Yorkshire Ambulance Service NHS

NHS Trust

*An Aspirant Foundation Trust*

# Risk and Clinical Quality Compliance Report 2014-15

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# Section 1.0

# Introduction

## 1.1 Purpose

The purpose of this report is to

- Present the Risk and Clinical Quality Compliance Report 2014-15 – 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 reactive approach.

Risks can be identified on a daily basis throughout the Trust by any employee and through the various reporting and learning process. 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 2014-15 are set out in the Trust's Annual Governance Statement.

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

Underpinning YAS's overall approach to patient safety, staff safety and risk management, are a number of specialist functions that ensure the further management of risk and safety in essential areas; these include Health and Safety, Information Governance, Security, Legal Services and Infection Prevention and Control.

## 1.3 Introduction – Clinical Quality Strategy

Clinical quality is a key focus for YAS and the approach reflected in our Clinical Quality Strategy reflects both the local quality priorities as well as the national and regulatory guidance. The focus remains on the three touchstones of clinical quality, these being:

- Patient safety (including medicines management and safeguarding)
- Clinical effectiveness – delivering clinically effective care to patients based on the best available evidence.

- Patient experience – ensuring patients are treated as individuals with care and compassion and appropriate regard to privacy and dignity.

Patient and staff safety are a priority for YAS. Management and analysis of the incident reporting system including near miss and issues/concerns is a critical function of the Risk and Safety team. By analysis investigation of incidents, analysis of themes and trends, feedback to directorates and clinical business units we can help to ensure that YAS is always learning and that we are continually developing the safety of our services.

The 2012-15 Clinical Quality Strategy provided a strong foundation for quality care and since 2015 marked the final year of the existing Clinical Quality Strategy: a refreshed three year strategy has been approved by the Trust Board. The development of the strategy and the identification of clinical quality priorities was informed by our staff, our stakeholders and patients. In addition, national and international evidence on best practice, together with learning from internal reporting and learning systems and risk assessments contributed to the strategy.

A number of important clinical and cultural issues are considered as the priorities for 2015-16. These are areas where there is strong evidence to indicate that YAS can make a real difference to patient care.

The 2015-18 Clinical Quality Strategy consists of a number of important elements:

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

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

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

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

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

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

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

Our vision is that we YAS will provide first class care for the local communities. This forms the foundation of the Clinical Quality Strategy for 2015-18.

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

# Section 2.0

# Risk and Safety

## 2.1 Risk Management

### Introduction – Risk and Safety

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

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

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

### 2.1.1 Delivery of work plans for 2014-15

YAS's systems of risk management for 2014-15 are set out in the Trust's Annual Governance Statement. Risks are identified proactively by the Board and senior management team as part of the 5-year and annual business planning cycles. In 2014-15, twelve strategic risks were aligned to the 8 strategic objectives within the Board Assurance Framework.

The corporate risk management framework is set out in the Risk Management and Assurance Strategy. This document describes our strategic approach to processes and monitoring arrangements for managing risk. The strategy describes the Trust risk management system and the mechanisms for providing the Trust Board with assurance that risks are managed efficiently and effectively.

During 2014-15, a key priority was to embed and strengthen risk management processes across the Trust using the Datix system to support this. Early 2014-15 the Trust developed and implemented a bespoke module within Datix to effectively capture and monitor all organisational risks. SOP's have been written and templates developed, to support staff with the process.
The objective was to deliver a robust, auditable process to underpin effective management of risk. An Internal Audit of the Trust's 'risk management maturity' provided significant assurance, concluding that the Trust had in place a sound risk management strategy and process which was communicated throughout the organisation, and that risks were effectively defined.

To build upon this, a further internal audit review was undertaken as part of the 2014-15 internal audit programme to examine the management of risk at local business unit level. This again provided YAS with significant assurance of the understanding, engagement, management and escalation of risk from Clinical Business Unit (CBU) level, through the Directorate and to the relevant governance groups or committees. We recognise, however that we can do more to strengthen these arrangements further and both the internal audit review and CQC inspection have helped to inform the risk management work plan for 2015-16.

### 2.1.2 Local Risk Management

All Directorates within the Trust use the Datix system to report and manage risks. A designated risk lead has been identified within each area; this individual supports the overall risk management agenda by acting as the specialist lead in their area and taking responsibility for monitoring the management of risk. Within the specific business areas, the Risk Manager meets regularly with the designated risk lead to review and update risks.

Senior members of the Standards and Compliance Team attend Clinical Business Unit meetings to apprise on quality and risk issues and offer support in the identification and management of risk. This ensures that not only the designated risk lead for the area is conversant on key risks but that other key personnel within that area are also aware. This arrangement further embeds risk management as part of the core business of the meeting and integral to each agenda item rather than being a disconnected process.

Relevant Committees and Groups have taken ownership of certain areas of risk to ensure they are reviewing Trust wide issues. A&E Operations consider their locality risks as well as taking an overview of risks across the directorate. Committees and Groups, such as Clinical Governance Group (CGG), also review risk categories from the risk register for example CGG selected categories of patient safety, clinical, safeguarding and infection prevention and control and reviews risks relating to these on a monthly basis. This process provides a clear audit trail of local management and escalation where appropriate of risks with a risk rating of 12 or above

### 2.1.3 Corporate Risk Report (CRR) and Board Assurance Framework (BAF)

The governance of the CRR is initially via Risk and Assurance Group (RAG) on a monthly basis and comprises of scrutiny of Strategic and Operational risks with a current risk rating of 12 and above, with reference to the table below and associated guidance for managers.

**Risk scoring = Likelihood x Severity (L x S)**

| | Likelihood score | | | | |
|---|---|---|---|---|---|
| Severity score | 1 | 2 | 3 | 4 | 5 |
| | Rare | Unlikely | Possible | Likely | Almost certain |
| 5 Catastrophic | 5 | 10 | 15 | 20 | 25 |
| 4 Major | 4 | 8 | 12 | 16 | 20 |
| 3 Moderate | 3 | 6 | 9 | 12 | 15 |
| 2 Minor | 2 | 4 | 6 | 8 | 10 |
| 1 Negligible | 1 | 2 | 3 | 4 | 5 |

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

All designated Risk Leads attend RAG and review the CRR, having an opportunity to update on their own directorate high rated risks as well as contributing to discussion on others that require consideration by the group. The Risk Manager and Associate Director of Risk & Safety are responsible for ongoing monitoring of risks to ensure they are regularly reviewed by the risk lead. An update on the CRR is provided bi-monthly to Quality Committee and oversight is by Trust Board where it is reviewed in conjunction with the Board Assurance Framework (BAF).

The BAF is a high level document that provides concise assurance to the Board and its committees on the management of principal risks to the Trust's strategic objectives. In 2014-15, twelve strategic risks were aligned to the 8 strategic objectives within the BAF. Monthly iterations made to the framework are prompted by assurance reports. The BAF and Corporate Risk Register are closely aligned and subject to comprehensive Executive and Non-Executive review through a quarterly cycle.

### 2.1.4 Key risks and emerging themes and trends

The Risk and Safety Team continue to analyse data arising from incidents, complaints and interprets feedback from patients, staff and the stakeholders. Triangulation of this data identifies themes and trends and highlights potential risks for consideration, complementing the view of risks identified through routine management process.

During 2014-15 a key risk to organisation has been the ability to respond, within performance targets, particularly for red 1 & 2 calls. This has been reviewed regularly at CGG and Risk Assurance Group (RAG). Systems and processes have been established within the Emergency Operations Centre (EOC) to prioritise delivery of safe care during periods of high demand. An operational improvement plan has focussed on key actions to improve response time performance. In addition, processes in EOC and Clinical Hub and the Risk and Safety team have been introduced to monitor delayed responses or delayed back up, due to pressure on resource and to support the continued delivery of safe care.

### 2.1.5 Looking ahead - key priorities for 2015-16

The following priorities have been set for 2015-16:

- Continue to work with risk leads and operational management groups across the Trust to ensure risks are proactively managed as part of core business and that mitigating actions are delivered as planned for identified risks.
- Maintain and develop the BAF with Executive Directors to ensure key risks to strategic objectives are being governed appropriately.
- Continue to refine the risk management system to provide a mechanism to capture progress against risks and support consistent management across the organisation, including further development of the Datix system proactively for Executive and Senior Management review of emerging and significant changing risks.
- Focus on the dissemination of learning across the organisation ensuring learning from incidents and complaints is shared and understood

- Continue to increase greater emphasis on reporting near-miss incidents and staff concerns to provide a valuable source of data for learning, for identifying potential themes and to alert to possible risks in order to inform practice and prevent actual incidents. This will include development of a freedom to speak up Guardian role and associated processes in line with recommendations from the national report.

- Further support the quality of the incident investigation process with root cause analysis training being delivered to key managers across the Trust to improve the quality of incident management

- Continue to pro-actively analyse themes and trends arising from incidents, complaints, claims, coroner's inquest and other sources, and report to the relevant groups and committees for oversight and to use this information to inform organisational learning and identification and mitigation of risk.

## 2.2 Information governance

Information governance includes the systems and processes through which Yorkshire Ambulance Service ensures that information, in particular personal and sensitive information, is dealt with legally, securely, efficiently and effectively. This in turn helps the Trust to deliver the best possible care to patients and to meet legal and good practice responsibilities in relation to information.

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

Yearly self-assessments against the Information Governance Toolkit requirements enable the Trust to measure compliance against the law, best practice and NHS guidelines.

In 2014-15 our internal auditors (East Coast Audit Consortium) audited the evidence in place to support the Information Governance Toolkit score, reporting 'significant assurance' against the overall completeness and adequacy of the Information Governance Toolkit prior to its end of year submission.

The Senior Information Risk Owner during 2014-15 was Steve Page, Executive Director of Standards and Compliance.

The Caldicott Guardian during 2014-15 was Dr Julian Mark, Executive Medical Director.

### 2.2.1 Information Governance Toolkit

Version 12 of the IG Toolkit was published on 13th June 2014. The number of 'requirements' remained at 35 and there were no major changes to requirements.

The July 2014 baseline assessment was submitted on 31st July 2014 with an overall score of 67% and the performance update was submitted by 31st October 2014 with an overall score of 77%.

The final end of year self-assessment submission was made prior to the deadline of 31st March 2015. The score was 82%.

| Initiative | Nos. of Req's | March 2014 Published Self-Assessment Submission | July 2014 Baseline Self-Assessment | October 2014 Performance Update Self-Assessment | March 2015 Published Self-Assessment Submission | Grade |
|---|---|---|---|---|---|---|
| Information Governance Management | 5 | 100% | 66% | 93% | **100%** | Satisfactory |
| Confidentiality and Data Protection Assurance | 8 | 83% | 70% | 79% | **83%** | Satisfactory |
| Information Security Assurance | 15 | 82% | 66% | 75% | **82%** | Satisfactory |
| Clinical Information Assurance | 4 | 66% | 66% | 66% | **66%** | Satisfactory |
| Corporate Information Assurance | 3 | 66% | 66% | 66% | **77%** | Satisfactory |
| **Overall** | **35** | **81%** | 67% | 77% | **82%** | Satisfactory |

There is a variation in the weightings of the requirements.

The Information Governance Manager met during the year with IG Toolkit requirement leads to progress actions required to maintain the existing scores and improve where this was feasible against each requirement. Significant work is involved in the actual maintenance of existing scores as well as progression towards full compliance against each of the 35 requirement areas.

Whilst continuing progress against the IG Toolkit appears positive, this should not be taken solely as a measure of the maturity of information governance in the organisation. The Trust's Information Asset Owners are integral to continuing to ensure information governance is embedded in all relevant systems and processes at a local level. The importance of this cannot be overstated as the Trust moves forward implementing new technical developments and ways of working.

### 2.2.2 Mandatory reporting

The Trust is obliged under national regulations to report serious incidents t the Health Commissioners office.
During 2014-15 there were two personal data-related incidents that met the Information Governance Serious Incidents Requiring Investigation (IG SIRI) criteria at level 2 severity or above.

<table>
<tr><th colspan="4">SUMMARY OF SERIOUS INCIDENT REQUIRING INVESTIGATIONS INVOLVING PERSONAL DATA AS REPORTED TO THE INFORMATION COMMISSIONER'S OFFICE IN 2014-15</th></tr>
<tr><th>Date of incident (month)</th><th>Nature of incident</th><th>Nature of data involved</th><th>Number of data subjects potentially affected</th></tr>
<tr><td>July 2014</td><td>A sub-contractor to the Trust sent an email to an internal Trust data analysis team for wider distribution as part of a normal reporting system. The routine email communication contained within it, in error, a raw extract of patient identifiable data in an excel document. This was then distributed, in error, to the normal email distribution list of internal Trust recipients as well as recipients within NHS commissioning organisations and other NHS partners.</td><td>Name, date of birth, address and minimal clinical information</td><td>555</td></tr>
<tr><td>August 2014</td><td>A password protected excel file containing a data-set was sent by e-mail on 5 known occasions to four staff working within two partner NHS commissioning organisations. The file was expected to be received by the recipients, but should not have contained an item of data capable of identifying patients.</td><td>Private residence conveyance address and clinical information in an excel data set.</td><td>940 episodes of care with the data set</td></tr>
<tr><td>Notification steps</td><td colspan="3">On both occasions a risk assessment was conducted and a decision made not to contact individuals. This was based on the level of risk associated with the incident, the recipients within the distribution list, as well as reference to the ICOs guidance on data security breach management.</td></tr>
<tr><td>Further action on information risk</td><td colspan="3">The Trust worked to contain the incidents by contacting recipients and asking them to positively confirm they had deleted the correspondence.<br>Both incidents were formally investigated using the Trust's established serious incident investigation procedures. Recommendations for changes and improvement to existing operational practices have been made as part of this process.<br>The Information Commissioner's Office did not feel it necessary to take any further action in relation to these incidents. However, the Trust will continue to monitor its information related risks in order to identify and address any weaknesses and ensure continuous improvement of its information governance arrangements.</td></tr>
</table>

The Trust had in addition a small number of personal data-related incidents of a lower level of severity (level 1) and these were:

| SUMMARY OF OTHER PERSONAL DATA RELATED INCIDENTS IN 2014-15 | | |
|---|---|---|
| **Category** | **Breach Type** | **Total** |
| **A** | Corruption or inability to recover electronic data | |
| **B** | Disclosed in Error | 9 |
| **C** | Lost in Transit | |
| **D** | Lost or stolen hardware | |
| **E** | Lost or stolen paperwork | 7 |
| **F** | Non-secure Disposal – hardware | |
| **G** | Non-secure Disposal – paperwork | |
| **H** | Uploaded to website in error | |
| **I** | Technical security failing (including hacking) | 3 |
| **J** | Unauthorised access/disclosure | |
| **K** | Other | |

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

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

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

### 2.2.3 Delivery of 2014-15 Work Plan

As previous years, an ambitious information governance work plan was set out for 2014-15. The purpose of the work plan is to set out what will be delivered and when it will be delivered, as well as providing a mechanism for monitoring progress against deliverables during the year. The work plan also provides a means of warning where there may be slippage against deliverables, in particular high priority deliverables, and captures ‘priority’, ‘impact’ and ‘effort’

against each deliverable. Many work areas within the work plan link directly to the IG Toolkit requirements and are continuous.

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 2014-15 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 assessment for 2014-15 and that the scores assigned were appropriate and justified. Evidence presented was reviewed by Internal Audit against IG Toolkit guidance to confirm that it was sufficient to support the self-assessment undertaken by the Trust against the requirements.

The audit was split into two review phases, to ensure all 35 requirements were reviewed. The interim review in Autumn 2014 focussed on the 16 requirements which achieved a score of 3 at the 2013-14 submission and required additional work and evidence to ensure that level 3 was maintained. Review of the evidence to support the self-assessed scores did not identify any significant issues. With the exception of requirements 12-302 and 12-308, the remaining 14 requirements examined were found to have adequate evidence in place.

The second phase of the review undertaken in February 2015 aimed to assess the overall completeness and adequacy of the Trust's completed IGT (pre-submission) including requirements assessed at level 2.

East Coast Internal Audit Consortium provided 'significant assurance'. The auditor noted in the final report that the overall level of completeness of the toolkit was excellent and they did not identify any significant areas where the evidence was lacking in content. The audit report will be submitted to the Trust's Audit Committee.

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 2013-15 and an individual IG workbook. Trust-wide awareness-raising actions included regular information governance messages in the weekly Operational Update bulletin, Clinical Catch Up and via poster materials.

The following IG related policies were reviewed and updated within 2014-15: IG Policy and IG Strategy.

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.

#### 2.2.4 Key achievements

Further progress has been made to reduce the risk relating to confidential paper-based records held and stored at some of the more remote sites across the Trusts estate. The records review work at Doncaster Ambulance Station was completed at the end of December 2014.

The following initiatives have been progressed which positively contribute to the Trusts assurances around information security.

- NetScaler has been implemented. This is a hardware device (or network appliance), which supports the firewall and VPN functions.
- It is deployed in front of web and database servers and it combines high-speed load balancing and content switching, data compression, content caching, SSL acceleration, network optimisation, application visibility and application security on a single, comprehensive platform. It enables staff to work securely on any device at any location and has currently been implemented for the Trusts secure remote access and is being implemented for internet access.
- Fully encrypted Smartphones using the latest technology have been deployed, replacing the BlackBerry device. The Smartphones are fully managed using Mobile Device Management software to track the device. In the event of loss or theft of the device, it can be remotely wiped. The Management software enables problems with the device to be fixed remotely as well as controlling mobile apps.
- Added Windows Update management capabilities through AssetDB in addition to the existing LanGuard automated patch management. This reduces the amount of time between patches being release by Microsoft and patches being installed on the Trust computers, in particular on EOC computers where automatic patch installation is not appropriate.
- Six monthly scheduled programme of risk assessments of the Trusts server room environments, which include checks that access rights are being reviewed by ICT staff and that the rooms are free from clutter.
- Weekly scheduled vulnerability testing of the externally accessible 'Resilience Website' which is used by the Trust for storing resilience planning information.
- Implementation of regular checks of who has access to critical shared folders (on the Trusts I drive), Mailboxes and distribution lists. ICT provide the relevant IAO with a report listing who has folder access, allowing the IAO to check that the access permissions are still appropriate. The process currently relies on the IAO making a request for the information, however an automated process has been developed, has gone through a ‘small test of change’ and is now to be rolled out.

