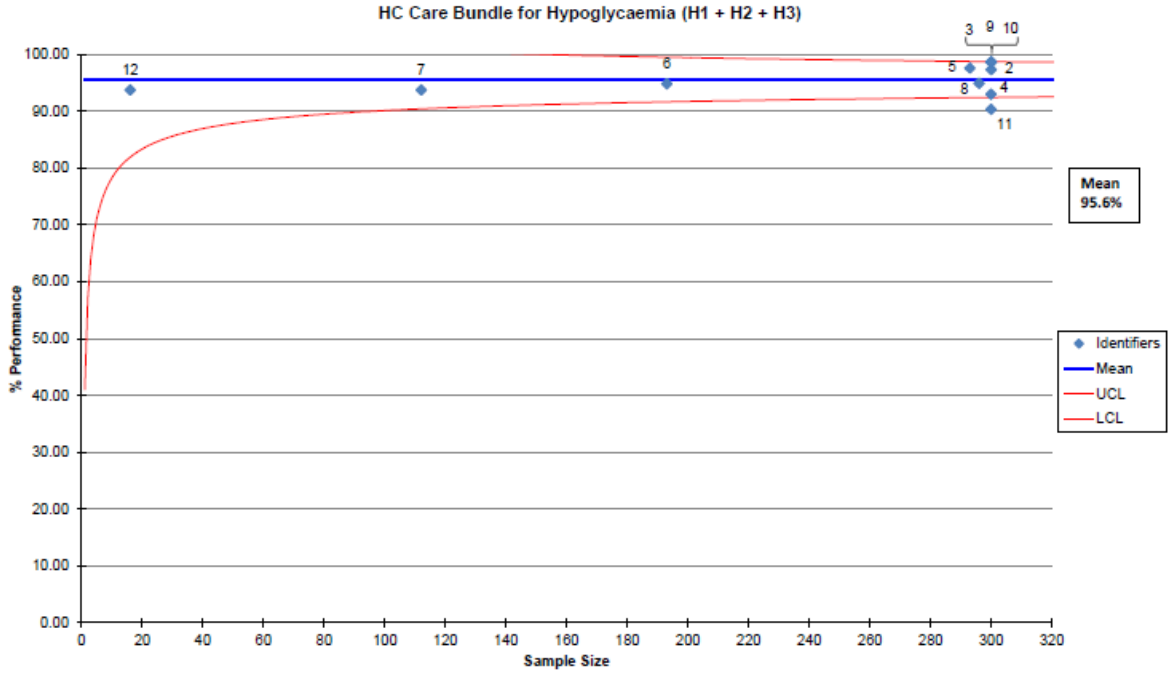
YAS = Trust number 5

Compliance with this CPI has slightly improved since cycle 11. Compliance with individual elements is good, with only V2 compliance less than the national mean at 86.8%

Hypoglycaemia CPI Results

The Hypoglycaemia CPI consists of;

- H1 Blood glucose before treatment
- H2 Blood glucose after treatment
- H3 Treatment for hypoglycaemia recorded
- H4 Direct referral made to an appropriate health professional
- HC Care Bundle (H1 + H2 +H3)



YAS = Trust number 5

Compliance against the care bundle remains high at 97.6% and excellent compliance against individual components including H4 Direct referral made to an appropriate health professional (88% compliance)

3.4.5 Ambulance Clinical Quality Indicators (ACQI)

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.

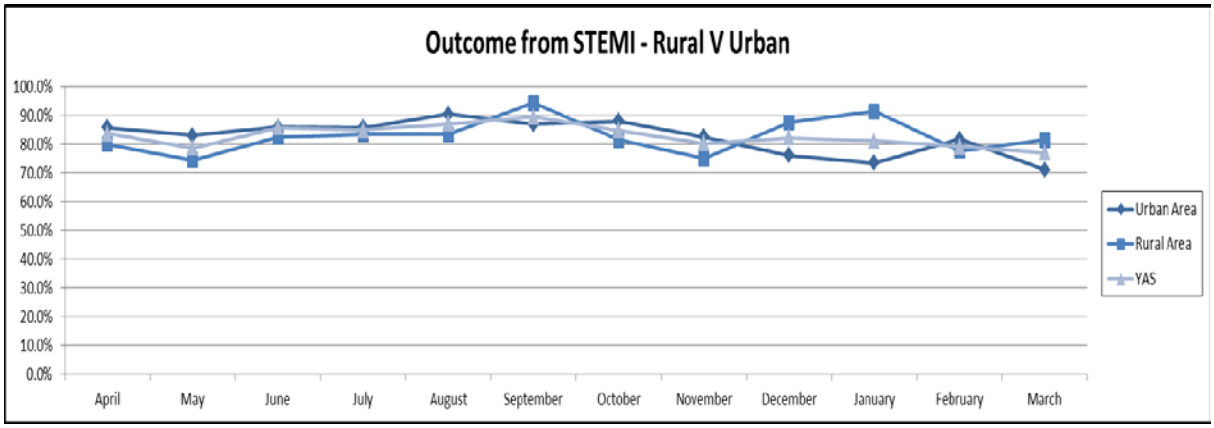
Outcome from acute ST-Elevation Myocardial Infarction (STEMI):

- Call for help to inflation of balloon (part of primary angioplasty procedure carried out in specialist hospital unit) time to be under 150 minutes.

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

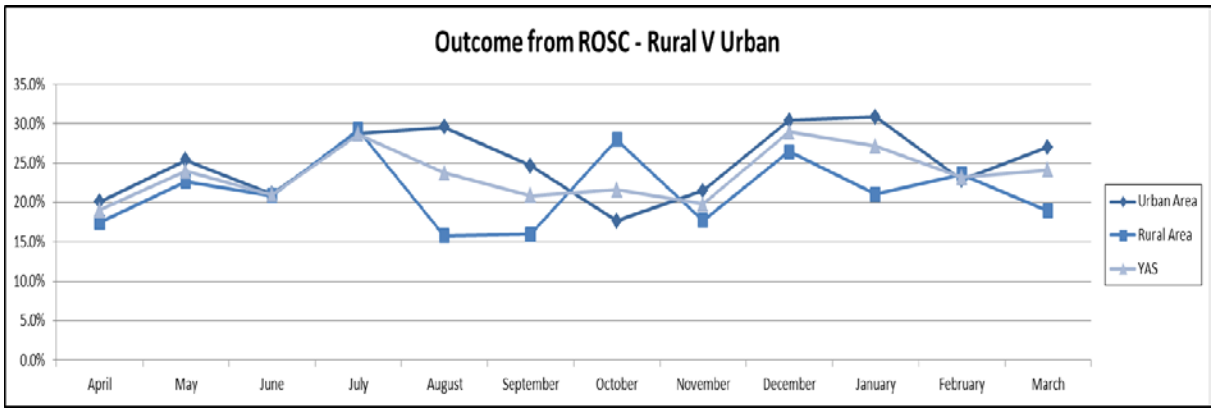
YAS has demonstrated an improvement across both indicators, with the STEMI care bundle increasing from 76.1% in 2012/13 to 82.8% in 2013/14. The STEMI 150

performance also remains high at 82.7% of STEMI patients receiving PPCI within 150 minutes of calling 999.

