NHS
Yorkshire
Ambulance Service
NHS Trust

# Risk, Quality & Safety Compliance Report 2017-18

| Section | Contents | Page No. |
|---|---|---|
| 1.0 | Introduction | 3 |
| | 1.1 Purpose | 4 |
| | 1.2 Introduction – Risk & Safety | 4 |
| | 1.3 Introduction – Clinical Quality Strategy | 5 |
| 2.0 | Risk and Safety | 7 |
| | 2.1 Risk Management | 8 |
| | 2.2 Information Governance | 10 |
| | 2.3 Health and Safety | 13 |
| | 2.4 Security | 22 |
| | 2.5 Infection Prevention and Control | 24 |
| | 2.6 Legal Services | 29 |
| | 2.7 Medicines Optimisation | 34 |
| | 2.8 Freedom To Speak Up | 43 |
| 3.0 | Clinical Quality | 49 |
| | 3.1 Patient Safety | 50 |
| | 3.2 Safeguarding | 55 |
| | 3.3 Patient Experience | 59 |
| | 3.4 Clinical Effectiveness | 70 |
| | 3.5 Local Audits | 73 |
| | 3.6 Quality Improvement | 84 |
| 4.0 | Assurance on Risk, Quality and Safety | 80 |
| | 4.1 Regulatory compliance with the Care Quality Commission | 81 |
| 5.0 | Looking ahead to 2018-19 | 84 |

# Improvements

## 2017 - 2018

NHS
Yorkshire Ambulance Service
NHS Trust

**96.7%**
Complaint response satisfaction

**39%**
decrease in staff affected moving and handling incidents since 2014/15

**+3**
hours our statutory and mandatory moving and handling training has increased by

**Air ambulance began carrying blood**

**83%**
would recommend Yorkshire Ambulance Service NHS Trust to friends and family

**8**
QI Fellows appointed within the Trust. From 6 business areas.

**Launch of YAS ePR**

**8440**
mental health cases managed by our mental health nurses in EOC

**387**
Bright Ideas submitted in 2017-18

**300**
patients survived following an out-of-hospital cardiac arrest. This is more lives saved than any other year

**56**
Staff accessed **Freedom to Speak Up** in 2017/18

**75%**
increase in Critical Friends Network (CFN) membership

# Section 1.0

# Introduction

## 1.1 Purpose

The purpose of this report is to

- Provide a summary of Trust developments in relation to risk, safety and clinical quality in 2017-18 and provide an additional level of detail to that in the Trust Annual Report and Quality Accounts.

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

## 1.2 Introduction

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

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

## 1.3 Introduction – Risk and Safety

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

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

YAS's systems of risk management for 2017-18 set out in the Trust's Annual Governance Statement.

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

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

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

## 1.4 Introduction – Clinical Quality Strategy 2015 - 2018

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

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

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

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

The strategy consisted of a number of important elements:

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

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

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

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

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

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

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

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

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

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

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

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

The Sign up to Safety work streams were embedded as part of the Clinical Quality Strategy and during 17-18 further progress was made with work-streams within the campaign, specifically in relation to focusing on the human factors which impact on caring in the Emergency Operations Centre (EOC), implementing best practice for the deteriorating adult and child and continuing the work of the Moving Patients Safely group.

The Clinical Quality Strategy has also included the Trust's CQUIN programme and for 17-18 the A&E CQUIN programme included the introduction of end to end reviews to promote system wide learning, improving care for patients with suspected sepsis and also using learning to improve the outcomes for patients who suffer a cardiac arrest. In the Patient Transport Service (PTS), the CQUIN focussed on the development of a patient portal which allows patients to view their transport bookings to validate the information.

The Trust mission, vision and values have been refreshed and re-launched in 2017 and a new Trust strategy is due for presentation in October 2018. This will inform both the new Quality Improvement Strategy and Clinical Strategy that have been developed following listening events and engagement with staff. These two critical strategies, will shape our clinical development and quality improvement activity over the next three to five years.

# Section 2.0

# Risk and Safety

## 2.1 Risk Management

### Introduction – Risk and Safety

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

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

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

### 2.1.1 Delivery of work plans for 2017-18

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

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

During 2016-17 two Internal Audits of the Trust's risk management procedures were conducted. The first provided significant assurance 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. The second reviewed the maturity of risk management across the Trust and concluded *The organisation has considered risk management and put in place strategies led from a risk management team. Strategy and policies are also in place and communicated and the "risk appetite" is defined*.

During 2017/18 we continued to develop our risk management infrastructure to achieve greater consistency of engagement by managers; building upon this expertise and engagement will gradually move us on the risk maturity matrix toward being 'Risk Managed'.

### 2.1.2 Local Risk Management

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

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

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

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

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

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

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

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

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

The BAF is a Board level document that provides concise assurance to the Board and its committees on the management of principal risks to achievement of the Trust’s strategic objectives. The BAF and Corporate Risk Register are closely aligned and subject to comprehensive Executive and Non-Executive review through a quarterly cycle as described above.

Some principal risks on the BAF 2017/18 were re-articulated and carried forward into 2018/19; these include delivery of performance targets and clinical quality standards to reflect the Ambulance Response Programme and implementation of workforce plans; capacity and capability to deliver change which reflects challenges major change programmes in the context of efficiency drivers; and strategies for staff engagement which has been broadened to encompass leadership and organisational culture.

### 2.1.4 Key risks and emerging themes and trends

The Directorate of Quality, Governance and Performance Assurance continue to analyse data arising from incidents, complaints, claims and interpret feedback from patients, staff and stakeholders. The team works closely with the Clinical Directorate and other subject matter experts to ensure that issues are fully understood. Triangulation of this data identifies themes and trends and highlights potential risks for consideration, complementing the view of risks identified through routine management processes.

During 2017/18 the Trust worked closely with commissioners and other system partners to manage risks relating to the wider health and social care system, particularly relating to hospital reconfigurations and handover challenges and delivery of national drivers such as the Ambulance Response Programme. These risks remain on the risk register into 2018/19.

### 2.1.5 Looking ahead - key priorities for 2018-19

The following priorities have been set for 2018-19:

- Continue to embed and enhance effective performance management of risk throughout the Trust
- Support risk leads and operational management groups to proactively identify and manage risk as an integral part of their core business
- Maintain and continually develop the BAF with Executive Directors to ensure key risks to delivery of strategic objectives are being appropriately governed.
- Continue to utilise identified themes and trends arising from incidents, complaints, claims, coroner’s inquests and other sources to support identification and mitigation of risk.
- Continue to work with commissioners and other system partners to collaboratively manage risk.

## 2.2 Information Governance

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

YAS aims to ensure that all information it holds is processed in accordance with the Data Protection Act 2018, Freedom of Information Act 2000, the General Data Protection Regulation and other related legislation.

The Senior Information Risk Owner (SIRO) during 2017-18 was Steve Page, Executive Director of Quality, Governance & Performance Assurance. The SIRO is an

executive director or senior management board member who takes overall ownership of the organisation's Information Risk Policy, acts as champion for information risk on the Board and provides written advice to the Accounting Officer on the content of the organisation's Governance Statement in regard to information risk.

The Caldicott Guardian during 2017-18 was Dr Julian Mark, Executive Medical Director. A Caldicott Guardian is a senior person responsible for protecting the confidentiality of patient and service-user information and for enabling proportionate and justified information-sharing.

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

Over the last five financial years the Trust has increased its self-assessment submission score by 12% to a score of 85% during a period where the Toolkit standards have become more stringent year on year (Rated 'satisfactory' against a satisfactory/unsatisfactory rating regime).

During 2017 the Trust prepared for the implementation of the General Data Protection Legislation which came into force on 25th May 2018. A review of our IG policies and procedures was undertaken, changes made to management of FOI and Subject Access Requests, our Information Assets and Data Flows were mapped to record the Lawful Basis for processing the data in accordance with Article 6 of GDPR. Oversight of this work plan was through IG Working Group, the RAG and TMG with assurance reported to Quality Committee and Board.

Our Information Asset Owners continue to embed effective information governance arrangements within their services, escalating risks and developing mitigation plans. We have strengthened our Records Management arrangements through collaborative working with IAOs to assess and manage records in accordance with Trust policy. The Trust continues to strengthen information sharing agreements with partner agencies, conducting rigorous risk assessments and Privacy (Data Protection) Impact Assessments for developments impacting on the management of information. The Trust is engaged in national information sharing projects such as the Summary Care Record, Record Locator Service and NHS Number programme, ensuring that information governance arrangements are in place to uphold the rights of data subjects.

### 2.2.1 Statement in Respect of Information Governance Serious Incidents Requiring Investigation (IG SIRI)

During 2017-18 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. Such incidents require reporting to the Information Commissioner's Office, Department of Health and other regulators as well as detailing within NHS Trust annual reports.

One incident was as a result of remedial action to the HR network drive, in which files within the drive inadvertently became available to YAS staff internally for a short period of time. The second incident related to a folder being created on the network

drive which is designed so that staff can temporarily collaborate with records that they would not normally have joint access to. Saved files were identified in this folder which contained personally identifiable information and these files were not removed from the folder after the collaboration had taken place.

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. The Information Commissioners Office outcome was satisfied with the investigation undertaken and required no additional actions to the comprehensive internal action plan.

The Trust is required to report lower level personal data-related incidents; these are detailed in the table below:

**Table 1: Summary of other personal data related incidents in 2017-18**

| *Category* | *Breach Type (national classification)* | *Total* |
|---|---|---|
| A | Corruption or inability to recover electronic data | 2 |
| B | Disclosed in Error | 32 |
| C | Lost in Transit | 3 |
| D | Lost or stolen hardware | 1 |
| E | Lost or stolen paperwork | 26 |
| F | Non-secure disposal - hardware | 0 |
| G | Non-secure disposal - paperwork | 0 |
| H | Uploaded to website in error | 0 |
| I | Technical security failing | 4 |
| J | Unauthorised access/disclosure | 10 |
| K | Other | 21 |

Themes and trends from personal data-related incidents are analysed and presented to the Information Governance Working Group to allow learning to be shared across the Trust and the organisation to put in place measures to prevent reoccurrence. All staff are proactively encouraged to report incidents and near-misses relating to the loss or disclosure of personal and sensitive data.

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

We take all incidents seriously and all are investigated to ensure that we improve our processes to minimise the likelihood of recurrence.

### 2.2.2 Looking ahead - key priorities for 2018-19

The following priorities have been set for 2018-19:

- Embedding and enhancing of effective management of Information Governance risk throughout the Trust
- Continuing support of Information Asset Owners to develop their IG knowledge and expertise
- Review of our IG training materials to ensure they are reflective of national requirements for all staff and a higher level training for our IG experts within the Trust

- Work collaboratively with ICT colleagues to complete and submit the Data Security and Protection Toolkit (replacement for IGTK)
- Implement software to strengthen capture and management of Records Of Processing Activities

## 2.3 Health and safety

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

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

### 2.3.1 Legislation changes / enforcement

During 2017-2018 there have been no significant changes to health and safety legislation affecting the Trust.

In December 2017 the enforcement MoU between the HSE/ LAs and CQC was re-issued. There has been no change in the enforcement allocation between HSE/LAs and CQC however, there has been further clarification to assist in determining the correct enforcing body.

The Trust was visited by a HSE inspector in January 2017 to assess the Trust's commitment to the reduction of musculoskeletal injuries amongst staff. Following the visit, the Trust received no recommendations / mandates for improvement.

In terms of enforcement action from the HSE within other ambulance Trusts, there has been 1 case of interest in 2017/2018:

Scottish Ambulance Service
Improvement notice issued by HSE due to "failure to ensure lifting operations involving the use of two post vehicle lifts in the maintenance department were properly planned & carried out in a safe manner by a competent person".

Legislation breaches included the Health and Safety At Work etc Act Section 2 *(Failure to ensure the health, safety and welfare of employees)* and Lifting Operations and Lifting Equipment Regulations Regulation 8 *(Failure to ensure that every lifting operation involving lifting equipment is properly planned by a competent person, appropriately supervised and carried out in a safety manner)*

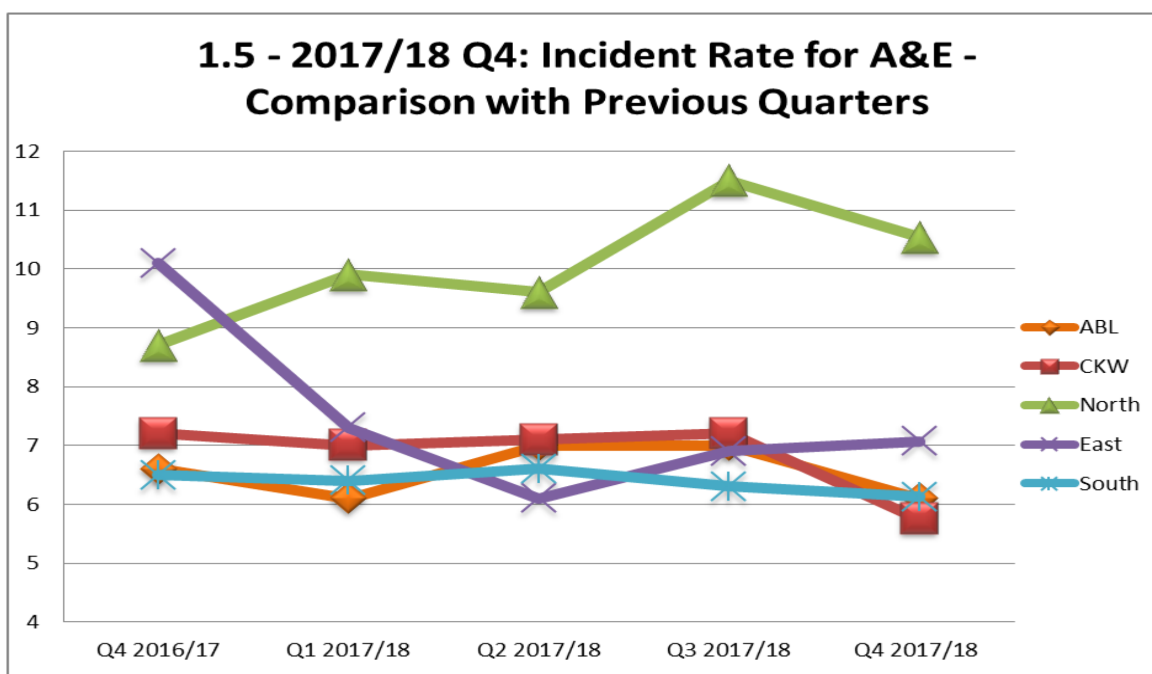
We as a Trust have reviewed our processes to ensure we are fully compliant with these regulations and the Fleet Management System is utilised to ensure vehicles are tested when required. This review has been supported by the Health and Safety Manager who is assured that our systems and processes are robust and meet the specific requirements.

### 2.3.2 Incident reporting

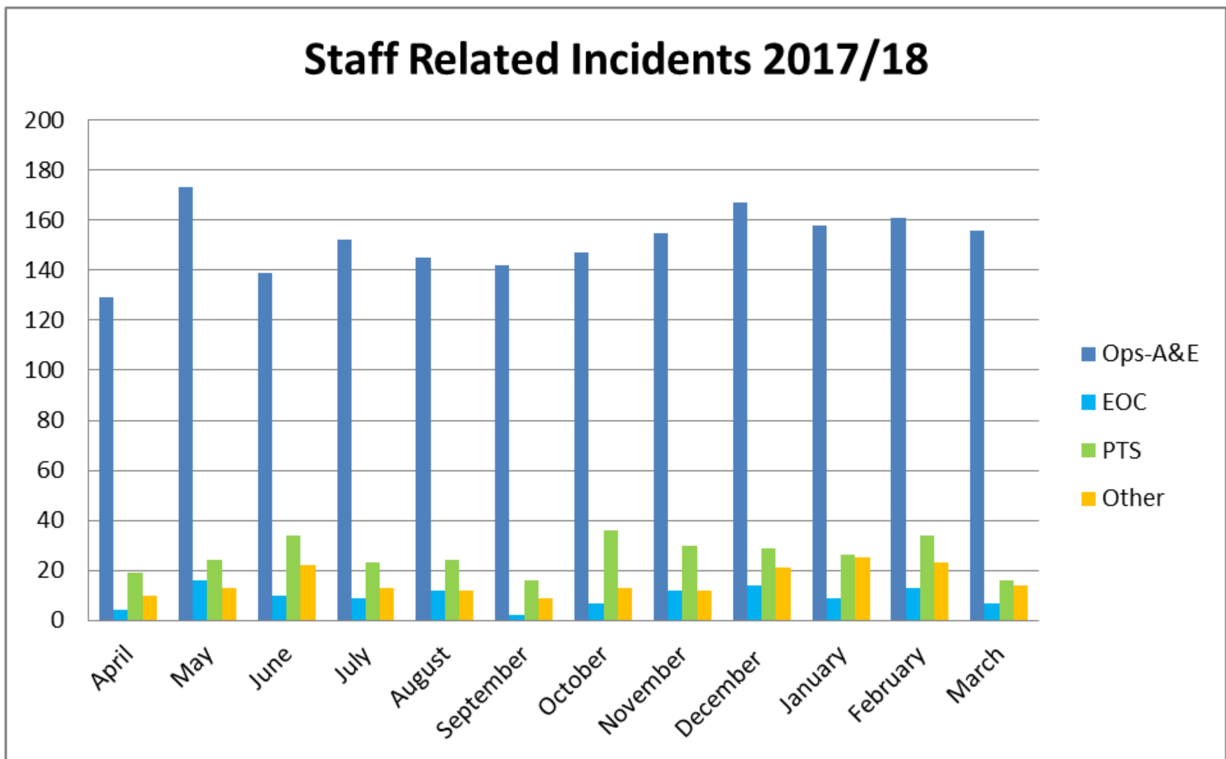
A&E and PTS operational services are where the Trust faces the greatest risks and subsequently records the largest number of incidents.

A gradual increase in PTS incidents has generally been seen over the year (until the last month).

For A&E there was a significant decrease in the total incident rate *(No. of incidents per 1000 responses)* for Hull and East A&E CBU which dropped from 10.1 in Q4 16/17 to 7.0 in Q4 17/18 whilst North area conversely saw a significant increase from 8.7 in Q4 16/17 to 10.54 in Q4 17/18. Other A&E areas remained stable with a slight decrease towards the end of the year. See graph below.



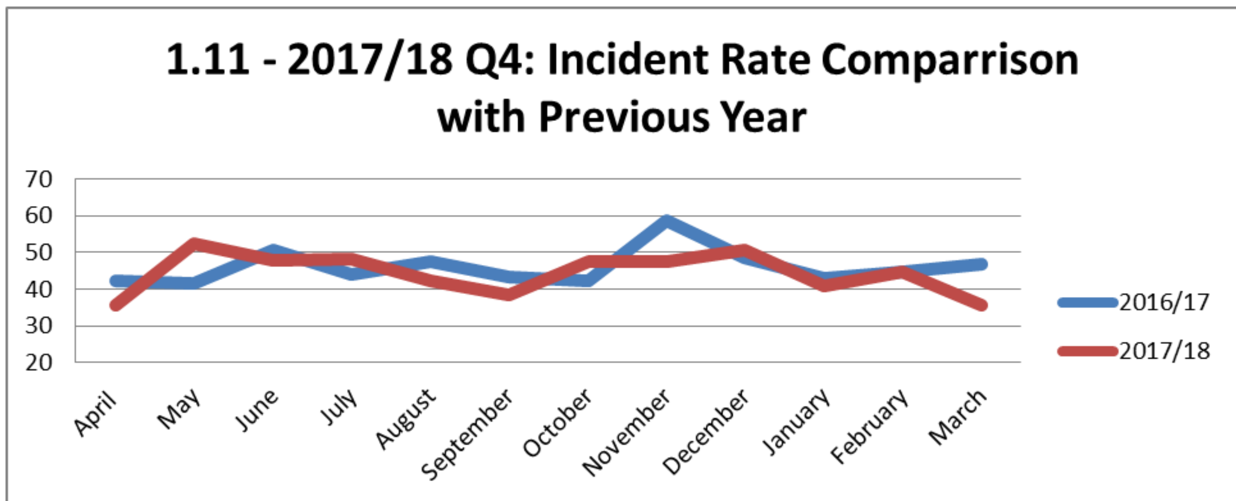

The graph below shows the number of staff related incidents reported in 2017-18.




Of the staff related incidents reported in 2017-18, 4.61% were graded with a severity of moderate or above (See table below for monthly breakdown). This is a reduction from the previous year (6.53%)

| | Apr-17 | May-17 | Jun-17 | Jul - 17 | Aug-17 | Sep-17 | Oct-17 | Nov-17 | Dec-17 | Jan-18 | Feb-18 | Mar-18 | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Total Moderate and Above | 11 | 8 | 12 | 12 | 6 | 12 | 6 | 7 | 7 | 11 | 11 | 14 | 117 |
| Total | 165 | 242 | 224 | 204 | 201 | 183 | 208 | 228 | 224 | 225 | 236 | 195 | 2535 |
| % Mod and Above | 6.66% | 3.57 % | 5.36 % | 5.88 % | 2.99 % | 6.56 % | 2.88 % | 3.07 % | 3.13 % | 4.88 % | 4.66 % | 7.18 % | 4.61 % |

The staff incident rate *(No of incidents per 1000 FTE staff)* ended in March 18 at the same level as it was in April 17 (35.5) however, the figure has been consistently higher for the rest of the year peaking in May and December. The yearly average is 44.2 up from 42.3 in 2016/2017 with a peak of 52.2 in May (see graph below).



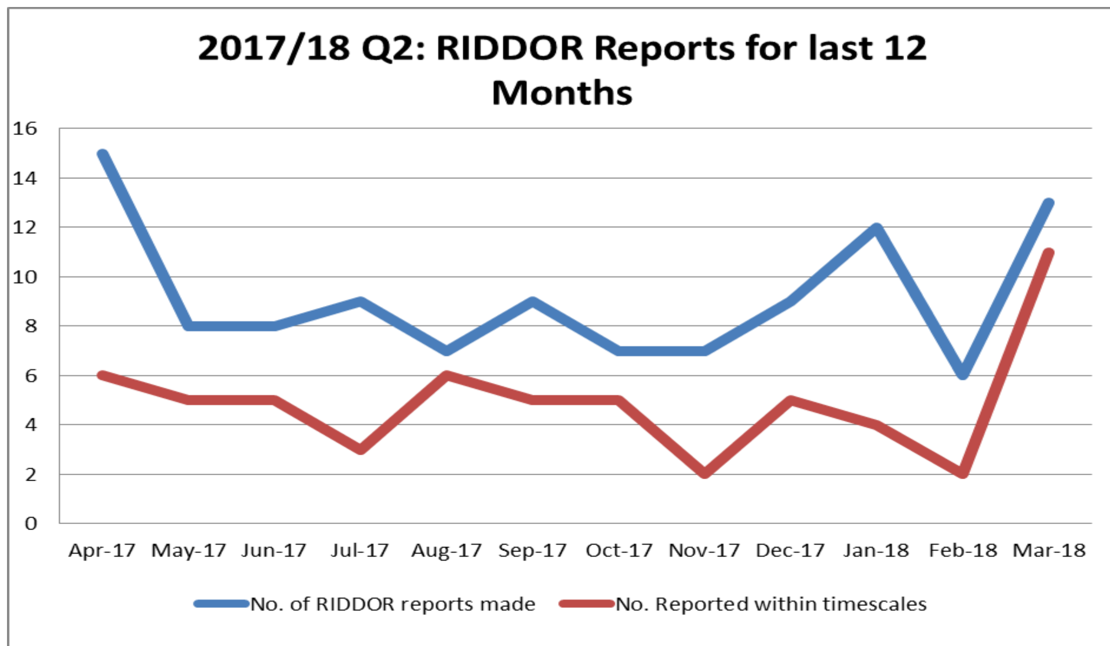

The top 3 reported incidents for staff have been consistent over the year and relate to moving and handling, slip, trip and falls and violence and aggression.