**ICO Good Practice Visit and Staff Survey**

During 2014-15 the Trust was invited to take part in a good practice advisory visit by the Information Commissioners Office (ICO). A visit took place in December 2014 and the ICO provided a number of recommendations in relation to the organisations information governance arrangements, which have been included in the proposed IG Work Plan 2015-16. The experience of the Good Practice Visit was positive and was part of an ICO initiative to work with the English ambulance trusts to understand and support their information governance arrangements.

As part of the initiative the ICO have proposed running an anonymous online survey and making it available to all staff within the English ambulances services. Whilst the Trust has indicated to the ICO it is willing to work with the ICO and take part in the online survey, there has not been (to date) a unanimous positive response from all ambulance services. The Trust is awaiting details of next steps from the ICO.

### 2.2.5 Key risks

In line with the Trusts Information Governance Strategy, the programme of quarterly (or six monthly for areas processing little personal data) IAO risk review meetings is continuing.

IAOs are encouraged to report and manage any identified information risks via the risk management process. The mapping of person identifiable data flows is one mechanism of identifying risks relating to information security and the IAOs are expected to review and re risk assess any person identifiable data flows covering their remit of responsibility, on an annual basis, in line with IG Toolkit requirements.

The privacy impact assessment (PIA) process aims to identify information related risk at the initial stages of a service development or implementation. The following PIAs have been signed off during 2014/15:-

- PTS SMS Text Messaging reminders to patients about travel
- NHS 111 SMS Text Messaging reminders to patients about their appointment
- PTS Online Bookings System giving limited access to Cleric Online by Locala and Opcare who are contracted private providers to the NHS)
- Video Toolkit involving the Trust working with a contracted media company to develop a suite of film clips for use in public engagement initiatives including recruitment.
- PTS Specific limited access to Cleric Online for Volunteer Car Service Drivers
- Development of a web site for the public to report where a public access defib is situated
- Making available electronically the NHS Protect Security Alerts to relevant operational staff groups

IG risks on the risk register are reviewed at each meeting of the IG Working Group.

The above actions help to provide a mechanism to ensure that any risks relating to paper based and electronic information and information assets are identified, reported and effectively managed.

The most significant risk relates to records management.

Datix ID 150 - Breach of the Data Protection Act due to theft or inappropriate access to identifiable information stored on YAS premises (secure and insecure).

**Risk Rating**
Initial – 12 (Moderate)
Current – 12 (Moderate)
Target – 4 (Low)

**Controls**

- IAO role is responsible for records management in their area.
- Records Management Policy setting out expectations in relation to management and storage of records.
- Restore (was CINTAS) Storage company is used to archive records in a secure environment.
- Implemented Records Amnesty in June 2013, repeated in 2014.
- Work at Doncaster Ambulance Station to review, archive and destroy records.

- Risk and Safety Team picking up any issues via Inspections for Improvement process which covers questions around records held locally on premises.

**Actions**

- Development and implementation of a Trust wide records management assurance exercise for 2015-16 to both search for and appropriately manage, paper-based records within YAS premises (and business functions) and inventory existing and already known about records held locally.

This continues to be an area of on-going improvement work.

As we move increasingly to paper light working, embrace new technologies and ways of working, continue to work with partners to provide support for certain service user groups, we are continually faced with different information governance challenges and risks. The Trusts risk management procedures, role of the IAO 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 2015-16

Priority work areas are detailed below, and are discussed in more detail in the IG Work Plan 2015-16.

- Development of and progression of IG Toolkit Action Plans for 2015-16
- Supporting policy, strategy and guidance development and communications to staff to aid implementation of policy.
- Progression of treatment plans relating to IG risks on the Standards and Compliance risk register.
- Supporting IG assessment of new processes and systems.
- Continued work to strengthen records management and archiving provision across all departments.
- Quarterly Information Asset Owner review meetings.
- Support the Legal Services team in management of records relating to high profile inquiries including Hillsborough and the national historical child abuse enquiry.

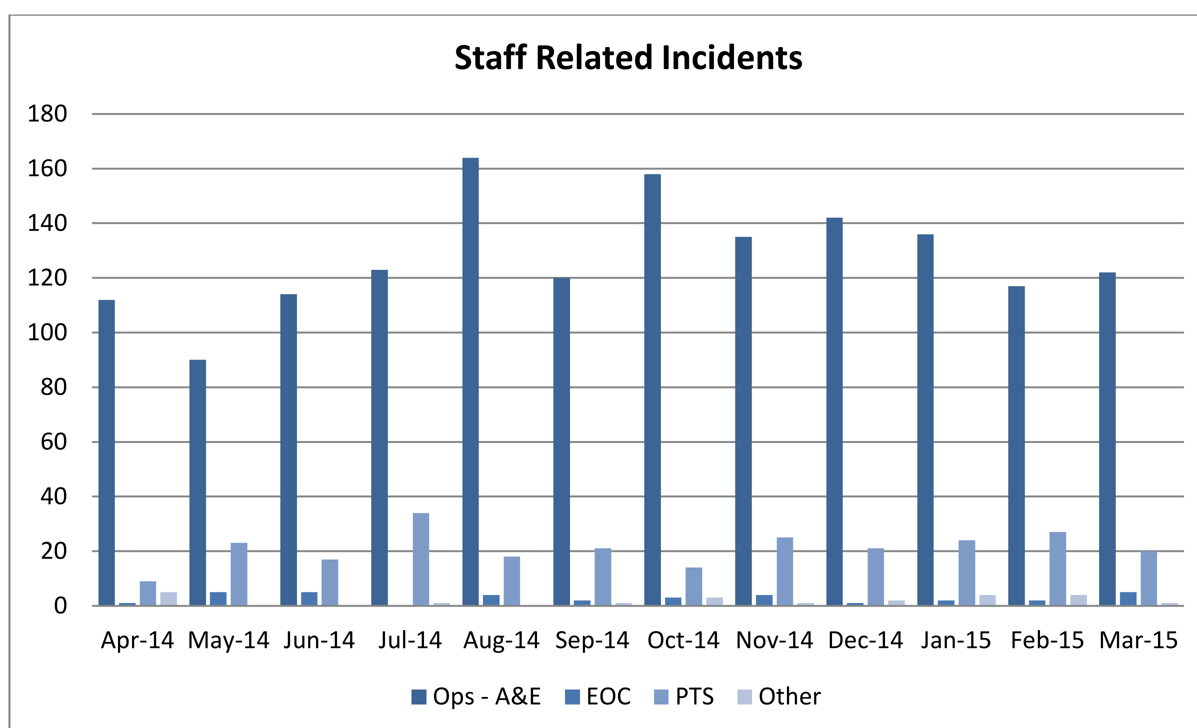
## 2.3 Health and safety

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

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

### 2.3.1 Incident reporting

This graph shows the number of staff related incidents reported in 2014-15.




Of the staff related incidents reported in 2014-15, 4.1% were graded with a severity of moderate or above (table below).

| | Apr 2014 | May 2014 | Jun 2014 | Jul 2014 | Aug 2014 | Sep 2014 | Oct 2014 | Nov 2014 | Dec 2014 | Jan 2015 | Feb 2015 | Mar 2015 | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Moderate and above | 15 | 9 | 16 | 3 | 12 | 12 | 8 | 9 | 10 | 8 | 5 | 6 | 113 |
| Total | 172 | 174 | 320 | 268 | 257 | 239 | 238 | 240 | 219 | 220 | 189 | 206 | 2742 |
| % Mod and above of total | 8.7 | 5.2 | 5.0 | 1.1 | 4.7 | 5.0 | 3.4 | 3.8 | 4.6 | 3.6 | 2.6 | 2.9 | 4.1 |

The overall incident rate for staff related incidents has risen since the beginning of the year. The yearly average is 38.5 (number of incidents per 1000 employees) with a peak of 45.9 in August.

Since the introduction of 24/7 reporting in June 2014, the total number of reported staff incidents has been above 160 per month for the majority of months which shows the positive impact this is having on the reporting culture.

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

The A&E and PTS operation services are where the Trust faces the greatest risks and subsequently records the largest number of incidents. A significant increase in the number of moving and handling incidents was seen for PTS in July however other types of incident remained stable.

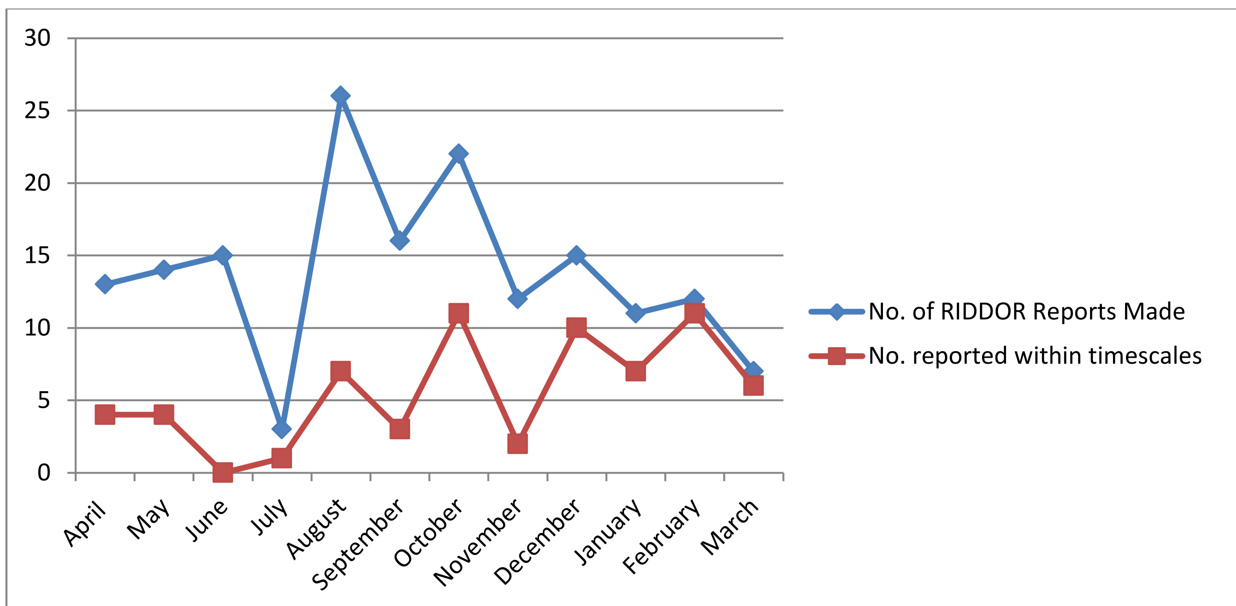
## RIDDOR reporting

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

In April and September 2014, the HSE sought additional assurance from the Trust regarding the timeliness of RIDDOR reports.

To address this, work was incorporated into the 2014-15 workplan. As a result a number of new measures / procedures have been put in place including a new SOP which built in an early identification process which flags potential RIDDOR incidents when they are reported. This process, together with increased scrutiny from the Health and Safety Manager, has led to a significant improvement in reporting timescales over the course of the year. This is shown in the graph below.

## RIDDOR Reports for 2014 / 2015




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

| Incident Type | Apr 14 | May 14 | Jun14 | Jul14 | Aug 14 | Sep 14 | Oct14 | Nov 14 | Dec 14 | Jan15 | Feb 15 | Mar 15 | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Hit by a moving, flying or falling object | 0 | 1 | 0 | 0 | 0 | 0 | 1 | 2 | 0 | 1 | 0 | 0 | **5** |
| Hit something fixed or stationary | 0 | 0 | 0 | 0 | 1 | 2 | 1 | 1 | 0 | 1 | 0 | 0 | **6** |
| Injured while handling, lifting or carrying | 9 | 7 | 9 | 3 | 13 | 8 | 15 | 5 | 9 | 5 | 6 | 5 | **94** |

| Slip, trip or fall on the same level | 3 | 5 | 3 | 0 | 6 | 2 | 3 | 3 | 4 | 2 | 1 | 1 | **33** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Fall from a height | 0 | 1 | 0 | 0 | 2 | 1 | 0 | 0 | 0 | 1 | 2 | 1 | **8** |
| Exposed to or in contact with a harmful substance | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 1 | 0 | **2** |
| Physically assaulted by a person | 0 | 0 | 2 | 0 | 0 | 2 | 1 | 0 | 1 | 0 | 1 | 0 | **7** |
| Another kind of accident | 1 | 0 | 0 | 0 | 4 | 1 | 1 | 0 | 1 | 1 | 0 | 0 | **9** |
| Collapse, overturn or failure of lifts/lifting equipment | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | **2** |
| Total | **13** | **14** | **15** | **3** | **26** | **16** | **22** | **12** | **15** | **11** | **12** | **7** | **166** |

These figures show that the highest number of harm incidents relating to staff are occurring from injuries sustained during moving and handling or as a result of slips, trips and falls. Addressing these areas of harm is a priority for the Trust and the 2014-15 work plan included focused work on moving and handling (see section below for details).

### 2.3.2 Delivery of Work Plan for 2014-15

#### Moving and Handling

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

- a comprehensive review of the Trust's patient risk assessment form
- a review of the moving and handling policy
- a review of moving and handling training materials
- scoping for the provision of specialist moving and handling advice

#### Emergency Response Bags

A large proportion of moving and handling incidents have historically been linked to the Trust's former emergency response bag (blue bag). A new emergency response bag was fully rolled out by the end of July 2014. Incident reports regarding response bags reduced significantly following this with a 64% reduction seen by September 2014. This has also impacted positively on associated staff injury claims.

## Carry chairs

New track carry chairs began to be rolled out across the Trust towards the beginning of 2014 to support staff in maneuvering patients on stairs.  Training on the use of the new carry chairs is being provided by Clinical Supervisors.  In each area 100% of all Clinical Supervisors were trained by the end of 2014-15 and 3 out of 4 operational areas reached 70% compliance for operational staff. Staff feedback indicated that whilst the new chairs have helped to address risks related to moving patients downstairs, they are not optimal for other scenarios. The Trust is therefore continuing to explore other carry chair options for 2015-16 to supplement existing provision.

## Bariatric support

YAS has 112 vehicles with the capability of transporting bariatric patients and an additional five incident support vehicles with the ability to transport specialist equipment to both pre-planned and emergency incidents involving bariatric patients. Deployment of the 5 specialist vehicles is extensive in some areas but varies across the Trust.
To address this, a further review of this deployment model is underway and  training to support increased utilisation.

## Display Screen Equipment

As part of a wider look at musculoskeletal (MSK) issues within the Trust, which are responsible for a significant amount of sickness absence and staff claims, work has been progressed in relation to Display Screen Equipment (DSE).

One of the biggest risk areas for the Trust in relation to DSE and related MSK issues is EOC.  To address this, an EOC Health and Safety Action Group was set up to focus specifically on the control room environment.

Trust wide, a new guidance document for the use of DSE has been produced and is available on the intranet. The document is supported by 25 DSE assessors spread across the Trust, who received specialist training in October 2014.

Work was also started on the production of a training video for staff along with the procurement of a corporate eye care scheme to provide low cost eye test and glasses provision for the Trust's DSE users in compliance with the Health and Safety (Display Screen Equipment) Regulations.

## High Risk Operational Risk Assessments and Standard Operations Procedures (SOPs)

A risk is on the Trust's risk register regarding the need to develop assessments regarding infrequent but high risk operational tasks e.g. work with asbestos, attendance at railway incidents etc. and therefore a project to complete these was incorporated into the 2014-15 work plan and work has progressed in line with this plan, with update reports to the Health and Safety Committee.

### Personal Protective Equipment (PPE)

Following a small number of potential asbestos exposure incidents in the previous year, a review of PPE provision was included in the 2014-15 work plan.

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

The outbreak of Ebola Virus in West Africa, and the implementation of emergency preparedness plans added a specific focus to this work. Following this, all ambulances were provided with a PPE pack containing a paper suit, goggles, boot covers and FFP3 face mask (as recommended in the needs analysis).

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

### Inspection for Improvement

The Inspection 4 Improvement (I4I) programme, which ensures that all YAS premises are inspected and assessed for compliance with Health and Safety, Security, Information Governance, Infection Prevention and Control and Risk Management Standards, has undergone a review. In order to gain improvement in areas where compliance is lowest, the inspection programme has undergone a risk stratification process and inspection teams now only revisit premises within a year if significant concerns have been highlighted. This has lead to a more targeted approach.

Further changes to the process have subsequently been developed for 2015-16 to ensure there is sufficient focus on the health and safety risk assessment elements of the process and to incorporate learning from the CQC inspection conducted in January 2015.

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

### Health and Safety Policy and Procedures

Significant progress has been made with the updating of H&S policies and procedures. Work includes a full review of the Health and Safety Policy in light of new H&S management guidance issued by the HSE and the production of new procedures for COSHH, PUWER, PPE, DSE and the completion of Risk Assessments.

### 2.3.3 Risk Assessment

Significant progress has been made over 2014-15 with the implementation of an updated formal risk assessment process.

A new manager's guide to completing a risk assessment has now been produced along with the formal risk assessment procedure. Risk assessment templates have been standardised and are now available on the intranet along with a risk assessment library which provides access to all staff.

## Key Risks

At the start of 2014-15 there were 3 risks on the Corporate Risk register which related to the quality of the Trust's Health and Safety Management System.

1) Health and Safety policy and associated guidance requires updating and development

As detailed in the section above, significant progress has been made with this risk and the risk has been removed from the corporate risk register in light of this mitigated action.

2) Inconsistent Health & Safety risk assessment process

As detailed in the section above, good progress has been made with this risk in relation to the procedural elements. The risk remains on the corporate risk register however further operational work is needed in relation to the application of dynamic risk assessment.

3) Failure to follow existing incident investigation process

Good progress has been made with this risk particularly in relation to more serious incidents and it is therefore no longer on the corporate risk register. The Trust now has in place a role within the Standards and Compliance team whose primary focus is to develop the Trust's incident reporting system including the improvement of incident investigation processes.