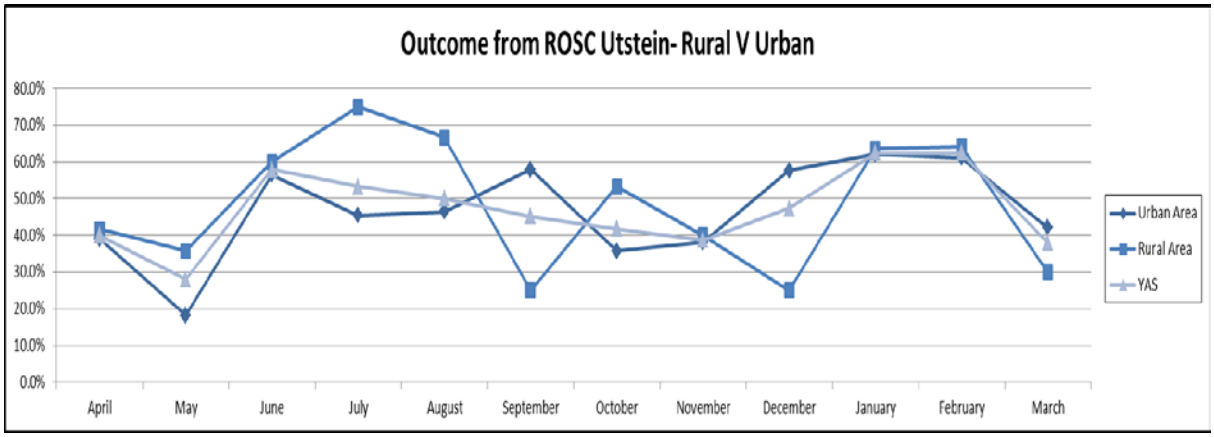


Outcome from Cardiac Arrest: Return of Spontaneous Circulation (ROSC):

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

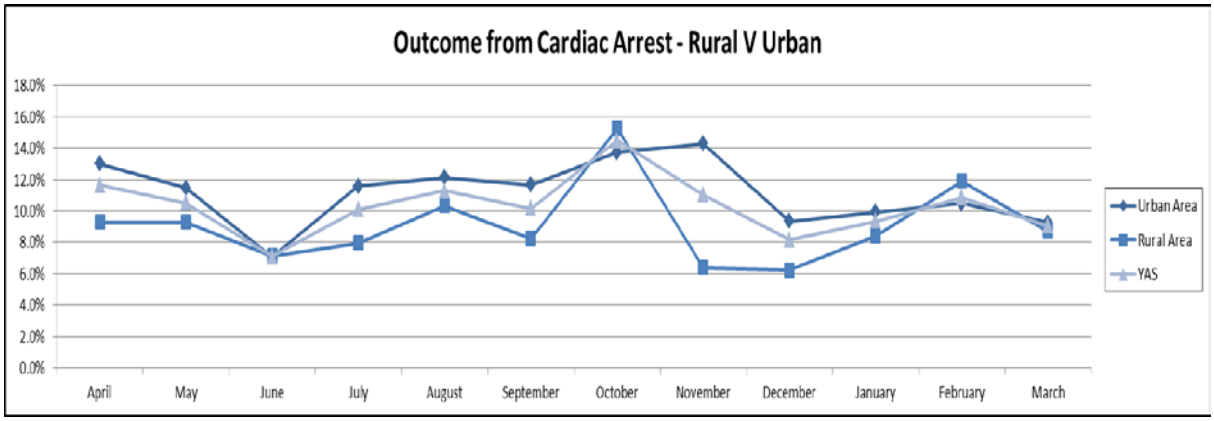


- Number of patients in Utstein group (where ventricular fibrillation – VF, or ventricular tachycardia – VT is recorded) for whom ROSC is achieved compared to the number where cardiopulmonary resuscitation was commenced

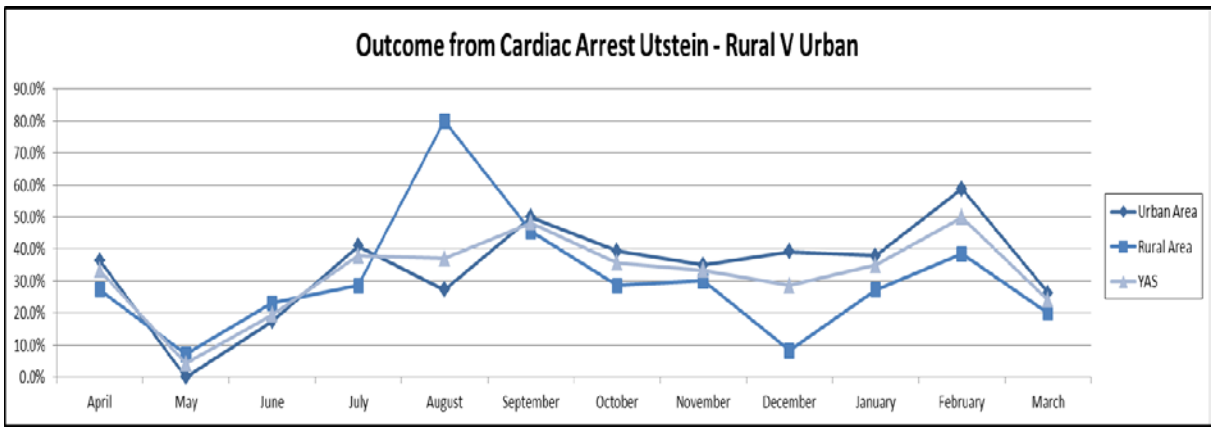


Outcome from Cardiac Arrest: Survival to Discharge:

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



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



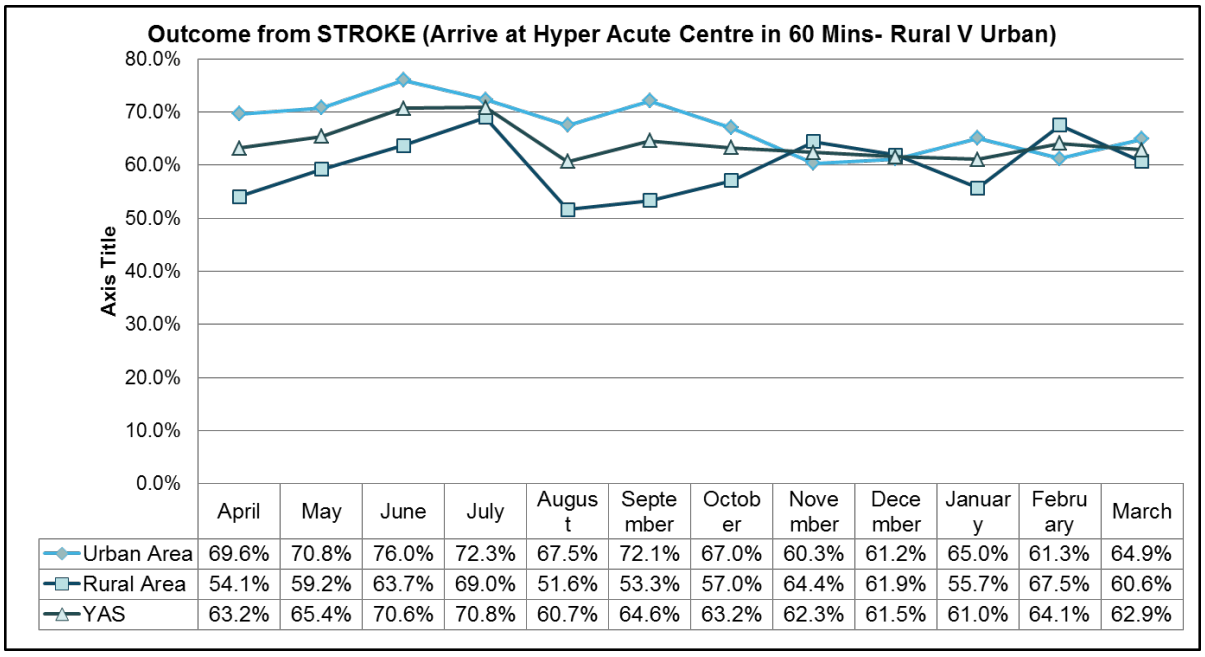
Outcome from Cardiac Arrest – Summary

	2012/13 Q4 baseline	2013/14
ROSC	20.3%	23.6%
ROSC Utstein	38.3%	47.8%
Survival to Discharge	6.2%	10.3%
STD Utstein	18.4%	32.5%