## RIDDOR reporting

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

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

## RIDDOR Reports for 2017 / 2018



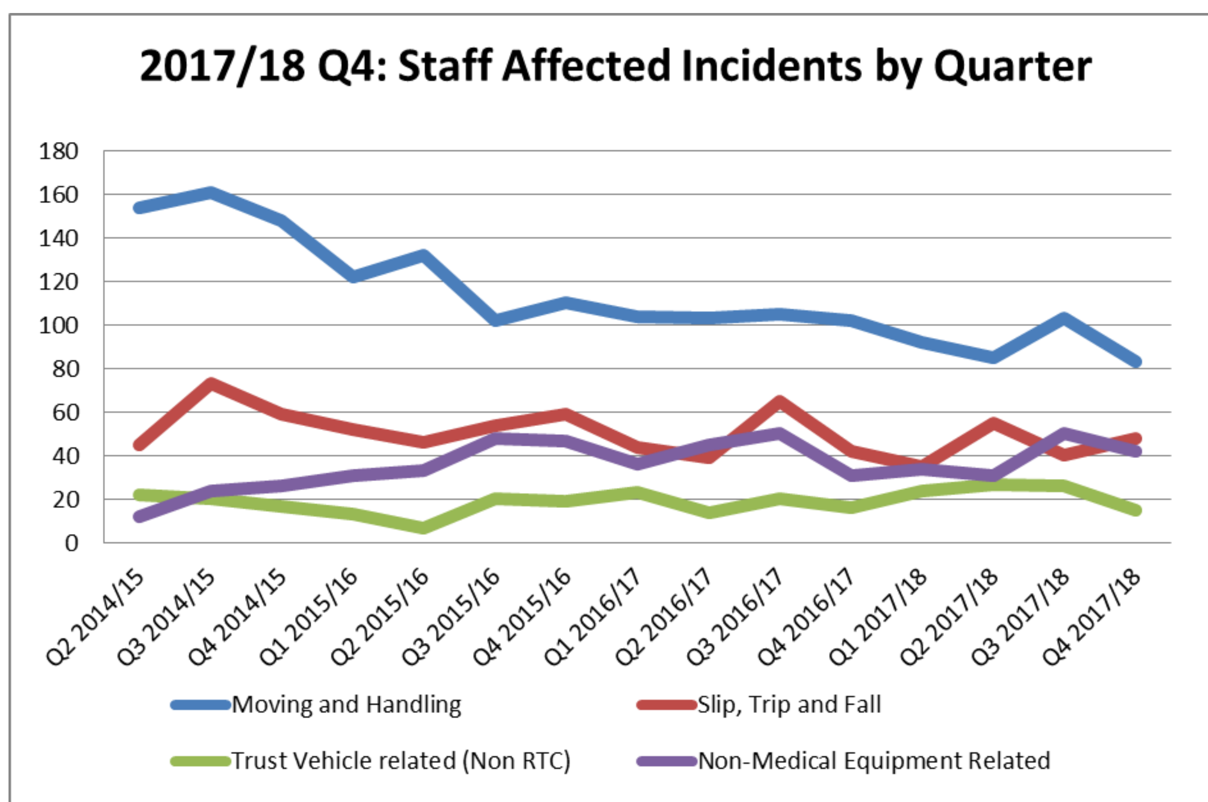
Analysis of the numbers of incident types reported under RIDDOR are shown below.

| Incident Type | Apr 2017 | May 2017 | Jun 2017 | Jul 2017 | Aug 2017 | Sep 2017 | Oct 2017 | Nov 2017 | Dec 2017 | Jan 2018 | Feb 2018 | Mar 2018 | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Contact with moving machinery or material being machined | 0 | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 3 |
| Exposed to, or in contact with, a harmful substance | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 1 |
| Fall from a height | 0 | 0 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2 |
| Hit by a moving, flying or falling object | 0 | 2 | 0 | 1 | 0 | 2 | 0 | 0 | 0 | 0 | 1 | 0 | 6 |
| Hit something fixed or stationary | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 1 | 4 |
| Injured while handling, lifting or carrying | 7 | 2 | 7 | 6 | 1 | 5 | 6 | 6 | 3 | 9 | 4 | 7 | 63 |
| Physically assaulted by a person | 0 | 0 | 1 | 0 | 2 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 4 |
| Slipped, tripped or fell on the same level | 5 | 0 | 3 | 2 | 3 | 4 | 0 | 1 | 6 | 0 | 0 | 7 | 31 |
| Trapped by something collapsing | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 1 | 0 | 0 | 0 | 2 |
| Biological Agent - Known Exposure | 1 | 0 | 0 | 1 | 0 | 1 | 0 | 0 | 3 | 0 | 0 | 0 | 6 |
| Biological Agent - Unknown Exposure | 0 | 1 | 1 | 0 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 4 |
| Lifting Equipment | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 |
| **Total** | **15** | **6** | **13** | **12** | **7** | **13** | **8** | **7** | **13** | **11** | **6** | **16** | **127** |

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 2017-18 work plan included focused work in these areas.
Wider learning from RIDDOR is communicated via the Trusts monthly Safety Update, and all RIDDOR reported incidents are discussed at local health and safety groups.

## Year on Year improvements

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



The following graph shows moving and handling incidents tracked back to Q1 2013/14 with significant changes to Trust practices highlighted
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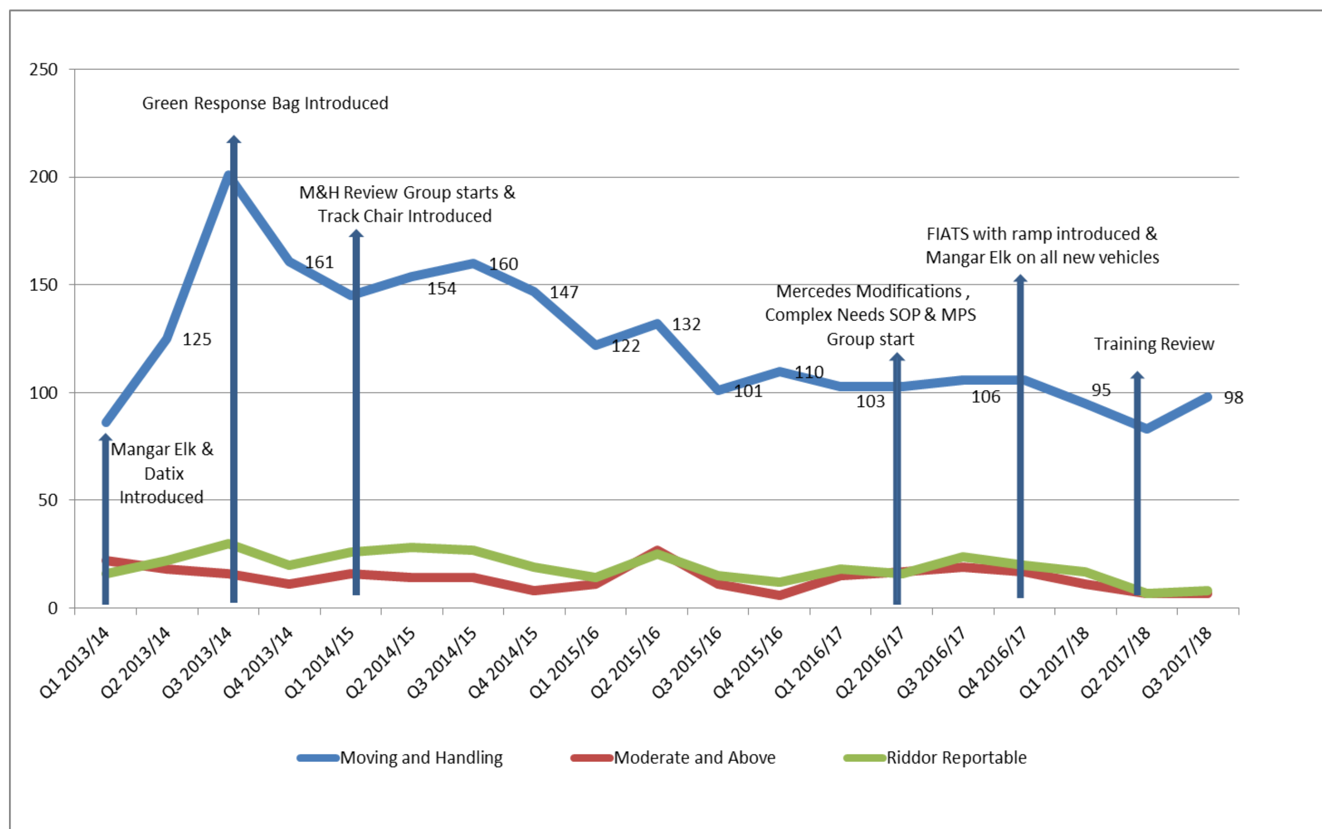
**2017/18 Q3: Moving & Handling Staff Affected Incidents**




It is clear that moving and handling incidents have significantly reduced over the last 3 years, thought to be due to initiatives such as the introduction of the new green response bag and the track carry chair and more recently the start of modifications to the Mercedes vehicle tail lifts, introduction of the new Fiat vehicles and the wider availability of the Mangar Elk. MSK incidents remain a theme in reporting and there continue to be new staff claims on related issue. Reducing the risk of MSK injuries to staff will therefore remain one of our key work-streams in 2018-19.

### 2.3.3 Delivery of Work Plan for 2017-18

#### Health and Safety Training

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

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

Delivery of the training ran throughout 17/18 and the knowledge gap at Senior Management level with regards to health and safety has now been almost eliminated

with the provision of IOSH accredited Leading Safely training to all members of TEG and TMG. Just a small number of senior managers (7 including 2 new starters) still need to complete this.

At line management level the gap has been addressed by the provision of IOSH accredited Managing Safely training to a select group of managers and supervisors drawn mainly from the Fleet, Estates and Facilities Directorate. Work was also started towards the end of 17/18 on the design of an internal non-accredited Health and Safety Training Course for all other managers.

## Moving and Handling

Moving and handling is consistently one of the Trust's highest reported incident types and one of the Trust's objectives is to reduce the incidence of musculoskeletal (MSK) injury among the workforce.

To support this, the Trust's Moving Patients Safely Group has continued to meet throughout 2017/2018 and make progress with its moving and handling work plan.

One of the key achievements was the review of statutory and mandatory training provided to staff for moving and handling. This review resulted in the face to face teaching time dedicated to moving and handling being increased to 4 hours for all frontline staff. The training content was also extensively reviewed to incorporate more practical work ensuring all attendees had the opportunity to be "hands on" during the training.

The revised training commenced in June 2017 and has received positive feedback.

The second key piece of work for 2017/2018 was the partnership working on moving and handling improvement with the Health and Safety Executive (HSE) and National Ambulance Risk and Safety Forum (NARSF).

As mentioned earlier, part of this joint work included a visit to the Trust by a HSE inspector to assess its commitment to the reduction of MSK injuries. The inspector met with a group which included the Chief Executive and a number Union Health and Safety Representatives and was given a presentation regarding the Trust's moving and handling work plan. Following the visit, the Trust received no recommendations / mandates for improvement.

The joint working for 2017/2018 has mainly focussed on identifying and capturing common moving and handling risks across the ambulance sector.

## Premise Inspections

The Inspection 4 Improvement (I4I) program, which ensures that all YAS premises are inspected and assessed for compliance with Health and Safety, Security, Information Governance, Infection Prevention and Control and Risk Management Standards, was sustained throughout 2017/18.

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

### Health and Safety Consultation with Employees

The implementation of a new guidance document regarding health and safety consultation has been underway in 17/18. All local health and safety committees in operational areas (North, South, East and West) are again meeting quarterly and a new local health and safety committee for Fleet, Estates and Facilities was established.

Consultation meetings for other areas of the Trust such as EOC, 111, PTS Comms and Support Services are still required.

### Enhanced Health and Safety Support to Fleet Department

The work stream in relation to the Trust's Fleet Department was maintained in the 2017/2018 work plan to continue addressing the need for health and safety improvement in that area.

Significant progress has again been made this year with the delivery of IOSH accredited Health and Safety Training for the whole Management structure from Director to Team Leader.

In addition, a new post of Standards and Compliance Manager for Fleet has been created and is held by a member of staff with a health and safety background.

As discussed in the section above, a dedicated local health and safety committee has also been set up to incorporate Fleet.

Health surveillance has re-commenced for Fleet staff following issues with the Trust's Occupational Health provision.

### Slips, Trips and Falls

Slips, trips and falls are a standing items on the work plan as they account for a significant proportion of injuries to staff.

An issue with the non-use of torches was identified in relation to slips, trips and falls and therefore, an audit was undertaken to ensure all vehicles had in place the required number of torches. Funding was also agreed for the provision of personal issue torches to ensure staff always have access to a torch if required.

### 2.3.4 Key Risks

The Health and Safety Work plan is aligned with key health and safety risks and therefore, the subjects discussed above are captured on the health and safety risk register which is reviewed quarterly at the strategic Health and Safety Committee.

Progress with key health and safety risks is detailed below:

*Health and Safety Training for managers*

As detailed in the section above, a skills gap has been identified with regards to health and safety training. Progress has been made in 2017/2018 with the commencement of a Health and Safety training plan.

*Moving and Handling*

A number of risks on the health and safety risk register relate to specific moving and handling issues. A new one was added in December 2017 to capture the long term harm that can be caused by frequent moving and handling

*IF the Trust does not consider the frequency, weight and forces involved in moving and handling tasks THEN staff may experience the cumulative effect of repeated actions RESULTING IN musculoskeletal injury*

Key actions include ensuring moving and handling considerations are fully considered during vehicle and equipment design and purchase. This is occurring through consultation at Trust Procurement Group which has fed into the introduction of the new lighter Corpuls defib and the new Fiat ambulance design which allows more space within the patient treatment area for staff to manoeuvre.

A second moving and handling risk where satisfactory progress has not been made is in relation to the movement of complex patients.

*IF the ISU is not made available quickly to staff as they require it THEN the resource and equipment will not be effectively utilised RESULTING IN harm to patients and staff*

The Moving Patients with Complex Mobility needs SOP was introduced in Sept 2016 and given a thorough review in August 2017. Current evidence suggests that the SOP is still not fully embedded and the ISU vehicles are still underutilised. This is being addressed through the Moving Patients Safely Group.

### 2.3.5 Looking ahead – priorities for 2018-19

For the coming year, there will be a focus on continuing with the health and Safety training program and making improvements for moving and handling.

Arrangements will be made to ensure the Trust's senior management are fully compliant with the IOSH accredited training and work will continue to develop the internal non-accredited Health and Safety Training Course for line managers.

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

Moving and handling remains a significant risk for the Trust and as such, the Moving Patients Safely Group will continue to meet 6 weekly. Work will also continue with the HSE and NARSF in 2018/19 along with the progression of other internal projects such as the re-design of the emergency response bag (green bag).

New work streams added for 2018/2019 are in relation to personal protective equipment (PPE) and garage air quality / diesel emissions.

Risk assessments for the Trust's Personal Protective Equipment will be updated in order to inform a review of boots, helmets, RPE and eyewear provision. A review will also take place of the air quality and diesel emissions found at ambulance stations across the Trust with the aim to improve environmental conditions for those working in garage areas.

The goals for 2018/19 include:

- To reduce MSK staff injuries within our workforce
- To improve health and safety knowledge / awareness
- Ensure PPE provision is suitable and sufficient

## Security

### 2.4.1 Introduction

Security management throughout 2017/18 was overseen by an accredited Local Security Management Specialist (LSMS). There is an annual work plan for security issues informed by internal priorities, national Security Management Standards and other in year developments. Toward the end of 2016 a trustwide security workshop was held to identify security priorities based on the national Security Management Standards, this informed the annual plan for 2017-18.

### 2.4.2 Incident reporting

Throughout 2017/18 the Risk Team have embedded robust systems and processes for incident management which has resulted in stronger management of risk and enhanced resilience. Reviews of policy and procedures have been undertaken to reflect these enhanced arrangements.

We continue to collate security and violence and aggression data and produce the RPA (Reporting of Physical Assaults) dataset. With the dissolution of the NHS Protect security function in 2017 the aforesaid dataset was not submitted to this national body in 2017/18, however we have maintained our internal reporting arrangements, which include analysis of themes, trends, contributory and aggravating factors, supported by collection of this data. We have also benchmarked nationally on physical assaults and sanctions via the National Ambulance Security Group.

A detailed understanding of contributory clinical or aggravating factors has informed development of training to staff in managing violence and aggression. Conflict Resolution Training is delivered to A&E Operations and PTS operational staff groups and training is in development for communications centres and other colleagues who have contact with the public.

The Risk Team continue to support application of the Safer Responding Procedure and Joint Decision Model by contributing to analysis of incidents where these processes are applied or indicated, to identify learning.

### 2.4.3 Sanctions and Redress

The Risk Team collate evidence to support decisions on placement and retention of Data Flags. Timely retrieval and collation of evidence is imperative to pursue sanctions against perpetrators of violence and aggression to our staff. The Risk Team work with the EOC Data Flag Coordinator, Legal Services Team and Fleet Team to obtain this evidence. Sanctions may include Data Flag warning letters issued by the Trust, Police cautions, fines, or potentially a prosecution.

Strengthening of processes in 2017/18 has resulted in a significant increase in sanctions to perpetrators of violence and aggression to YAS staff as shown in the table below:

| Type of sanction recorded on Datix | 2016/17 | 2017/18 |
| --- | --- | --- |
| Community service order | 4 | 4 |
| Custodial sentence | 1 | 5 |
| Fines | 2 | 7 |
| Internal sanction, data flag/warning letter issued | 7 | 113 |
| Police cautions | 3 | 3 |
| Suspended prison sentence | 0 | 4 |
| Verbal Police warning | 0 | 1 |
| Total | 17 | 138 |

It is evident in the table above that more staff have been willing in 2017/18 to pursue and achieve a successful prosecution. This is positive progress. Work continues to strengthen the support provided to staff, both the victim and their immediate line management team, in order to ensure we are supporting staff welfare needs in the most appropriate manner and increasing numbers of successful prosecutions.

### 2.4.4 Site Security Risk Assessments

A programme of Site Security Risk Assessments was commenced in 2017/18 and priorities identified core infrastructure security risk at critical sites, fleet workshops and a number of ambulance stations. Estates remedial works required were reported and where possible these were incorporated into the round of major estates works completed in Q4 2017/18. Proposals for future capital investment are being developed and prioritised. The programme of assessments will continue throughout 2018/19 and risk-based follow up of actions will be delivered.

### 2.4.5 Looking Ahead – Priorities for 2018-19

The following are identified as priorities within the 2018-19 work plan:

- To ensure that any future Security Management standards submissions are made in accordance with national requirements and to continue to progress existing action plans until future arrangements are clear
- To take a risk-based approach to prioritisation of investment to mitigate infrastructure security risk, and monitor delivery of remedial actions from site security risk assessments
- To further strengthen capture of sanctions for violence and aggression and security-related incidents and pursue redress
- To strengthen our support to staff following a violence and aggression incident to pursue sanctions
- To ensure that the financial and operational impact of criminal damage to Trust assets to is taken into consideration as part of any criminal proceedings

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

- To contribute to national and regional initiatives and directives through LSMS networks

## 2.5 Infection prevention and control

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

In 2017-18 the YAS Director of Infection Prevention and Control remained Steve Page, Executive Director of Quality Governance and Performance Assurance.

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

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

The key IPC compliance requirements for YAS are:

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

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

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

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

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

### 2.5.2 Delivery of work plan for 2017-18

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

The 2017-18 annual programme of work described the activity in relation to maintaining compliance to both the Health Care Act (2008) and the CQC Key Lines of Enquiry. The key priorities are delivered through agreed work-plan.

Progress with the 2017-18 work-plan has included:

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

- A schedule for the review of IP&C procedural documents is in place. The current list of IP&C procedural documents meet Health and Social Care Act 2012 requirements, are in date and fully ratified. Adherence to infection prevention and control (IPC) policies and procedures remains a key priority in order to promote both patient and staff safety. The number of IPC related policies has been reduced in order to assist staff to find the information they require quickly and easily. During 2017-18 the following policies have been reviewed or developed;

    - Decontamination of medical devices and vehicles
    - Norovirus management guidance
    - Dress Code and Uniform Policy
    - Hand Hygiene policy

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

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

- Infection prevention and control elements for station are assessed during the Inspections for Improvement programme, which includes an overall compliance rating. Compliance with IPC related elements has increased over the annual inspections during 2017-18 largely down to the work completed by Estates in relation to improvement in medical gases storage, consumables storage, linen storage and controlled drug cupboards.

- The Infection Prevention and Control practitioner continues to work with the Occupational Health provider to ensure all staff are offered the correct immunisation, health surveillance and follow up services as required.

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

### 2.5.3 Compliance with CQC standards

During 2017-18 YAS continued to focus on maintaining compliance with the requirements of the *CQC Essential Standards of Quality & Safety* – outcome 8: cleanliness and infection control.

The inspection in September 2016 identified an overall improvement in compliance with all IPC and decontamination practices; however some inconsistencies remained, in PTS in particular. This included cleaning of vehicles between shifts and consistent region wide compliance with bare below the elbows policy. These issues were addressed with a focussed event for PTS managers and team leaders using QI methodology they designed a system for on board vehicle checks that ensure a standard compliance is achieved across all PTS vehicles.

Focussed work has also been undertaken within PTS to ensure safe transportation of oxygen and clean and safe provision of children restraint seats.

### 2.5.4 IPC audit

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

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

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

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

IPC good practice reminders have been publicised regularly through the Staff Update throughout the year; examples include articles about the patient safety implications for being bare below the elbows, how to respond if you have a sharps injury and common errors staff make when using sharps. We have also implemented Mucosal Atomiser Devices to completely remove the need for sharps to be used when delivering Naloxone, as this has been recognised as a time when a high risk sharps injury is most likely. Where required safety alerts have been used to inform staff of changes in practice or equipment that affects their IPC practice.