It is recognised that further work is needed to ensure consistent follow up of minor incidents and near misses and effective feedback to staff across the Trust relating to learning and improvement. This is a priority for action in 2015-16

Moving and Handling Risks

In addition, there were 3 moving and handling risks on the Trust risk register in relation to training in the use of carry chairs, use of the emergency response bag and the training and deployment of the bariatric support equipment. The carry chair risk was on the corporate risk register but has been downgraded due to progress in implementation. The bariatric support equipment remains unchanged due to limited progress and the emergency response bag has been closed down due to the reduction in associated moving and handling injuries during 2014-15. Please see previous section for progress details.

### 2.3.4 Looking ahead – priorities for 2015-16

An important focus for the coming year will be further development of local Health and Safety management processes with support from the corporate Health and Safety team.

This will require managers to undertake a more proactive role, to include risk assessments, independently using a framework / tool kit provided by the Trust Health and Safety Manager.

In order to effectively perform these tasks, managers require the appropriate skills and management framework and therefore key priorities for 2015-16 are:

1) increase managers knowledge of health and safety service responsibilities.

2) the provision of formal certificated H&S training to local management

3) refinement of the corporate support offered to managers on a day to day basis.

In addition, work will be on-going in relation to moving and handling as this is a long term priority for the Trust. The work of the Moving and Handling task and finish group will continue through 2015-16 lead by the Head of Safety.

Work is also underway to complete outstanding elements of the DSE work started in 2014-15 along with the first year of the High Risk Operational Risk Assessments and SOPs work plan.

Slip, trips and falls are the second highest RIDDOR incident for the Trust and are logged on the Trust risk register. Therefore, a new work stream for 2015-16 is the review of the Trust's management of slip, trip and falls and the creation of a prevention plan.

## 2.4 Security

### 2.4.1 Delivery of Work Plan for 2014-15

At the end of 2014-15, 24 ambulance stations and 9 strategic premises across YAS had full access control and CCTV. A further 3 sites have access control, but no CCTV: All station premises (61 stations) have secure Controlled Drugs (CD) Rooms, with a total of 64 CD Rooms across the Trust.

The original Hazardous Area Response Team Operational Support Unit (HART OSU) at Morley is in the process of being decommissioned, with the HART Team having now taken up occupancy in the new building at Manor Mill Lane, Leeds.

Bulk Morphine Safes have been installed at Magna, Beverley, Harrogate and Bradford; in response to local hospitals no longer being able to supply us with Morphine, due to changes in licencing legislation. The CD Rooms at Burn Hall and Elm Bank were decommissioned to free up safes and equipment for this purpose, thereby reducing overall costs for these additional safes.

Across the Trust there are now a total of 238 vehicles that have CCTV cameras fitted (186 at year end 2013-14). These consist of:

116 WAS type DCA vehicles
9 DCA 4 x 4 vehicles
49 RRV vehicles
64 DCA van conversions

Vehicle CCTV systems consist of three 'motion detection' cameras that capture any activity around the vehicle and one camera that can be activated by staff to start recording in the saloon, if they feel that their safety is being threatened. Saloon cameras only record when activated.

Existing fleet without CCTV will not be fitted with it, as these are likely to be decommissioned over time, but all new fleet has the CCTV kit installed as part of the vehicle specification.

CCTV footage may be requested by the police or other agencies following incidents involving our vehicles. The retrieval, download and viewing of all CCTV images are subject to the Trusts' CCTV Policy and Code of Practice.

### SELF-REVIEW TOOL (SRT) NHS PROTECT

Following an audit in January 2014 of the 2013-14 SRT, in the form of a full scrutiny of Standard 4 (Hold to Account), the Trusts' SRT was not selected to be audited during 2014-15.

There are some minor changes to the 2015-16 Standards, one of which is the introduction of a pilot standard for the reporting of incidents on the SIRS database. However, YAS was a pilot site for the new SIRS reporting process and is using the SIRS website to complete its annual Reporting Physical Assaults (RPA) submission; therefore this standard is already being met.

### 2.4.2 Security Incidents – Reporting and Actions Taken

During the period April 1st 2014 to March 31st 2015 the following number and types of incidents were reported via the Trust incident reporting system (DATIX). These type of incidents all fall into the SIRS category and have been uploaded directly to the SIRS database at NHS Protect.

The following **232** SIRS security incidents were reported in 2014-15:

| Incident type | Number |
|---|---|
| Physical assault on staff by patient/relative or public | **149** |
| Threats of physical violence and verbal abuse by patient/relative or public | **76** |

| Thefts of trust property | **6** |
|---|---|
| Incidents of criminal damage to trust property ie vehicles, equipment and premises | **1** |

### Security and Violence/Aggression Incidents Reported on Datix

During the period April 1st 2014 to March 31st 2015, the following number and types of incidents were reported via the Trust incident reporting system (DATIX), although not all incidents are reportable to SIRS (e.g. lost ID cards):

| Security Incidents | 2013-14 | 2014-15 |
|---|---|---|
| | 194 | 423* |
| | *14-15 data includes: 134 security badges, 72 mobile phones, 29 radios, 39 uniforms} | |
| Violence & Aggression Incidents | 2013-14 | 2014-15 |
| | 499 | 686 |

This increase is likely to be due to higher awareness around the importance of reporting and the ease of reporting due to the 24/7 phone line.

### Prosecution of Offenders

YAS has policies and procedures in place to support staff who may be subject to violence and aggression in the workplace.

The LSMS can provide advice and guidance to staff and managers on what actions can be taken when an incident of physical or verbal abuse is reported and what to expect when a case goes to court. The LSMS can also support staff by attending court with them, if required.

Unfortunately, because prosecutions are ultimately sought by the victim, staff are under no obligation to inform the Trust of the outcome. Therefore, this can create challenges in gathering comprehensive details in relation to criminal sanctions.

In 2015-16, the LSMS will look into ways of developing direct contacts through the Police and Crown Prosecution Service (CPS), which will enable the details of all criminal sanctions that are awarded to be gathered and subsequently reported.

A total of **15** warning letters were sent out to patients during 2014-15, in response to unacceptable behaviour.

### 2.4.3 Key Risks

In order to address the risk identified on the Corporate Risk Register in relation to the provision of functioning CCTV, a review by the Fleet department has been undertaken. This includes a refresh of the Standard Operating procedure for ensuring vehicle CCTV equipment is working and recording correctly.

### 2.4.4 Looking Ahead – Priorities for 2015-16

The secure access point to Restricted Security Alerts is being designed to enable audits to be carried out that will show how many and which staff are accessing the site. The NHS Protect Area Security Management Specialist, has expressed an interest in seeing how successful this site proves to be in informing staff of persons who may pose a significant risk to their safety.

The site security surveys have been incorporated into the '6 Facet Survey' of the YAS estate and will be completed during 2015-16.

Work is underway to complete the 2015-16 Self-review tool for NHS Protect and is due for submission in November 2015.

A full re-structure of the Safety and Security Policy is underway, with the procedural elements of the document being removed and re-presented as separate standard operating procedures (SOP) to allow for ease of reference for staff.

Finally, the LSMS continues to form good working relationships with partner organisations and is working towards development of 'Single Points of Contact' (SPoCs) where necessary, to aid in effective lines of communication.

## 2.5 Infection prevention and control

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

In 2014-15 the YAS Director of Infection Prevention and Control remained Steve Page, Executive Director of Standards and Compliance.

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

The key IPC compliance requirements for YAS are:

**Hand hygiene**: all clinical staff should demonstrate timely and effective hand-washing techniques and carry alcohol gel bottles on their person.

**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 of 35 days in and line with the agreed Standard Operating Procedures.

**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 2014-15

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

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

The 2014-15 annual programme of work described the activity in relation to maintaining compliance to both the Health Care Act (2008) and the CQC Essential Standards of Quality & Safety. The key priorities are delivered through agreed work-plan.

Progress with the 2014-15 work-plan has included:

- Review of the information for staff on the Trust intranet including development of an infection prevention and control section within the new Clinical Application programme. This 'IPC App' gives an A-Z guide for clinical staff about pathogenic microorganisms and outlines the requirements for personal protection, care delivery and decontamination requirements.

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

- A schedule for the review of IP&C procedural documents, including those related to NHSLA is in place. The current list of IP&C procedural documents meet Health and Social Care Act 2008 requirements, are in date and fully ratified. Adherence to infection prevention and control (IPC) policies and procedures remains a key priority in order to promote both patient and staff safety. The number of IPC related policies has been reduced in order to assist staff to find the information they require quickly and easily. During 2014-15 the following policies have been reviewed;

    - Post Occupational Exposure Management Procedure
    - Norovirus Management Guidance
    - Hand hygiene Policy
    - Aseptic Technique and Invasive Devices Guidance
    - Decontamination of Medical Devices and Vehicles Procedure

- The Infection Prevention and Control Practitioner has attended all Emergency Departments to undertake validation audits of vehicle cleanliness and hand hygiene. This has included review of the date of consumables within the vehicle when this has been possible.

- Infection prevention and control elements have been included in the new Inspections for Improvement programme, including an overall compliance rating.

- The Infection Prevention and Control practitioner continues to work with the Occupational Health provider to ensure all staff are offered the correct

immunisation, health surveillance and follow up as required. Progress has been made with the implementation of the Post Occupational Exposure management guidance.

- Assessment of the Deep Cleaning programme has been undertaken by Infection prevention and Control practitioner in conjunction with Head of Facilities and the local facility supervisors. The Standard Operating Procedures have been reviewed and updated in line with new guidelines and evidence. Monitoring via visual inspection continues. Specific training for Deep Cleaning Operatives has been developed and delivered.

### 2.5.3 Compliance with CQC standards

During 2014-15 YAS continued to focus on maintaining compliance with the requirements of the *CQC Essential Standards of Quality & Safety* – outcome 8: cleanliness and infection control.

Peer review for CQC requirements.

The National IPC group from Ambulance services undertake a yearly peer audit validation process that reviews 8 key indicators;

1. Audit tools
2. Cleaning
3. Policies and procedures
4. IPC Team management
5. Communication
6. Team development
7. Training and Learning
8. Equipment and uniform

NEAS undertook a peer review of YAS IP&C functions in Q1 2014/15 and found a broad level of compliance with these indicators following a paper based review. Further benchmarking, to include assessment of care delivery, is suggested for 2015-16.

#### CQC Inspection January 2015

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

### 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 (IPR). Audit compliance across all areas has

improved over the year, with the majority of business and practice areas achieving 95% compliance. Where areas were found to be non-compliant targeted action was taken by the Risk and Safety team. Premise cleanliness audits are the most frequent area of reported lower compliance. Where there is a risk to patient safety action is taken by the Head of Safety. This is done in partnership with local managers, facilities managers and other departments as required.

Fleet have an agreed process for repairs to upholstery and vehicle audits within PTS have shown some improvement in year to this effect.

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

Validation of the hand hygiene audits provides further information about any perceived or actual barriers to hand hygiene in clinical practice and gives us a deeper understanding about the current use of gloves. It allows for on the job information and re-training as required. The role of an interim supporting Infection Prevention & Control Nurse throughout Q3 and Q4 greatly increased the contact staff had with trained IPC personnel and this was valuable in building their knowledge and compliance in IPC practices.

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. Staff have not been used to being consistantly challenged about this or their hand hygiene practice. A more comprehensive campaign will be undertaken during 2015-16 to ensure all staff understand the requirement to be bare below the elbows and compliant with hand hygiene needs.

IPC good practice reminders have been publicised through the weekly Operational Update staff bulletin throughout the year; with specific updates sent in response to the Ebola virus during the height of the outbreak in West Africa.

### 2.5.5 Vehicle deep cleaning

Deep cleaning is undertaken by a dedicated cleaning team for every vehicle at least every 35 days. Deep cleaning audit results are reported via the IPR. Where the audit results show a fall in acceptable levels of compliance the Head of Safety will work collaboratively with the Locality Managers and Facilities team to determine and resolve the issues. This has been a successful approach to resolve issues in the North and East where compliance had fallen below the agreed standard. A full re-training package was put in place for the Deep Cleaning operatives throughout 2014-15 and this included specific infection prevention and control sessions for these members of staff.

| Facilities Quality indicators | Apr-14 | May-14 | June-14 | Jul-14 | Aug-14 | Sep-14 | Oct-14 | Nov-14 | Dec-14 | Jan-15 | Feb-15 | Mar-15 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Operational Vehicle Deep Cleaning to Schedule % SLA - Compliance | 98% | 97% | 97% | 98% | 98% | 97% | 96% | 96% | 93% | 89% | 90% | 90% |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Operational Vehicle Cleanliness Audit - Compliance % - Ambulances and Cars | 96% | 98% | 99% | 98% | 98% | 98% | 97% | 98% | 96% | 97% | 97% | 96% |
| Station/Premises Cleanliness Audit - Compliance % | 97% | 90% | 97% | 99% | 98% | 97% | 99% | 98% | 98% | 99% | 99% | 97% |
| Unscheduled Deep Clean Request Turnaround in hours | <24 | <24 | <24 | <24 | <24 | <24 | <24 | <24 | <24 | <24 | <24 | <24 |

### 2.5.5 IPC training

IP&C training is provided on appointment to the Trust through corporate and local induction. Refresher training is provided on a 2 yearly basis via the Statutory and Mandatory Workbook. Training content and delivery is reviewed by the Head of Safety and representatives from Education and Training Department. The proportion of YAS staff compliant with IP&C training continued to increase in 2014-15 and at year end was at 93.5% .

As part of a wider piece of work relating to the development of clinical applications, IP&C content is being made available for use on a smart phone or from within the tough book system. This will improve staff access to knowledge about specific microorganisms and assist in informing staff of procedural changes.

The Ebola virus outbreak has led to increased awareness of infectious diseases. This was an opportunity to enhance staff awareness. Additional training sessions on infectious diseases were offered via the clinical development sessions run by Royal College of Paramedics. Uptake of these sessions was excellent across the region.

### 2.5.6 Infection Prevention and Control Incident review

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

Incidents reported within 2014-15 have increased slightly from 2013-14. This is likely to be a combination of increased awareness and ease of reporting. Occupational exposure incidents remain the highest reported incident category. Each incident and near misses involving exposure is reviewed by the Risk and Safety team prior to allocation to a local manager for action and where appropriate staff are advised to attend an occupational health appointment for assessment and to arrange any further support required.

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

### 2.5.7 Key risks

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

A major additional risk within 2014/15 was in relation to readiness and resilience for the Ebola virus; this risk has been reviewed and managed by the Ebola Clinical reference group.

During the Ebola Virus outbreak in West Africa the Department of Health required specific responses from all healthcare providers in respect of their readiness and

resilience. The Ebola Clinical Reference Group was established and led by the Associate Director for Resilience and Special Operations. YAS implemented a programme for fit testing for respiratory protection and provided enhanced personal protective equipment on all vehicles. A clinical response flow chart was agreed and implemented for use by 111, EOC and frontline crews. Incidents related to Ebola calls were monitored by the group and a substantial amount of reference work with other care providers was undertaken by group on behalf of YAS. YAS were seen to be flexible, responsive and supportive. HART undertook several simulation transfers with local hospitals to support testing their processes and a number of potential positive transfers during the height of the outbreak. Feedback to all concerned was excellent.

#### 2.5.8 Next steps for 2015-16

- An Infection Prevention and Control road show that includes the 5 moments of hand hygiene, use of standard precautions and effective vehicle decontamination processes will be run across the Trust within Q2 and Q3 in 2015-16. The focus on engagement with staff, patients and public to increase knowledge and compliance with all infection prevention and control practices.

- A key focus will be a compliance with bare below the elbows practice. Fob watches are being purchased to provide positive support to staff for removing wrist watches.

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

- YAS will work collaboratively to ensure a flexible response to on-going infection prevention and control issues and outbreaks, locally, nationally and internationally, for example the Middle East Respiratory Syndrome (MERS).

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

- The IPC Practitioner will work collaboratively with Estates, Facilities and Operational staff to ensure all stations and vehicles are clean and safe for patients and staff, using the Inspection for Improvement process and monthly audits to inform and measure this standard. Pilots of Make Ready and vehicle preparation processes are being implemented to include more standardised vehicle cleaning systems.

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

- The IPC Practitioner will support PTS service to understand common infections and give them clear and available guidance on the actions required to prevent further spread.

- The IPC Practitioner will continue to benchmarking YAS IPC systems and processes with other ambulance services and be active within the National

Infection Prevention and Control Ambulance group, including taking part in research project for deep cleaning frequency.

- Weekly monitoring of key indicators by the Director of Infection Prevention and Control will increase management focus on ensuring consistent delivery of standards.

## 2.6 LEGAL SERVICES

### 2.6.1 Inquests

The Legal Services Team actively manages all Coroner Inquests, which is inclusive of identifying and managing risk, Trust reputation, identifying learning and providing staff support. In 2014-15 the Legal Services team managed 360 inquest cases, which is an increase compared to 300 cases in 2013-14. YAS employees gave evidence (oral or written) to 196 inquests this year. 164 are still awaiting a hearing date.

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. Rule 43 was replaced by a Regulation 28 notice or Prevention of Future Death (PFD) report, which means that Coroners now have an obligation rather than discretion to issue such a report in any matter where they consider action is necessary with a view to preventing future deaths.

In 2014-15, the Trust received two PFD reports. The first report related to systems issues associated with the escalation of stand-off situations, and allocation of resources to back up single responders in this situation. A number of actions were put in place during the investigation of this incident which resulted in a review and planned implementation of a new system which would strengthen the communication and management of any future stand-off situations.

The second report involved a cross border incident where concerns were raised in relation to the communication systems between the Emergency Services within the different regions, and the systems that were used within YAS for locating out of area addresses. A review of the national cross border memorandum took place between all the ambulance Trusts as a result.

Both individual learning points and common themes are identified and actions implemented from review and management of inquest cases. Organisational learning actions have included reviewing and implementing a new process for the management of stand-off situations, a review of training and education for management of potential spinal injuries and a national review of the cross border memorandum. For Serious Incidents that result in a death, the coroner is proactively informed and learning points are identified through this process.