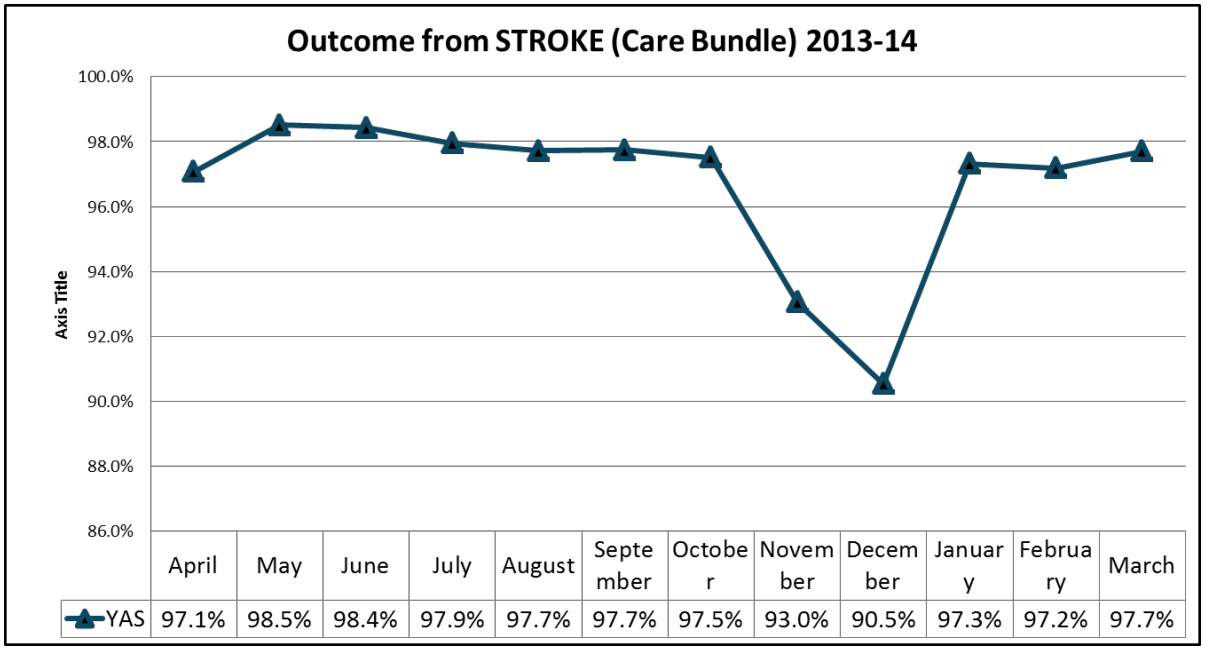
There have been improvements across all outcome indicators for cardiac arrest from last year. In terms of patient impact, there is a 43.4% improvement of the previous year's data with a total of 124 patients who survived a cardiac arrest in the Utstein group discharged from hospital alive.

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.



	April	May	June	July	August	September	October	November	December	January	February	March
Urban Area	69.6%	70.8%	76.0%	72.3%	67.5%	72.1%	67.0%	60.3%	61.2%	65.0%	61.3%	64.9%
Rural Area	54.1%	59.2%	63.7%	69.0%	51.6%	53.3%	57.0%	64.4%	61.9%	55.7%	67.5%	60.6%
YAS	63.2%	65.4%	70.6%	70.8%	60.7%	64.6%	63.2%	62.3%	61.5%	61.0%	64.1%	62.9%



	April	May	June	July	August	September	October	November	December	January	February	March
YAS	97.1%	98.5%	98.4%	97.9%	97.7%	97.7%	97.5%	93.0%	90.5%	97.3%	97.2%	97.7%

Despite a difficult year for Stroke services YAS has continued to perform well, and improved on 2012/13 performance. YAS continues to outperform the national average of 62.7% of patients arriving at a Hyper Acute Stroke Unit within 60 minutes with 64.1% of YAS patients arriving within 60 minutes.

Compliance with the stroke bundle remains high with an average of 96.6% compliance (compared with 96.2% in 2012/13)

ACQI Summary

ACQI	End Q 4 (12-13)	End Year (13-14)	National year end
Stroke 60	60.70%	64.1%	63.6%
Stroke Care Bundle	96.20%	96.6%	96.5%
STEMI Care Bundle	76.10%	82.8%	80.0%
Outcome overall ROSC	20.30%	23.6% (^ 3.3%)	26%
Utstein (ROSC)	38.3%	47.8% (^9.5%)	46.8%
Overall ROSC STD	6.20%	10.3%	8.7%
Utstein STD	18.4%	32.5%	25.9%
CPI	Cycle 11	Cycle 12	National
Single Limb	41.7%	37.9%	(6)
Asthma	79.3%	79.7%	(4)
Febrile convulsion	72.6%	74.3%	(4)
Hypoglycaemia Care Bundle	95.6%	97.6%	(5)

3.4.6 National Institute of Health and Care Excellence

The National Institute of Health and Care Excellence NICE publish guidance that aims to improve the clinical and cost effectiveness of care for health and social care organisations. Produced monthly, this guidance is reviewed by Clinical Excellence team for relevance and application. If applicable, the guidance is sent to an appropriate clinical or organisational leads for impact reviews and status reports. Any actions and/or recommendations are reported to the Clinical Governance Group where next steps are agreed.

The Clinical Excellence team maintains a register of all applicable guidance. This register is reviewed on a monthly basis for progress and contains a twelve month period of applicable guidance. For the period 1st April 2013 – 31st March 2014, seventeen areas of NICE guidance were reviewed following identification of relevance.

Six areas of guidance required no action by ourselves, Nine areas of applicable guidance were reviewed some of which resulted in changes being made to ensure

compliance: i.e. to include relevant guidance in clinical pathway work, inclusion of information within Statutory & Mandatory workbook.

Two areas of guidance CG167 (the acute management of myocardial infarction with ST segment elevation) and CG176 (head injury) were reviewed and judged to require additional work to ensure compliance with these specific areas of guidance. This work has been ongoing and will roll over into the period 1st April 2014 – 31st March 2015.

3.4.7 Local Audit

Clinical audit is a quality improvement process that seeks to improve patient care and outcomes through a systematic review of care against explicit criteria. Where indicated changes are implemented at an individual, team, or service level and further monitoring is used to confirm improvement in healthcare delivery.

Audit activity is monitored through the Clinical Audit Plan. In addition to the national ACQI and CPI monitoring processes, audits performed during the 2013/14 period include;

- Anti-emetic compliance and usage audit
- Emergency Care Practitioner Antibiotic Usage
- National Ambulance Non-Conveyance audit
- Glucagon compliance and usage re-audit
- NICE head Injury compliance audit
- NICE Febrile Illness compliance audit

3.4.8 Next steps for 2014-15

1. Continue to drive improvements across all ACQIs and CPIs through improved communications with front line clinicians.

2. Continue to drive improvements in outcomes from cardiac arrests through initiatives such as the Red Arrest Team response model, supporting the introduction of AMPDS 12.2 and piloting innovation in cardiac arrest management.

3. Increase the number of clinician led audits performed to help inform future practice and involve front line clinicians in developing clinical practice.

4. Improve the quality and timeliness of clinical data through the introduction of the Electronic Care Record, Data Warehouse, and Clinical Apps.

5. Continue to develop and expand the use of Emergency Pathways to improve patient care, ensuring Right Care, Right Place.

3.5 Patient Experience

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

Gaining Service User feedback is aligned with national priorities as set out in the Government's 2010 policy document; Equity and Excellence Liberating the NHS. It is one of the eleven Ambulance Quality Indicators and the 'NHS Operating Framework 2013-14 Everyone Counts – Planning for Patients 12/13' makes a clear commitment to seeking and acting on Service User feedback. It states: "our aim is to ensure that all NHS funded patients will have the opportunity to leave feedback in real time on any service by 2015."

More recently, the 2013 Report on the Mid Staffordshire NHS Foundation Trust Public Enquiry highlights again the importance of proactively seeking feedback from patients and being open with and acting on the results.

Patient feedback is also an essential element of monitoring the Yorkshire Ambulance Service achievements against the Care Quality Commission required Standard 1 Respecting and involving people who use services.

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

3.5.1 Complaints, Concerns, Comments and Compliments

All our staff strive to get the job right first time, every time, however, in any complex service, mistakes can happen and problems occasionally occur. When people tell us about their experiences we listen, we 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.