### 2.5.5 Vehicle deep cleaning and premise cleanliness

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

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

Pilots of Make Ready and vehicle preparation processes, that include a more standardised vehicle cleaning system, have been implemented and supported in order to assess efficiency and effectiveness.

ATP swabbing has been utilised to ensure high compliance with the cleaning processes and is now used as standard within the Facilities Deep Cleaning team.

Using this swabbing system has illustrated that AVP is successful in reducing the environmental bio-load when compared to the cleaning that takes place in business as usual. AVP is going to be extended during 2018-19 to include Leeds, Huddersfield and a hub at Doncaster.

### 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 2017-18 and at year end was at 94%. Plans are in place to refresh the training format and content and move toward the development of an on-line e-learning training system.

### 2.5.6 Infection Prevention and Control Incident review

| IP& C Incidents by Sub Category | 2013-14 | 2014-15 | 2015-16 | 2016-17 | 2017-18 |
|---|---|---|---|---|---|
| Clinical/Medical Sharp Injury | 44 | 61 | 46 | 50 | 56 |
| Contact with communicable infection | 28 | 29 | 28 | 38 | 70 |
| Contact with Blood/Bodily Fluids | 17 | 25 | 27 | 36 | 43 |
| Cleanliness Issues | 7 | 5 | 2 | 16 | 22 |
| Availability of PPE | 0 | 2 | 3 | 5 | 0 |
| Bite | 2 | 6 | 5 | 7 | 6 |
| Lack of availability of Equipment | 1 | 2 | 0 | 3 | 2 |
| Waste Disposal | 5 | 3 | 3 | 3 | 4 |
| Failure to follow YAS Procedure/Protocol | 1 | 5 | 3 | 5 | 0 |
| Vaccinations/Immunisations | 0 | 0 | 0 | 2 | 1 |
| Totals | 105 | 138 | 117 | 165 | 204 |

Incident reporting has increased during 2017-18. This is likely to be due to increased awareness of reportable infection prevention and control incidents and the focus on the importance of reporting incidents per se. This is particularly of note for the contact with communicable disease reported incident. Further work to understand this increase in reporting is underway for 2018-19.

Clinical medical sharps include significant exposure incidents as well as clean unused sharps incidents. Significant exposure incidents make up 70% of the reported total for 2017/18, with 39 staff having a significant occupational exposure. The IPC Practitioner works closely with operational staff and Occupational Health Advisors to ensure timely support and treatment is given to these staff members. Many of these incidents have occurred during a failed cannulation attempt and is suggestive that staff are not following the correct procedures when a failed attempt occurs. During 2018-19 we will audit operational staff practice and confirm practice and make improvements.

Staff are becoming more aware of the infection risks posed by the care they deliver as during their training, best practice events and CPD events. During 2018/19 we will have a strong focus on protecting yourself by undertaking a dynamic risk assessment and utilising the correct personal protective equipment.

### 2.5.7 Key risks

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

Trust responsibilities outlined in the Green Book remains recorded as a risk as there is a requirement to have provision for post occupational exposure prophylactic treatment with antibiotics, should this be deemed necessary following potential exposure. It is possible that this risk will be mitigated should 111/YAS become a prescribing centre in the future, but for now this issue remains on the risk register.

A new risk added for 2017-18 is lack of correct and complete records for immunisation status of staff. This is a joint risk with IPC Practitioner and the Health and Well-being Lead. At the end of the current Occupational Health Contract, YAS will insist that a full and complete record set for all staff immunisation status is passed from the exiting provider to the new provider.

Two measles outbreaks have occurred within West Locality during 2017-18, one in Leeds region and one in Bradford. Both were recorded on the risk register during the time and managed by the IPC Practitioner, Regional Operations Centre and Public Health England, with support from OH and Well-Being Lead to ensure timely assessment of vaccination status of staff.

### 2.5.8 Next steps for 2018-19

- Further audit work to embed and review practices in relation to bare below the elbow and issue of new fob watches.
- Development of a Clinical Audit process for insertion of indwelling devices including cannula insertion, to increase best practice and reduce needle-stick injury following failed cannulation.
- Further engagement with service users and public, and exploration of hand hygiene audits undertaken by frequent users of the Renal PTS service.
- Focus on ensuring all staff undertake a risk assessment process and employ the correct personal protective equipment when caring for patients with known or suspected infection.

## 2.6 LEGAL SERVICES

### 2.6.1 REQUESTS FOR INFORMATION

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

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

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

A large volume of requests are received each month. The figures for 2017-18 are shown below, in comparison to previous years.

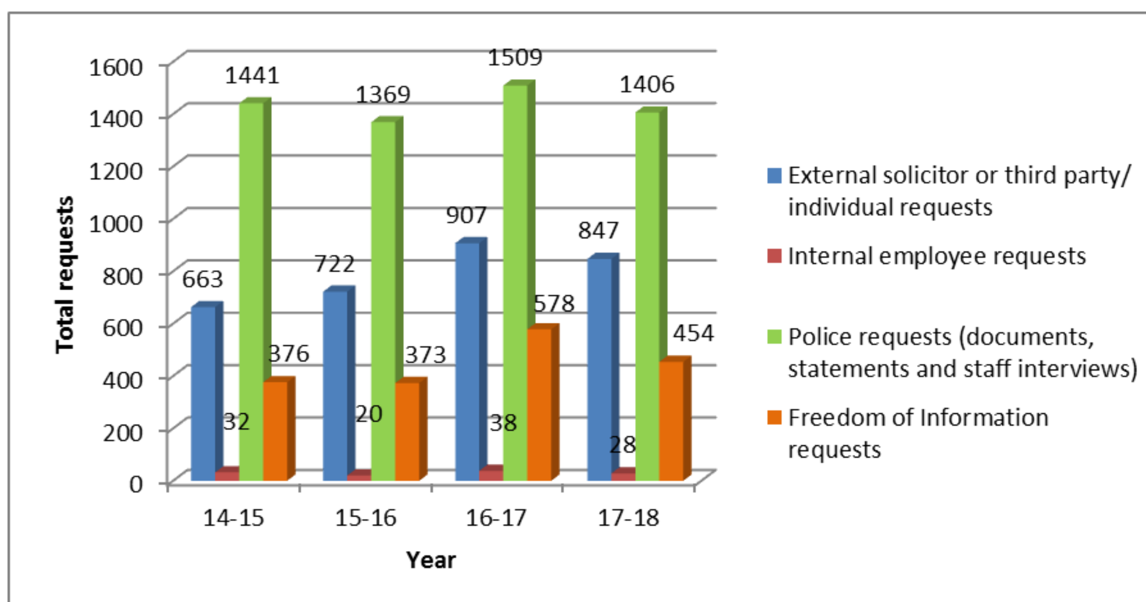



*Figure 1: Total number of information requests received by year*

The volume of information requests dealt with by the legal services team remains consistently high year on year with high compliance rates being maintained which is a positive achievement across the department. The Legal Services Team work hard to maintain this level of compliance and regularly review and revise the processes to maximise efficiency.

From 25 May 2018 the General Data Protection Regulation (GDPR) was introduced which is a new framework for data protection laws. This is designed to modernise data protection legislation and aims to increase the rights of individuals and gives them more control over their information. The UK also implemented a new Data Protection Act (DPA 2018) which replaces the 1998 Act. This change impacts on the organisation as a whole, but specifically in relation to subject access requests for information there are two changes of note:

- Previously a fee could be charged for the access of records but under the new legislation no fees can be charged;

- The timescale for the release of records has decreased from 40 working days to one calendar month.

The Legal Services Team have reviewed the processes and documentation to ensure that it is in line with the changes described and to ensure the shorter timescales associated with these requests can be managed.

Further work is planned for 2018-19 to continue improve the understanding of the Freedom of Information requirements for departments across the Trust to assist with the quality and efficiency of the responses provided. Work will also be taken forward with the communications team to enhance the Trust publication scheme including publishing of regularly requested data sets.

To date there have been no complaints made to the Information Commissioners Office around the handling of requests for information.

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

The Legal Services Team actively manage all Coroner Inquests, which is inclusive of identifying and managing risk, maintaining Trust reputation, identifying learning and providing staff support. The Trust's involvement in inquests continues to remain at high volume in relation to attendance of staff as witnesses, particularly within the A&E Operations Directorate. During 2017-18 YAS received 522 new Coroner requests and employees gave evidence (oral or written) at 294 inquests. There are a further 309 cases that are still awaiting a hearing date (these are all open inquests not just for the previous year). This year has seen the highest amount of new inquest cases (522) with an overall increase in inquest cases over the past five years. In 2016/17 428 new cases were reported and 440 in 2015/16 compared to 360 in 2014/15, and 300 cases in 2013/14.The amount of inquests we have provided evidence to (written or oral) has consistently remained high over the years (between 200-300).

During 2017-18, those Inquests that involve potential risks to the Trust focussed mainly on delayed response times within the A&E service, and these were mainly concerned with delays to lower priority coded calls in which time the patient deteriorated, and how they are managed within the Emergency Operations Centre (EOC). Those reported have consisted of a combination of demand/resource issues and human factors within the EOC. Lessons and actions have been taken on an individual case basis and are also fed back into wider Trust work streams.

In all cases where a concern is raised the Trust provides an investigation report and where oral evidence is required, this is undertaken by an appropriate senior manager at the inquest.

Both individual learning points and common themes are identified and actions implemented from review and management of inquest cases. During 2017/18 there were a number of inquests and incidents involving the management of cardiac arrests. This led to a review and reconfiguration of the ALS training which is now included as part of the clinical refresher training.

## Prevention of Future Death Reports

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

During 2017-18 YAS received two PFD reports, briefly detailed below:

- An inquest that was held in South Yorkshire in April 2017 concerned a patient who collapsed in a public place. The call was given an Amber coding which has a target response time of 19 minutes, but the overall response time was 42 minutes. The patient was in cardiac arrest on arrival and he later died at hospital. It was identified that there were a number of resources that were available but had not been allocated and the incident had not been escalated when the response time was exceeded. The Coroner felt that a further review of the dispatch protocols in place was required. This review took place and a response was provided to the Coroner explaining the systems and processes in place within the EOC.

- An inquest that was held in South Yorkshire in October 17 concerned a patient who was feeling suicidal and had involvement with mental health services. An ambulance was called by the patient and police also attended. The police arrived first and spoke with the patient who refused to go to hospital but agreed to speak with a mental health worker over the telephone. The police cancelled the ambulance but there was miscommunication in relation to the referral to the crisis team which was not made by either service. The patient was found deceased the next day. The Coroner raised concerns about the effectiveness of the pathway for communicating information directly to the crisis team. A response was provided to the Coroner to clarify the role of the mental health nurses within YAS and work has been undertaken to improve the communication between the emergency services in situations such as this.

## Risks

The implementation of strict timescales for concluding an inquest means that Coroners now aim to set inquest dates much earlier, with short timescales for the Trust to provide documentation and information, review the cases and implement any actions that are required. Coroners are able to enforce a fine of up to £1,000 if deadlines are missed. The trust has not received any fines in this regard.

The high volume of requests received together with short timescales puts pressure on both the Legal Services Team and individuals and departments across the Trust who are involved in producing statements or investigation reports for the Coroner. The Legal Services Team provide support through this process and try to identify witnesses/commence an investigation as soon as possible so not to cause any delay. It remains a risk in relation to capacity across the Trust to complete these requests from the Coroner in the timescales set.

PFD reports have taken on a more central role within the Coronial process. The Coroner has a duty to make a PFD report where evidence gives rise to a concern that there is a risk that future deaths will occur in the same circumstances and action should be taken to reduce this risk. It is therefore important that where areas of concern are identified, that the Coroner is provided with an investigation report and a fully implemented action plan. The Legal Services Team continues to work closely with other departments across the Trust to provide support and assistance to any member of staff involved in the inquest process.

All inquests are reviewed individually by the Deputy Medical Director and moderate and high risk cases are regularly brought to the fortnightly Incident Review Group so any ongoing clinical risks can be identified in a timely manner and managed effectively.

### 2.6.3 Claims

The Legal Services Team actively manages claims in conjunction with NHS Resolution, who run the NHS pooling scheme, which includes management of all Employer's Liability (EL), Public Liability (PL), Clinical Negligence (CNST) and Property (damaged and lost) claims. This is inclusive of reports to specific departments on minimising future risk, identifying learning, managing reputation and staff support.

### Claims reporting

The table below details the total amount of open claims (inclusive of new claims reported) that have been reported under the NHS Resolution Insurance Schemes over the past 5 years. At the end of 2017-18 there were 179 open claims, with 93 new claims being reported. The data shows a decrease in new claims reported this financial year which is a positive indicator of the effectiveness of steps taken to reduce harm to both staff and patients. The implementation of the low value claims portal now means that claims are investigated and a decision on liability made much more quickly than previous years so it is hoped that there will continue to be a reduction in the amount of open claims.

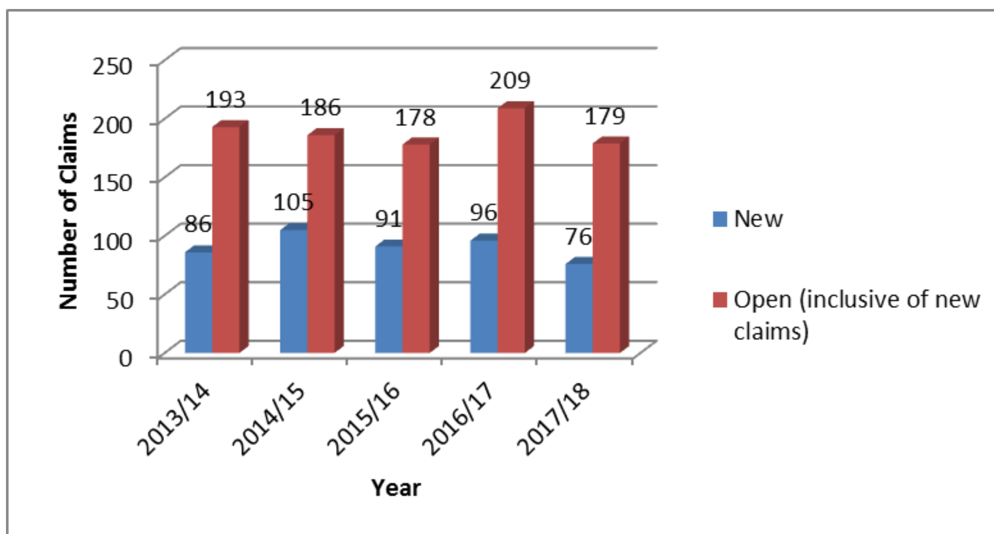



Figure 1: Total number of new and open claims (EL/PL/CNST).

## New Claims

The table below details the new claims reported over the last 5 years. The highest volume of claims is Employer Liability claims which, along with all claims have reduced this year.

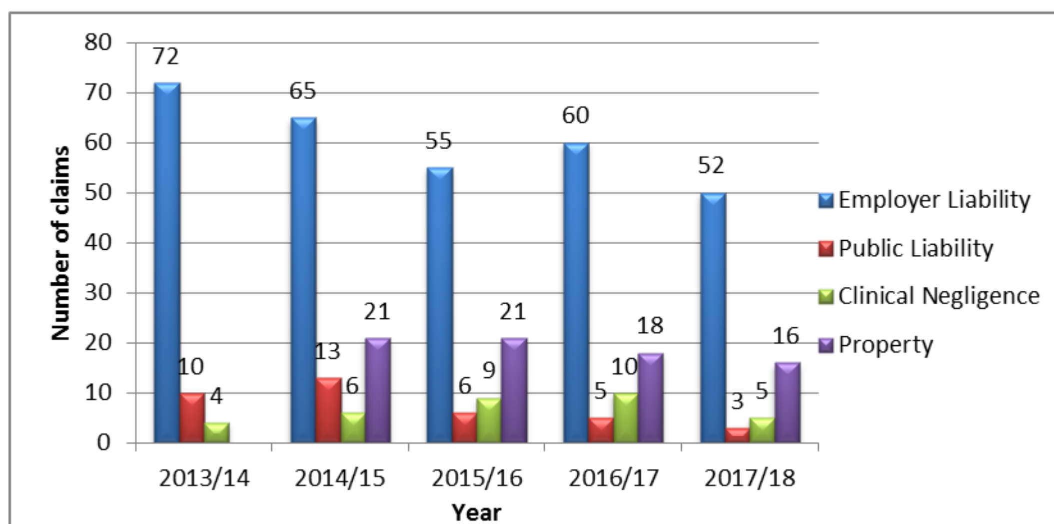



Figure 2 – New claims reported (EL/PL/CNST/Property)

## Employer Liability (EL) Claims

Employer Liability Claims continue to be the main focus of claims workload within the Legal Services Team; 52 new claims were reported in 201718, with 116 open. The main focus of the claims within this category continues to be moving and handling with 30 open claims. Injuries arising from equipment, for example carry chairs, stretchers and wheelchairs, and from assisting patients with movement remain the highest in this category. Claims arising from injuries sustained from Trust vehicles are the second highest category of claims (27 claims) which mainly consist of injuries from tail lifts and ramps.

A number of claims have been reported relating to alleged defective chairs within the NHS 111 service, these are under investigation and current procedures have been reviewed.

The on-going work streams from the Moving Patients Safely group continue to support with the reduction of staff injuries, and new guidance on manual handling risk assessments for equipment and vehicles is being produced. New risk assessments, including improved manual handling assessments have commenced and are supported by a newly developed mandatory training programme that encourages the use of dynamic risk assessment on scene and safe utilisation of relevant equipment.

## Public Liability (PL) Claims

PL claims remain in low numbers and in 201718 there were 3 new PL claims reported. This demonstrates a positive patient safety culture within the Trust. The majority of these claims were from injuries sustained during transfer of the patient to the vehicle, either as a result of a trip or fall, or injury from equipment.

### CNST Claims

In 2017/18 there were 5 new CNST claims reported and 26 currently open. These claims are potentially very high value claims with reputational impact on the Trust.

The key themes within these claims are in relation to alleged delays in providing treatment to the patient, clinical assessment on scene, particularly in patients who have deteriorated following a decision not to convey to hospital and patients who have sustained a fall whilst in our care.

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

### Looking ahead – priorities for 2018-19

- Continued work across departments within the Trust to encourage more ownership and transparency of claims within locality areas. It is hoped that this will allow for a focus on earlier identification of themes and trends of reported claims, and any lessons learned as a result. This aims to both support improvements to staff and patient safety, and reduce the number of claims reported.
- Continue to work closely with the Quality, Risk and Safety team to enhance investigation skills across the Trust, and encourage early investigation at incident stage which supports the management of the claim at a later stage.
- Continue to work with operational management groups across the Trust to ensure themes and trends arising from claims and inquests are reviewed and identified actions are implemented to demonstrate learning.
- Improve the training, education and awareness for staff involved in legal proceedings.
- More communication for localities and departments in relation to claims to ensure they remain a focus with local performance and governance arrangements.

## 2.7 MEDICINES OPTIMISATION

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

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

During 2017-18 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 Optimisation Group (MOG). MOG is responsible for ensuring that procedures are followed in practice and that YAS complies with all national guidance and for providing assurance to the Trust Board via CGG and Quality Committee.

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

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

The Ambulance Service Clinical Practice Guidelines set out the list of drugs which may be used by any qualified paramedic trained A&E clinician. In addition, Patient Group Directions (PGDs) allow suitably trained staff to administer and/or supply specific drugs when specifically indicated by a patient's condition, which are not within the schedule 17 and 19 exemption lists.

### 2.7.2 Medicines Management Work plan

Developments during the last year include:

- Introduction of new medicines to the YAS formulary including blood, calcium chloride and tranexamic acid for post-partum haemorrhage.
- Introduction of pre-filled syringes for ketamine and fentanyl for the critical care doctors to allow safer administration during rapid sequence induction of anaesthesia.
- Change to the controlled drug procurement and supply to stations. The procurement and supply of controlled drugs has changed from external delivery to stations, to a single point of delivery to the main CD safe and then internal logistics delivery CDs to individual stations. This allows the use of one main register and also complies with the CD license requirements.
- Continuation of clinical audits: UCP analgesic audit, Entonox and midazolam audit have been completed.
- Improvements to the prescription only medicines registers; to reduce time and improve the standard of documentation new registers have been produced that reflect the medicines pouches.
- Introduction of sticker books for all injectable medicines. Ring bound books containing standardised stickers for drawn up injectable medicines have been produced and distributed.
- Continuation of specialist paramedic education.
- Approval gained to conduct a pilot looking at improving the medicines process in the Hull and East area.