### 2.6.2 Risks

The implementation of strict timescales for concluding an inquest means that Coroners now set inquest dates much earlier, with short timescales for the Trust to review the cases and

implement any actions that are required. The Legal Services Team 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. Coroners are now able to enforce a fine of up to £1,000 if deadlines are missed.

PFD reports have taken on a more central role within the Coronial process. It is possible for a PFD report to automatically be made in circumstances where the Coroner is not provided with a final Serious Incident Report and a fully implemented Action Plan; or where there is evidence that the recommendations arising from the Serious Incident Report or Action Plan have not been adequately implemented or communicated to staff. Given both the volume of inquest cases and the tight timescales for concluding Inquests, this is challenging to manage for the organisation.

### Hillsborough Legal Proceedings

#### 2.6.3 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. YAS's involvement in the inquests continues and they are currently scheduled to run until Spring 2016.

#### 2.6.4 Current position

A dedicated team comprising internal and external resources, initially established in March 2013, have managed YAS involvement in the Inquests to date, Internal skills 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, pre match planning and 'events of the day' have been heard and the currently timetabled are the individual Inquests of the 96 deceased. This will be followed in the autumn of 2015 by 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 and pathology of individual deceased.

### 2.6.5 Next Steps

Workload has been high throughout the latter phases and YAS will continue to be fully engaged in the hearing of expert evidence.

As throughout the previous 18 months, a 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 appropriately.

The Inquests and their conclusions will be the subject of intense media coverage and a media handling strategy has been developed. Whilst proceedings are ongoing the Coroner's direction on media reports prohibits commentary but once the Inquests are concluded this will be lifted.

### 2.6.7 Claims

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

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

An internal audit of the management of claims was undertaken during 2014-15 by East Coast Audit Consortium with significant assurance reported. Recommendations from this report are being implemented, and The Legal Services team continue to work closely with the NHSLA to identify areas of improvement to increase the amount of successful claims and reduce the cost to the Trust.

### 2.6.8 NHSLA 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 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 clinical negligence claims. The NHS LA is currently developing more detailed benchmarking information for non-clinical claims.

In August 2013 the Ministry of Justice extended its Claims Portal which is used for motor personal injury to include Employers' Liability and Public Liability (EL and PL) claims. During 2014-15 the use of the Portal has become much more embedded and it is now the compulsory route for EL and PL claims valued at up to £25,000 for damages. For these claims there is a limited time to investigate of 30 days for employer liability claims and 40 days for public liability claims. The result of this scheme is that claims are settled much quicker, and the costs remain low. The risk associated with this scheme is that the shorter

timescales puts pressure on departments within the Trust to investigate the claim and make a decision on liability.

### 2.6.9 Claims reporting

The table below details the total amount of open claims (inclusive of new claims reported). At the end of 2014-15 there are 186 open claims. 159 of these are EL claims (85%), 11 PL (6%) and 16 CNST claims (9%). The data shows that the number of new claims reported continues to increase, but the past year has seen a reduction in the amount of open claims.

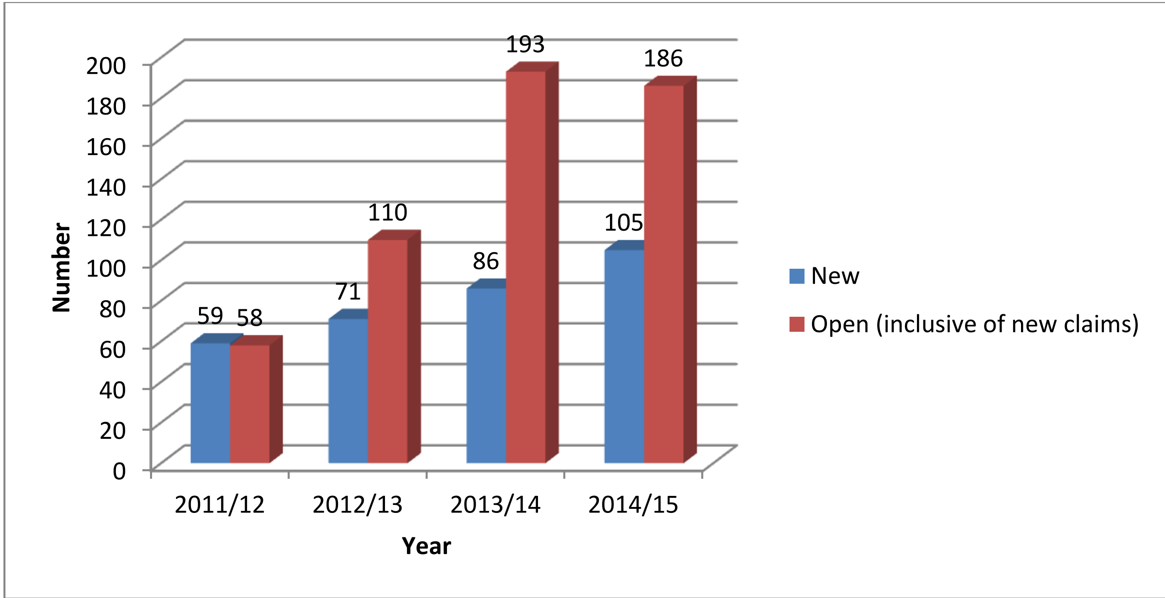



Figure 1: Total number of new and open claims (EL/PL/CNST).

### New Claims

The table below details the new claims reported from 2011. The highest volume of claims is EL claims, but these have decreased in number in 2014-15. CNST and PL claims continue to remain the lowest categories, but have slowly increased with the highest number reported this financial year for both.

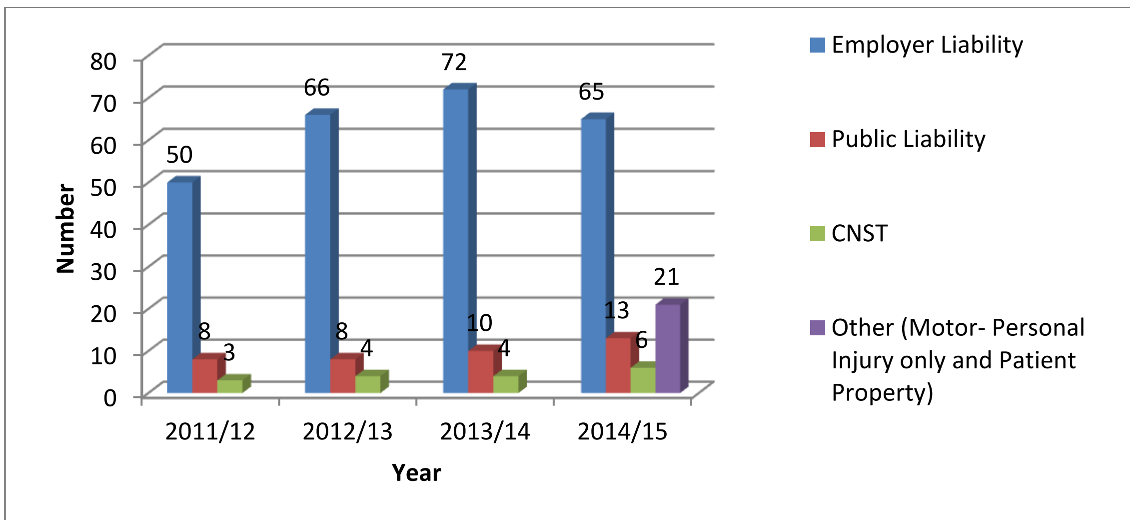



Figure 2 – New claims reported (EL/PL/CNST/Other types of claim)

## Employer Liability (EL) Claims

EL claims remain the highest volume of claims reported, although there has been a reduction in the number reported during 2014-15. The most common claims continue to be those relating to moving and handling claims (57%), in particular relating to the response bag, injuries whilst using equipment to move a patient (carry chair/stretcher/wheelchair), and injuries whilst moving a patient (non- equipment related).

Vehicle related claims are also high (17%) as a result of problems with tail-lift, seats, heavy steering and vehicle doors, followed by slips, trips and falls claims (15%),

During 2014-15 a small number of exposure related claims were reported, particularly in relation to hearing loss as a result of long term noise exposure during the course of employment with the Trust.

Since the removal of the blue response bag, the claims have started to reduce in number (15 compared to 28 in 2013-14) and it is hoped that this will continue.

A recall of vehicles to refit a modified tail lift is currently in progress, and the Trust wide Inspection for Improvement programme continues to progress and are used to highlight slips, trips and fall hazards within the workplace.

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.

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 (PL) Claims

In 2014-15 there were a total of 13 PL claims reported, with the number of claims reported remaining relatively low over the years. This demonstrates a positive patient safety culture within the Trust. The number of claims relating to slips, trips and falls has decreased. The highest category of claims reported relates to injuries sustained from Trust vehicles, particularly tail lifts and vehicle doors.

The work relating to the Safety Thermometer continues within the Trust 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. The Trust has also submitted an improvement plan for the NHSLA Sign up to Safety campaign which focuses on a number of areas including falls.

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

### CNST Claims

In 2014-15 there were 6 new CNST claims reported, which, although is a slight increase from previous years, continue to remain in low numbers. The NHS LA risk profile for the Trust indicates for the value of claims paid and the number of reported claims the Trust is rated in the top 20% best performing Trusts for CNST. This is positive for the Trust as it demonstrates a high standard of patient care.

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

The main focus of these claims is the treatment of a potential spinal injury. There are currently 5 open claims relating to this. Two claims reported during this year related to an alleged misdiagnosis where a decision was made to leave the patient at home and the condition deteriorated.

Education and training of staff in spinal immobilisation following a traumatic fall remains a key focus within the Clinical Directorate and across the Trust. This workstream also forms part of YAS Sign Up To Safety Campaign.

A further workstream within the Sign Up to Safety Campaign is focused on deterioration in adults and children which will include further training and education around clinical assessments and recognising and responding to deterioration.

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

### 2.6.10 Looking ahead – priorities for 2015-16

- A focus on the improvement of the claims reporting. The claims module on the Datix system has undergone a full revision which will strengthen the quality of the claims data available. The enhanced reporting process will allow for an emphasis on earlier

identification of themes and trends of reported claims, and any lessons learned as a result. This aims to both support improvements to staff and patient safety, and reduce the number of claims reported.

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

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

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

## 2.7 MEDICINES MANAGEMENT

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

YAS's approach to medicines management is set out in the Trust Medicines Management Policy and the underpinning Drug Management Protocol and Controlled Drug Medicines Standard Operating Procedure.

During 2014-15 the Accountable Officer for Controlled Drugs has been the Executive Medical Director.

### 2.7.1 Background

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

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

- National Institute for Health and Care Excellence (NICE)
- Quality, innovation, productivity and prevention programme (QIPP)
- 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.

### 2.7.2 Medicines Management Work plan

Ketamine and Midazolam have been in use by Yorkshire Air Ambulance, and Hazardous Area Response Team Paramedics since February 2013. The usage of ketamine and midazolam continues to be discussed at the monthly MMG. A re-audit is currently being completed. There has been an international manufacturing problem with ketamine 10mg/ml since June 2014, to enable YAS to continue to provide the best quality of care an unlicensed product has been procured. Patient group directions (legal document that allows paramedics to administer ketamine to patients) cannot be used for an unlicensed medication. To enable staff to continue to administer ketamine, a verbal prescription from the Medicines Incident commander on call is gained before patients receive the treatment. This has been written into the Ketamine standard operating procedure, and is working well. There are still supply issues with the unlicensed ketamine, moving forward a decision needs to be made as to whether YAS change to a different strength of ketamine, to allow a licensed product to be procured regularly. There are also plans to allow the new enhanced care team to administer ketamine and midazolam, which makes the ability to procure medicines regularly more important.

### 2.7.3 Review of Adverse Incidents Relating to Medication

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

- Accidental administration of the wrong medication

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

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

  Both new implementations will be reviewed to identify reductions in incidents.

- Missing or out of date medicines

  Prescription only medicines audit continues to be undertaken to help reduce the number of out of date and missing medicines.

### 2.7.4 Monitoring Usage of Controlled Drugs

- UCP and paramedics morphine usage is reviewed every month and discussed at the monthly medicines management group. To identify over/under usage. The 5 top middle and bottom users PRFs are reviewed for pain scores, indication and dose used. To date there have been no issues identified with regards to usage.

### 2.7.5 Patient Group Directions (PGD's)

- The new specialist paramedics role has been rolled out and they have received training in 5 PGDs, Amoxicillin, flucloxacillin, trimethoprim, prednisolone and doxycycline.

### 2.7.6 Introduction of New Patient Group Directions and JRCALC medicines

- Misoprostol for postpartum haemorrhage has been approved and is in vehicles, paramedic training is ongoing.

- IV paracetamol was trialled in the North CBU and was found to have positive outcomes, the roll out to the rest of the areas requires approval from the Medicines Management Group. The results of the trial and the financial implications will be presented the MMG and CGG.

### 2.7.7 Management of key risks

- 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.

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

### 2.7.8 Next steps for 2015-16

- The Trust Pharmacist is working with the Make Ready Project Manager and Procurement team to produce a plan for medicines make ready bags throughout the region; to produce more efficient working – enable paramedics to spend more time treating patients, reduce errors, improve patient safety, and ensure YAS is working within the updated legislation and regulations whilst negating the requirement for multiple government licences. Change to vehicle CD possession to reduce the number of CD breakages will also be discussed.
- IV paracetamol roll out and audit and misoprostol audit,
- Temperature monitoring pilot – 50 temperature loggers will be placed into vehicles and morphine safes to identify whether the change in the external temperature has any effect on the temperature of the medications. The data will be removed and analysed at the end of Summer and Winter. The results will be correlated with the 6 other ambulance services taking part in the pilot.
- Audit of the specialist Paramedic PGD medicines
- In depth review of controlled drug breakages – The number of breakages has steadily risen during 2014-15; there has been an increase in damaged vials and vials shattering during opening.

# Section 3.0

# Clinical Quality

## 3.1 Patient Safety

### Progress against the work-plan for 2014-15 includes:

- Further use of the Patient Safety Thermometer data to monitor, report and inform interventions that can be used to reduce the level and risk of harm occurring in the three identified areas. Progress has been made in reducing both falls whilst in receipt of care and injuries whilst in receipt of care. The Education and Training department have worked with Risk and Safety team to develop a comprehensive falls prevention awareness manual that reflects learning from incidents. Medicines management has seen reductions in errors relating to fluids and confusion between paracetamol and aspirin following changes to storage of these items.

- The Quality and Risk team continually analyse incident and complaint data to track levels of harm and identify causal factors, triangulating common themes and increasing trends to determine intervention. The level of incidents reported by staff continues to increase, although rates of moderate and above harm have not increased which is suggestive of an increasingly safety focussed culture. Monthly reporting to the National Reporting and Learning System continues. YAS remains within the average for both reporting and levels of harm reported.

- The Quality and Risk team have engaged widely on the safety culture within YAS using a range of activities that include; reporting the results of work on patient safety via visual communications such as posters, visiting stations and areas of work to discuss barriers and enablers to safety culture within YAS, ensuring lessons learnt from serious incidents are shared across the organisation and including alterations in policies, procedures and training materials. However it is acknowledged that this is an area that YAS can improve further and will be a focus for 2015-16.

- YAS representatives regularly attend the National Ambulance Patient Safety group and have shared their work on the safety thermometer amongst other teams. Work in 2015-16 is likely to include a move to agree national data definitions of patient harm and learn further from patient safety programmes which have achieved success in other services.

- A full review of YAS moving and handling training provision, policies and procedures, available moving and handling equipment and its usage was undertaken during 2014-15. This baseline assessment has been used to form the Sign up to Safety work-stream – Moving Patients Safely. This particular work plan will commence in 2015-16 as part of YAS' Sign up to Safety 3 year programme.

### 3.1.1 Incident reporting

Yorkshire Ambulance Service encourages staff to report patient safety incidents. During 2014-15 we have seen an increase the numbers of incidents reported. A positive safety culture is indicated by high overall incident reporting levels but with few serious incidents and we continue to work towards achieving this. Plans for 2015/16 include further development of our learning from incidents and near misses.

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

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

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

A Clinical Patient Safety Improvement group has been established with terms of reference that include taking action to rectify themes identified within IRG. This group will also review all the Sign up to Safety work-streams within 2015-16. It is attended by representatives from all Directorates and Chaired by Associate Medical Director.

### 3.1.2 Number of Adverse Incidents for 2014-15

| | A&E Operations | EOC (Emergency Operations Centres) | NHS 111 (incl LCD) | PTS (Patient Transport Services) | Others | Total |
|---|---|---|---|---|---|---|
| Apr 2014 | 336 | 23 | 62 | 63 | 27 | 512 |
| May 2014 | 349 | 23 | 58 | 90 | 17 | 537 |
| Jun 2014 | 530 | 28 | 49 | 84 | 32 | 723 |
| Jul 2014 | 570 | 34 | 57 | 107 | 33 | 801 |
| Aug 2014 | 635 | 43 | 42 | 64 | 23 | 807 |
| Sep 2014 | 525 | 33 | 40 | 77 | 18 | 693 |
| Oct 2014 | 494 | 40 | 41 | 77 | 26 | 678 |
| Nov 2014 | 506 | 36 | 65 | 79 | 22 | 706 |
| Dec 2014 | 501 | 47 | 75 | 79 | 18 | 720 |
| Jan 2015 | 485 | 62 | 58 | 91 | 29 | 725 |
| Feb 2015 | 412 | 63 | 69 | 96 | 29 | 669 |
| Mar 2015 | 456 | 44 | 83 | 91 | 22 | 696 |
| Total | 5799 | 476 | 697 | 998 | 297 | 8267 |

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 2014-15

| | A&E Operations | EOC (Emergency Operations Centres) | NHS 111 (incl LCD) | PTS (Patient Transport Services) | Medical - Operations | Other | Total |
|---|---|---|---|---|---|---|---|
| **Apr 2014** | 67 | 10 | 53 | 15 | 1 | 4 | 150 |
| **May 2014** | 56 | 12 | 43 | 29 | 2 | 3 | 145 |
| **Jun 2014** | 96 | 14 | 46 | 28 | 4 | 1 | 189 |
| **Jul 2014** | 129 | 14 | 48 | 35 | 0 | 4 | 230 |
| **Aug 2014** | 157 | 24 | 35 | 27 | 3 | 6 | 252 |
| **Sep 2014** | 123 | 19 | 31 | 26 | 6 | 1 | 206 |
| **Oct 2014** | 102 | 22 | 29 | 37 | 1 | 3 | 194 |
| **Nov 2014** | 113 | 21 | 52 | 25 | 2 | 0 | 213 |
| **Dec 2014** | 104 | 30 | 59 | 22 | 0 | 6 | 221 |
| **Jan 2015** | 121 | 45 | 47 | 31 | 1 | 3 | 248 |
| **Feb 2015** | 100 | 48 | 64 | 34 | 2 | 3 | 251 |
| **Mar 2015** | 102 | 26 | 69 | 28 | 0 | 6 | 231 |
| **Total** | 1270 | 285 | 337 | 576 | 22 | 40 | 2530 |

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 that are often outside the control of YAS. The Risk and Safety team have developed a new service to service process that allows us to highlight to other services care concerns that have been reported on Datix by our staff about their services. YAS have representatives on the care pathway groups across the region and give feedback about incidents and issues via these network meetings. YAS continue to work in partnership with acute, community and social care providers to minimise these incidents and report progress and issues to commissioning groups as appropriate.