3.5.2 Number of Complaints, Concerns, Comments and Compliments received

A&E

Complaints, concerns and comments	Apr 2013	May 2013	Jun 2013	Jul 2013	Aug 2013	Sep 2013	Oct 2013	Nov 2013	Dec 2013	Jan 2014	Feb 2014	Mar 2014	Total
Attitude and Conduct	9	15	21	16	14	21	15	17	21	29	11	16	**205**
Clinical Care	15	17	15	33	21	28	30	13	26	36	24	22	**280**
Driving and Sirens	4	6	8	8	4	7	9	6	7	10	6	5	**80**
Call Management and Response	27	24	10	28	23	34	36	29	32	33	41	43	**360**
Other	1	0	1	0	0	110	0	0	0	1	0	1	**4**
Total negative	**56**	**62**	**55**	**85**	**62**	**90**	**90**	**65**	**86**	**109**	**82**	**87**	**929**
Compliments	76	51	39	38	17	16	11	27	49	17	1	78	**420**

PTS

Complaints, concerns and comments	Apr 2013	May 2013	Jun 2013	Jul 2013	Aug 2013	Sep 2013	Oct 2013	Nov 2013	Dec 2013	Jan 2014	Feb 2014	Mar 2014	Total
Attitude and Conduct	6	11	3	13	3	8	5	8	5	5	7	5	**79**
Clinical Care	2	5	3	3	5	4	5	9	4	6	6	7	**59**
Driving and Sirens	2	2	1	0	1	3	4	3	4	4	4	4	**32**
Call Management	1	1	2	4	1	6	0	4	2	1	0	4	**26**
Response	24	27	22	41	25	28	24	21	34	24	15	14	**299**
Other	15	9	9	7	8	5	5	4	2	2	2	4	**72**
Total negative	**50**	**55**	**40**	**68**	**43**	**43**	**43**	**49**	**51**	**42**	**34**	**38**	**567**
Compliments	5	0	2	1	0	0	1	1	3	3	0	3	**20**

NHS 111 (including Local Care Direct)

Complaints, concerns and comments	Apr 2013	May 2013	Jun 2013	Jul 2013	Aug 2013	Sep 2013	Oct 2013	Nov 2013	Dec 2013	Jan 2014	Feb 2014	Mar 2013	Total
Attitude and Conduct	7	4	7	2	2	2	3	3	2	3	3	6	44
Clinical Care	24	23	8	15	15	10	22	11	11	18	11	19	187
Operations	12	4	5	16	7	9	15	6	11	7	4	12	108
Total negative	**43**	**31**	**20**	**33**	**24**	**21**	**40**	**20**	**24**	**28**	**18**	**37**	339
Compliments	9	26	13	14	13	6	10	10	14	26	7	3	151

3.5.2 Number of formal complaints

YAS continues to be committed to the principles of ‘Listening, Responding, Improving – a guide to better customer care’ DH 2009. This guidance accompanies the Complaints Regulations and encourages organisations to ensure that they handle expressions of dissatisfaction with their services. Furthermore, this is done 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 – e.g. 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, 364 were handled as formal complaints. This is an increase of 107 formal complaints compared to 2012-2013. Additional systems are being reviewed as to thematic analysis in number of formal complaints which are upheld following investigation.

Within the NHS 111 service, the rate of complaints and concerns fell significantly during the year as the volume of activity increased and the new service became fully embedded.

3.5.3 Referrals to the Parliamentary and Health Service Ombudsman (PHSO)

In 2013-14 three people referred their complaints to the Parliamentary & Health Services Ombudsman. One case was closed with no further action, one was upheld and one remains in process with the PHSO.

3.5.4 Learning from Complaints, Concerns, Comments and Compliments

Learning from complaints, concerns and comments continues to be very important to YAS in the provision of a high quality service for all. To aid learning, the service 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 2013-14 are:

- Complaints about falls occurring or seatbelts not being used have led to policy refresh and communications with staff which have contributed to the organisation wide work on falls reduction.

- Concerns have been raised regarding the disconnection or removal of parts of patients' equipment by ambulance clinicians when attending patients and transporting them to hospital. This led to problems when patients were discharged from hospital as they were unable to use their equipment until an

engineer had attended to complete repairs. An article was published in the staff bulletin to remind clinicians of best practice when attending patients using home oxygen equipment.

- Complaints where patients have perceived that clinicians are dismissive of their condition have led to work to share patients' experiences and perceptions with clinical staff in the training and education environment.

- A revision has been made to the form for booking patient transport journeys which fall outside of the contract arrangements. This arose from a complaint where a booking was cancelled by the Clinical Commissioning Group (CCG) and replaced by a taxi booking as a more cost effective option. The taxi was inappropriate in this case as the patient required wheelchair transfer to and from the vehicle; however this information was not apparent to the CCG. The booking form now contains all relevant information on which an appropriate decision can be made.

- Feedback from complaints and concerns has been used in the corporate induction training programme to ensure that all new employees are informed of the importance of Dignity and Respect to patients at all times. Dignity Action Day 2014 has also acted a focus for the promotion and awareness of the importance of compassionate care.

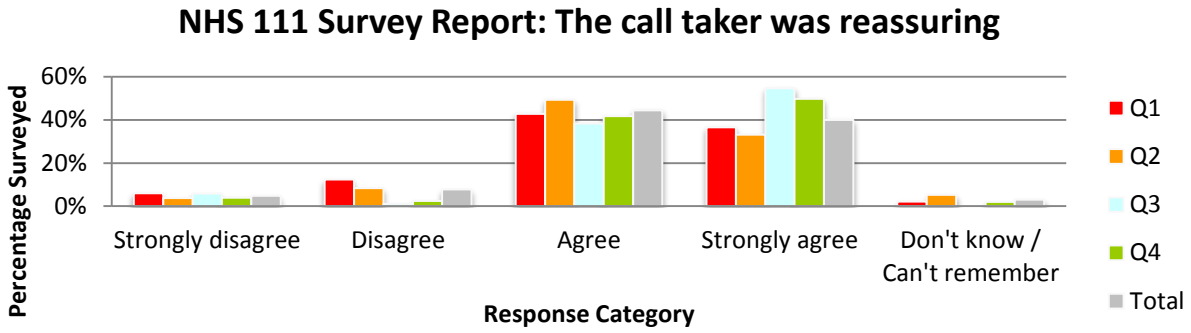
- A complaint involving a patient with meningococcal septicaemia has led to a variety of awareness work regarding meningitis. Front line staff have been made aware of other medical conditions masking the symptoms of meningitis. Furthermore, teaching materials have been obtained from the meningitis trust to distribute to front line staff. A new sepsis/meningitis identification tool for front line staff to use, again to aid the detection of meningitis is to be introduced and will be in use from April 2014.

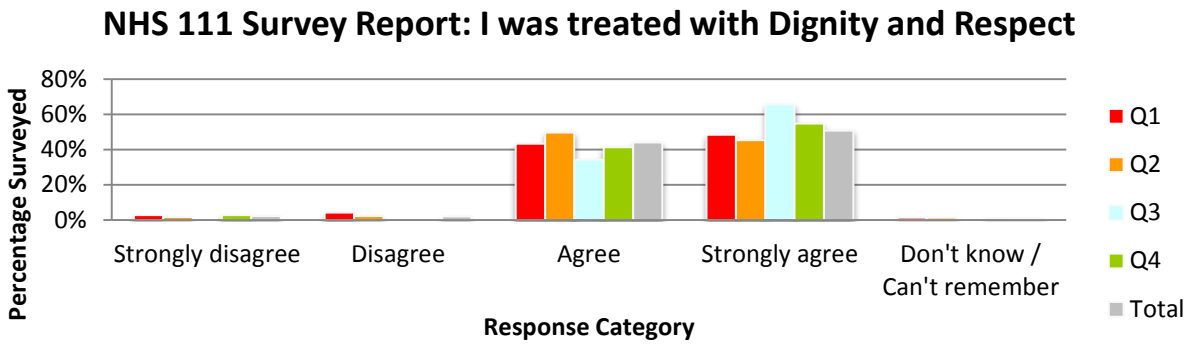
3.5.5 Patient Experience Surveys

YAS continues to survey patients their experience of care across all areas. We then monitor these 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.

3.5.6 NHS 111 Survey

Extract from results





NHS 111: Themes and Trends from narrative feedback

- Delays in patient care for palliative care patients the main concerns are delays in pain relief, accessing Doctors.

  Actions Taken
  - Use of Special Patient Notes (SPNs) reinforced
  - New SPN template designed
  - NHS 111 staff have been trained to input SPNs
  - National/ regional work regarding Adastra/ System 1 integration
  - Palliative care selected as one of the annual audits regional palliative care audits, to be completed in June 2014

- Incorrect referrals – staff errors due to NHS 111 Directory of Service (DoS) issues.