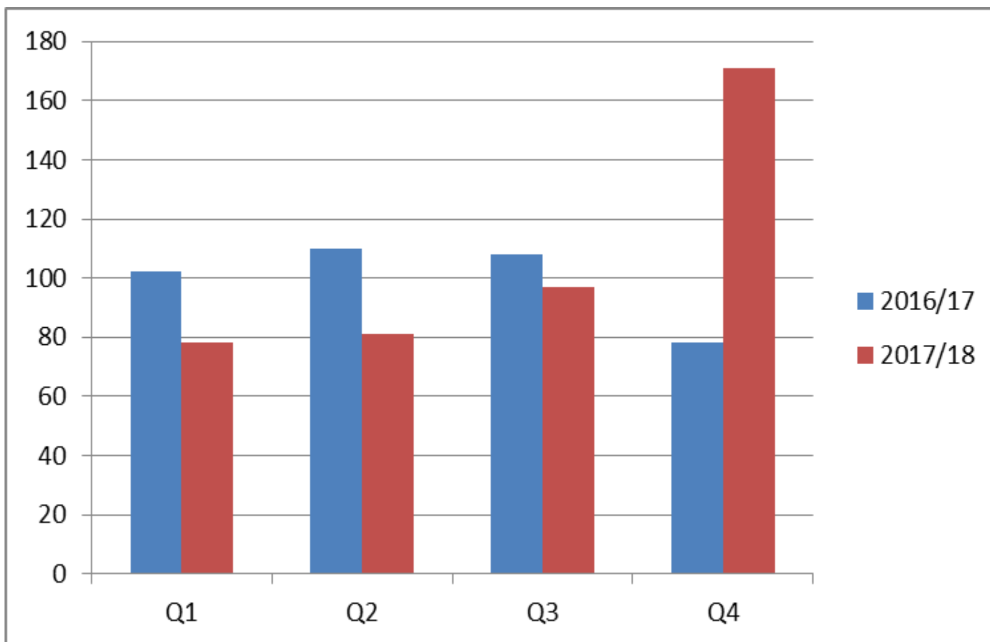
### 2.7.3 Review of Incidents Relating to Medication

The MOG review all incidents relating to medicines and medicines optimisation. There has been an increase in non- controlled drug reported incidents with 427 reported in 2017/18 compared with 398 during 2016/17. However, there has been a reduction in

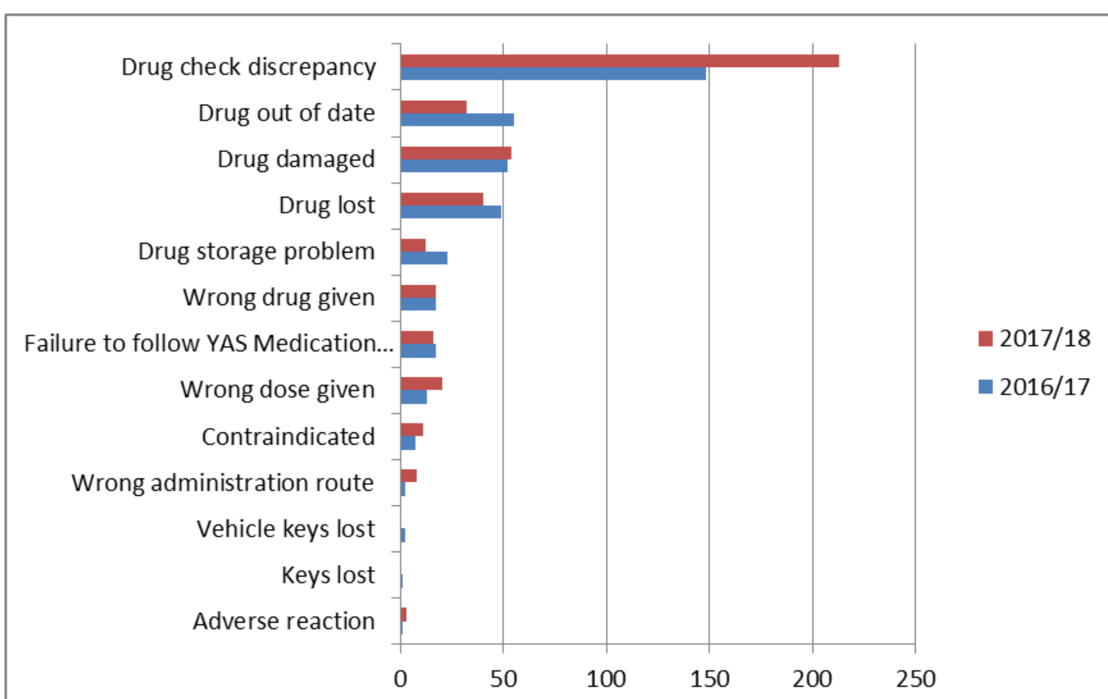
the number of controlled drug incidents reported, 384 during 2017/18 compared with 399 during 2016/17.

The following chart shows all non-controlled drug incidents comparing 2017/18 to 2016/17. In quarter 4 of 2017/18 the logistics and procurement team started reporting all the discrepancies found in the medicines cabinets located in the hospitals. This led to an increase in DATIX incidents reported. The new data allows the MOG to follow trends.

**Non-controlled drug incidents**

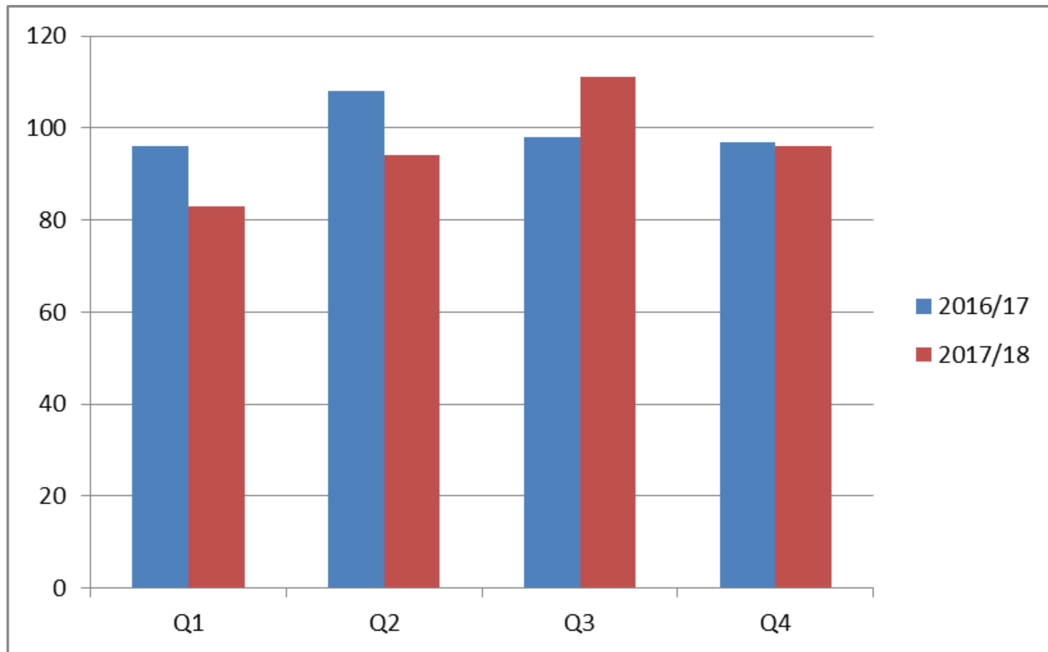



The following shows a breakdown of the incidents into sub category, as you can see drug check discrepancy shows the biggest change year on year.

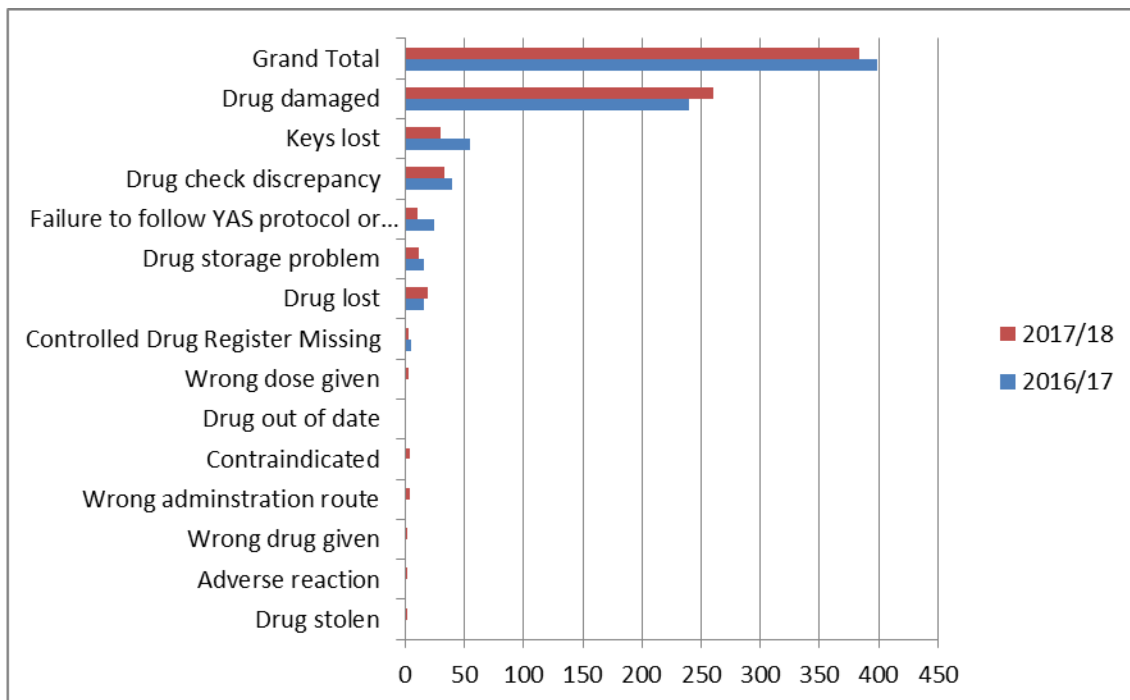


### Controlled Drug Incidents

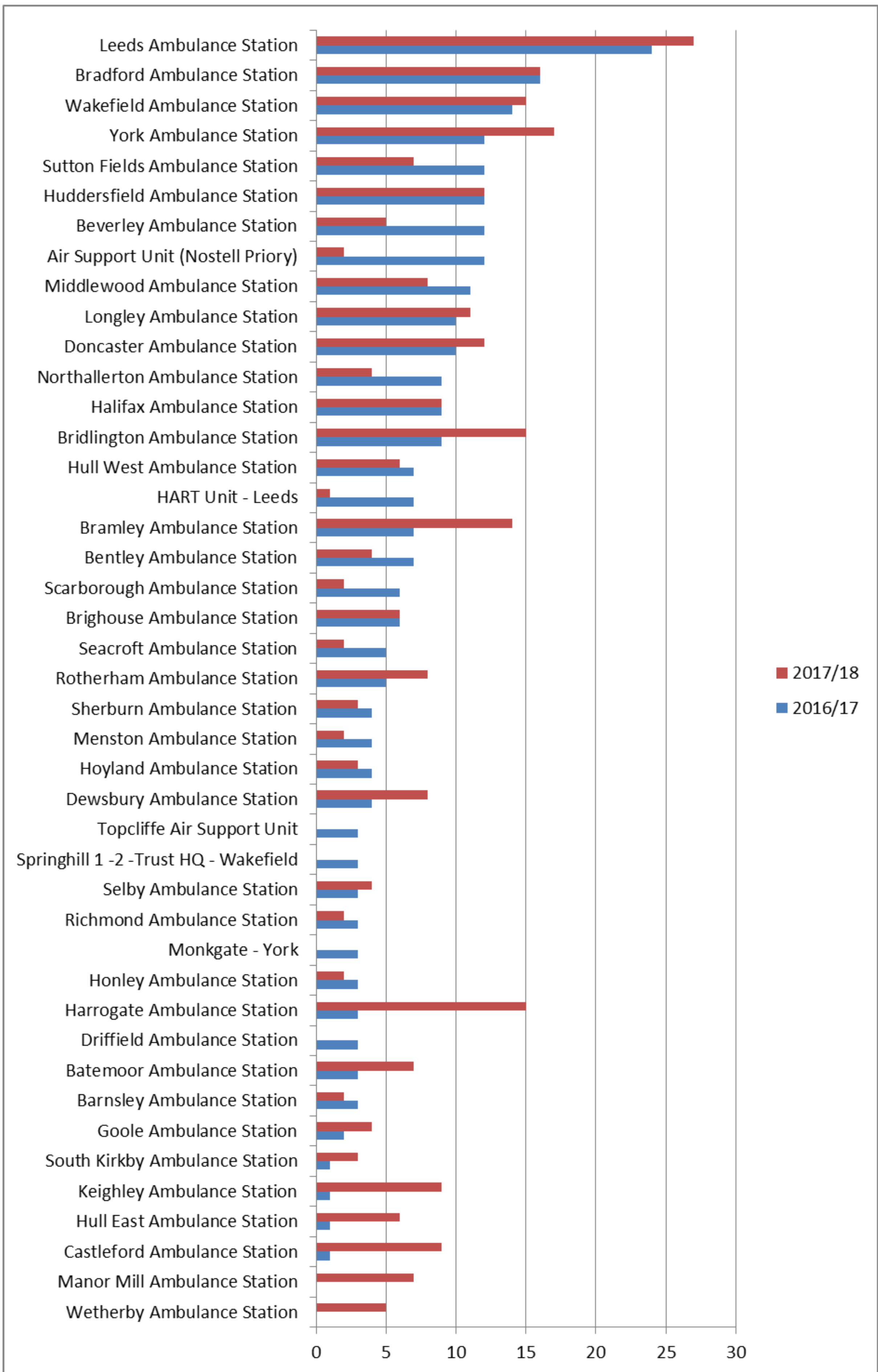
The graph below shows the controlled drug incidents for 2017/18 compared to the previous year.




The graph below shows the incidents broken down into sub categories. Vehicle safe key loss has reduced by about 40% year on year.



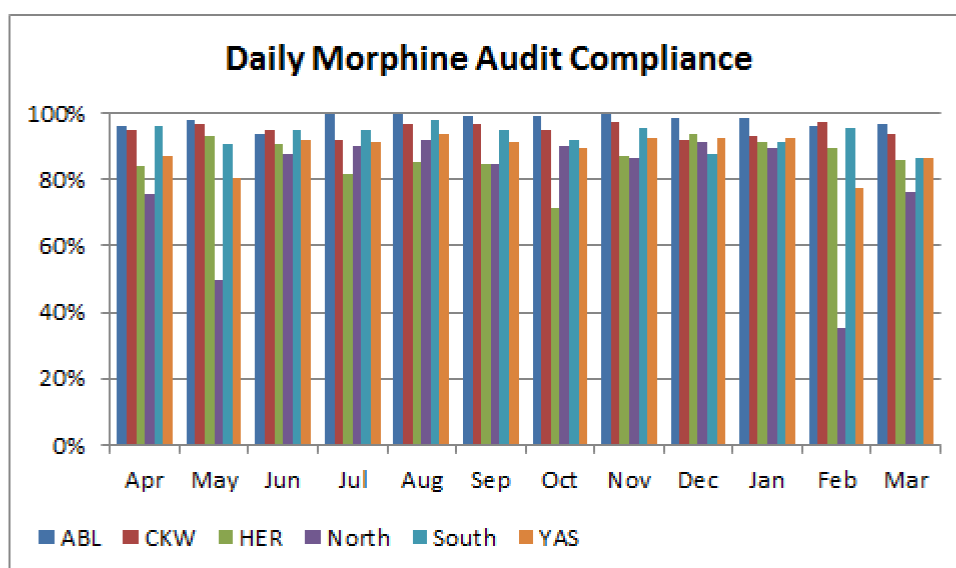

The following graph shows controlled drug breakages by station. There has been a rise in the number of breakages, the addition of ketamine and midazolam to the controlled drugs safes where a RAT team is in situ has led to an increase in breakages in certain stations (Harrogate). To try and minimise breakages in the future, the new AVP and HUB stations are being fitted with flooring and work surface coverings that will reduce the risk of smashing.


Leeds Ambulance Station
Bradford Ambulance Station
Wakefield Ambulance Station
York Ambulance Station
Sutton Fields Ambulance Station
Huddersfield Ambulance Station
Beverley Ambulance Station
Air Support Unit (Nostell Priory)
Middlewood Ambulance Station
Longley Ambulance Station
Doncaster Ambulance Station
Northallerton Ambulance Station
Halifax Ambulance Station
Bridlington Ambulance Station
Hull West Ambulance Station
HART Unit - Leeds
Bramley Ambulance Station
Bentley Ambulance Station
Scarborough Ambulance Station
Brighouse Ambulance Station
Seacroft Ambulance Station
Rotherham Ambulance Station
Sherburn Ambulance Station
Menston Ambulance Station
Hoyland Ambulance Station
Dewsbury Ambulance Station
Topcliffe Air Support Unit
Springhill 1 -2 -Trust HQ - Wakefield
Selby Ambulance Station
Richmond Ambulance Station
Monkgate - York
Honley Ambulance Station
Harrogate Ambulance Station
Driffield Ambulance Station
Batemoor Ambulance Station
Barnsley Ambulance Station
Goole Ambulance Station
South Kirkby Ambulance Station
Keighley Ambulance Station
Hull East Ambulance Station
Castleford Ambulance Station
Manor Mill Ambulance Station
Wetherby Ambulance Station
0
5
10
15
20
25
30
2017/18
2016/17

### 2.7.4 Monitoring Usage of Controlled Drugs

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

The Controlled Drugs safes must be check and audited every 24 hour period, to ensure that the stock levels are correct, and that all Morphine has been returned. The following graph shows compliance over the 2017/18 period for each CBU. The North has a number of stations where in a given 24 hour period there may not be a paramedic on station. This has not been reflected in the data. Both the North and East have put strategies in place to improve the compliance.




### 2.7.5 Patient Group Directions

1. Blood for the management of severe blood loss due to major trauma, for the Critical Care paramedics.
2. Calcium Chloride for the management of potentially developing hyperkalaemia following release from a crush injury for the critical care paramedics
3. Tranexamic acid for the treatment of post-partum haemorrhage following treatment of misoprostol for all paramedics

### 2.7.6 Medicines audits

#### Urgent Care Practitioner (UCP) analgesics audit

YAS deploys UCPs to patients who may benefit from clinicians with additional skills, enable the patient to be safely managed at home. This baseline audit was requested by the Medicines Optimisation Group to monitor the administration and supply of analgesics by UCPs in accordance with YAS PGDs.

In summary, this audit has identified:

1. Of those patients who indicated pain as a symptom, 91% received an initial administration of analgesia, within a mean time of 29 minutes from the UCP arriving at scene.
2. Pain score is a requirement for some PGDs, yet is only recorded 41% on Patient Care Records (PCR).
3. 95% of patients received ongoing care instructions and/or advice recorded.
4. The completion of the PCR Drug Administration boxes is inconsistent, particularly the recording of drug supply.

Recommendations include:

1. UCPs to be reminded of the legal requirement for accurate PCR recording.
2. As required by the PGD, UCPs receive regular training, especially in NICE guidelines for analgesic use for specific clinical conditions.
3. PGDs are reviewed to control symptomatic relief/pyrexia during infectious illness.

### Benzylpenicillin Audit

Benzylpenicillin is a lifesaving antibiotic when given early in a patient with suspected meningitis. In this audit 123 patients were given a stat dose of benzylpenicillin. The median age of patient was 8 years. 79 (64.2%) were children, under the age of 18, while the rest were adults (18 years and over).

Key Points/Recommendation

1. 65% of hospitals were pre-alerted regarding the incoming patients to allow for rapid assessment and infection prevention and control procedures.
2. The PGD clearly states benzylpenicillin should be used as a first line treatment for meningococcal septicaemia only. There were three cases where treatment was for non-meningococcal sepsis. Documentation of whether the patient was suspected to have meningitis was poor; with only 76.4% (94) of patients having a documented working impression of suspected meningitis.
3. It must be noted that 6.5% (8) of patients had received an incorrect dose of benzylpenicillin for their age group and the development of the JRCALC guidelines on an app should help with dose checking in children.

### Nitrous oxide/Oxygen Audit

Pain should be assessed, documented and managed as per clinical best practice. Nitrous oxide is a gas, which when combined with oxygen in 50:50 mixture, creates excellent analgesia. This audit looked at appropriate use of nitrous oxide/oxygen

Key Points/Recommendations

1. 51/52 records found Nitrous oxide/Oxygen was given appropriately to patients with a pain score of 4-10, moderate to severe pain.

2. In 19 cases there was either only one or no pain scores were recorded; this represents 37% of the records sampled.

## 2.8 FREEDOM TO SPEAK UP

### 2.8.1 Introduction

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

In June 2016 YAS appointed its first FTSU Guardian working 22 ½ hours per week in the role supported by ten FTSU Advocates who represent the business function to which they are most closely aligned. Together the FTSU Guardian and Advocates support staff who wish to raise concerns through the FTSU process.

2017-2018 saw the FTSU process start be become more embedded across the trust with an improved awareness of the philosophy and strategic aims becoming evident through engagement of both staff and managers.

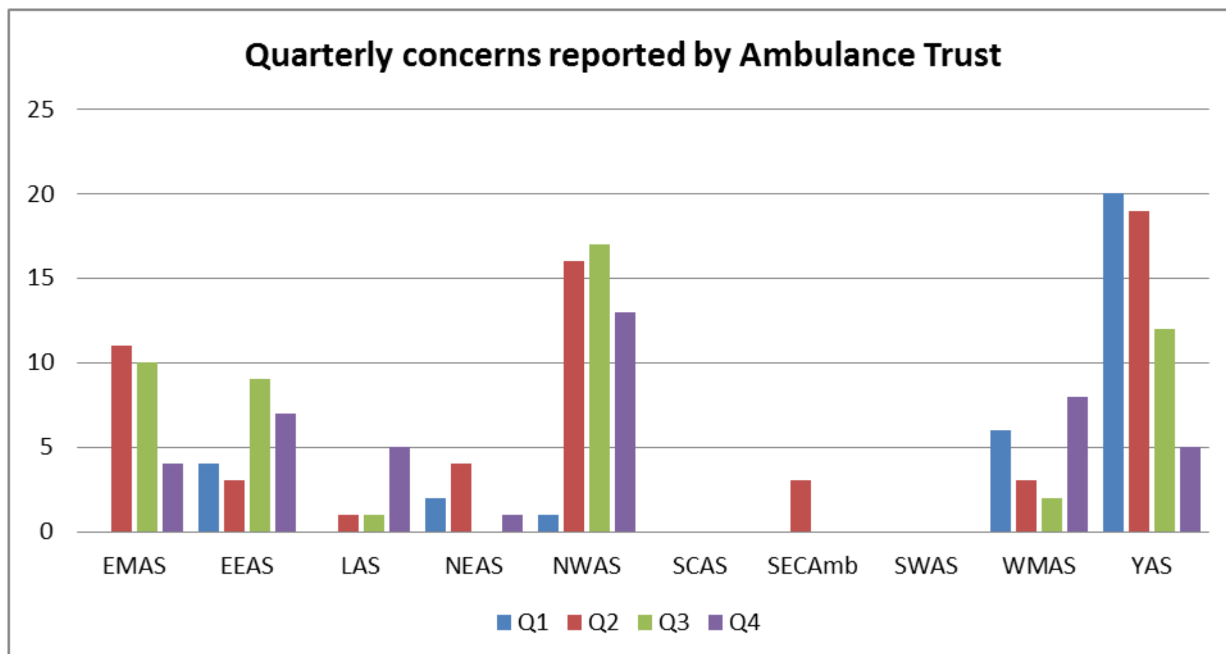
### 2.8.2 Recording of Concerns

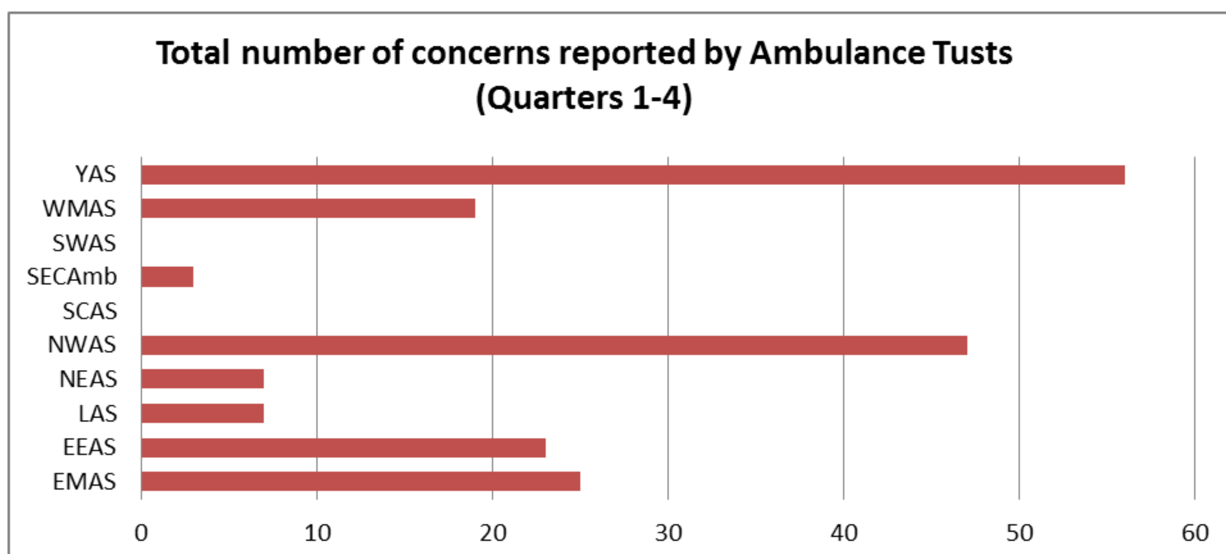
FTSU concerns are recorded on a secure partition of the Datix system which has been specifically adapted to meet the 'Recording Cases and Reporting Data' recommendations from the National Guardian’s Office (NGO).