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

The new Falls Awareness document has been circulated widely within PTS and staff are made aware during their training of the need to carefully assess the patients moving and handling needs at every contact as these requirements can change on a

daily basis. Falls tend to occur when the patient attempts to mobilise without the support of the PTS staff member. Staff are encouraged to request patients who are at risk of falling to wait for the staff to be there to support them before attempting to move. Injuries tend to include skin tears and scrapes from the equipment. Fleet review each vehicle to ensure usage has not led to sharp areas that can cause injury during use.

### 3.1.4 Serious Incidents

| Serious Incidents | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Ops - A&E** | 3 | 3 | 7 | 6 | 3 | 1 | 2 | 4 | 5 | 2 | 1 | 1 |
| **EOC** | 2 | 1 | 4 | 0 | 3 | 0 | 2 | 0 | 2 | 3 | 0 | 1 |
| **PTS** | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 1 | 1 | 1 |
| **111** | 0 | 0 | 1 | 1 | 0 | 2 | 0 | 0 | 0 | 2 | 0 | 1 |
| **OTHER** | 0 | 0 | 0 | 1 | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 0 |
| **TOTALS** | **5** | **4** | **12** | **8** | **8** | **3** | **5** | **4** | **7** | **8** | **2** | **4** |

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.

In June, July and August of 2014 there were a number of SI relating to our delayed response or delayed back up. Incidents were investigated and reported as required to CCG's. A review conducted by the Executive Medical Director and Executive Director of Standards and Compliance highlighted that there was only a weak …. Link between responses over the 8 minute target and clinical outcome for patients.
Improving YAS' ability to respond in a timely manner to all calls is the focus of the Trust's performance improvement plan and real time monitoring of harm in incidents where delays have occurred is part of the EOC processes. Where delays are identified by frontline clinical staff they are required to report using the Datix system.

### 3.1.5 Delivery of Safer Care CQUIN for 2014-15

Improving patient safety continues to be a high priority and this is the third year we have committed to the further development of our Safety Thermometer programme, as part of our Commissioning for Quality and Innovation (CQUIN) programme.

During analysis of the incident data management system falls, injuries and medication errors were all highlighted as areas of harm for patients. These were benchmarked against indicators being gathered nationally as part of the work-stream being progressed through the national Quality Governance & Risk Directors (QGaRD)

- **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. Lack of dynamic risk assessment of the patient's capabilities on day prior to moving and handling techniques had led to some slips, trips and falls and or associated injuries. Over 2014-15 we worked with frontline staff to ensure review the needs and capabilities of the patient at the time of movement and employ the correct equipment and moving procedures to help them undertake the task without incident.

An audit to review the availability of all moving and handling equipment on A&E and PTS vehicles was undertaken to ensure staff had access to the required. Where there were gaps in provision new equipment was ordered.

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

Analysis of data during 2014-15 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.

The Risk and Safety team has worked with frontline staff and Fleet to ensure that all equipment within YAS vehicles are safe to use and without sharp edges.

One incident was reported as major. This involved the use of a LUCAS external compressions device, which was on trial use in 2 regions of the organisations. The LUCAS system had a faulty cap and the system pressed onto the patient's chest during compressions causing bruising. The device was immediately removed from use and the fault reported to the manufacturer and MHRA. The MHRA have received a full report back from the manufacturer and are satisfied with the review and response. The system is no longer in use within YAS.

One incident was reported as moderate. This involved a laceration to a patient's right leg following the foot plate falling onto it during moving and handling of the patient from stretcher to wheelchair. The wheelchair is the property of Emergency Department at Pinderfields hospital. The nursing team present at the time were aware of the incident and removed the faulty chair from use.

- **Medicine errors**

Most medication errors relate to incorrect dose, being not in line with JRCALC guidance. There have been two drug contraindications during Q4; these have been unavoidable during medication delivery as the information to make the assessments were not available to the members of staff at the time.
Changes in medication storage, in line with learning from incidents and human factors work, were made in 2014-15. These include improvements in storage for oral medication and clearer identification of N/Saline and Dextrose. These changes assist staff to recognise the difference when delivering fluids or oral medication quickly in an emergency situation.

Audits to ensure all medications are available in the vehicle and in date are continuing and compliance with these audits are improving. Staff do recognise the importance of these audit checks and are involved in the process.

The Medicines Management Group (MMG) review all medication incidents and proposed actions. These have included regular feedback using the Safety Thermometer performance briefing, introduction of monthly vehicle medicines audit, peer review of medicine related SOP/policies, review of monthly assurance reports at MMG to identify compliance against the audits and more timely actions from incident reports.

### 3.1.6 Next steps for 2015-16

Work on the patient safety thermometer, as a specific work-stream, is now complete but monitoring and feedback using this tool will continue and findings will inform future policies, procedures, training and education along with operational systems and processes within both A&E and PTS.

The Sign Up to Safety work-streams have now been agreed for 2015-16 and make up a wider 3 year plan with key objectives and pledges defined by the overarching aims to listen, learn and act. Honest and open reporting within a safety focussed culture is something that YAS continually aims for.

The four Sign up to Safety work-streams for 2015-16 include:

- Care of the deteriorating adult – this work stream includes the national CQUIN for improving recognition and treatment of sepsis.
- Care of the deteriorating child – this work will include the development of an early warning scoring system for children.
- Moving patients safely – this will improve safety for patients by reducing slips, trips, falls and other injuries associated with moving and handling. It will also cover more complex situations, such as, spinal immobilisation or the swift extraction processes needed for multiple trauma cases as well as moving and handling of patients with complex needs – including deployment of the incident support units and other specialist moving and handling equipment.

- Human factors research to inform team development plan for Emergency Operations Centre to reduce errors and escalate issues of concern in a timely manner, thereby reducing patient harm.

Implementation of recommendations arising from the national freedom to speak up review is a further priority for 2015-16. This work will also address wider culture, systems anda processes to support staff in raising concerns about safety and quality and ensuring appropriate learning and ????

## 3.2 Safeguarding

### 3.2.1 Introduction

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

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

### 3.2.2 Delivery of 2014-15 work-plan

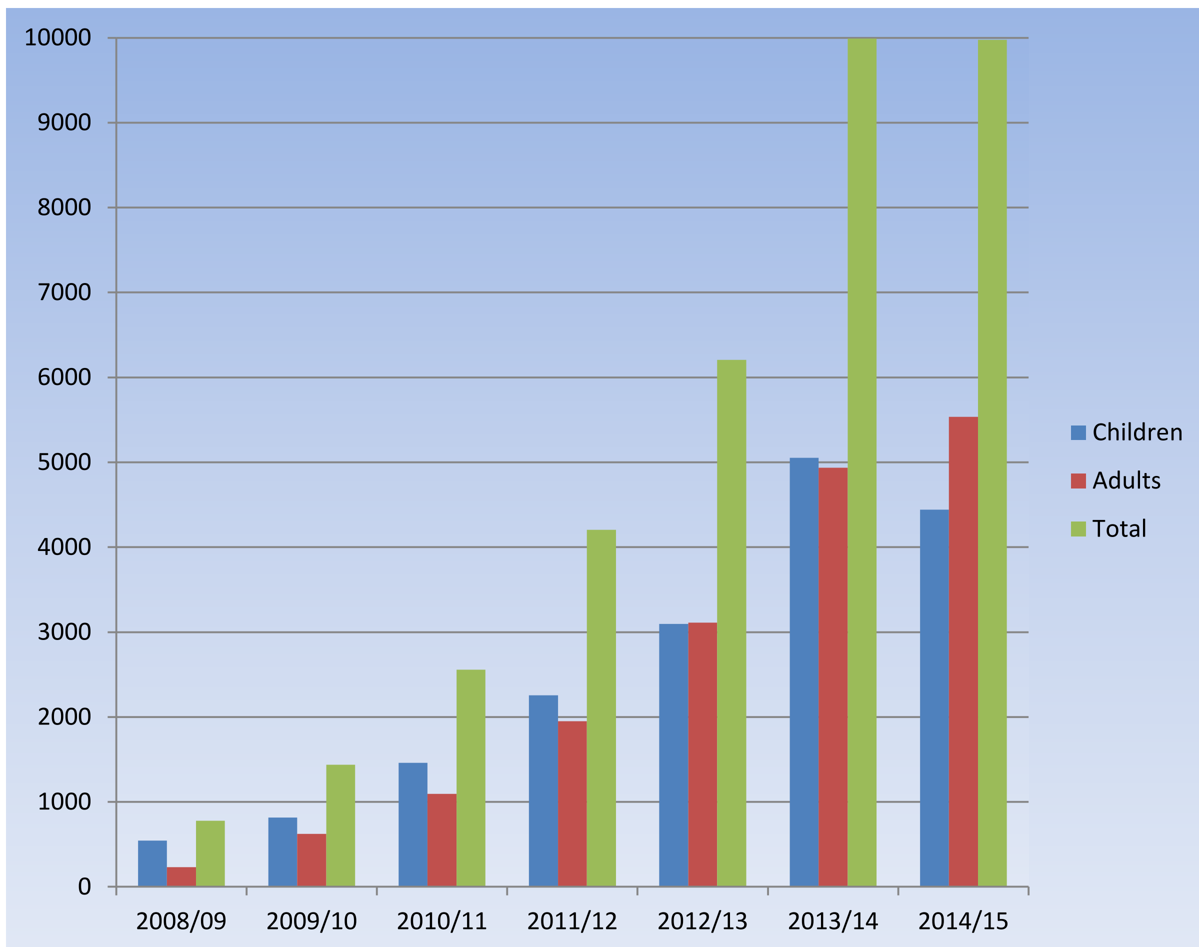
The safeguarding 2014-15 work-plan included:

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

- Raise awareness of Prevent to all staff, including the delivery of training. This is a mandatory requirement of the Department of Health's implementation of the 'Prevent' element of the Government's counter-terrorism strategy.

- 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

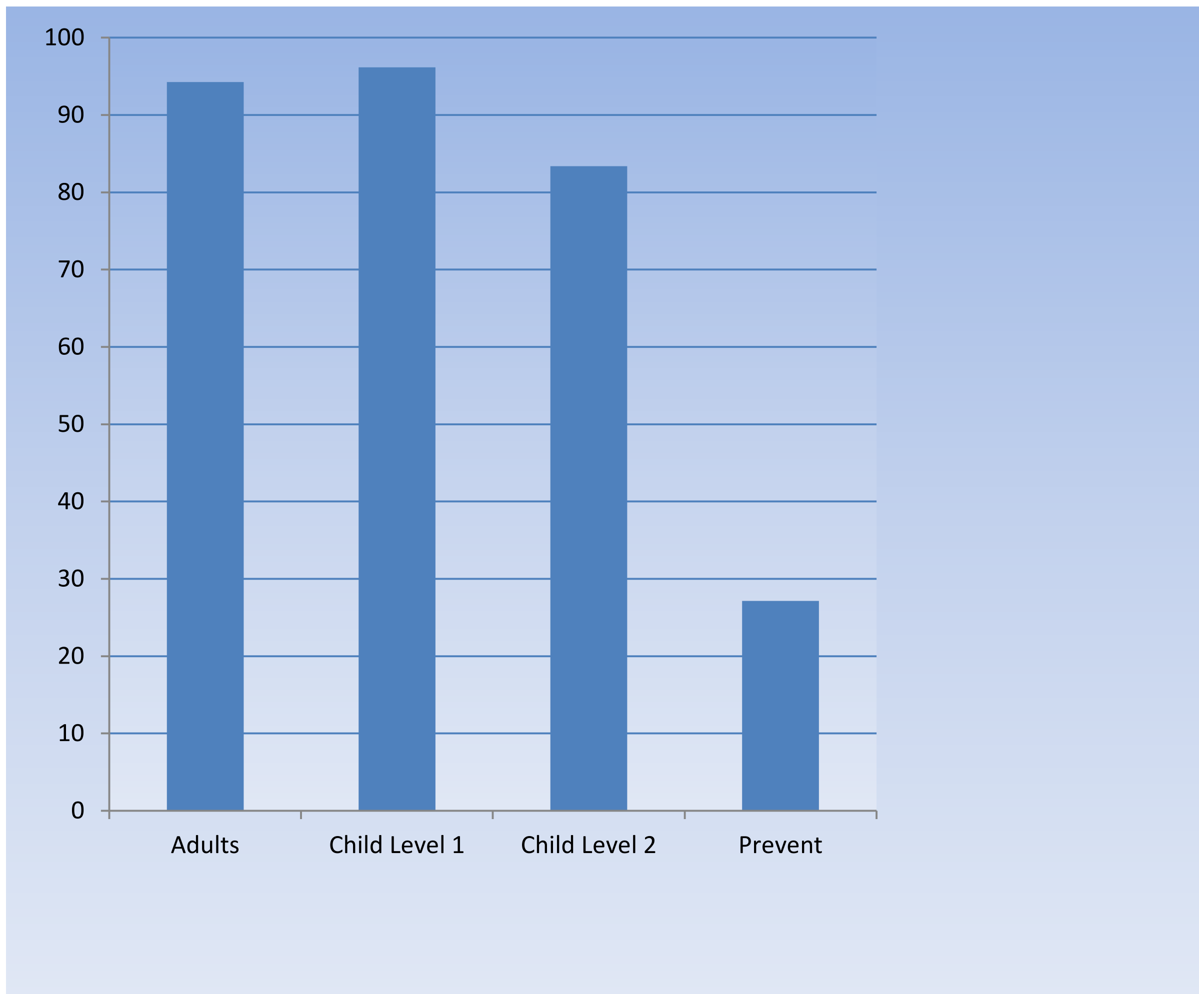
### Numbers of adult and child referrals to social care




YAS staff made a total of **9977** referrals to social care in 2014-15. This compares to **6206** in 2012-13 and **9990** in 2013-14. The referral rate profile has changed this year; the number of children's referrals had decreased for the first time. The adult referral rate is significantly increasing. It is not clear why the child referrals have declined, although the increase in adult referrals may have been due to training and awareness campaigns run by the Safeguarding team following the introduction of the Care Act (2014). Further analysis and audit will be required to examine determinants such as quality.

## 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 2014-5.

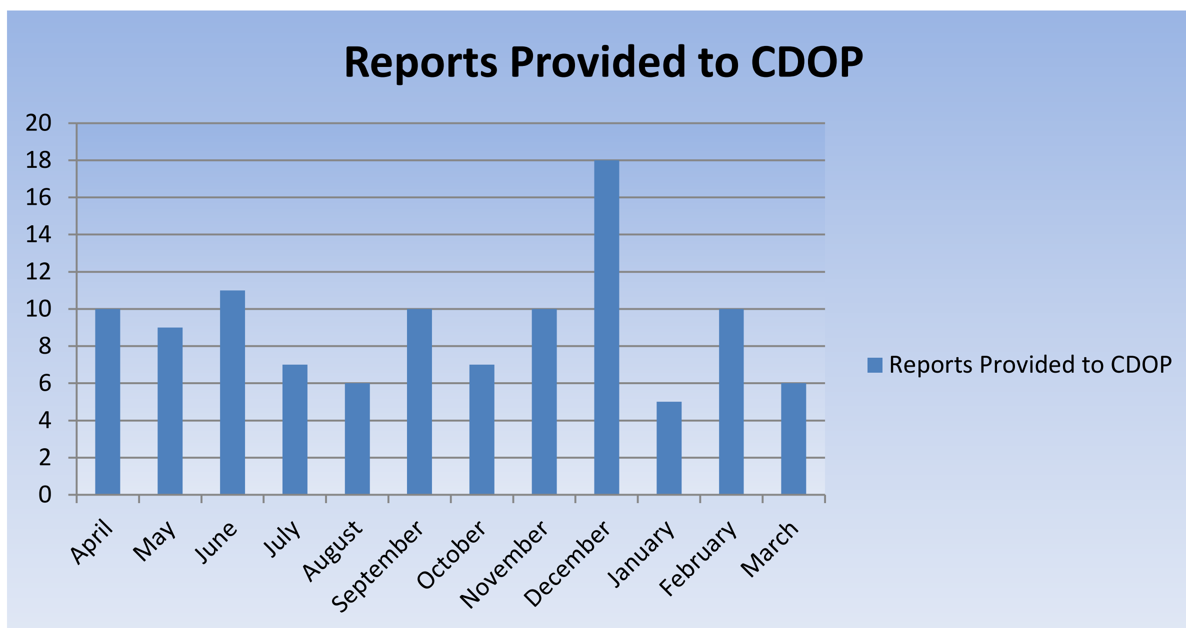
The safeguarding team have a safeguarding training practitioner in post having commenced August 2015. A training needs analysis will be undertaken, all training will be updated to reflect new guidance, and Prevent training will be taken forward as a priority during the remainder of 2015-16.