  Actions Taken
  - Staff training, instructions/ use of maps to locate areas/ wall board messaging
  - Rewording of GPOHs on DOS
  - NHS 111 Team leader training sessions
  - NHS 111 staff workshops
  - Discussion with NHS pathways regarding national DOS improvements

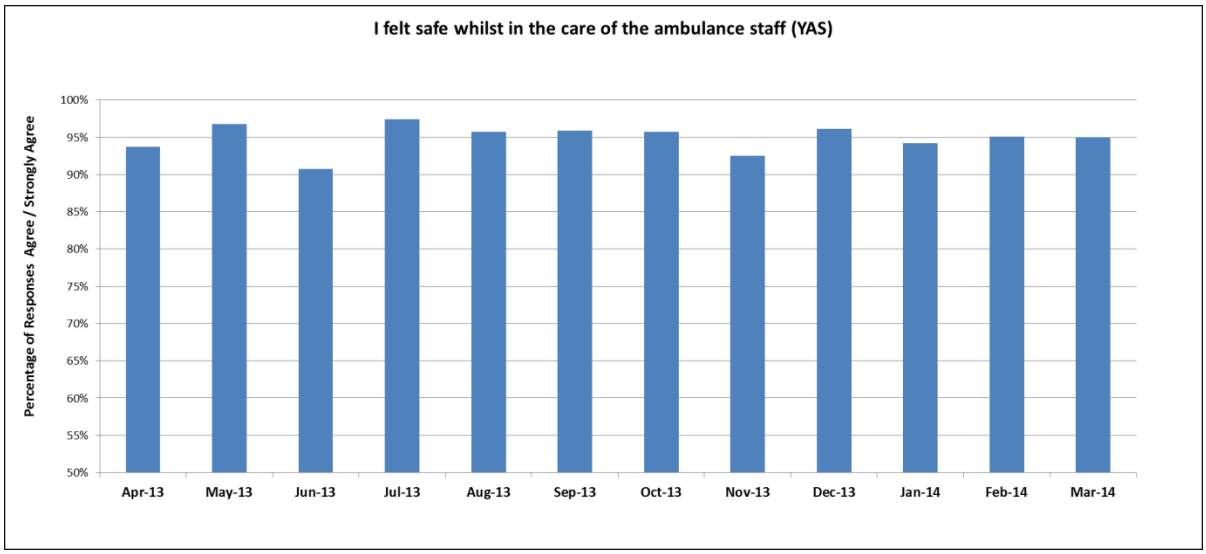
- Worked with the CCG/ CSU DOS leads to make information clearer for staff

- Dental appointments, accessibility for patients

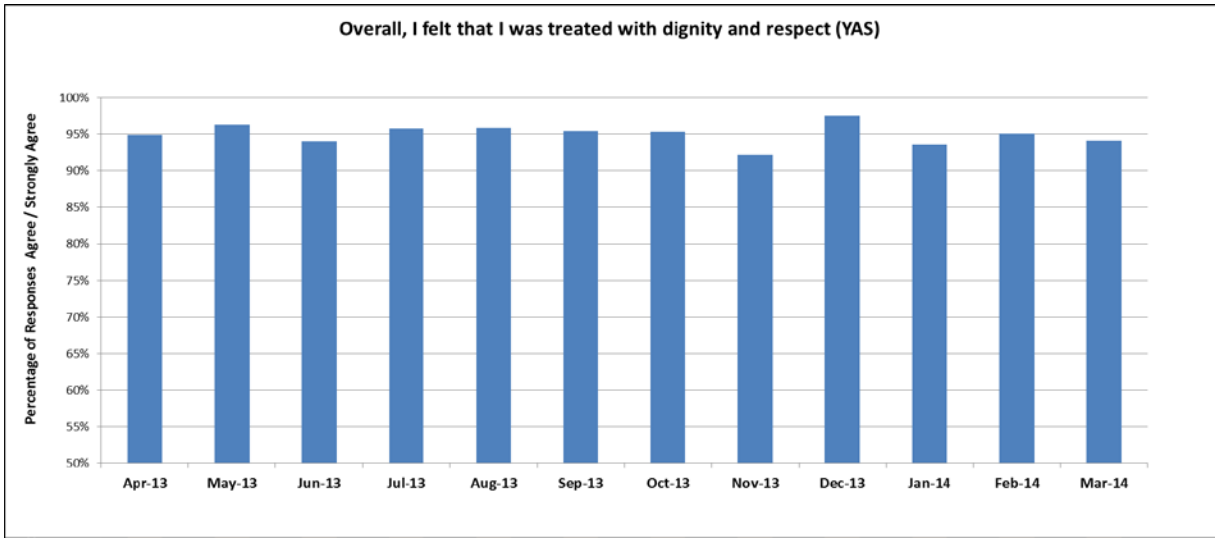
  Actions Taken
  - NHS 111 Customer Relationship Managers working with commissioners/ Local Area Teams/ NHS England
  - End to end reviews of dental cases with SY & B and North Lincolnshire , particular emphasis on dental overdose cases,
  - NHS 111 Governance working with Local Area Teams to manage dental complaints
  - Pressure on NHS Pathways to review dental assessments and to consider the use of dental nurses

3.5.7 A&E Survey

Extract from results



	Apr 2013	May 2013	Jun 2013	Jul 2013	Aug 2013	Sep 2013	Oct 2013	Nov 2013	Dec 2013	Jan 2014	Feb 2014	Mar 2014	YTD
Agree / Strongly Agree	93.7%	96.8%	90.8%	97.4%	95.7%	95.9%	95.8%	92.5%	96.2%	94.2%	95.1%	95.0%	94.9%



	Apr 2013	May 2013	Jun 2013	Jul 2013	Aug 2013	Sep 2013	Oct 2013	Nov 2013	Dec 2013	Jan 2014	Feb 2014	Mar 2014	YTD
Agree / Strongly Agree	94.9%	96.3%	94.1%	95.9%	95.9%	95.4%	95.3%	92.2%	97.5%	93.6%	95.1%	94.1%	95.0%

A&E: Themes and Trends from Narrative Feedback

- Service users acknowledge and appreciate the dignity and respect afforded to them during YAS care however one service user expressed concern when no blanket was offered when they were cold.
- Greater appreciation of extra care and support afforded to elderly service users and also patients at end of life.

- Some service users expressed concern regarding the length of time waiting for an ambulance.
- Some service users expressed concern regarding moving and handling (uncomfortable equipment/ambulance and walking to ambulance)
- Appreciation of the care of under 18 year olds.

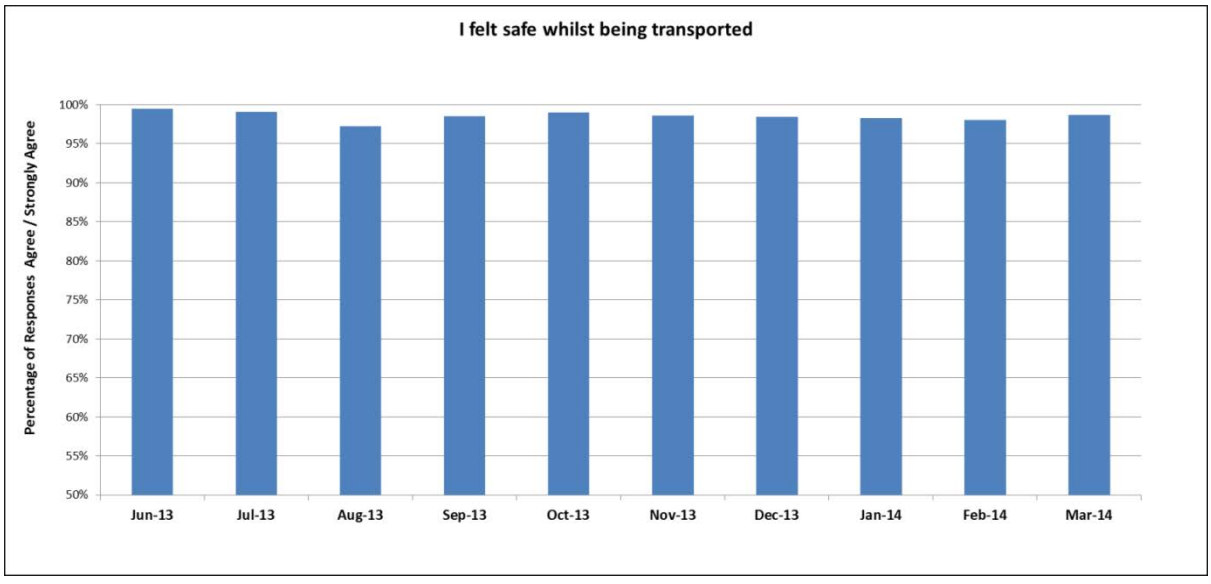
Action

- Feedback from complaints and concerns has been used in the corporate induction training programme to ensure that all new employees are informed of the importance of dignity and respect to patients at all times. Dignity Action Day 2014 has also acted as a focus for the promotion and awareness of the importance of compassionate care.
- End-of-Life Care: Patients at the end of life have very specific and individual needs. It is important that their preferences for care and place of death are honoured. YAS continues to work with partners involved in caring for people at the end of life to ensure that patients receive their chosen pathway of care. This has been recognised by regional colleagues and commissioners and the end-of-life care pathway is now in place across the whole of Yorkshire.
- Changes in Emergency Operation Centre script for emergency calls relating to triage with a clearer description as to who will carry out any return calls.