All NHS Trusts were required to submit their final Quarter 4 data (01 Jan – 31 Mar) in April 2018. This concluded the first year in which the NGO attempted to collect FTSU concerns data from all NHS Trusts. While the charts below provide an opportunity to compare YAS FTSU activity with other ambulance Trusts in England, it should be noted that some of these Trusts have yet to fully implement their FTSU strategy while others established their strategy part way through the reporting period. As a result some ambulance Trusts have submitted limited or no-data.

There is always a difference of opinion around what an open, engaging and transparent Trust would look like in respect to FTSU concerns. Some argue that a high number of concerns reported suggest an open and engaging workforce who are not afraid to report issues or concerns while a contrasting viewpoint argues that a low number of concerns reported indicates a ‘safe’ organisation. Irrespective of these two contrasting viewpoints there is a general consensus that all Trusts will generate some FTSU concerns even in small numbers and those who are reporting zero or “no data” may need to revisit their FTSU strategy. A better opportunity to compare like for like data will present itself towards the end of the second year of FTSU data collection. (March 2019).

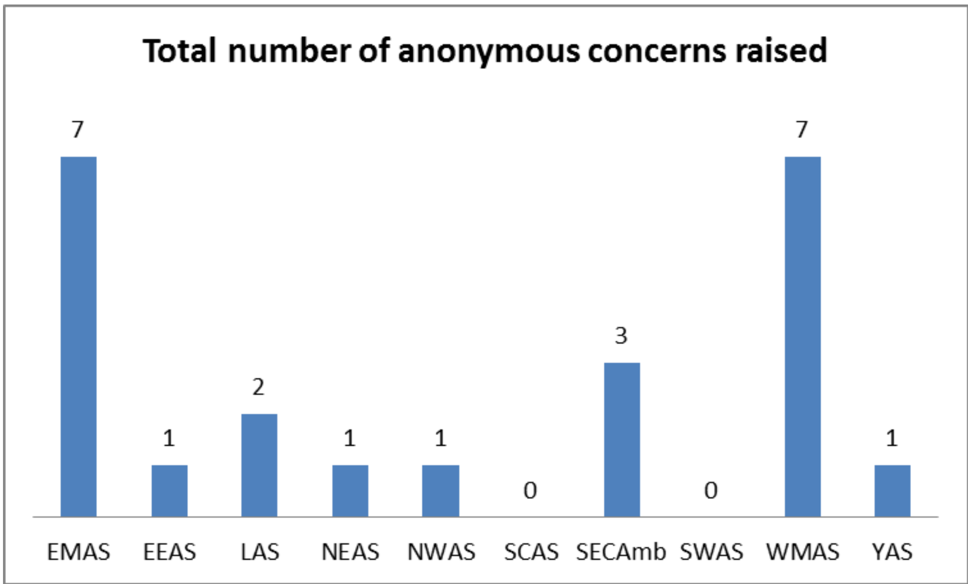
The two charts below indicate the number of FTSU concerns reported by quarter and in total from April 2017 – March 2018.

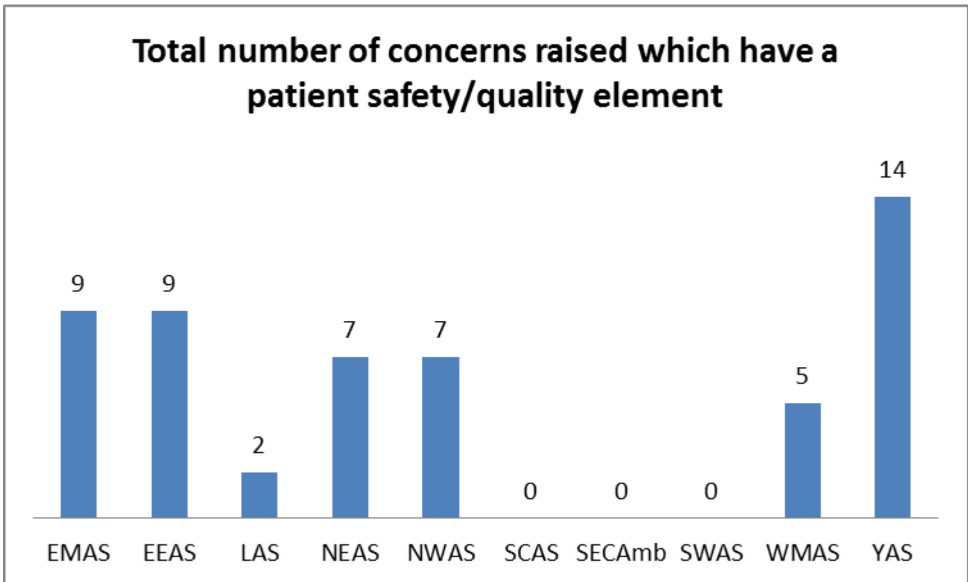


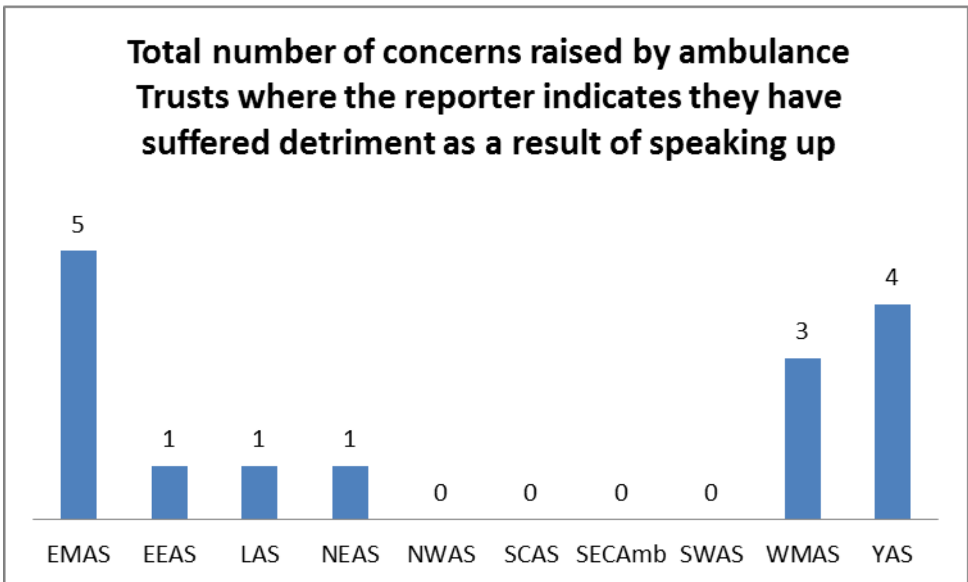




The NGO also requests data on the number of concerns:

- Reported anonymously
- Which are believed to have an element of patient safety/quality
- Which are believed to have an element of bullying & harassment
- Where the reporter believes they are suffering detriment as a result of speaking up
  The following charts indicate the responses from the ten ambulance trusts over the twelve month reporting period in relation to the NGO requirements above.


Total number of anonymous concerns raised
7
1
2
1
1
0
3
0
7
1
EMAS
EEAS
LAS
NEAS
NWAS
SCAS
SECAmb
SWAS
WMAS
YAS


Total number of concerns raised which have a patient safety/quality element
9
9
2
7
7
0
0
0
5
14
EMAS
EEAS
LAS
NEAS
NWAS
SCAS
SECAmb
SWAS
WMAS
YAS


Total number of concerns raised by ambulance Trusts where the reporter indicates they have suffered detriment as a result of speaking up
5
1
1
1
0
0
0
0
3
4
EMAS
EEAS
LAS
NEAS
NWAS
SCAS
SECAmb
SWAS
WMAS
YAS

The YAS FTSU Guardian identified a noticeable decline in concerns being reported through FTSU over the past 12 months. It was unclear if this decline was as a result of a reduction in staff engagement by the FTSU Guardian and Advocates, a better understanding of the FTSU policy and opportunities to raise concerns through the line management processes or simply an indication of a more content workforce. Nevertheless, a FTSU awareness week took place in May 2018 in an attempt to raise awareness of the FTSU process at YAS.

To improve the rigour of the FTSU process a concern tracker document was introduced. This tracker forms the basis for discussions at a fortnightly concern review meeting attended by the Chief Executive, the Executive Director for Quality, Governance & Performance Assurance, the Director for Workforce and Organisational Development, the Head of Investigation and Learning and the FTSU Guardian. This process ensures there is a clear management plan and response for all issues raised and that any barriers or issues experienced by the FTSU Guardian can be addressed appropriately. Moreover, this approach ensures senior leaders have greater visibility and understanding of the concerns being raised through FTSU.

Ensuring that vulnerable groups feel supported to raise concerns is one of the key principles of Freedom to Speak Up. Raising FTSU awareness in Student Paramedics is being addressed by the Guardian presenting a tailored session at Sheffield Hallam, Teesside and Bradford Universities. Support for the LGBT community is also being addressed through FTSU attendance at planned local and national events in addition to having FTSU listed as a support option on the LGBT website (https://www.ambulancelgbt.org/resources/supporting-our-staff/). The FTSU guardian is also afforded opportunities to present to the BME forum. Engaging with Community First Responders (CFRs) has proved challenging however the principles of FTSU has been covered in CFR Continual Professional Development (CPD) events

**The breakdown of 56 concerns raised at YAS during this reporting period is as follows:**

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

- A&E Operations – 37
- EOC – 2
- Fleet & Estates – 5
- NHS 111 – 8
- PTS – 1
- Corporate - 3

### 2.8.3 Engaging with external organisations:

#### Yorkshire & Humber FTSU Guardian Network

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

### National Ambulance Network for FTSU Guardians

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

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

### Other engagement opportunities and working group attendance.

The trust Guardian continues to present to Student Paramedics. It is hoped that by engaging early in their careers, staff will be able to appreciate the benefits of raising concerns which may also influence a change in organisational culture.

The FTSU Guardian also engages with the following organisations:

- Freedom to Speak Up National Guardians Office
- Public Concerns at Work (Whistleblowing Charity)
- NHS Improvement
- College of Paramedics

Other engagement opportunities have included attendance at:

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

In addition to the above the FTSU Guardian also regularly attends the following working groups:

- Health & Wellbeing Working Group
- Post Incident care Working Group
- Sanction & Redress Working
- Departmental Cultural Improvement Working Group

### 2.8.4 Learning from FTSU

The most noticeable theme to emerge from the 56 concerns raised was concerns raised connected to the recruitment/secondment policy. In particular this has focussed on allegations of cronyism. While there was little evidence found to support these

allegations it was concerning that these processes were perceived to be unfair. As a result, the Human Resources department have made a number of improvements to the following:

- The shortlisting process has been reviewed and improved to provide greater transparency
- Recruitment Guidance and Policy have been updated
- Recruitment and Interview Training has been reviewed and improved
- The emphasis on providing accurate and timely feedback has been strengthened.
- Work is underway to embed a values based approach into the recruitment process

### 2.8.6 Summary

In summary, Freedom to Speak Up continues to embed itself at YAS with staff, managers and trust leaders increasingly engaging with the process. The increase in representation at network meeting and working groups clearly demonstrates the value and importance being place on the contribution being provided by the FTSU Guardian and Advocates. It is anticipated that following the submission of a second year of data to the NGO trust will be better placed to understand what a good reporting culture looks like while also identifying any national or sector trends. There is still work to be done in regards to collecting feedback from staff who have raised concerns in addition to celebrating and disseminating the learning for those concerns raised.

## 2.9 Next steps for 2018-19

The focus for 2018-2019 is to continue to embed FTSU in the hope that it becomes business as usual at YAS. Over the next 12 months there will be particular emphasis placed on identifying and celebrating the lessons learned from staff that chose to speak up at YAS and where appropriate share this learning with the wider ambulance community.
The Trust will also be focussing on self-assessment against national guideline published in 2018 and on development of a new FTSU strategy to shape our continued focus on the development of an open, learning culture.

# Section 3.0

# Clinical Quality

## 3.1 Introduction

The Clinical Quality Strategy 2015-18 set out a 3 year programme of clinical quality improvement. This is underpinned by an annual implementation plan focused on each of the key domains. The Clinical Quality Strategy final year was 2017-18 and work has already begun to review progress made and make plans for progression in 2018-2021, in line with the Integrated Business Plan, best practice guidance and learning from both national and local agenda.

The annual programme of patient safety improvements is informed by the priorities in the clinical quality including relevant national Sign up to Safety priorities and national and local CQUINS.

### 3.1.1 Progress against the work-plan for 2017-18 includes:

#### Sign up to Safety Campaign

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

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

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

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

During 2017-18 the Quality and Safety team have undertaken an awareness campaign with frontline staff to ensure they feel supported to report incidents and concerns and that the Trust is delivering on its promise to promote a 'just culture' for all staff. Staff who are involved in serious incidents in particular need support to ensure there are no negative outcomes from their experience. During 2018-19 the team will be looking to review staff support during serious incident investigations and work to develop a second victim programme and support network.

In collaboration with provider organisations and Commissioners, as part of the local CQUIN programme, YAS have developed an end to end review process for incidents where different services have inputted to the care delivery and something has gone wrong within that patient pathway. This has given the opportunity for system wide

learning and has enabled changes to be made at key points to improve the patient experience and care delivery in the future. Commissioners have indicated that this may become part of the contract going forward, however before this is confirmed the process for end to end review needs to be careful quantified and any additions to our contract managed to ensure realisation of gains from the process have real impact across the system, including for the Trust.

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

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

### EOC Human Factors

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

### Moving Patients Safely

The Moving Patient Safely Group's main focus in 2017-18 was the review and development of the mandatory training offer for moving patients. The training has been increased to four hours of face to face contact focussing on scenario based training sessions with an opportunity to try equipment in the class room setting to develop skills and confidence in dynamic risk assessment and use of the equipment. Early evaluations suggest this is having a positive impact on how patients are moved in the clinical setting.

The group has also undertaken surveys of equipment available to support the safe movement of patients in both PTS and A&E services with a view to make recommendations about future purchasing of equipment to Trust Procurement Group, and in ensuring equipment is fit for purpose and used appropriately. Reviews of new kit are undertaken by the MPS group and tested for impact in small tests of change in the clinical setting, with staff and patient feedback being considered.

Musco-skeletal (MSK) incidents for staff have fallen during 2017-18 and the level of harm associated with these has reduced but they remain the second most common reason for absence and a considerable number cumulate in a staff claim.

### Recognition and treatment of deteriorating adult; including sepsis CQUIN.

Identifying patients at risk of deteriorating is central to initiating timely management and improving patient outcomes. An early warning score is based on a simple scoring system in which a score is allocated to physiological measurements, and is then aggregated. This aggregated score then enables clinicians to rapidly assess how

unwell the patient is, communicate consistently with other health care professionals, and monitor deterioration. The National Early Warning Score 2 (NEWS 2) has been launched and the clinical directorate have rolled out the changes to this assessment score across the A&E service. Ongoing work with ePR has ensured the new system in included in the electronic form as a mandatory field which will further increase compliance and ensure accurate addition of the score as it is calculated automatically.

#### Recognition and treatment of deteriorating child.

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

#### National Ambulance Safety Group

YAS representatives regularly attend the National Ambulance Safety Group and have shared their work on the serious incident framework for excessive responses with other services. Work in 2017-18 includes working collaboratively with the Health and Safety Executive (HSE) to understand and reduce the mechanisms for MSK injury within the Ambulance Sector and set a sector standard for best practice in moving patients safely.

### 3.1.2 Incident reporting

Yorkshire Ambulance Service encourages all staff to report all incidents whether these be patient incidents, staff safety incidents or incidents that affect the organisation. This also includes the reporting of near miss incidents as we look to build a positive safety culture which is indicated with high incident reporting levels but a low level of harm.

In April 2017 the Datix system was re-launched, this included a full review of the system and how we categorise incidents and also awareness raising across the Trust. The re-launch provided an opportunity to improve the quality of the data reported on Datix, ensure correct processes were in place for issues that needed reporting elsewhere within the Trust but not on Datix and making sure the infrastructure of the system helped to identify learning more easily so we can continuously improve the way in which we deliver services.

During 17-18 a total of 8,912 incidents were reported averaging at 743 incidents per month. This was a slight decrease against 9,083 incidents reported in the previous year (average of 757 per month) but this was expected due to the data cleansing as part of the re-launch and the quality of the information contained in the system is much higher. The second half of the year saw an increase on the first half of the year and this is expected to continue to rise.

Support is provided to managers through the set-up of dashboards, Datix road shows that took place last year, drop-in sessions, bespoke training and wider management training, to be able to undertake Datix investigations. Whilst the quality of the investigations has improved there is still an issue in managers completing investigations in a timely manner, enabling learning and feedback to the reporter.

Auto-feedback was established as part of the re-launch so that any completed investigation findings are fed back to the person who reported the incident. Whilst this is an improvement, this is an area that needs to be further improved upon.

Data submitted into Datix is continually analysed and reviewed alongside other metrics such as complaints to identify common themes and trends for escalation where necessary. This is facilitated through the Incident Review Group (IRG). Data is also submitted externally through the National Reporting and Learning System (NRLS) and Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR).

NRLS reporting covers the reporting of patient related incidents including the level of harm and the organisational KPI for this each year is to keep moderate or above harm to patients at a rate of less than 3% against total number of patient related incidents reported. For 17-18 this was 2%.

### 3.1.3 Number of Adverse Incidents for 2017-18

The breakdown of incidents can be seen below

Within 17-18 the most commonly reported incident was Trust Vehicle Related at 1500 followed by EOC response related at 1127 and Violence & Aggression at 866. These are the same top three categories as 16-17 however EOC response related was the largest category last year.

Trust Vehicle Related incidents have reduced since 16-17 and the Vehicle Accident Reduction Group (VARG) has been working through interventions throughout the year to help reduce these numbers.

| | A&E Operations | EOC (Emergency Operations Centres) | NHS 111 (inc LCD) | PTS (Patient Transport Services) | Others | Total |
|---|---|---|---|---|---|---|
| **Apr 2017** | 400 | 64 | 54 | 69 | 81 | **604** |
| **May 2017** | 488 | 87 | 87 | 92 | 120 | **787** |
| **Jun 2017** | 433 | 84 | 61 | 117 | 117 | **728** |
| **Jul 2017** | 429 | 81 | 58 | 107 | 98 | **692** |
| **Aug 2017** | 459 | 54 | 66 | 91 | 77 | **693** |
| **Sep 2017** | 443 | 59 | 78 | 115 | 81 | **717** |
| **Oct 2017** | 471 | 80 | 93 | 145 | 111 | **820** |
| **Nov 2017** | 477 | 60 | 52 | 122 | 89 | **740** |
| **Dec 2017** | 530 | 57 | 71 | 86 | 93 | **780** |
| **Jan 2018** | 541 | 62 | 81 | 117 | 120 | **859** |
| **Feb 2018** | 490 | 61 | 77 | 87 | 96 | **750** |
| **Mar 2018** | 509 | 52 | 65 | 78 | 90 | **742** |
| **Total** | **5670** | **801** | **843** | **1226** | **1173** | **8912** |

EOC response related incidents are assessed for the severity and local investigation conducted, sometimes being escalated if necessary for more in-depth analysis. Real time reporting occurs in the EOC with incidents reported if they breach defined timescales and harm is believed to have been caused to the patient as a result.

The Trust, along with other ambulance services is working hard to address reports of violence and aggression against staff members. Through the recruitment of additional staff the Trust is able to take more cases through the prosecution and a zero tolerance approach is taken for any reports of this behaviour towards our staff members.

### Incidents Relating to Patient Care 2017-18

The table below shows the breakdown of patient related incidents by the service area.

| | A&E Operations | EOC (Emergency Operations Centres) | NHS 111 (incl LCD) | PTS (Patient Transport Services) | Other | Total |
|---|---|---|---|---|---|---|
| Apr 2017 | 61 | 47 | 35 | 21 | 2 | 166 |
| May 2017 | 66 | 47 | 53 | 21 | 2 | 189 |
| Jun 2017 | 72 | 50 | 32 | 34 | 2 | 190 |
| Jul 2017 | 72 | 46 | 28 | 36 | 2 | 184 |
| Aug 2017 | 88 | 29 | 38 | 31 | 0 | 186 |
| Sep 2017 | 100 | 30 | 58 | 35 | 0 | 223 |
| Oct 2017 | 94 | 44 | 62 | 37 | 4 | 241 |
| Nov 2017 | 98 | 20 | 28 | 41 | 5 | 192 |
| Dec 2017 | 112 | 33 | 41 | 24 | 4 | 214 |
| Jan 2018 | 111 | 37 | 44 | 44 | 7 | 243 |
| Feb 2018 | 82 | 30 | 47 | 18 | 0 | 177 |
| Mar 2018 | 89 | 21 | 40 | 31 | 1 | 182 |
| Total | 1045 | 434 | 506 | 373 | 29 | 2387 |

Some of the highest categories of patient related incidents includes response related both within the A&E operations service and within the OOH service (LCD and 111).

YAS continues to monitor incident rates against 3 key harms; falls whilst in receipt of YAS care, injury whilst in receipt of YAS care and medication errors whilst in receipt of YAS care. These are tracked on a daily, weekly and monthly basis using the “harm free care days” methodology utilised in the national hospital Safety Thermometer data.