The training needs analysis will review the current workforce needs and ensure that all those who require Level 2 children's training are identified. Volunteers will be included in this analysis.

## 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

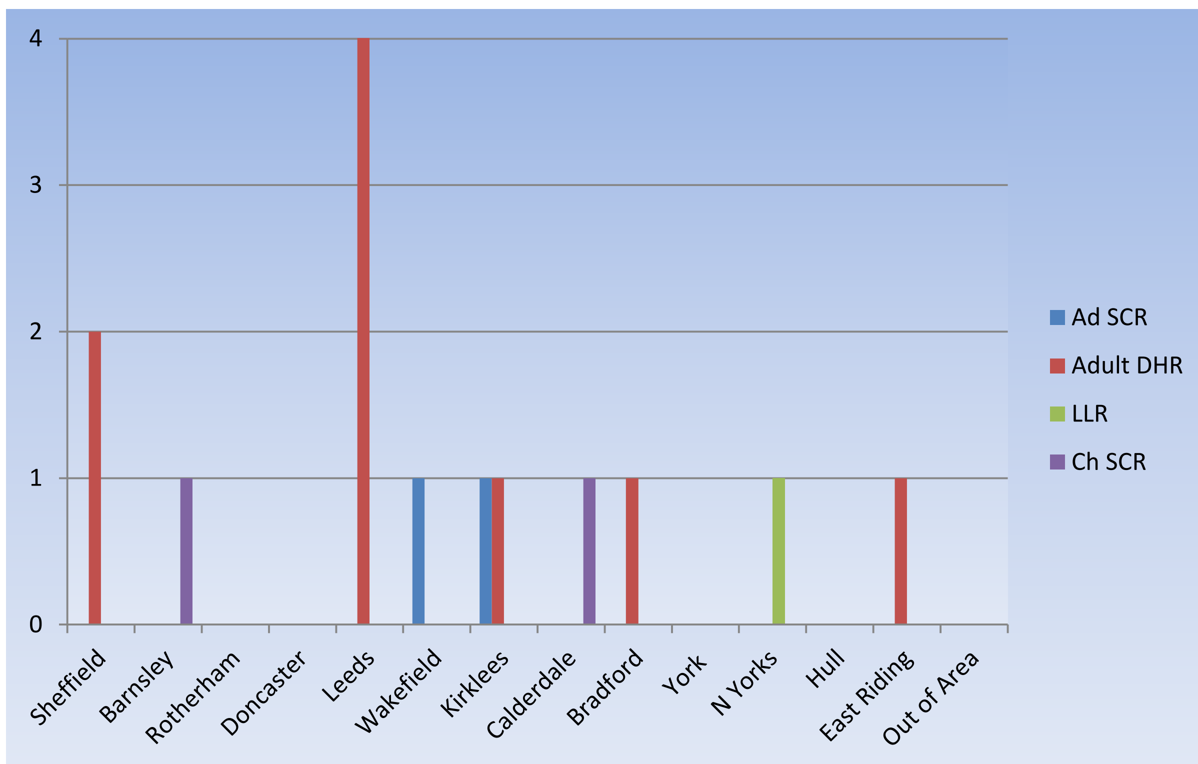
safeguarding children board and are made up of representatives from health and social care, the police and coroners.




In 2014-15 YAS provided **109** reports to CDOPs.

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

The data below provides an update on the number of Serious Case Reviews (SCR), Domestic Homicide Reviews (DHR) and Learning Lessons Reviews (LLR) that YAS has been notified of during 2014-15. Cases and associated action plans are monitored to completion via the YAS Incident Review Group (IRG) and approved for closure at Clinical Governance Group.




There are currently **4** potential SCR's pending a decision from the Local Safeguarding Boards, **3** child, **1** adult.

Lessons learned for YAS included:

- Bulletin in OU June 2014 reminding staff to complete safeguarding training within 3 months of expiry date
- Bulletin in OU August 2014 reminding staff to complete appropriate safeguarding referrals where parents are substance misusers, even if Police are in attendance
- Bulletin in OU November 2014 reminding staff to complete child safeguarding referrals for self-harm/para-suicide/suicide where children are present or witness

### 3.2.3 Key Achievements

- The team have continued to produce safe and effective work during a time of considerable change with the introduction of the Care Act and the Prevent agenda.

### 3.2.4 Key Risks

- Information Governance in the historic databases
- Alignment of all processes around the confidential management of allegations against staff
- Compliance with Trust policy on Non-conveyance of under 2's
- Training needs of the volunteer workforce

### 3.2.5 Workplan for 2015-16

- Capture all safeguarding activity on the Trust Risk Management System (Datix) with full implementation by Q4 2015-16
- Increase Prevent training compliance to 80% by end of financial year
- All policies, procedures and guidance to be updated

- Safeguarding training to be refreshed
- Safeguarding team 'rebranding', increase in visibility and quality performance
- Scope and introduce Audit plans as an ongoing Audit cycle

### 3.2.6 INVESTIGATION INTO MATTERS RELATING TO SAVILE

Between July 2014 and January 2015, YAS were engaged with the Savile Legacy Unit and conducted an investigation to better understand the association Savile had with the former West Yorkshire Metropolitan Ambulance Service. The investigation covered the period 1975-1995. The methodology included identification and interviewing current and past staff, including senior managers and chief officers at the time of Savile's association with WYMAS. It also included an extensive archive search reviewing documentation relevant to the investigation.

The investigation uncovered no specific allegations of abuse by Savile connected to his association with the ambulance services. A number of the governance practices at the time were found to be significantly less rigorous than those in place today and the report therefore highlighted these and provided assurance to the Trust Board in relation to the Trust's current arrangements.

The report was published and was made available to the public.

#### Independent Enquiry into child sexual exploitation in Rotherham

The Jay report (2014) determined the significant severity of child sexual exploitation which occurred in Rotherham between 1997-2013. The Trust has considered the recommendations from this review and they have informed policy revision.

## 3.3 Patient Experience

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

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

Patient feedback is also an essential element of monitoring the Yorkshire Ambulance Service achievements against the Care Quality Commission requirements. The Trust has made a firm commitment to listen and act upon what our patients, service users and carers have to say about the standard of our care. We continue to review and improve upon our methods of obtaining Patient Experience so that we can achieve a high response rate from our patients, the greater the response, the more we learn as an organisation.

Throughout 2014-15, the YAS Expert Patient has continued to champion the 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.

The Friends and Family test was introduced as part of the National Standard NHS contract in 2014 for acute provider organisations. This has been extended to include the ambulance sector in the 2015-16 contract.

### 3.3.1 Complaints, Concerns, Comments and Compliments

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

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 – eg verbal or short email) but where they do not wish this to be recorded as a formal complaint.

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

### 3.3.2 Developments in 2014-15

- Review and approval of new 4Cs Policy
- Implementation of policy in A&E, EOC and PTS
- Process changes – proportionality of approach

- Implementation of Quality Audit (benchmarking with EMAS)
- Strengthened governance of escalated and Ombudsman cases
- Integration of EOC complaints handling with Corporate team

### 3.3.3 Number of Complaints, Concerns, Comments and Compliments received 2014-15

| A&E Complaints, concerns and comments | Apr 2014 | May 2014 | Jun 2014 | Jul 2014 | Aug 2014 | Sep 2014 | Oct 2014 | Nov 2014 | Dec 2014 | Jan 2015 | Feb 2015 | Mar 2015 | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Attitude and Conduct | 12 | 14 | 18 | 10 | 10 | 15 | 14 | 23 | 12 | 18 | 11 | 20 | **177** |
| Clinical Care | 12 | 9 | 13 | 10 | 12 | 22 | 10 | 7 | 5 | 1 | 9 | 5 | **115** |
| Driving | 9 | 7 | 8 | 6 | 4 | 4 | 8 | 10 | 5 | 7 | 6 | 8 | **82** |
| Call Management and Response | 44 | 48 | 61 | 52 | 51 | 30 | 58 | 44 | 59 | 53 | 34 | 42 | **576** |
| Operational Procedures | 23 | 18 | 23 | 13 | 13 | 5 | 20 | 15 | 11 | 27 | 25 | 22 | **215** |
| Other | 0 | 1 | 0 | 2 | 0 | 2 | 1 | 0 | 1 | 0 | 0 | 1 | **8** |
| **Total** | **100** | **97** | **123** | **93** | **90** | **78** | **111** | **99** | **93** | **106** | **85** | **98** | **1173** |
| **Compliments** | **64** | **50** | **64** | **33** | **54** | **19** | **0** | **0** | **104** | **132** | **152** | **177** | **849** |

| PTS Complaints, concerns and comments | Apr 2014 | May 2014 | Jun 2014 | Jul 2014 | Aug 2014 | Sep 2014 | Oct 2014 | Nov 2014 | Dec 2014 | Jan 2015 | Feb 2015 | Mar 2015 | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Attitude and Conduct | 8 | 3 | 11 | 6 | 9 | 11 | 11 | 6 | 6 | 2 | 11 | 7 | **91** |
| Clinical Care | 9 | 2 | 6 | 7 | 5 | 6 | 8 | 12 | 5 | 12 | 8 | 8 | **88** |
| Driving and Sirens | 5 | 2 | 2 | 3 | 1 | 5 | 5 | 4 | 2 | 9 | 0 | 9 | **47** |
| Call Management | 5 | 4 | 6 | 4 | 3 | 11 | 7 | 5 | 2 | 4 | 4 | 3 | **58** |
| Response | 21 | 19 | 39 | 26 | 25 | 47 | 49 | 43 | 36 | 39 | 30 | 28 | **402** |

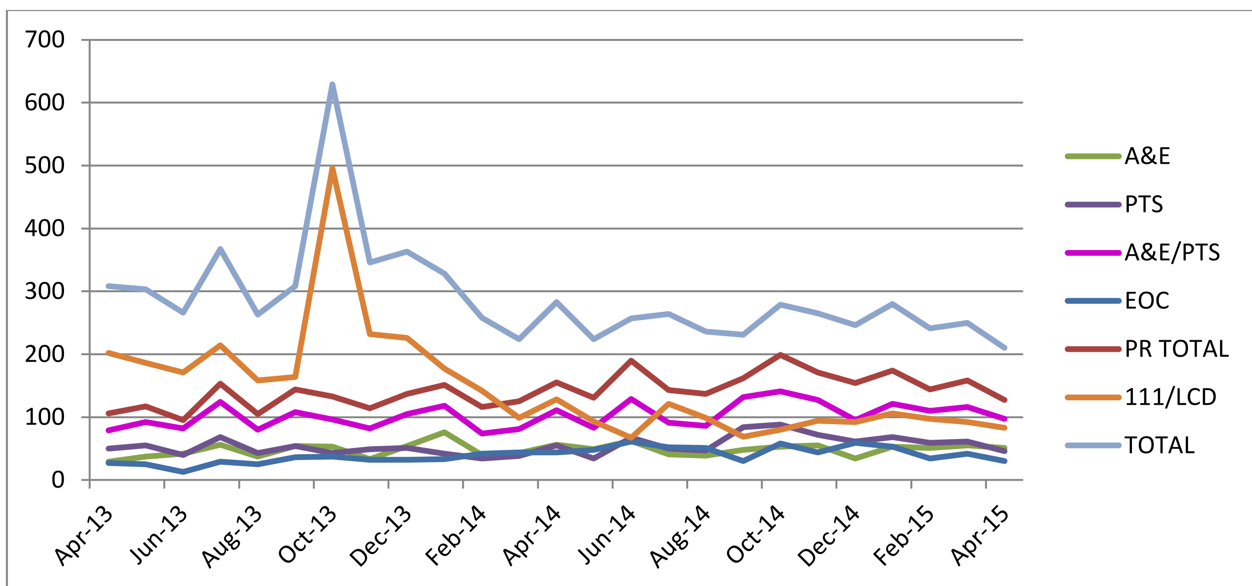
| Other | 7 | 5 | 4 | 4 | 4 | 4 | 8 | 2 | 5 | 5 | 6 | 6 | **60** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Total** | **55** | **35** | **68** | **50** | **47** | **84** | **88** | **72** | **56** | **71** | **59** | **61** | **746** |
| **Compliments** | **7** | **1** | **5** | **0** | **5** | **6** | **1** | **0** | **12** | **10** | **9** | **12** | **68** |

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

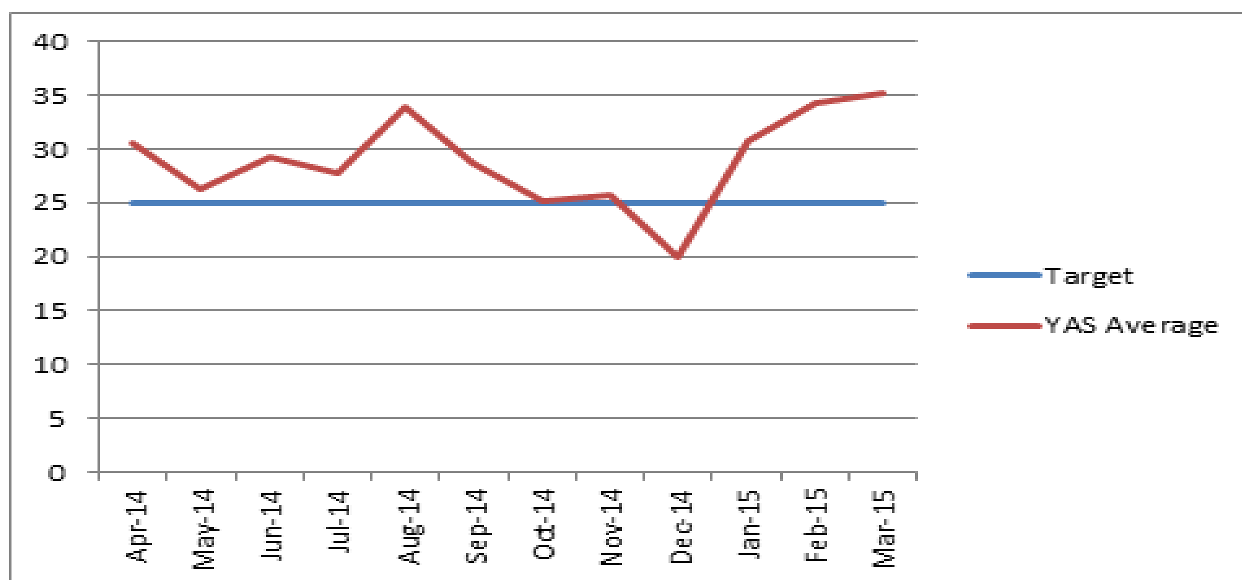
In 2014-15, 15 people referred their complaints to the Parliamentary & Health Services Ombudsman. Four cases were closed with no further action, one was partially upheld and ten remain on-going.

| Date | Number of cases referred to & Parliamentary and Health Services Ombudsman | Cases closed with no further action | Cases upheld | Currently on-going (time of report) |
|---|---|---|---|---|
| 2012-13 | 7 | 5 | 1 | 1 |
| 2013-14 | 3 | 1 | 1 | 1 |
| 2014-15 | 15 | 4 | 1<br>*(Part upheld)* | 10 |

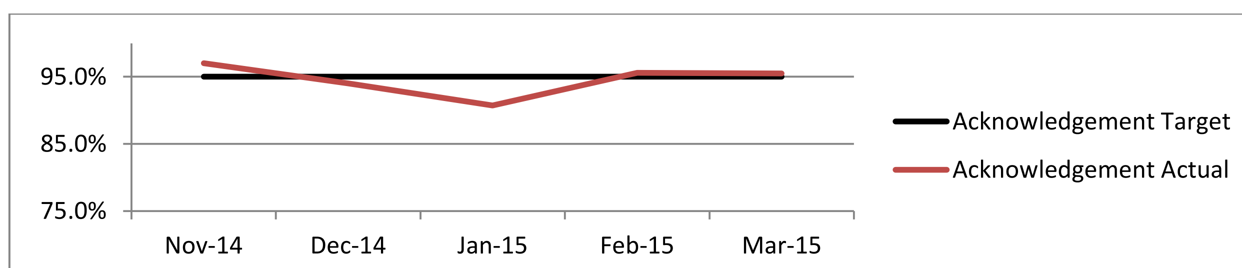
### 3.3.5 Number of Complaints Received 2013-15 (Trend)



### 3.3.6 Response Times (2014-15)




### 3.3.6 Three Day acknowledgment time to initial complaint (November 14* to April 15) Trend




** N.B: In November 2014, the EOC complaints handling service activities was transferred to the central Patient Relations Service (within Standards and Compliance Directorate)*

Changes have been made to the Trust policy and management process to deliver improved response time for complaints and focus on these will continue into 2015-16.