3.5.8 PTS survey

Extract from results

From June 2013 we commenced routine surveying across all PTS areas.



	Jun 2013	Jul 2013	Aug 2013	Sep 2013	Oct 2013	Nov 2013	Dec 2013	Jan 2014	Feb 2014	Mar 2014	YTD
Agree / Strongly Agree	99.5%	99.1%	97.2%	98.5%	99.0%	98.6%	98.5%	98.3%	98.1%	98.6%	98.5%

	Jun 2013	Jul 2013	Aug 2013	Sep 2013	Oct 2013	Nov 2013	Dec 2013	Jan 2014	Feb 2014	Mar 2014	YTD
Agree/ Strongly Agree	99.5%	100%	98%	99.5%	99.5%	100%	98.5%	98.3%	100%	99.3%	99.3%

PTS Narrative feedback

- Some patients have concerns regarding reaching their appointment on time
- 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.
- 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/appointment.
- Service users expressed their appreciation for the helpfulness, care and compassion shown to them by PTS staff.

Actions:

- A number of initiatives have been instigated and actions will be continually reviewed and addressed within the Patient Experience Programme 2014-15. These include team leader training sessions that focused on patient safety and patient experience feedback, review and upgrade of PTS fleet vehicles and expanding the role of staff within patient reception centres to ensure improved customer care.

3.5.9 Patient Stories

The use of Patient Stories continues to provide a unique opportunity to connect with patients, service-users, relatives and carers. YAS actively listens to real experiences reflected in order to learn from them. Methods used to record patient stories can be via film, narrative or voice recording.

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 2013-14:

- RTA (Road Traffic Incident) bereavement – providing information to family and giving thanks to the crew members for their care under difficult circumstances.
- Reflections by a YAS paramedic involved in an RTA who became a patient whilst at work.
- ECG (heart tracing) – a service user who re-contacted YAS to say "thank you" and gain a copy of his ECG recording taken whilst in YAS care for him to use to compare with any further heart tracings.

3.5.10 Residents of Rural Areas Survey

Two postal surveys of patients residing in rural areas were undertaken during Quarter 1 and Quarter 2 2013-14 as part of the CQUIN programme. It showed that service users in the rural areas report a significantly high level of satisfaction in the service we provide:

	Quarter 1	Quarter 3
Call taker listened and were reassuring: satisfaction	90.7%	91.1%
Length of journey time as: good/excellent	96.4%	97.5%
Service they received from YAS as: good/excellent	98.3%	98.5%
Treated with Dignity and Respect	99.4%	98.8%

However, an area of particular significance is the number of patients contacting another health care provider (48.1%) prior to calling 999 for the ambulance service. This survey shows patients believed they had a primary care condition and were seeking an appropriate service. For example 61.5% of patients reported that they did not understand why they were being told to contact the ambulance service after contacting another provider first. This reflects the scope to introduce alternatives to 999 for patients with pre-existing illness or a long term condition.

Therefore two key actions were taken following the survey outcomes:-

- Provided feedback to YAS staff via the internal publication 'Front Line Focus' to encourage staff to continue in their efforts to provide an excellent service.
- Engagement with CCG commissioners providing a copy of the recent survey report, with the view of working together to manage HCP demand/requirements.
- Drive to encourage CCG sign-up to 'GP in Hours' pathway.

3.5.11 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 is

using this resource as another channel to listen and respond to online service user feedback.

3.5.12 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 1st February 2014 by actively demonstrating support and encouraging staff to celebrate upholding patients' rights to dignity and respect. Information of the YAS Dignity and Respect campaign is available via the YAS intranet.

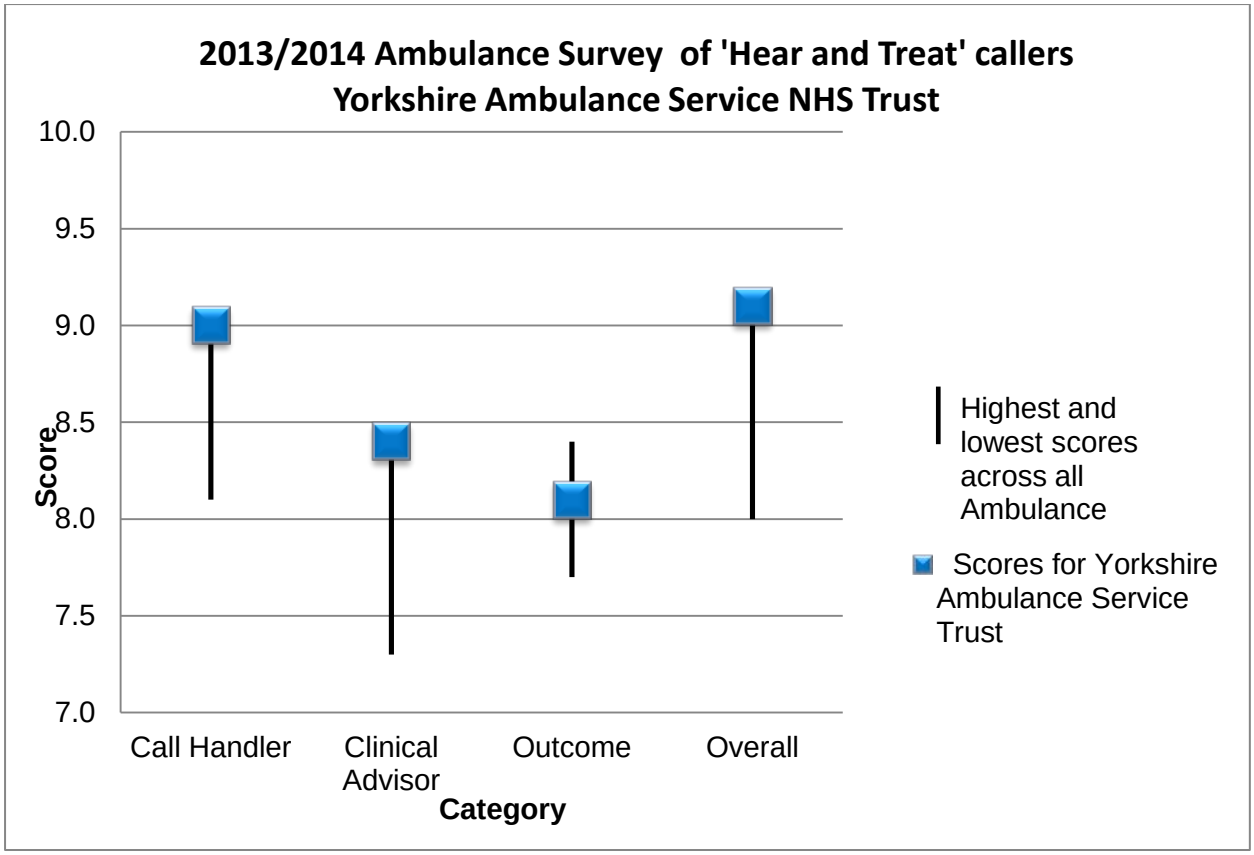
3.5.13 National Ambulance Patient Experience Ambulance Survey – Hear & Treat

This report describes the 2013/2014 CQC survey of callers to ambulance 'Hear and Treat' services. These callers received telephone triage and advice from trained clinical support advisors when calling '999'.