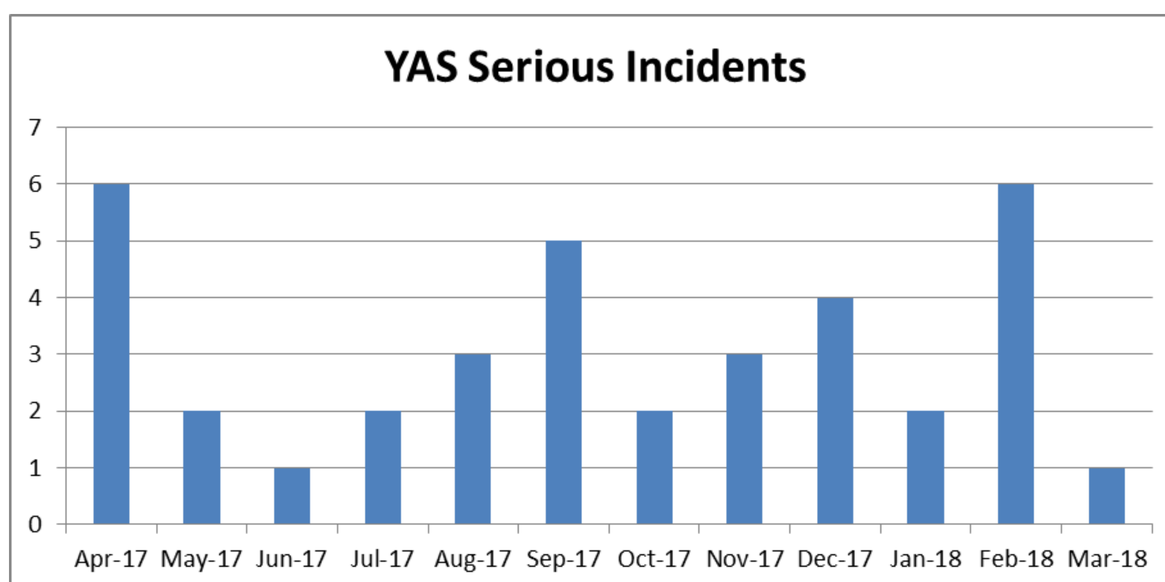
The safety thermometer keeps frontline staff informed of the level of incurred harm in their patient group during care delivery for these 3 indicators. It encourages an open and honest reporting culture for incidents and informs staff of the actions to take in order to prevent further incidents. There has always been an acknowledgement that as we raise awareness of these incidents the number reported may increase; however having now run the Patient Safety Thermometer for four years it is likely that we have reached an average baseline from which we can work to reduce, thereby reducing harm to our patients. Medicine errors are a good indication of progress made within this remit with incidents now falling year on year and evidence of reductions being sustained.

Falls, injuries and medication errors make up a small proportion of reported patient related safety incidents, with rates being consistently below 0.05% harm. They are however patient harms that Yorkshire Ambulance Service has zero tolerance for.

Following launch of the national Sign up to Safety campaign; which has an ambition to reduce harm within the NHS by up to 50%, Yorkshire Ambulance Service has succeeded in reducing medication errors by 80% over 3 years using the Safety Thermometer data and feedback system, from 54 in 2014-15, 25 in 2015-16 and only 14 throughout 2016-17. These medicine errors are those that have the potential to cause harm to patients and do not include breakages or loss of controlled drugs.

### 3.1.4 Serious Incidents

The Trust reports Serious Incidents in line with the National SI Framework and during 17-18 reported the following:




The breakdown can be seen below:

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

A total of 37 SIs were reported in 17-18. This compared with 51 reported in 16-17. In January 2017 the internal threshold for response related SIs was reviewed and amended in order to focus on those incidents where there had been service or care delivery failures. As a result of this change, fewer SIs were reported in 17-18 in relation to the ambulance response, but these provided a sharper focus on identification of key learning.

A theme identified towards the end of 16-17 and into 17-18 related to ineffective breathing descriptors not being identified quickly enough on 999 calls. This initiated a further education package for call takers during June and July away days so that staff could learn from the SIs reported and develop their own knowledge in relation to descriptors of ineffective breathing and the implications of this. This was then tracked following a cluster of SIs and since that time only one has been reported of a similar nature in over 12 months.

Another theme identified from SIs during 17-18 was in relation to cardiac arrest management. Five SIs reported during August 2016 and September 2017 identified that the advanced clinical training provision in relation to cardiac arrests was not effective enough to give staff the necessary skills, incorporating human factors, to be able to manage cardiac arrests appropriately. This has resulted in a full review of the training and an improved training package being delivered from October 2018 incorporating simulation, protected stand-down time, equipment practice and clinical supervision.

## 3.2 Safeguarding

The profile of safeguarding children and adults at risk continues to grow and change and is a key priority across YAS. Both policy and practice have been reviewed to ensure compliance with legislation and good practice guidance. The Safeguarding Team continues to engage and support staff within all departments including the EOC, A&E Operations, PTS and NHS 111 to identify safeguarding priorities to ensure quality patient care.

### Multi-agency working

The Safeguarding Team has contributed to Serious Case Reviews (26), Safeguarding Adult Reviews (12), Learning Lessons Reviews (6) and Domestic Homicide Reviews (18) across the Yorkshire region; 93 written reports have been provided to Child Death Overview Panels.

The work to produce a generic patient information leaflet to ensure potential victims of domestic abuse have access to relevant contact numbers for advice or support has been completed and is in use.

### 3.2.1 Safeguarding Training Compliance

The Trust is achieving its target for Safeguarding Children Level 1 and Level 2 compliance.

Compliance for Children and Adult Level 1 is gained by completion of the Trust Statutory and Mandatory workbook.

Safeguarding Adult Level 2 training was being delivered as a classroom session as part of the ECA and PTS course during Q1-Q3; the Safeguarding Children, Adult and Prevent Basic Awareness eLearning course was introduced in December 2017 to replacing the previous training therefore, compliance with Adult Level 2 had shown a marked increase during Q4.

| Training | Q1 | Q2 | Q3 | Q4 | Delivery method |
|---|---|---|---|---|---|
| **Children Level 1** | 96.2% | 95 % | 94.9% | 94% | Workbook |
| **Children Level 2** | 90% | 88.8% | 83.7% | 74% | eLearning |
| **Adult Level 1** | 94.9 % | 93.8% | 93.9% | 93.6% | Workbook |
| **Adult Level 2** | 4% | 9.5% | 13.3% | 33.5% | eLearning |
| **Prevent Basic Awareness** | 95.% | 95% | 91.3% | 90 % | Workbook eLearning |
| **Annual Prevent update** | | | | Completed 9.4.18 | Staff Update Issue 113 |
| **WRAP (Trust wide)** | 88.1 % | 88.4% | 88.5% | 88.2% | Classroom |
| **WRAP A&E** | 96.5% | 92% | 92% | 90.51% | Classroom |
| **WRAP PTS** | 77.7% | 82.4% | 86.5% | 86.7% | Classroom |

## Safeguarding ‘Roles and Responsibilities’

To complement the eLearning course and allow for case based and scenario discussions staff in A&E Operations, PTS and NHS111 receive a two-hour classroom based session as part of their statutory and mandatory day; this is a ‘Roles and Responsibilities’ session facilitated by members of the safeguarding team.

All staff are required to have completed the eLearning course before attending the ‘Roles and Responsibilities’ classroom session.

## Workshop to Raise Awareness of Prevent

The Workshop to Raise Awareness of Prevent (WRAP) ‘train the trainers’ sessions have been delivered to 12 new trainers across the Trust. The Home Office has recently relaxed the guidance around the delivery of the WRAP to allow organisations to tailor the content to the needs of their staff and the current package used by YAS has been updated.

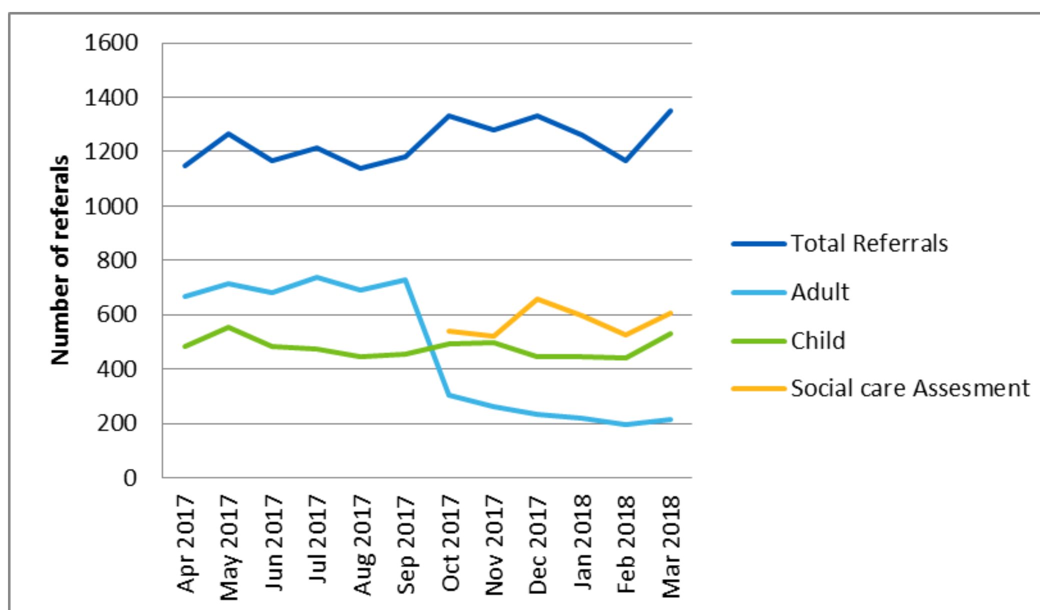
NHS England have recently developed an eLearning course that meets the requirements of the WRAP and removes the need for staff to come into a classroom in order to complete the course. Consideration of using the eLearning course will take place during Q2 of 2018-19.

### 3.2.2 Safeguarding Referrals

During 2017-18, 14842 safeguarding referrals were made to adult and children social care teams. This is an increase of 6% from the year 2016-17 when 13962 referrals were made.

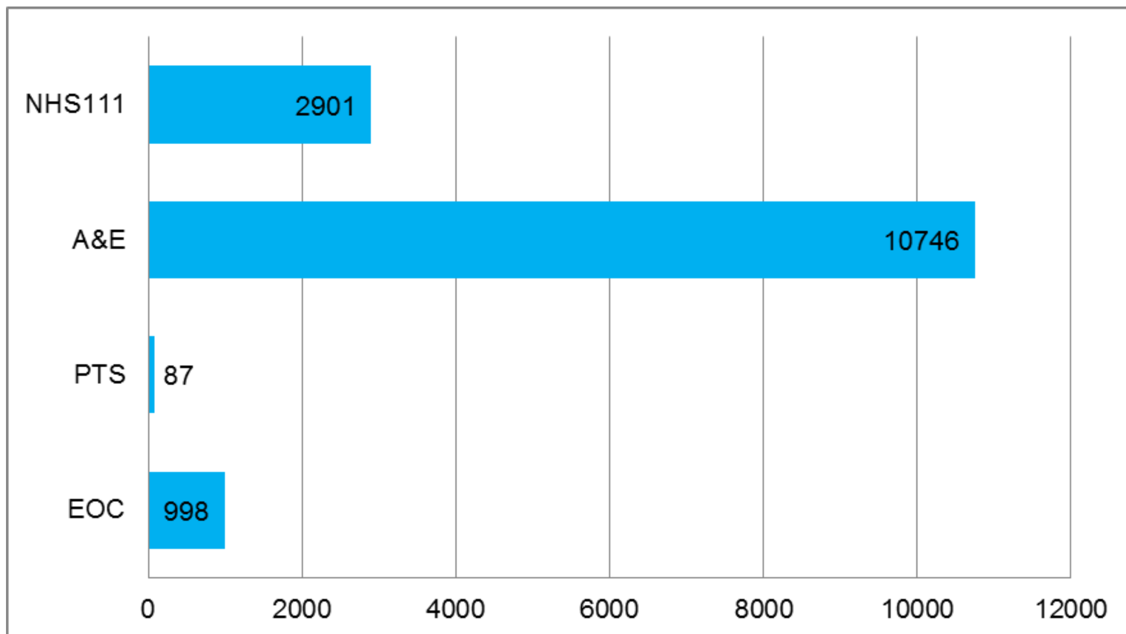
| Safeguarding Referrals 2017-18 | |
|---|---|
| Safeguarding Adult | 5650 |
| Safeguarding Children | 5744 |
| Social Care Assessment | 3448 |
| **Total Referrals** | **14842** |

The 2016-17 safeguarding audit highlighted the need for the introduction of a Social Care Assessment referral form; this happened at the beginning of Q3 2017-18, since then there has been an expected decline in the number of safeguarding adult referrals being made.




Work has been undertaken to raise awareness of the Social Care Assessment (SCA) referral through training sessions and Staff Update to ensure that staff are aware that they can make this referral and how it differs from a safeguarding adult referral.

Safeguarding referrals are made by frontline staff that treat patients face to face or by telephone in either the EOC or through contact with NHS111.




PTS referrals equated to 0.6% of all YAS referrals; this percentage has fallen from 1.1% in 2016 - 17 audits. During Q4, the face to face safeguarding 'Roles and Responsibilities' session was included in the statutory and mandatory training days for PTS staff; initial feedback from PTS staff is that their knowledge and confidence to make a safeguarding referral improved following these sessions however, not being aware they were required to complete the eLearning and access to computers during their working day featured significantly as a reason for non-compliance. It is anticipated that as more staff attend the sessions the number of referrals made by PTS will increase during 2018-19.

### 3.2.3 Safeguarding Audit

The aims and objectives of the annual safeguarding audit plan during 2017-18 were:

**Q1** - To measure whether the correct category of abuse was selected and reflected in the details of the concern in the referrals. The definitions of abuse are defined for children in statutory guidance, Working Together to Safeguard Children (2015) and the Care Act 2014 for adults.

**Q2** – NHS England guidance (2017) requires an annual audit of Prevent referrals in order to measure whether the concerns raised appropriately reflect the risk relating to the radicalisation of adults and children. Therefore the Q2 audit was to meet this requirement.

**Q3** – The revised format of the referral forms went live at the beginning of Q3. The aim of the Q3 audit was to measure the impact the revised format had on referrals in correctly identifying harm or abuse using the specific definitions in Working Together to Safeguard Children (2015) and the Care Act 2014.

**Q4** - To measure health desk call handlers compliance, when completing the referral forms, ensuring that the safeguarding concerns of the person making the referral are accurately captured. This audit was carried out by an EOC Senior Clinical Advisor.

### Audit Summary of Key Findings

- The combined adult and child safeguarding referral form needs to be separate and the correct categories of abuse for adults and children should reflect the definitions in Working Together to Safeguard Children (2015) and the Care Act 2014.
- Despite the high compliance figure for Workshop to Raise Awareness of Prevent (WRAP), the identification of radicalisation or the risk of radicalisation in not reflected in the number or quality of Prevent referrals made by YAS staff.
- Further work needs to be undertaken to help staff identify when an adult safeguarding referral is required and when a SCA referral should be made. Specifically, to support staff to understand the Care Act 2014 definition of an 'adult at risk'. This is currently being addressed through the eLearning and the 'Roles and Responsibilities' sessions.

### Audit Recommendations

- Continue to improve staff knowledge, skills and competence regarding safeguarding with current safeguarding training plan and matrix.
- Work with the YAS Lead Nurse for Urgent Care (lead for MCA) to determine how staff knowledge, skills and competence can be improved regarding the understanding of the Mental Capacity Act 2005.
- Work with an EOC Senior Clinical Advisor to amend the current safeguarding children referral form to include an Early Help/Request for Support option. (Children Act 1989 and Working Together to Safeguard Children 2015)
- Future audit needs to be undertaken to measure the accuracy of safeguarding referrals being received by the correct Local Authority.
- Consider the use of the NHS England WRAP eLearning course to replace the current classroom based delivery model.

### 3.2.4 Other Developments

### Paediatric Liaison Service Business Case

The safeguarding team and frequent caller team have worked closely together to identify frequent paediatric callers. Criteria includes children under 18 years of age, where 2 or more 999 calls per month have been identified in more than 1 month; over a 6 month rolling period. A Trust wide scoping piece of work is complete, and has included NHS 111 and a business case is in development for a paediatric liaison role, which will support best practice and provide a quality service at YAS in relation to frequent caller children.

## 3.3 Patient Experience

Understanding the experience of patients and their families and carers is an underpinning element of the care and services we deliver at YAS and is embedded within our enabling strategies, particularly the Clinical Strategy and the Quality Improvement Strategy.

The Trust is committed to listening and acting upon what our patients, service users and carers have to say about the standard of our care. We continue to review and

improve upon our methods of obtaining Patient Experience so that we can achieve a high response rate from our patients, the greater the response, the more we learn as an organisation.

### 3.3.1 Complaints, Concerns, Comments and Compliments

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

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

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

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

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

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

### 3.3.2 Progress in 2017-18

- In 2017-18 the average response time to complaints was 28 working days against a target of 25 working days.
- 88% of complaints met timescales agreed with complainants against a target of 85%.
- There was a high level of satisfaction with complaint responses – 96.8%
- Only 0.07% of cases handled progressed to Ombudsman investigation
- 2 cases were investigated by the Ombudsman during the year – one was partially upheld and one was not upheld.

### 3.3.3 Number of Complaints, Concerns, Comments and Compliments received 2017-18

| Complaints and Concerns (including issues raised by healthcare professionals ) received by subject | | | | |
|---|---|---|---|---|
| | **A&E** | **PTS** | **111/LCD** | **TOTAL** |
| **Attitude** | 177 | 73 | 105 | 355 |
| **Operational issues** | 157 | 82 | 214 | 454 |
| **Clinical/Patient Care** | 151 | 121 | 429 | 701 |
| **Delayed response/timeliness** | 393 | 410 | 0 | 803 |
| **Call Handling** | 121 | 29 | 0 | 150 |
| **Other** | 23 | 2 | 19 | 47 |
| | | | | |
| **Total** | **1022** | **717** | **767** | **2510** |
| **Demand** | 670,777 | 774,341 | 1,378,284 | 3,469,079 |
| **Proportion** | 0.15% | 0.09% | 0.06% | 0.07% |

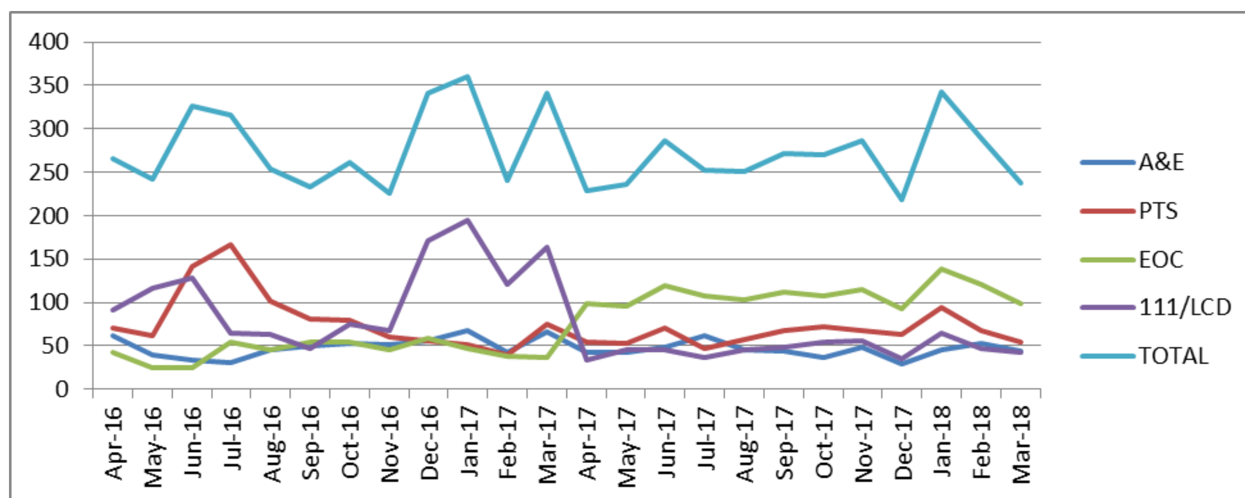
| Compliments received | | | | |
|---|---|---|---|---|
| | **A&E** | **PTS** | **111/LCD** | **TOTAL** |
| **Total** | **603** | **40** | **124** | **767** |

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

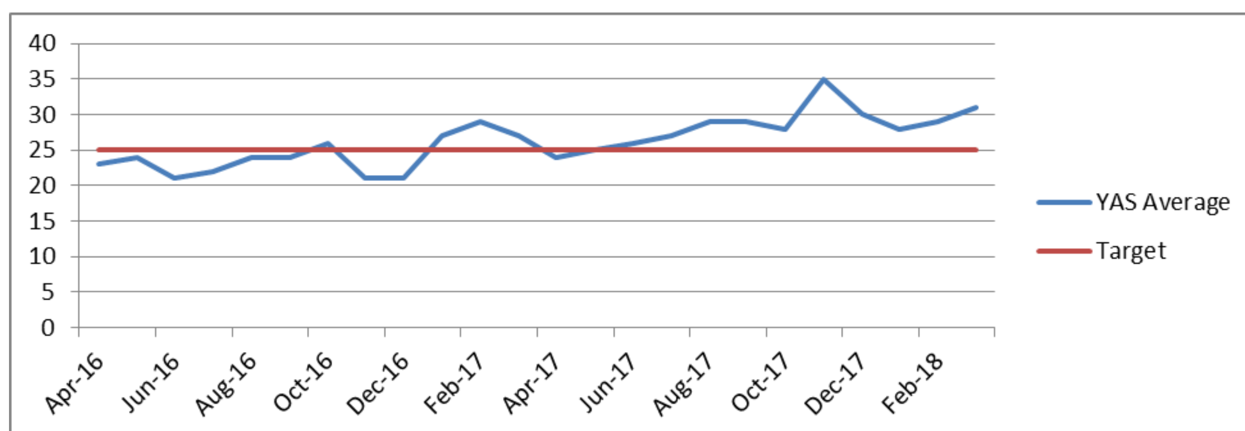
In 2017-18, 1 complaint was accepted for investigation by the Parliamentary and Health Services Ombudsman (PHSO). During the year the PHSO completed 2 investigations - one was not upheld and one was partly upheld.

| Date | Number of cases referred to Parliamentary and Health Services Ombudsman | Cases closed with no further action | Cases upheld or partly upheld | Currently on-going (time of report) |
|---|---|---|---|---|
| 2015-16 | 21 | 14 | 2 | 5 |
| 2016-17 | 16 | 16 | 2 | 0 |
| 2017-18 | 1 | 1 | 1 | 0 |

### 3.3.5 Number of Complaints Received 2016-18 (Trend)




### 3.3.6 Average Response Times

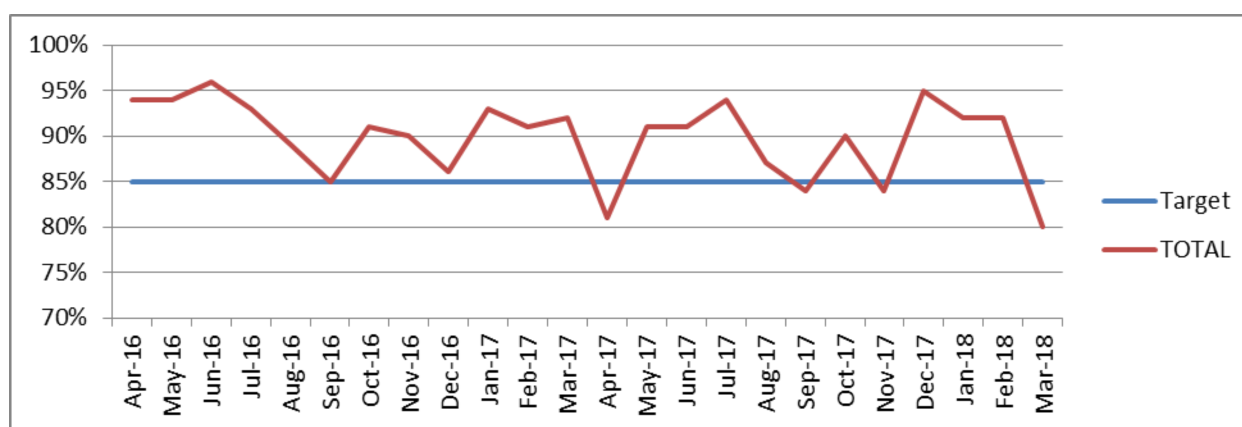



Average response times have increased during the year with the target timescale being met for only three months at the beginning of the year. This is an internal target and not a regulatory requirement, nevertheless, we recognise the value in responding to complaints in a timely manner as well as to a high quality standard.