### 3.3.7 A&E and EOC Complaints received/Activity: Comparison to peers (Q4 2014-15)

A&E/EOC complaints received/Activity

| | | | |
|---|---|---|---|
| ▪ LAS | 0.28% | SCAS | 0.10% |
| ▪ EMAS | 0.24% | SECAmb | 0.10% |
| ▪ NEAS | 0.15% | EEAST | 0.10% |
| ▪ YAS | 0.14% | NWAS | 0.10% |
| ▪ WMAS | 0.11% | SWAST | 0.09% |

### 3.3.8 Developments for 2015-16 (Patient Relations)

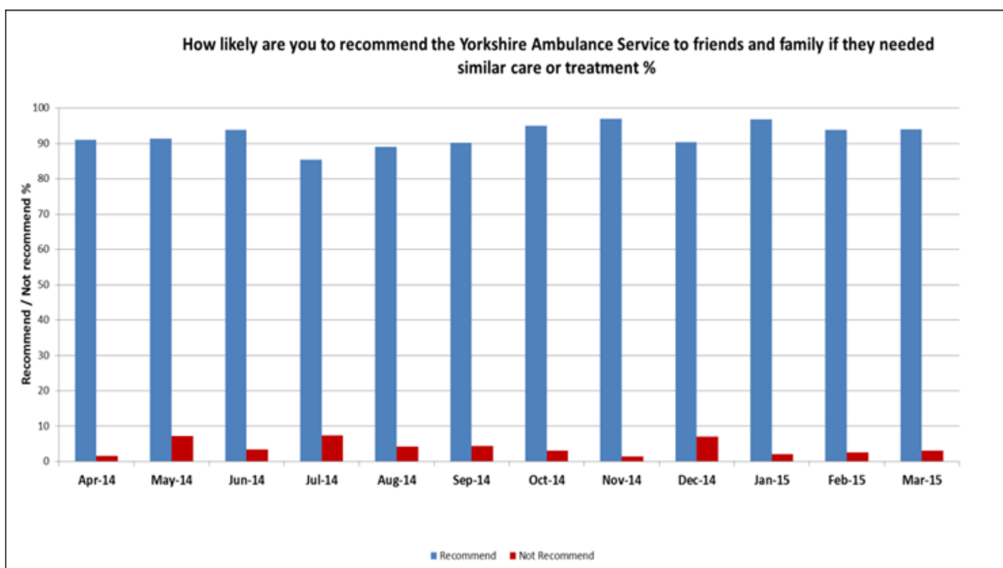
- Implementation of revised policy in NHS111(commencing July)

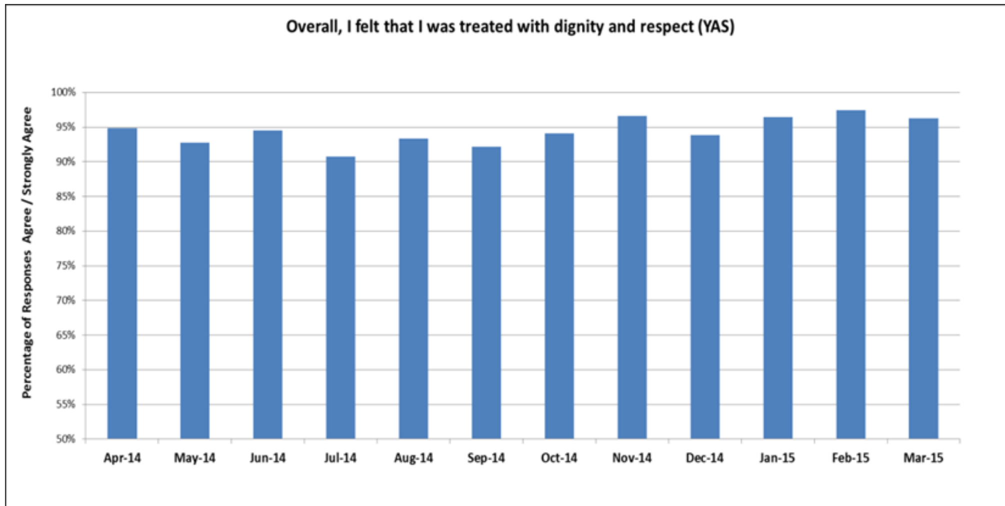
- Implementation of Complainant Satisfaction Survey (from September)
- Awareness of problem solving role at point of contact for services
- Briefings for Exec Team and Senior Management on the role of the PHSO and learning from PHSO feedback
- Development of new Integrated Board Report for Service Lines to facilitate improvements in learning from feedback
- Implementation of Action Plan monitoring
- Contingency plans for workload peaks – monitoring age of open cases
- Focus on quality of A&E and EOC investigations to reduce escalation rates
- Focus and a timeliness of response to continue to improve time of both initial acknowledgment and final response

### 3.3.9 Patient Experience Surveys

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

### 3.3.10 A&E Survey Results

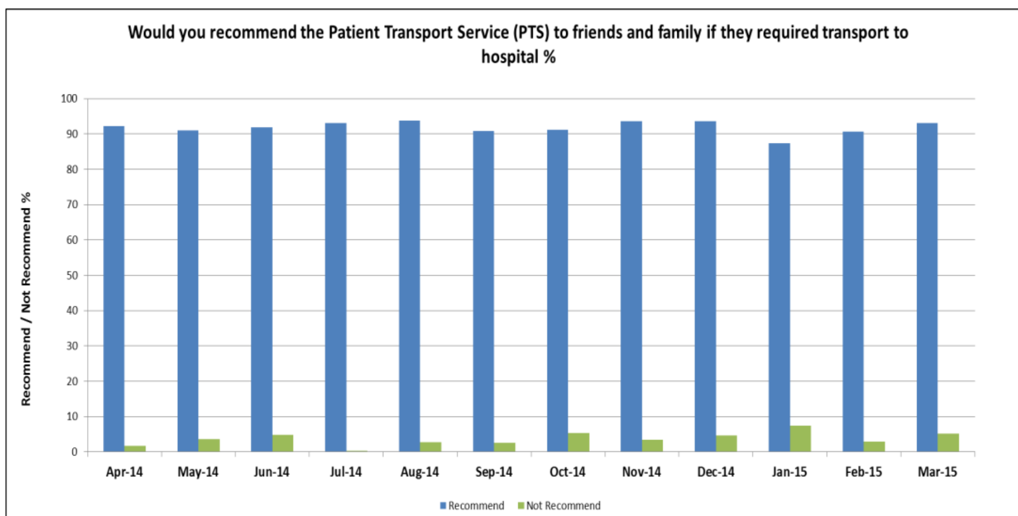


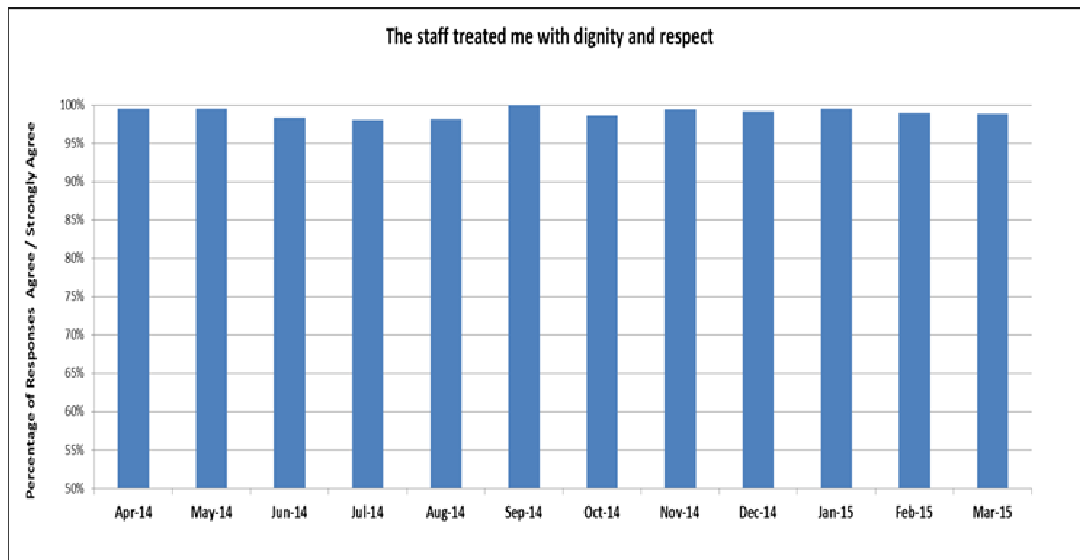



## A&E: Themes and Trends from Narrative Feedback

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

## 3.3.11 PTS survey results






## 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 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.

## Patient Survey Narrative

The award winning patient survey programme has continued throughout 2014-15 with a monthly survey including the "Friends & Family test". The results from these surveys are shared at every level of the organisation, used to inform specific work streams though education and training and provision of a quality indicator.

I called for ambulance as my nearly 19 year old diabetic son was dying. Me and my 6 year old daughter were hysterical. I would just like to say a huge THANK YOU to the lady that took our call as she was just brilliant. Also the Ambulance staff that arrived and took him to hospital. Thank you to you all. My Son made it and is now home. Without you and your wonderful staff it could had been a different story. Wish I could thank you all personally. You are all awesome. You deserve special honours xxxxx

The main issue I have was the length of time I had to wait for an ambulance

I met lovely staff, all caring. Ensured I was safely in my house, a credit to PTS. Journey pleasant. Thank you for making my recovery

The paramedics were amazing and saved my boyfriend's life - he'd gone into a full blown asthma attack. We have so much respect for the work the paramedics/call handlers undertake and the way in which they do it. Thank you

I travel with PTS at the same time each week for my dialysis but I am often late getting there and late getting home.

I must stress the kindness and respect received from the drivers. I was very grateful for the help especially when I arrived at Pinderfields Hospital. The driver wheeled me to the place where I was operated on. Every driver was also helpful. On reaching home the drivers unlocked the door and helped me inside my home.

### 3.3.12 Learning from PTS and A&E Complaints, Concerns, Comments and Compliments

Learning from complaints, concerns and comments is very important. To help this the service report themes, trends and lessons learned are reported through the clinical governance structure. 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. Examples of lessons learned and actions taken in 2014-15 are:

**PTS services**

- Review and amendment of the PTS booking process for patients with complex needs
- Analysis and partnership working to better understand the delays in PTS, specifically from arrival at the hospital to booking in at the relevant clinic
- The development of real time performance monitoring in PTS
- Implemented real time booking procedures in PTS, this has simplified and strengthened the process and reduces the risk of missed hospital appointments.
- Implemented new working patterns that reflect capacity and demand

**A&E services**
**Trust wide initiatives:**

- Performance Improvement Plan
- Introduction of dedicated ambulances and staff for urgent calls not requiring an emergency ambulance
- Building greater resilience for periods of high demand through effective resource utilisation
- Values based recruitment
- Increased use of case based learning in training and education
- Use of Patient Experience Story to Board programme has enabled senior management to receive real life experiences of the Yorkshire Ambulance

Service. These filmed stories are available to all staff to us within training or self-reflection.

- Roll out of the Friends and Family Test to See and Treat patients. This feedback is being triangulated with other quality indicators

**Local initiatives:**

- Reconfiguration of the dispatch bays
- Increasing senior visible clinical leadership in call centre for 999
- Revised procedures for supporting paramedics on scene with a patient based on clinical need

### 3.3.13 Patient Stories

Throughout 2014-15, patient stories have continued to be presented to the Trust Board meetings. These provide a unique opportunity to connect with patients, service-users, relatives and carers. YAS actively listens to real experiences reflected in order to learn from them. Methods used to record patient stories can be via film, narrative or voice recording. Through discussion with patients and families what have taken part with the Story to Board process, have found the process beneficial. Board members have also reported that the Story to Board reminds the Board of the patient voice.

Patient stories are used in training and considered an effective learning resource. The Patient Story is available to all staff via the Staff Intranet, and is shared with operational management teams and the Clinical Governance Group, to demonstrate the importance of these patients and being empowered to deliver a caring and dignified service.

Examples of patient stories undertaken during 2014-15:

- A husband’s experience of an A&E crew who attended to his wife who had collapsed whilst at home.
- A paramedics experience of providing care to Ebola Patients in Africa
- A families experience following the cardiac arrest and successful resuscitation of their 10 year old son
- A families experience of the care given to their father when he had breathing difficulties.

### 3.3.14 Patient Opinion Website

The Patient Opinion website is a patient feedback not-for-profit social enterprise enabling patients to share their experiences of healthcare services. Its aim is to help facilitate dialogue between patient and health service providers and to improve services and staff morale. It has the particular benefit of giving YAS management access to real time patient experience feedback. YAS joined this platform in February 2013 and have used this resource as another channel to listen and respond to online service user feedback. YAS has responded to all comments received through the Patient Opinion Website.

### 3.3.15 Being Open: Duty of Candour

The requirements for Being Open and Duty of Candour include a set of principles that healthcare staff should use when communicating with patients, their next of kin or appointed representative, following a patient safety incident in which the patient/service user was harmed or potentially harmed. This process is utilised to ensure communication fosters an approach of transparency and openness when things go wrong.

YAS continues to use these principles as part of an agreed process by which patient and/or next of kin are contacted to discuss their case where there has been moderate or severe harm. This process is monitored within the Incident Review Group on a 2 weekly basis which also enables liaison and information sharing between other departments in contact with individual cases (such as Coroners, Legal, Safeguarding and Patient Relations).

As part of quality assurance Key Performance Indicators are being set in order to ensure adherence to policy, production of a quality process, which is provided in a timely manner. These Key Performance Indicators will form part of the Standards and Compliance Dash Board, which is reviewed monthly by senior managers within the Directorate.

In addition to the monitoring of KPIs for Being Open and Duty of Candour, arrangements have been made for dip sampling of Being Open cases on a monthly basis for review of process and quality of response.

### 3.3.16 Review of Work Plan 2014-15

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

- Enhance guidance for staff when gathering service user feedback.
- Ensure that the 4Cs practice and procedures are reflective of best practice and consistency across the Trust
- Setting and monitoring of organisational targets for complaint handling.
- Enhance electronic contact methods for 4Cs.
- Implementation of the Friends and family Test (FFT) CQUIN for Staff and Patients.

### 3.3.17 Planned Work Plan 2015-16

The Patient Experience and Patient Relations Work plan for 2015-16 is reflective of the Clinical Quality Strategy priorities, contract requirements and CQUIN goals. These include gaining a better understanding of those with:

- Physical and learning disability
- Parents and children
- Renal patients
- Dementia
- Palliative care needs
- Sepsis
- Mental health needs
- Pain management

The number of methodologies used to gain patient feedback will be increased and will include:

- Focus groups with specific groups of service users
- Utilising existing service user group within communities
- Interviews
- Focussed population specific surveys
- Collaborative working with provider organisations to extend scope to a patient journey across health and social care boundaries with a view to improving the patient experience

A reporting framework will be developed for each work stream but in principle this will use the existing governance structures and also align to any revision in structures within other service lines.

## 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;

- Referral for Primary Angioplasty for STEMI
- Maternity
- Referral to Hyper-acute stroke services
- Suspected Neck of Femur
- Major Trauma
- Vascular emergencies

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 2014-15 was to achieve improvement initiatives in all CPIs and ACQIs and this was achieved.

CPIs were agreed for all English ambulance services through the National Association of Ambulance Service Chief Executives and it's supporting clinical subgroups. The ACQIs are collected monthly producing national data the results, the CPI's are collected in cycles and support local initiatives to improve care. The data is collected from patient care records and shows how many patients received all the correct assessments and treatments for their condition. The full set of agreed actions that should be carried out for each patient with a particular condition is known as a care bundle.

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

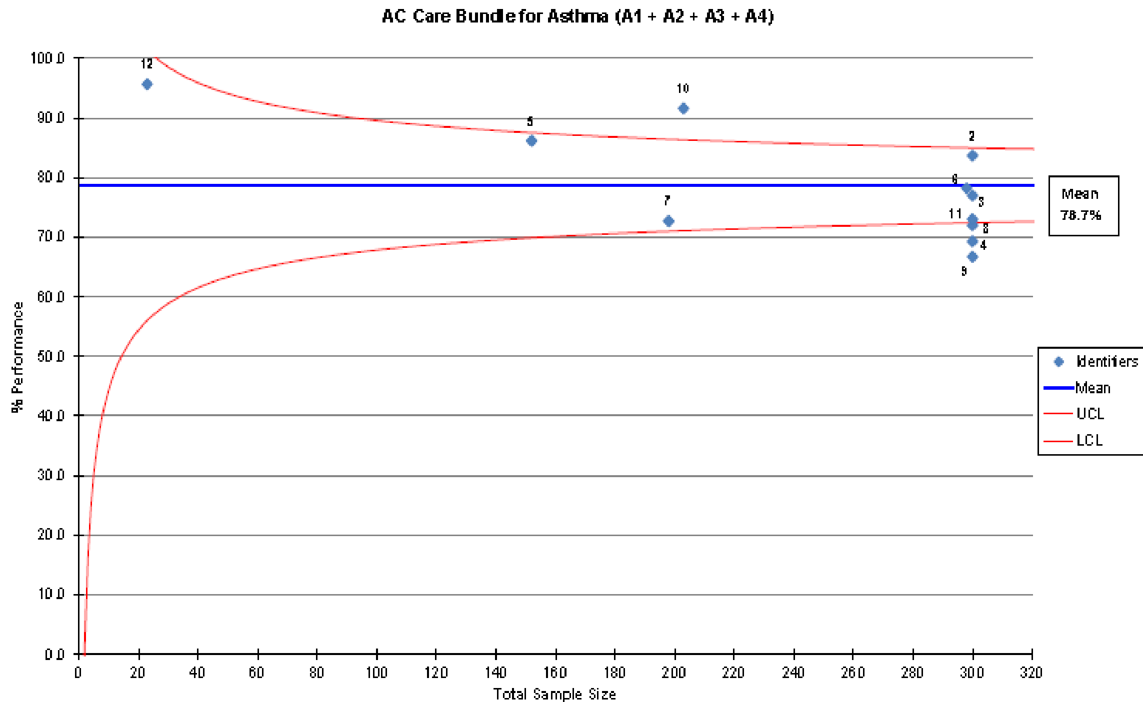
CPI cycles thirteen and fourteen were reported in 2014-15, Hypoglycaemia is no longer a CPI as the annual year on year performance was reported consistently above 95% for all trusts.