The survey included ten ambulance trusts and the sample included all callers aged 18 years or older who had received clinical advice from the ambulance service when they called '999' between 1st and 31 December 2013. The results will be used by the external agencies as part of assessing quality of care.

Scoring

For each question in the survey, the individual (standardised) responses are converted into scores on a scale from 0 to 10. A score of 10 represents the best possible response and a score of zero the worst. The higher the score for each question, the better the trust is performing.



Category	Highest Score achieved across all Ambulance Services	Lowest Score Achieved across all Ambulance Services	Scores for Yorkshire Ambulance Service Trust
Call Handler	9.0	8.1	**9.0**
Clinical Advisor	8.4	7.3	**8.4**
Outcome	8.4	7.7	**8.1**
Overall	9.1	8.0	**9.1**

This illustrates a high standard of care provided for patients who do not require an ambulance and can be treated on the telephone.

3.5.14 Building Relationships with Healthwatch

Since Healthwatch was launched in April 2014, YAS has been proactive in building relationships with the 15 Local Healthwatch organisations in Yorkshire and the Humber.

A successful partnership event was held in June 2013. Representatives of Healthwatch attended the event where there were presentations about the services provided by YAS and plans for the future. Delegates also participated in workshops looking at opportunities to jointly influence key quality and safety priorities.

During 2013-14, building on the learning from the Partnership Event, our engagement with Healthwatch included:

- Providing access to a catalogue of YAS publications to support Healthwatch information and advice services.

- Co-hosting an event, 'Moving Together – No Decision Without Me', with Healthwatch Hull, inviting patients and the public to looking at how we can best keep people safe and confident when moving.

- Responding to questions from Healthwatches in East Riding of Yorkshire and North Yorkshire regarding specific issues raised by local communities. We received thanks for the information provided and confirmation that this had been accepted to the satisfaction of the people raising the issues.

- Arranging an opportunity for a Healthwatch Kirklees representative to observe our Patient Transport Service – spending time in a patient reception centre and on a vehicle. We are awaiting the report with feedback from this visit.

- Receiving positive feedback from Healthwatch Rotherham as part of their commitment to acting on all feedback, positive and negative. This resulted in the A&E clinicians' involved receiving acknowledgement and commendation from our Chief Executive.

- Regular sharing of Stakeholder e-News and Healthwatch-specific updates – many of which resulted in articles within local Healthwatch newsletters.

3.5.15 National recognition at the Patient Experience Network Awards

In 2013, Yorkshire Ambulance Service became the winners of the Setting the Stage Measure, Reporting and Acting" category at the Patient Experience Network (PEN) Awards. The PEN is a 'not for profit' membership based network that welcomes all involved in delivering the patient experience, with a commitment to continuously improve. The aim of the PEN is to provide a valuable, practical resource/service for all healthcare organisations wishing to improve the patient experience. A key emphasis of the network is learning from each other and sharing best practice.

YAS was nationally acknowledged for the patient experience survey programme.

3.5.16 Work Plan 2014-15

The Patient Experience and Patient Relations Work plan for 2014-15 includes:

- Expanding consultation with service user groups (e.g. policy, service re-design, highlighted themes and trends).
- Enhancing the analysis of themes and trends of patient experience feedback and ensure effective communication with operational colleagues.
- Explore additional methods of gathering service user experience.
- Enhance triangulation between 4Cs and patient experience surveying.
- Produce additional guidance for staff when gathering service user feedback.
- Setting of organisational targets for complaint handling.
- Enhance electronic contact methods for 4Cs.
- Implementation of the national Friends and family Test (FFT) requirements for Staff and Patients.
- Implement peer review process of individual complaints to inform further improvement in management processes.

Clinical Quality Strategy Next Steps for 2014/15

The Clinical Quality Strategy is due for review by March 2015. This process is commencing in 2014/15 and will include an extensive programme of engagement with staff and the public to inform and underpin the updated strategy for April 2015 onwards.

Section 4.0

Legal

4.0 Legal Services

4.1 Inquests

During 2013-14 the Trust gave evidence, written or oral, to 300 inquests. No Prevention of Future Death Reports were issued and no adverse conclusions were recorded against the Trust.

Learning points are identified from review and management of these cases. Organisational learning actions have included clarifying and rewording of the non-conveyance policy, raising awareness for the assessment of dehydration and a review of responses to inter-facility transfers. For Serious Incidents that result in a death, the coroner is proactively informed and learning points are picked up through this process.

4.1.1 Reforms

From 25th July 2013, parts of the Coroners and Justice Act 2009 came into force and from that date, all inquests are conducted under the new Statutory regime with replacement Coroners' Rules and Regulations. The key changes that impact the Trust are highlighted below:

- Inquests must be concluded within 6 months from the date the coroner is made aware of the death. Inquests not completed within 12 months must be reported to the Chief Coroner, with an explanation for the delay.
- The coroner has the power to summon witnesses and require the production of statements and documents. Fines of up to £1000 can be issues by the coroner for the failure to comply with a notice requiring evidence to be given or produced.
- Rule 43 is replaced by a Regulation 28 notice or Preventing Future Death report. Coroners are now under a duty rather than a discretion to issue such a report in any matter where they consider action is necessary with a view to preventing future deaths.

4.1.2 Risks

The implementation of strict timescales for concluding an inquest means that Coroners have begun to set dates early, including the final inquest date. Legal Services now identify witnesses as soon as there is an awareness of a reportable death or notification from the Coroner that an inquest is to be heard, obtain witness availability and ensure that statements are prepared and all relevant documents collated for sending to the Coroner without delay. Organisations and clinical staff are much less likely under the new regime to receive sympathy from Coroners in the event of delay and, if deadlines are missed, risk a fine of up to £1,000. Coroners in the Yorkshire area have indicated that reports must be produced within one month of the request.

Preventing Future Death Reports are taking on a more central role. It is possible for a Report to automatically be made in circumstances where the Coroner is not provided with a final Serious Incident Report and a fully completed Action Plan; or where there is evidence that the recommendations arising from the Serious Incident Report or Action Plan have not been adequately implemented or communicated to staff. Given the tight timescales for concluding Inquests, this is challenging for the organisation.

4.2 Claims

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

The NHS Litigation Authority act as the Trust's insurers and are responsible for the management of all Employer's Liability (EL), Public Liability (PL), and Clinical Negligence (CNST) claims on behalf of the Trust.

4.2.1 Reforms

Since April 2014 the NHS LA standards and assessment process has been replaced by a Safety and Learning Service. Further to the development and implementation of this outcomes focused scheme, one objective is that in time, it will allow members to benchmark themselves against other Trust members, and provide a safety and learning library where best practice and other key learning documents are shared.

At present data is only available for CNST claims. As the scheme gains experience, much wider and more detailed benchmarking information should become available.

4.2.2 Claims reporting

The table below details the new claims reported from 2011. The highest volume of claims are Employer Liability claims which have increased year on year and constitute 84% of the new claims reported in 2013-14. Clinical Negligence is the lowest reported at 5% in 2013-14.