There have been delays with the provision of necessary information from frontline services during the year to enable complaint investigation and resolution which has impacted on the average response times. The provision of emergency services has to be prioritised over complaint handling and as a result there has been a longer lead time in obtaining Emergency Operations Centre dispatch analyses and call handling audits for complaint investigation, in addition to the availability of Patient Care Records and hence, statements from clinicians.

There is ongoing liaison between the Patient Relations Team and operational services to ensure that processes are as efficient as possible and to ensure that responding to patient and carer concerns is prioritised appropriately.

### 3.3.7 Percentage of cases meeting due dates agreed with complainants




The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 require that response times are agreed with complainants on a case by case basis and does not therefore set down a target timescale for all complaints. The Regulations recognise that complainants prefer a quality response as opposed to a quick response as long as they are kept informed of progress. During 2018-19 we will continue to focus on both response times agreed with individual complainants and on overall average response time to ensure that we deliver an effective and responsive service to members of the public that raise concerns.

### 3.3.8 A&E and EOC Complaints received/Activity: Comparison to peers (2017-18)

A&E/EOC complaints received/Activity

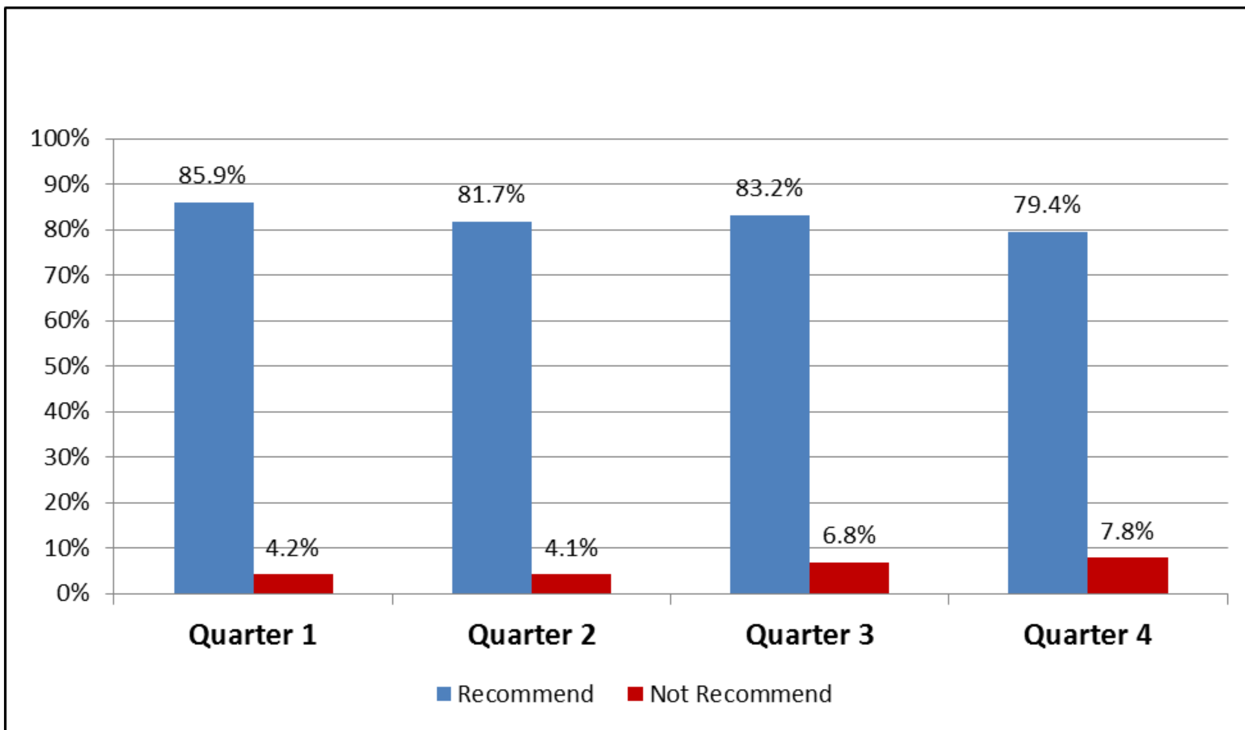
- EMAS 0.15%
- SECamb 0.09%
- SWAST 0.11%
- NWAS 0.09%
- WMAS 0.10%
- YAS 0.08%
- EEAST 0.10%
- LAS 0.05%
- NEAS 0.10%
- SCAS 0.05%

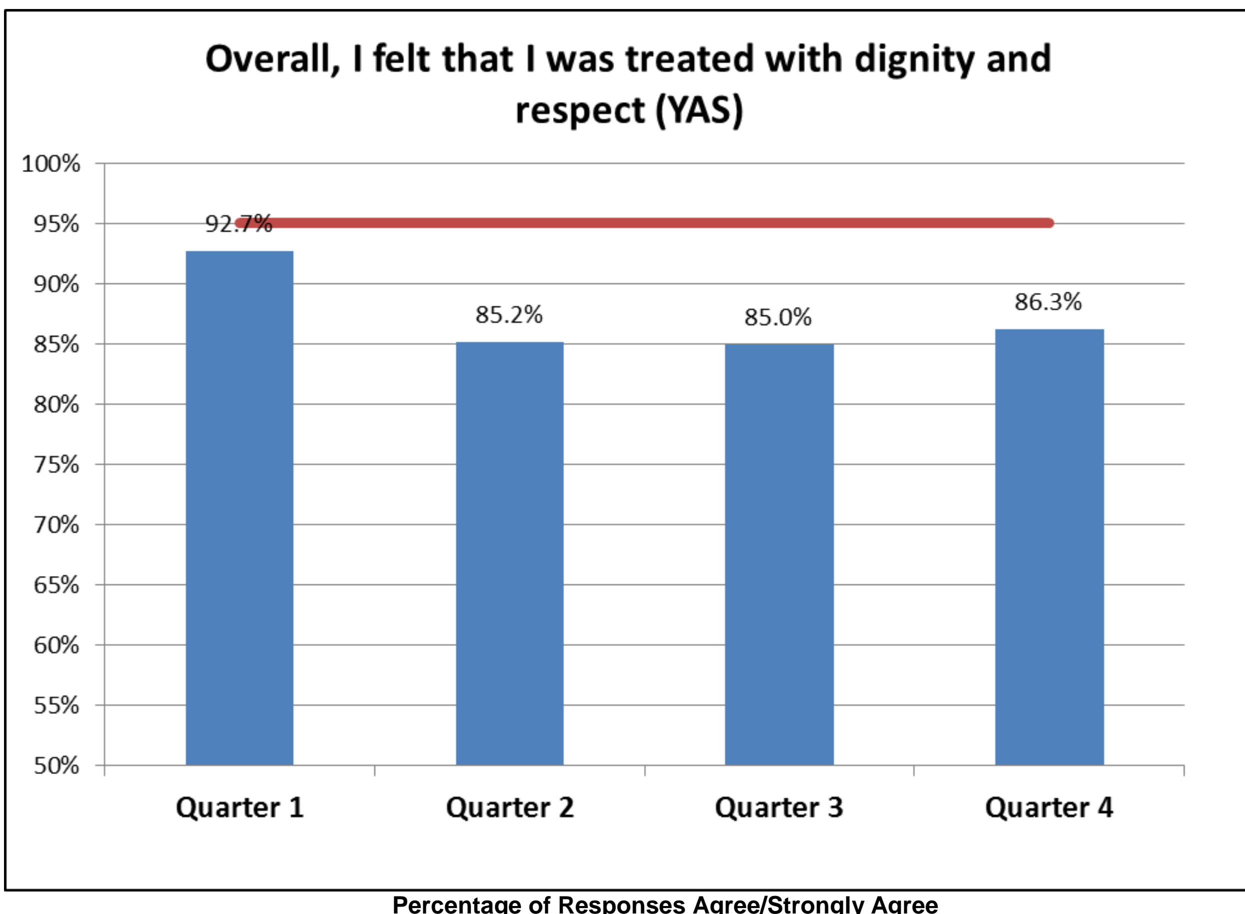
### 3.3.9 Patient Experience Surveys

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

### 3.3.10 A&E Survey Results

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




**Percentage of Responses Agree/Strongly Agree**

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

- The greatest proportion of feedback received relates to the positive comments about customer service and the caring attitude of our staff.
- The negative comments we have received relate mainly to the length of time waiting for an ambulance.
- There is an emerging theme that includes the attitude of crews and call handlers, with apparent frustration with call handler questions and callers feeling their needs are more urgent than we recognise.

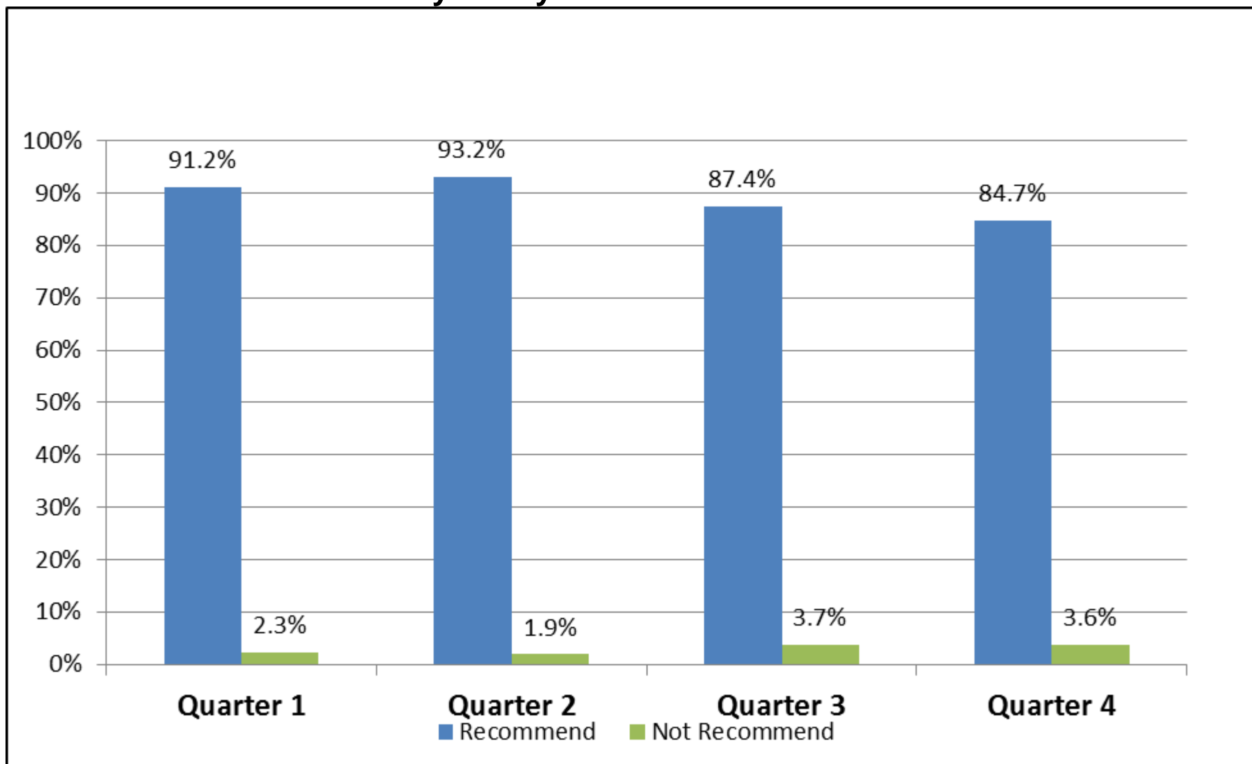
Actions from this include;

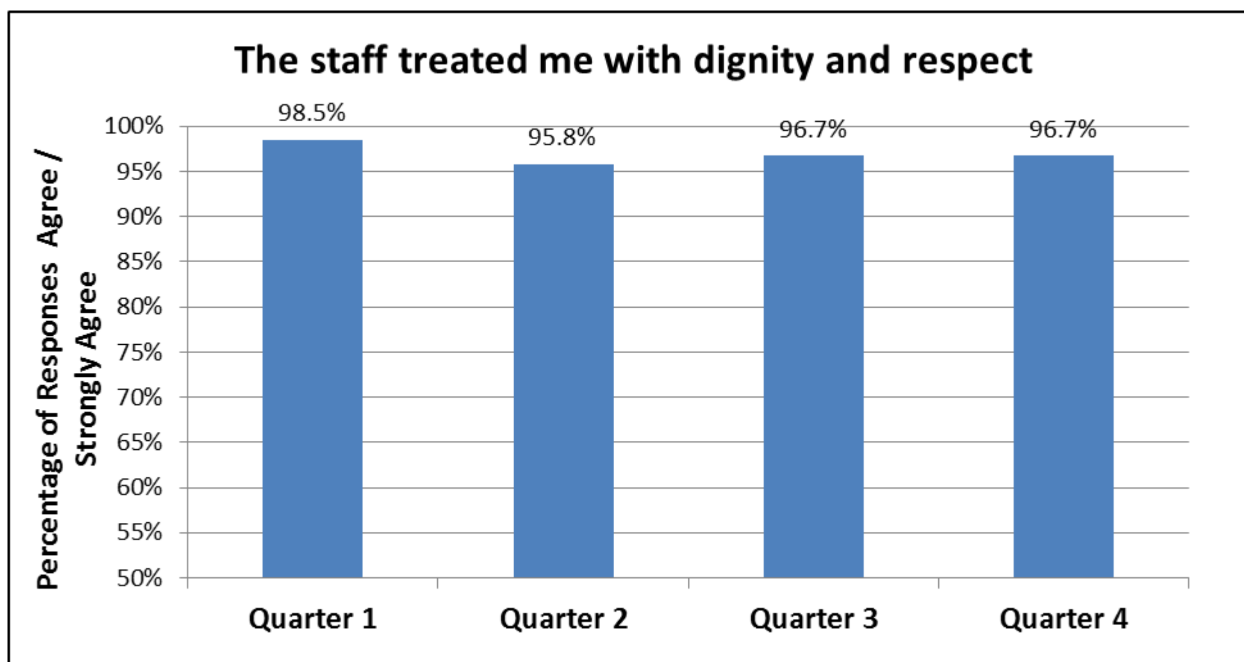
- Work on Communication Skills Training involving local management and Organisation Development continues. This work is to continue across the whole of the Trust, with a focus on Diversity and Inclusion education involving local management. Trends in Attitude complaints for individual staff members are escalated to Sector Commanders for consideration of application of the repeat offenders process.

- Development of EOC recognition scheme which supports and promotes excellence in customer service.

### 3.3.11 PTS survey results

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






### PTS Narrative feedback from patient survey

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

Actions from this include;

- Investment to reduce the age of the PTS Fleet
- Review of system and processes for booking to improve efficiency of collection times.

### 3.3.12 Learning from Complaints, Concerns, Comments and Compliments

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

In Quarter 2 of 2017-18 there was a 50% increase in complaints about Attitude and Communication Skills in the A&E South Yorkshire area which included trends involving vulnerable patients. These were discussed at the Clinical Quality Development Forum in October and a working group including the Head of Diversity and Inclusion and Operational Management met to produce an action plan with a focus on Diversity and Inclusion education involving local management.

The volume of Attitude and Communication Skills A&E complaints have fluctuated across the whole Trust area throughout the year and further discussions have taken place with Organisational Development resulting in a commitment to provide a training package to be accessed Trust wide. The Patient Relations team continue to monitor individual staff member histories and escalate to senior A&E Operational Management for consideration of appropriate action under HR procedures or relevant training and support.

In Quarter 3 of 2017-18 there was an 81% increase in the number of complaints about 'Collected late from/did not arrive at Clinic' which is consistently the highest category of complaint within the PTS service. The same quarter also saw an increase in the volume of cases relating to Patient Care/Injury to patients by 95%. Some of this increase was attributable to the increase in private provider activity. Examples of cases are patient caught hand in tail lift, banged foot into kerb whilst in wheelchair and other general lack of care issues such as left patient outside (at home, care home or hospital), did not help patient down steps, did not help patient with bags, did not assist to walk, left key safe door wide open, etc. Each case has been addressed on an individual basis and the trends in respect of private providers were escalated to PTS Management who continue to work with our private providers to ensure they operate at the standard that we expect.

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

- A complaint concerning the death of a patient with an abdominal aortic aneurism led to a change in routing of back pain calls for further clinical assessment through to the clinical hub in EOC instead of passing the call through NHS111;
- A complaint concerning the safe transport of a two month old baby led to an amendment to the Policy for the safe transportation of young children and babies, strengthening this to make it safer for patients
- A complaint about a patient's children being left at home alone led to further guidance for staff in relation to conveying a parent to hospital and the actions that must be taken to leave children in the care of a responsible adult; and
- A complaint regarding a delayed response to a patient with abdominal pain led to awareness raising within the EOC clinical call back and comfort calls.

### 3.3.13 Patient Stories

Throughout 2017-18, patient stories have continued to be presented to the Trust Board meetings. These provide a unique opportunity to connect with patients, service-users, relatives and carers. YAS actively listens to real experiences reflected in order to learn from them. Methods used to record patient stories can be via film, narrative or voice recording. Patients and families that have taken part with the Story to Board process have found the process beneficial. Board members have also reported that the Story to Board reminds the Board of the patient voice.

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

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

Examples of patient stories recorded during 2017-18:

- A story of a patient who had had two 999 responses over a three day period and not been conveyed to hospital. The third 999 call the following day resulted in conveyance to hospital where it was found he had a perforated bowel. The patient died the next day from septic shock. His family complained and were unhappy with the way their complaint was handled. The case led to learning for YAS in relation to holistic approaches to patient care, exploration of different approaches to the management of repeat callers and early escalation for complaints which exceed their timeframes.

- A story of a patient who suffered with asthma and called 999 having a severe attack. The patient was impressed with the compassionate care she received and the speed of response, both in the ambulance arriving and the crew's actions in transferring her to the ambulance and getting her to hospital quickly. The story illustrates the effect that a compassionate approach to patient care has and how this enhances the whole patient experience.
- A story of a lady who called 999 for her husband who had collapsed and had difficulty breathing. During the call her husband stopped breathing and she started CPR as instructed by the call handler but it took 31 minutes for an ambulance to arrive. The story illustrates the difficulties and anxiety faced by family members during delayed responses. The investigation found the delay was due to a failure to recognize the patient was not breathing effectively which affected the priority coding of the call. Sadly, the patient died. An action plan has been developed and implemented relating to system changes and education/awareness for call handlers.
- A story of a man whose family called 999 when he collapsed at home. The patient had Alzheimer's and the story illustrates the experience of the family who felt the crew lacked compassion and respect for the patient and for them when they tried to advise the crew about the patient's level of confusion. This led to the family making a complaint. The process of investigating the complaint gave an opportunity for the crew to reflect on how they handle such situations in the future and to gain an improved understanding of Alzheimer's disease and the impact it has. Wider work is now happening across the Trust in relation to Dementia specifically.

### 3.3.14 Care Opinion and NHS Choices Websites

The Care 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. NHS Choices website also allows patients and members of the public to share their experiences in a similar way. These platforms have the particular benefit of giving YAS management access to real time patient experience feedback. YAS uses these resources as other channels to listen and respond to online service user feedback. YAS has responded to all comments received through the Care Opinion and NHS Choices Websites.

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

### 3.3.15 Duty of Candour – Being Open

During 17-18 the Trust initiated the Duty of Candour process in relation to 53 cases. For all of these cases the patient and/or the relatives were informed that an investigation was ongoing into the event and given an opportunity to receive the findings from this. Findings were shared with those who requested, via a face-to-face meeting, via telephone or in writing based on their individual preference.

8 cases reported during the year involved face to face meetings to share the findings, led by the Head of Investigations & Learning and supported by the investigating manager and/or the lead for the area in which the incident occurred. Overall, feedback from families suggest that the meetings are beneficial in terms of being

open and transparent and throughout this process, helping families come to terms with what has happened.

Audits are in place on a monthly, quarterly, bi-annual and annual basis to ensure the process for identifying cases that have met the Duty of Candour criteria, is robust.

### 3.3.16 Critical Friends Network (CFN)

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

During 17-18 the focus for the patient experience work has been around embedding the CFN; signing up additional people to be a part of it and ensuring YAS staff members are familiar with the CFN so that they can ensure engagement from the start of project development.

During the year the group has expanded from 8 to 14 members all from a range of backgrounds who can bring their individual skills and experience to the group. Recruitment events have taken place at community engagement events, through the production of a CFN application form being included within complaint responses, being available at Patient Reception Centres (PRCs) and at local GP Practices.

The team has also visited other Trusts to share ideas for engagement, including East Midlands Ambulance Service and Bradford Teaching Hospitals Trust and in 2018 were visited by a representative from the Improvement Academy to help review and strengthen the process.

Some of the projects that the CFN have worked with us on, include developing the PTS survey, designing the new website, contributions to the patient leaflet, input into the Quality Account and reviewing and advising on the Accessible Information Standards (AIS). Looking ahead to 18-19 there are some exciting projects to be involved with including the CQC mock inspection and the national Project A initiative.

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

The key priorities for patient experience heading into 18-19, including patients relations include:

- Continuing to embed the CFN into business as usual at YAS with plenty of pro-active engagement with the group/
- Increasing the membership and engagement of the Critical Friends Network (CFN)
- Integrating the use of the CFN into YAS processes for improving effectiveness of services and the development of new initiatives and the ongoing implementation of Quality Improvement Strategy
- Look to ways of capturing equalities monitoring data for complainants.
- Ensuring full learning is extracted and shared from the complaints reported.