- Asthma
- Single Limb fracture (trauma)
- Febrile convulsion (paediatric care)
- Falls in Older people (pilot 1)*

#### Asthma YAS CPI results

Asthma care bundle includes:

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



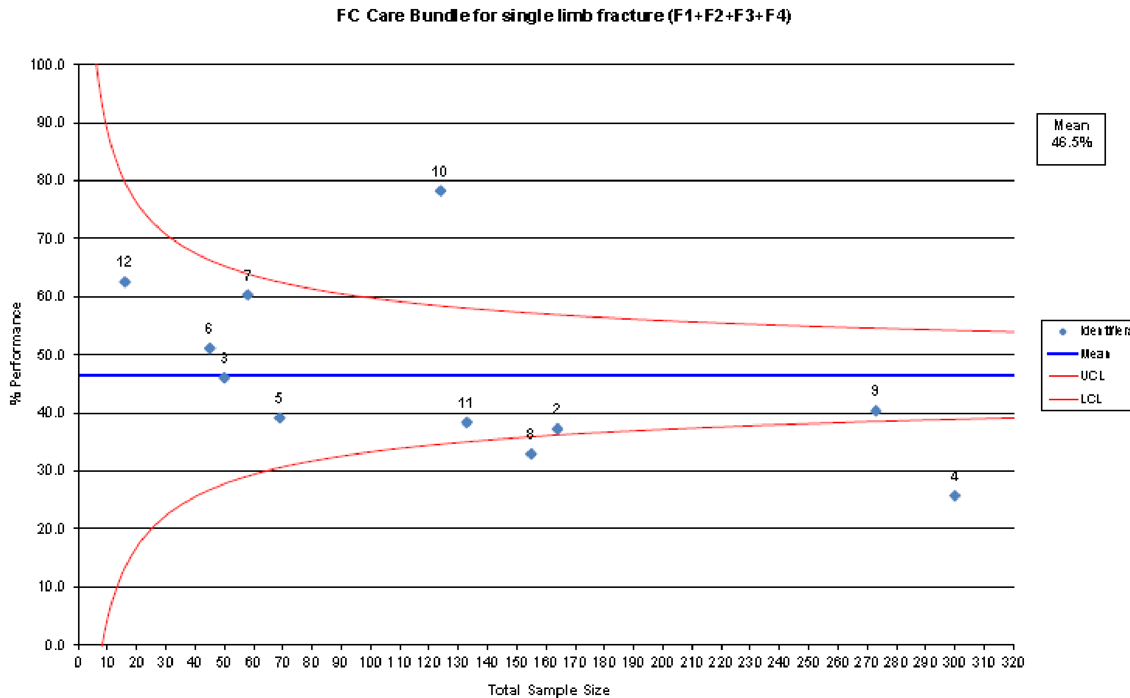

YAS = Trust number 5

YAS has 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)




*All numbers presented on the funnel plots are there to indicate and identify each service and should not be deemed a ranking for each service. Appendix 1 provides more detail in how these charts are calculated and how they should be interpreted.

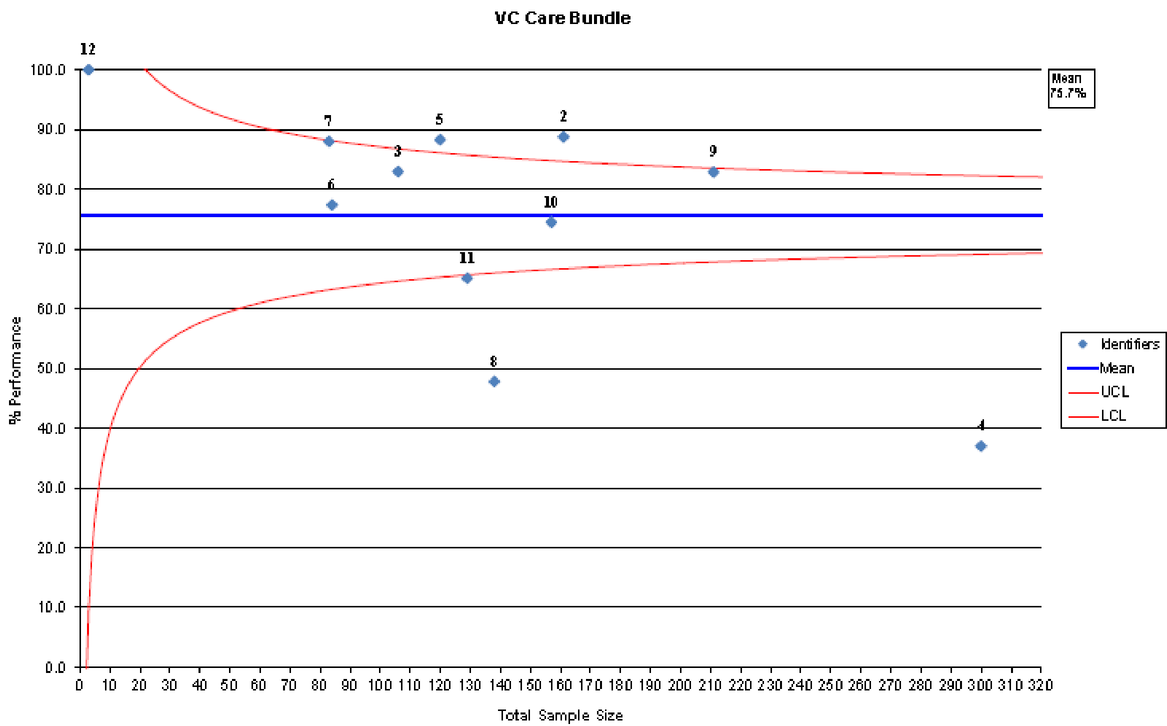
YAS = Trust number 5

Compliance to the Single Limb fracture remains poor despite work to improve awareness. Recording of two pain scores and use of analgesia are the elements remain the missing elements of this care bundle. The sample size is low when compared with other CPIs and demonstrates difficulties capturing this group of patients. Recording of pains scores pre-post treatment is a focus over 2015-16.

## 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)



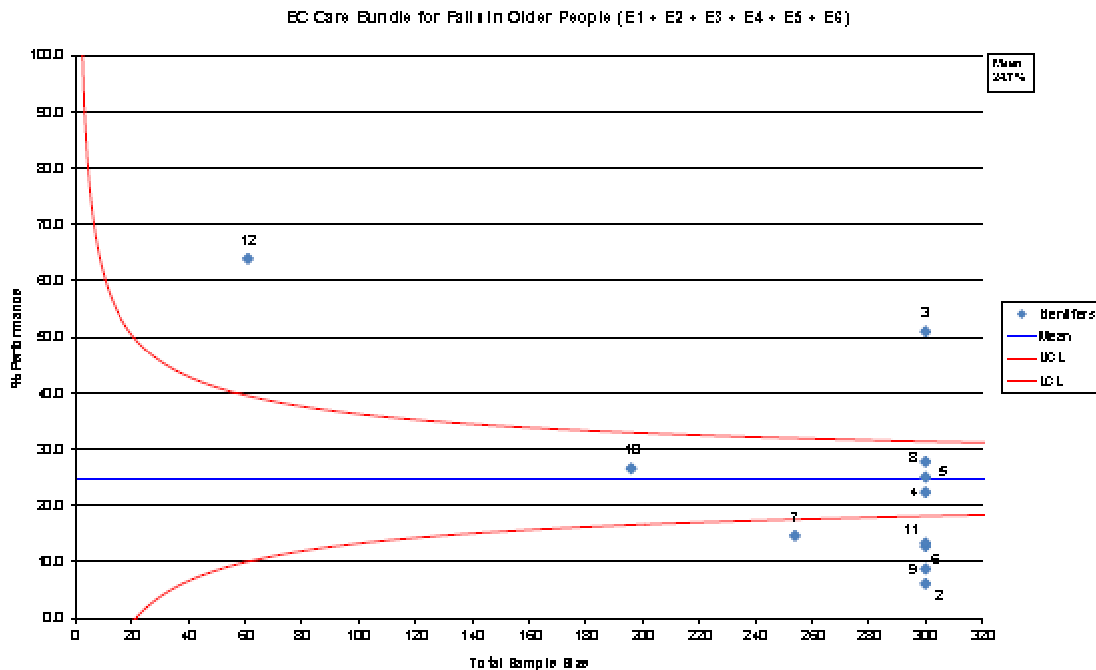

*All numbers presented on the funnel plots are there to indicate and identify each service and should not be deemed a ranking for each service. Appendix 1 provides more detail in how these charts are calculated and how they should be interpreted.

YAS = Trust number 5

Compliance with this CPI continues to improve resulting in the trust reporting one of the top performers in this care bundle. Focused work around this care bundle has improved recording of all elements.

Elderly Falls CPI (pilot) new in 2014 the care bundle for falls in older people is made up of

- E1 Primary observations recorded
- E2 Recorded assessment of the cause of the fall
- E3 Recent history of falls documented
- E4 12 lead ECG assessment
- E5 Recorded assessment of mobility
- E6 Direct referral to an appropriate health professional




n.b The chart identifer used on the funnel plot does not relate to an ambulance service ranking and is used purly to assist in data identification.

YAS = Trust number 5

From the first pilot it was highlighted some data definition and collection issues for a number of trusts. Compliance against the care bundle found YAS as middle of the range no one element was highlighted within YAS data the findings were collectively low performance. It has to be noted that due to the lack of national guidance the inclusion/ exclusion groups were not comparable for each trust.

### 3.4.5 Ambulance Clinical Quality Indicators (ACQI)

The four ACQIs are:

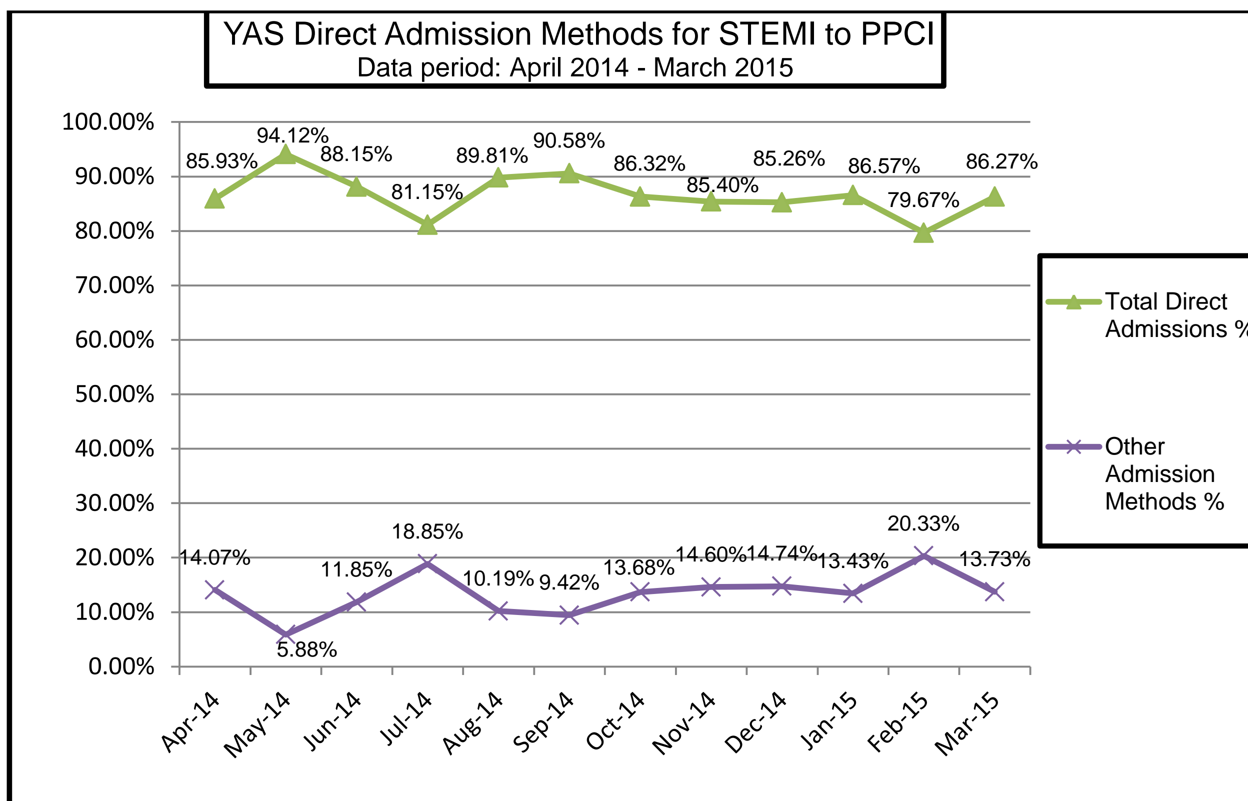
- Outcome from acute ST-Elevation Myocardial Infarction (STEMI)
- Outcome from cardiac arrest: return of spontaneous circulation (ROSC
- Outcome from cardiac arrest: survival to discharge
- Outcome from acute stroke

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 82.8% in 2013/14 83.5% in 2014/15. The STEMI 150 performance also remains high at 86.27% of STEMI patients referred direct by YAS to a heart centre see chart below. With 88.4% 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

| | 2013/14 Q4 baseline | 2014/15 |
|---|---|---|
| ROSC | 23.6% | 22.9% |
| ROSC Utstein | 46.8% | 51.5% |
| Survival to Discharge | 10.3% | 10.6% |
| STD Utstein | 32.5% | 40.2% |

There have been improvements across all outcome indicators for cardiac arrest from last year. In terms of patient impact, there is a continual improvement of the previous year's data with a total of 292 patients who survived a cardiac arrest 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.

YAS patients arriving at a Hyper Acute Stroke Unit within 60 minutes has fallen to 55.5% following a national downward trend. Challenges at some acute trusts in recruiting stroke medical staff particularly in Scarborough and Airedale has resulting in redirection of patients to further receiving centres.

**Percentage of Face Arm Speech Test (FAST) positive stroke patients (assessed face to face) potentially eligible for stroke thrombolysis, who arrive at a hyperacute stroke centre within 60 minutes of call**

| | | Incidents | Performance (%) | Overall |
|---|---|---|---|---|
| East Midlands Ambulance Service NHS Trust | 58.0 | 1,571 | 58.0 | ↓ |
| East of England Ambulance Service NHS Trust | 55.3 | 2,859 | 55.3 | ↓ |
| Great Western Ambulance Service NHS Trust | | | 0.0 | |
| Isle of Wight NHS PCT | 58.7 | 213 | 58.7 | ↓ |
| London Ambulance Service NHS Trust | 58.7 | 6,420 | 58.7 | ↓ |
| North East Ambulance Service NHS Trust | 67.3 | 1,876 | 67.3 | ↑ |
| North West Ambulance Service NHS Trust | 67.2 | 4,128 | 67.2 | ↑ |
| South Central Ambulance Service NHS Trust | 54.0 | 2,021 | 54.0 | ↓ |
| South East Coast Ambulance Service NHS Foundation Trust | 66.3 | 5,258 | 66.3 | ↑ |
| South Western Ambulance Service NHS Foundation Trust | 55.0 | 3,352 | 55.0 | ↓ |
| West Midlands Ambulance Service NHS Trust | 46.9 | 2,763 | 46.9 | ↓ |
| Yorkshire Ambulance Service NHS Trust | 55.5 | 4,230 | 55.5 | ↓ |
| **Overall for period** | **Higher is better** | **34,691** | **59.1** | |

# Section 4.0

# Assurance on Risk, Safety & Clinical Quality

## 4.0 Assurance on Risk, Safety and Clinical Quality

### 5.1 Regulatory compliance with the Care Quality Commission

The CQC conducted the planned inspection of YAS against the regulatory quality and safety standards between 13 and 16 January 2015. All service areas of YAS were inspected, with the exception of NHS 111. The Trust commented on the factual accuracy of the draft report and received a final draft ahead of the Quality Summit. The report was published in September 2015 but is referred to in this report as initial feedback influenced Trust developments in 2014-15 and implementation of the action plan will continue throughout 2015-16

The publication of the report included the ratings as below:

| | SAFE | EFFECTIVE | CARING | RESPONSIVE | WELL LED | OVERALL |
|---|---|---|---|---|---|---|
| **Emergency and urgent care** | Requires improvement | Requires improvement | Good | Requires improvement | Requires improvement | Requires improvement |
| **PTS** | Requires improvement | Requires improvement | Good | Requires improvement | Requires improvement | Requires improvement |
| **EOC** | Requires improvement | Requires improvement | Good | Good | Requires improvement | Requires improvement |
| **Resilience** | Inadequate | Not rated | Not rated | Good | Requires improvement | Requires improvement |
| **Overall** | Requires improvement | Requires improvement | Good | Requires improvement | Requires improvement | Requires improvement |

5.2 A number of recommendations have been made to the Trust and in summary these are:

The Trust must:

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

The Trust should:

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

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

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

Since inspection the Trust has a comprehensive action plan which details the required actions both in the short and longer term including issues already highlighted through the inspection process. This plan is actively managed by the Trust Executive Group.

### 5.2 Standards and Compliance Directorate

This report demonstrates the progress in terms of our systems of risk management, safety and quality that we have achieved at all levels of the Trust in 2014-15. The support provided by corporate teams has strengthened and developed significantly, as has the interface between corporate functions and local, frontline operations.

The Standards & Compliance Directorate redefined key roles and responsibilities and increased the support and expertise provided in areas including incident reporting, information governance and infection prevention and control.

### 5.3 Quality reporting

Information about quality and safety is reported to Trust Board via the monthly Integrated Performance Report (IPR) and in locality dashboards. This provides a mechanism for identifying and monitoring compliance with key performance indicators and regulatory standards, as well as monitoring emerging themes. The IPR is subject to close scrutiny at Trust Board and Quality sub-committee which has the lead committee role for scrutinising all aspects of quality and safety. Locality-level scrutiny of risk, safety and quality is via the five Locality Operational Management Groups and the Patient Transport Service management group.

## 5.4 Internal audit

During 2014-15 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 2014-15 were:

| Audit subject | Outcome |
|---|---|
| Compliance with health and safety Requirements | Significant assurance |
| Risk Management Framework | Scoped |
| Clinical Quality Strategy | Significant assurance |
| IG TOOLKIT | Significant assurance |
| Complaints, Comments, Claims and Compliments | In progress |
| Health and Safety – Moving and Handling | Significant assurance |
| CQC Standards | Significant assurance |
| Quality Accounts and Strategy | Significant assurance |

## 5.5 External scrutiny

Throughout 2014-15 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.

# Section 6.0

# Looking ahead to 2015-16

## 6.0 Looking Ahead to 2015-16

The 2015-16 work plans detailed in this report all reflect available guidance and best practice on key aspects of risk management, quality and safety and are informed by learning from a range of internal reporting and feedback processes. Specifically these actions link to the overarching strategic and operational goal of achieving compliance with CQC, Foundation Trust requirements and the Clinical Quality Strategy 2015-18. This has included a full review of National Published Reports, including learning from the Public Inquiry into Mid-Staffordshire NHS Foundation Trust and the Savile Report with targeted actions to address its implications for YAS.

The Directorate will continue to foster cross-departmental working relationships. Together, the Directorate will continue to build and embed the patients voice, 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. This will focus on the contribution made by every individual employee to delivering safe, high quality care through patient centred professionalism.