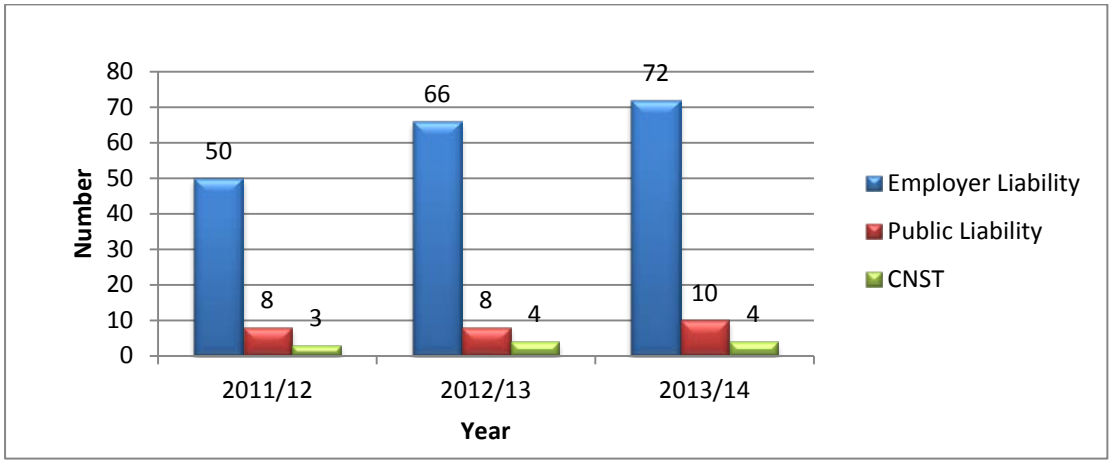


Figure 1: New claims reported (EL/PL/CNST)

Employer Liability Claims

In general, a steady increase in EL claims can be seen with 2013/14 reporting the highest number of new claims received (72). This is consistent with the increase in manual handling and equipment themes of 'response bag', 'carry chair' and an increasing 'claims culture' within the Trust.

The clinical response bag has been removed from the Trust which should result in a decline in these claims. The new rucksack style response bag has now been implemented across the Trust, and roll out of the new track chair and the training for its use are continuing. Lighter defibrillators and ECG machines will be introduced in 2014/15.

New guidance on manual handling risk assessments for equipment and vehicles is being produced. New risk assessments, including improved manual handling assessments have commenced. The Health and Safety team are working closely with the training department to identify and address key issues. A guide on lifting accessories/tools is currently being developed.

The legal services team continue to work closely with localities to reduce these claims and have strengthened links with the HR business partners in the areas to ensure early communication of potential issues.

Public Liability Claims

In 2013-14 there were a total of 10 Public Liability claims, with the number of claims reported remaining relatively low over the years. This demonstrates a positive patient safety culture within the Trust. The highest category is slips trip and falls with 6 new claims being reported this year (60%).

YAS leads a regional falls network that is committed to working to reduce and prevent falls for patients. A Safety Thermometer has been established to drive improvements in performance, raise awareness to staff and implement interventions to reduce patient harm, with a particular focus on falls. Monthly analysis of falls data is on-going to monitor any themes or trends, including reviews of locations, vehicles and equipment that may be of concern.

New risk assessments, including improved manual handling assessments have commenced across the Trust.

CNST Claims

These remain low for the Trust and there were only 4 new claims reported in 2013-14. The NHSLA risk profile for the Trust indicates for the value of claims paid and the number of reported claims the Trust is rated in the top 20% best performing Trusts. This is positive for the Trust as it demonstrates a high standard of patient care.

All cases are reviewed individually by the Clinical Directorate and any lessons learned are disseminated through the Trust. From June 2014 key themes and trends from CNST claims will feature in the monthly clinical catch up communications for staff.

The internal programme aimed at reducing patient falls is continuing throughout 2014/15 with a detailed work plan.

4.3 Hillsborough Legal Proceedings

4.3.1 Background

Following publication of the Hillsborough Independent Panel Report in 2012, legal proceedings relating to the Hillsborough disaster were initiated in 2013/14 and include an ongoing criminal investigation, Independent Police Complaints Commission investigation and concurrent Inquests into those 96 who died on 15 April 1989. YAS, as one of the existing successor organisations to South Yorkshire Metropolitan Ambulance Service (SYMAS), are Interested Persons for the purposes of the new Inquests which commenced in March 2014. Given this status, YAS' approach is to assist the Coronial function in ensuring that all relevant evidence is identified and made available to the Court and providing robust support to ambulance witnesses involved in the processes. The Inquests are currently scheduled to run until July 2015.

4.3.2 Current position

A dedicated team comprising internal and external resources, initially established in March 2013, have managed YAS involvement in the Inquests to date, proceeding on the basis that there are parts of the hearing where it is acceptable for YAS to be present without an accompanying lawyer to actively minimise costs. The skills of the internal team have been utilised in a strategic and cost effective manner in that a large degree of preparatory work has been and will continue to be conducted internally.

The Inquests are phased in terms of topic area; stadium safety and pre match planning evidence have been heard and are followed by events of the day, movements of the deceased, expert evidence and pathology.

Given the volume of disclosure, the workload has been high in terms of reviewing and assessing documentation and audio visual material, including the analysis of expert reports on emergency response and survivability of individual deceased.

4.3.3 Next Steps

As the Inquests move into topic areas directly linked to emergency response it is anticipated that the workload will remain high until summer 2015 and as such resources will be continuously reviewed.

The risk based approach to attendance will continue to facilitate careful control of legal spend and appropriate representation at the hearing will be dynamically assessed from review of witnesses' evidence.

Emerging risks will be reviewed carefully for learning points and if these are identified action will be taken to address any issues and the information shared with the services.

The Inquests and their conclusions will be the subject of intense media coverage and a media handling strategy has been developed. This will include information for the public on the significant documents in ambulance services and in major incident management since the time of the disaster.

4.4 Looking ahead – priorities for 2014-15

Work is on-going within the Risk and Safety team to enhance investigation skills across the Trust, and encouraging early investigation at incident stage which supports the management of the claim at a later stage. This includes an increased emphasis on documentation and record keeping.

More robust claims reporting is currently being developed utilising the Datix system to triangulate the data with incidents and complaints. This will allow for earlier identification of themes and trends and claim ‘hot spots’ within the Trust, with the aim of both improving staff and patient safety, and reducing the number of claims reported.

Themes and trends identified will inform reports to Senior Management Group and Risk and Assurance Group meetings. There will also be quarterly attendance from the legal services team at locality board meetings to discuss the claims for that particular area to ensure early identification of issues.

Section 5.0

Assurance on Risk, Safety & Clinical Quality

5.0 Assurance on Risk, Safety and Clinical Quality

5.1 Standards and Compliance and Clinical Directorates

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 2013-14. The support provided by corporate teams has strengthened and developed significantly, as has the interface between corporate functions and local, frontline operations. Developments in the Standards and Compliance and Clinical Directorates have redefined and streamlined key roles and responsibilities and increased the support and expertise provided in areas including incident reporting, patient safety, information governance and infection prevention and control.

5.2 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 Committee which has the lead committee role for scrutinising all aspects of quality and safety.
The Quality Committee together with the Audit Committee has a key role in the review and monitoring of key risk for the Trust. Their scrutiny of the Board Assurance Framework and Risk Register informs the boards' position in terms of assurance of the management of risk within the organisation.

Locality-level scrutiny of risk, safety and quality is undertaken via the five Locality Operational Management Groups and the Patient Transport Service Management group. From 2013-14 equivalent quality management arrangements have also been in place for the NHS 111 service.

Formal quality monitoring is supplemented by regular face to face contact with staff via the Listening Watch programme and a wide range of other department visits and meetings. Monthly team brief and support services with clinical supervisors provide an opportunity for two way communication. The annual staff survey and more frequent pulse surveys introduced in 2014 also provide valuable information on quality and safety and inform Trust improvement plans.

5.2 Internal audit

During 2013-14 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 2013-14 were:

Internal Audit Assignment Summary 2013/14

Description of Audit	Assurance Level	
Service Transformation Programme - Programme Management & Project Governance	S	*Still in draft*
Quality Governance - CQUINs	L	
111 Service	S	
Quality Governance - Incidents/SUIs	S	
IG Toolkit - Focus on Specific Areas	S	
Infection Prevention & Control - Compliance with National Requirements	S	
Quality Governance - PALS / Patient Experience	S	
Board Assurance Framework	S	
IG Toolkit - Part 2 - pre submission evidence check	S	

L =Limited Assurance
S= Significant Assurance

Actions arising from Internal Audit report recommendations are assigned to individual managers and progress is monitored via the management system, with assurance reports to the Audit Committee.

5.3 External scrutiny

Throughout 2013-14 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. A further review will be conducted by Internal Audit in quarter 1 of 2014/15.

Section 6.0

Looking ahead to 2014-15

6.0 Looking Ahead to 2014-15

The 2014-15 workplans detailed in this report reflect available guidance and best practice on key aspects of risk management, quality and safety and are informed by learning from a range of internal reporting and feedback processes. In addition they link into an overarching strategic context of achieving compliance with developing 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 2013-14 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 2014-15 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.