- Develop a systematic approach to monitoring and reporting of actions taken as a result of complaints

## 3.4 Clinical Effectiveness

### 3.4.1 Background

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

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

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

### 3.4.2 New Clinical Guidelines

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

In 2017/18 NICE published over 250 types of guidance or standards 34 papers were appraised as relevant to the trust and the health care it delivers. An example of how the trust puts into practice learning from NICE is
Head Injury: Assessment and early management (Clinical Guideline; 176) the trust practice and guidelines used within YAS were reviewed and reflect the advice across the pathways for Trauma and Clinical best practice guidelines ( JRCALC).Child abuse and neglect (Nice Guidance; 76) changes to be reflected in the trusts safeguarding education material and Sore throat (National Guideline; 84) this and a number of other guidelines all address the issue of antimicrobial use managed through PGD use and medicines management group within the trust. Monitoring and feedback is through clinical audit and the actions plans for improvement.

### 3.4.3 Pathway Development and Monitoring

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

- Referral to GP

- COPD pathways
- Referral to Urgent treatment centres
- Hypoglycaemia pathways
- Access to EPU
- Referral for Mental health advise
- Referral for Primary Angioplasty for STEMI
- Maternity ( if booked or un-booked )
- Referral to Hyper-acute stroke services
- Suspected Fractured Neck of Femur (#NOF)
- Major Trauma
- Vascular emergencies
- Gastro-Intestinal (GI) emergencies

Over 2017/18 YAS worked closely with Doncaster CCG and the Single Point of Access (SPA) to support YAS clinicians in how to best navigate care for patients where alternatives to E&D were the best option for their presenting condition. This use of a SPA supports efficient use of resources and where possible, caring for patients closer to home without the need for attendance at hospital.

The monitoring of available pathways also supports the health economy to evaluate changes in the service delivery and the impacts intended or not. In 2017/18 some areas of the Yorkshire region had changes to emergency care provision (Mid Yorkshire Acute Trusts and York and Scarborough Foundation trust). Increased transfers and longer journey times often results, offset by better outcomes for patients where skills, equipment and support services.

#### Public Health

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

Over 2017/18 YAS have been working with Public Health England
on sharing the PHE messages as well as focusing on the reduction of accidents and suicide prevention. This involves YAS local champions supporting promoting the value of brief interventions and its impact on raising health risks to particular groups of patients.

### 3.4.4 Clinical Quality Monitoring

Clinical audit is an essential part of the assurance, development and learning process for an organisation. The clinical audit programme provides a framework from which the clinical information and clinical audit staff organise audit through the year. YAS clinical audit follows the Health Quality Improvement programme (HQIP) firming the health care provider role of the service.  All Ambulance services report against a set of clinical quality standards.  These are the Ambulance Clinical Quality Indicators

(ACQIs); which are a set of performance measures developed by Association of Ambulance Chief Executives (AACE) and agreed by NHS England. Over 2017/18 the audit focus has been to work with NHS England to develop and pilot a new set of quality indicators with the aim of testing and implementing across the services in 2018/19. This has led to some changes to reporting schedules over the year.

### 3.4.5 Ambulance Clinical Quality Indicators (ACQI)

The ACQIs are:

- Outcome from acute ST-Elevation Myocardial Infarction (STEMI)
- Outcome from cardiac arrest: return of spontaneous circulation (ROSC – Utstein group)
- Outcome from cardiac arrest: survival to discharge – (Utstein group)
- Outcome from acute stroke
- Stroke 60- suspended October 2017

#### Outcome from Cardiac Arrest

In 2017/18 Yorkshire Ambulance Service attended 3023 cardiac arrests, and achieved a Return of Spontaneous Circulation (ROSC) in 27.6% patients. The Utstein group showed a ROSC rate 47.2%. (The Utstein group are patients who had resuscitation (ALS or BLS) commenced/continued by EMS following an out-of-hospital cardiac arrest of presumed cardiac origin, where the arrest was bystander witnessed and the initial rhythm was Ventricular Fibrillation (VF) or Ventricular Tachycardia (VT))

The YAS Resuscitation Plan for 2015-20 concentrates on improving survival to discharge from out of hospital cardiac arrest, which is of more significance to the patient rather than the measure of ROSC at arrival at hospital. The Survival to Discharge for 2017/18 is 10.1% for all cardiac arrests and 27.7% for the Utstein group. In 201/18 a total of 300 patients survived to discharge following an Out of Hospital Cardiac Arrest.

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

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

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

| | 2015/16 | 2016/17 | 2017/18 |
|---|---|---|---|
| ROSC | 26.37% | 27.4% | 27.6% |
| ROSC Utstein | 57.14% | 35.7% | 47.2% |

| Survival to Discharge | 8.82% | 10.1% | 10.1% |
|---|---|---|---|
| STD Utstein | 37.05% | 37.1% | 27.7% |

**Outcome from Acute Stroke**:

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

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

YAS attended 3511 patients who were diagnosed with an acute stroke in 2017/18, 43% arriving at a HASU within 60 minutes. 98.1% patients received the full care bundle for acute stroke.

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

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

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

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

In 2017/18 YAS received 11542 calls coded as chest pain and during this time period clinicians diagnosed 1585 patients with ST elevation myocardial infarction (STEMI). Care bundle compliance was 79.6% at the end of 2017/18. Actions to improve the care bundle have been, to improvement the recording of pain score, an essential element of the STEMI care bundle this year.

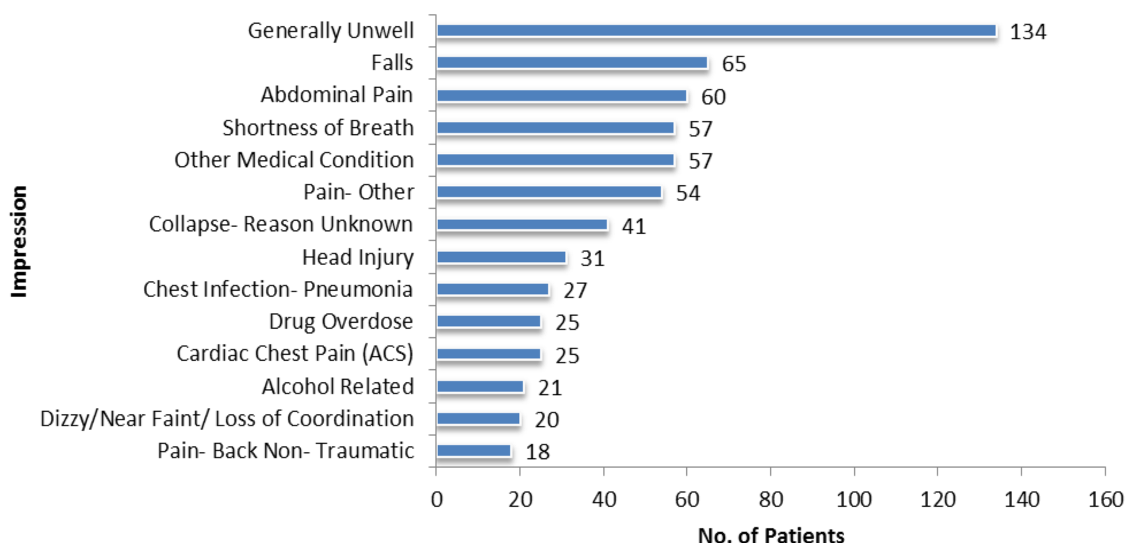
## 3.5 Local Audits

'The Day in the Life of YAS' provided the Trust with a 24hr snapshot of the clinical care we delivered on a single day, December 25th 2016.

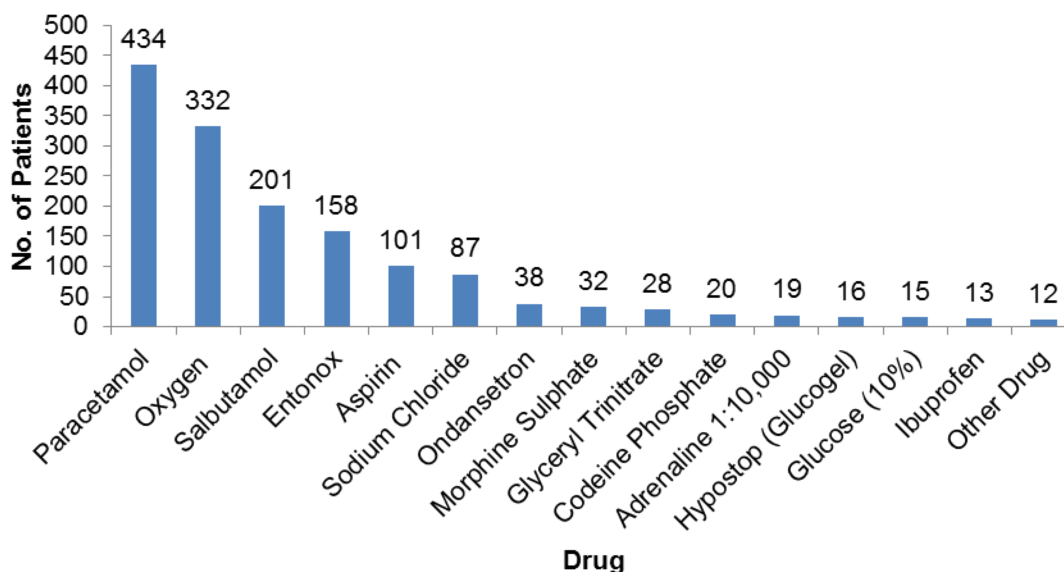
EOC staff answered 2372 emergency 999 and healthcare professional calls

- YAS clinicians attended 2101 incidents
- 1562 patients were taken to hospital, with Northern General Hospital in Sheffield taking the highest number of patients
- 15 patients suffered a cardiac arrest, of which 5 had a return of spontaneous circulation (ROSC)
- We recorded that 611 patients had a 12 lead ECG
- 180 intravenous cannulations were undertaken

The table below highlights the working impression for those patients with a face to face assessment, with generally unwell being the most frequently documented.




The table below highlights the type and number of medicines administered with paracetamol being the most frequently administered drug.



A number of other local audits have included the monitoring of the introduction of new treatments, and adherence to best practice use of antibiotics and use of activated Charcoal in suspected overdose.

### Major Trauma

Nationally the change to major trauma provision implemented in 2012 has resulted in saving 1,600 lives. The Trust continues to work with the major trauma networks across the region to ensure that those patients involved in traumatic incidents receive the best possible care. This year YAS has worked with the South Yorkshire network to provide an in situ simulation session involving staff from both YAS and the acute Trusts. We have also worked with the North Yorkshire and Humber network on the trauma intermediate life support course where YAS provides a number of candidates and instructors for each programme. YAS has worked with the West Yorkshire network in running a mass casualty table top exercise with Public Health England which was designed to stress test the network in both the pre hospital and in hospital settings.

### Mental Health

2017/18 following the introduction of a full team of Mental Health nurses in the EOC in 16/17 applying a validated assessment tool to support clinical assessment and management. The benefits of this service were aligned to the crisis care concordat ensuring patients get a service to support them in mental health crisis. Over 2016/17 the mental health nurses at YAS managed 8,440 mental health incidents providing expert clinical assessment and advice to patient's staff and other partners e.g. police.

### Falls and Frailty

To facilitate the Trusts aims in providing a Falls service which involves both internal and external partners/stakeholders and provides the best outcome for the patient, the Trust approached the Health Foundation for funding to run a pilot project which will aim to provide a partnership response model across the Yorkshire Ambulance Service foot print to enable a minimum standard of response, remote clinical assessment and referral to appropriate service for patients who have fallen.

YAS received 79,241 calls relating to falls during 2017/18, equating to approximately 10% of total calls received for the year. Just over 68% of falls calls involved patients in the over 65 high risk age category, according to CAD data.

### Sepsis

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

The Sepsis Audit was reported as part of a two year CQUIN. It was found that 83.4% of all the patients audited were defined as having red flag sepsis (the most serious type of sepsis), requiring immediate treatment with intravenous fluids, oxygen therapy and immediate transfer to hospital. IV fluid therapy was given to 59.1 % of red flag patients, $SpO_2$ levels were recorded and maintained in 90.0% of the patients and pre-alert was completed by 89% of crews.

The overall compliance with the care bundle improved greatly when Quarter 4 2017-18 when compared to the previous years' data, with 54.4% meeting the care bundle. When the exceptions are included this increases to 65%. The care bundle compliance has been increasing since April 2015 mainly due to the training in the use of the YAS sepsis screening tool. Over 2018/19 a new sepsis care bundle will be introduced as part of the national ACQI.

#### Mortality

The monitoring of mortality within the health care system is widely used to provide an indicator for patient safety. Pre hospital ambulance mortality is not commonly defined or routinely collected, however, national work over 2017/18 to review how ambulance trusts could collect this data is progressing. YAS continues to review all deaths in the care of the service and over 2017/18 have added a senior panel to review selected cases to ensure organisational learning. 4.51% of all deaths had some aspect of care that steps may have been taken to prevent the death, the most common being contact with a Health Care Professional within 72 hours of the death. The Mortality Screening process is constantly being refined and improvement are being made to develop multi-disciplinary panels to review specific cases in more detail.

#### Clinical Documentation

In YAS, clinical documentation has been paper based for the last number of years. YAS generate over 2,400 forms in the course of a 24 hr period. Over 2017/18 we have developed and piloted an electronic version of the existing paper form called YAS ePR. The benefits are; improved clinical documentation it is clear and legible, timely access to information for YAS and other healthcare providers managing the patient. Over 2018/19 the YAS ePR will be introduced across YAS, ensuring timely reporting for audits and investigations.

## 3.6 Quality Improvement

### 3.6.1 Bright Ideas

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

The Bright Ideas scheme has gone from strength to strength over 2017-18 since it's relaunch and the scheme has become embedded within YAS corporate/support services and A&E operations. We have seen an increase in weekly submissions and the QI team are now receiving approximately eight to ten ideas on average per week from staff members which has led to 36 ideas implemented during 2017-18. Below is a selection of the ideas successfully implemented:

### Absorbeze pads

A suggestion was submitted for a change of safety gel for absorbing spilt fluids. The Bright Idea was to replace existing gel with Absorbeze pads. They are small, thin and highly absorbent pads which can sit in the bottom of a vomit bowl, and prevent spillage of such fluids in the back of a moving ambulance. They had been used them in a previous ambulance service and found to be very effective. This Bright Idea idea was agreed at TPG and implemented.

### PAT Slides - PTS

A Bright Idea was submitted suggesting all PTS stretcher vehicles carry pat slides. This will not only ensure a safe transfer of patients from and to stretchers/beds/clinical beds it will also help staff avoid muscular skeletal injuries. This idea was discussed and approved at the PTS Governance Group and TPG, PAT slides were then purchased and distributed.

### Student epaulettes

A Bright Idea was suggested to introduce light sky blue coloured 'Student Paramedic' epaulettes for direct-entry student paramedics on placement with YAS, in line with other NHS ambulance Trusts. This idea will enabled staff to support direct-entry students appropriately on placement, for example, appropriate delegation of tasks or clinical skills, ensuring adequate supervision of students and providing additional support which may be required with less experienced students. The idea was discussed at the newly formed Epaulette Group and TPG and approved.

### Pot cups/flasks

An idea what submitted to say that in the canteen at Springhill you are given a plastic cup and can take a plastic lid, when purchasing a hot beverage. It was suggested that staff could use their own pot mugs or the larger flask like cups with a clip on lid, and by doing this we would all be helping to reduce waste and plastics that invariably end up in the oceans. Posters were put up around Head office and the canteen to advise staff and communications sent out to all staff.

### Next Steps

During 2018-19 we will be introducing an alternative way of submitting a Bright Idea through a dedicated phone line. We will also be conducting additional work to further embed within NHS111 and PTS; this is following a survey looking at how each service line uses the scheme including any barriers that staff perceive.

We have recruited 8 Quality Improvement Fellows, seconded for a period of twelve months, this new role is designed to run alongside their current substantive position. The Fellows will split their time evenly between their substantive role and that of QI Fellow. The Fellows will begin their role April 2018. As part of their role the Fellows will work alongside the Quality Improvement team and link into the Bright Ideas scheme to support review and follow up of ideas.

## 3.6.2 Trust approach to Quality Improvement

2017/18 marked the final year of the current Clinical Quality Strategy, and review of progress and achievements has been covered earlier in the report.

During 2017/18, building on scoping work undertaken in 2016-17, we confirmed our approach to increasing the capacity and implementation of Quality Improvement methodology for the Trust.

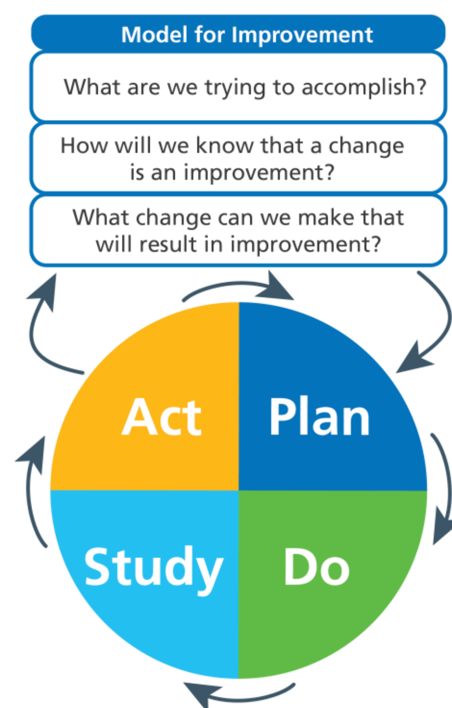
The Quality Improvement Strategy will enable and empower all staff in the Trust to have a positive influence on patient care, whatever their role. The strategic principles within this strategy include:

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

The Trust approach is based on the Institute for Healthcare Improvement Model for Improvement as the overarching methodology. It is focused on the principle of engaging staff in all parts of the organisation as experts in their own areas of work. This QI work will be led by the Quality, Governance and Performance Assurance Directorate, with the Head of QI driving the engagement underpinned by structure, rigor and analysis provided by the Performance Management Office.

There are huge benefits of to be gained in developing a uniform approach to Quality Improvement (QI) across the Trust, based on models and evidence of best practise. The successful implementation of a YAS QI approach will be dependent on fully engaging teams at all levels and across all areas of the Trust. The Trust undertook a rigorous diagnostic assessment to understand current capacity, readiness and capability within the Trust since the Trust has not previously had a wide scale approach to QI before. This provided a detailed picture at all levels within the Trust, with a focus on safety, quality and patient experience and allowed us to engage with a number of trusted providers with a view to develop a strategic partnership to further develop our QI capacity and capabilities.

## The Model for Improvement




This is an attractive model for the Trust, due to its simplicity and evidenced success, and was identified during the scoping visits. It offers a structured approach to Quality Improvement and consists of two parts. The first part asks three questions to define the project/idea:

1. What are we trying to accomplish?
2. How will we know change is an improvement?
3. What changes can we make that will result in improvement?

The second part is the PDSA (Plan, Do, Study, Act) cycle. The cyclical nature allows change to be refined and improved through repeated cycles of testing and learning. This then provides a vehicle for

continuous improvement.

### Next steps for 2018-19

YAS entered an initial twelve month partnership with the Improvement Academy (IA) commenced April 2018. The IA is part of the Yorkshire and Humber Academic Health Science Network and has extensive experience in QI, working throughout the region and nationally. IA will provide the education, mentoring and coaching for the core QI team and newly recruited QI fellows. Alongside this support the IA will also provide education and expertise to the Board and senior leaders in the form of improvement workshops to be delivered during quarter 2/3 in 2018-19.

IA will contribute to and advised with the development of the YAS QI Strategy and will continue to support the Trust on the implementation and embedding of the QI agenda at all levels. It is envisaged that a form of strategic partnership will continue into future years of implementation, although the support provided will change as increased internal capacity and capability to support QI is developed.

# Section 4.0

# Assurance on Risk, Safety & Clinical Quality

# 4.0 Assurance on Risk, Safety and Clinical Quality

## 4.1 Regulatory compliance with the Care Quality Commission

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

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

Overview of ratings published 21 August 2015:

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

Overview of ratings published 1 February 2017:

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

The Care Quality Commission has not undertaken an inspection of YAS since September and has indicated that, whilst a repeat inspection is now within timeframe, due to their trust reported indicators, we are not a priority for inspection at this point in time. The Trust has a developed a quality improvement plan which will support the journey from Good to Outstanding over the coming years. The on-going delivery of the Quality Improvement Compliance Plan will be managed through the Quality Assurance Working group, informed by the Inspection for Improvement process and mock CQC inspections, reported at Trust Management Group with assurance provided to the Quality Committee.

## 4.2 Quality Governance

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

### 4.3 Quality reporting

Information about quality and safety is reported through the operational and governance structure through locality dashboards. Monthly review in Trust Management Group ensures a focus on any performance exceptions and associated mitigating actions. The Trust Board receive the monthly Integrated Performance Report (IPR). This was reviewed and refreshed during 2016/17 and sustained over 2017-18. Both these provide a mechanism for identifying and monitoring compliance with key performance indicators and regulatory standards, as well as monitoring emerging themes. The IPR is subject to close scrutiny at the Quality Committee Audit Committee and the Trust Board. The Quality Committee has the lead committee role for scrutinising all aspects of quality and safety. Locality level scrutiny of risk, quality and safety is via the operational service lines locality operational management groups for 999 emergency service, Patient Transport Service and NHS 111.

### 4.4 Internal audit

Development of the annual internal audit plan is informed by the Trust's Board Assurance Framework and Corporate Risk Register, as well as external guidance and discussion with relevant senior personnel. The plan is signed off by the Audit Committee and is reviewed regularly by the Committee during the year to ensure that the priority issues are adequately addressed.

The Internal Audit programme for 2017/18 focused on areas of risk for the organisation. In year a total of 24 reports were produced with relevant assurance ratings, of which a small number were considered to provide a "reasonable" level of assurance, as opposed to substantial or good

A number of issues were highlighted during the year as a result of the Internal Audit programme in aspects of:-

- Data quality/KPIs due to a lack of visibility of documented procedures for the development of and reporting of KPIs in relation to specific workforce measures.
- Inspections for improvement, relating to the need to strengthen formal follow up on recommended action and the governance arrangements relating to those actions.
- End of Shift Overtime, the robustness of systems in relation to verification of accurate end of shift overtime claims has improved since previous audits but still requires further work to ensure a systematic approach across A&E.

These issues have been considered in the relevant management forum and mitigating actions agreed and in progress to resolve any outstanding issues. The Audit Committee reviews management assurance on completion of related action plans. The Trust also has in place an annual counter fraud work programme, which is monitored via the Audit Committee.

### 4.5 External scrutiny

In March 2018 the trust commissioned an external Well Led review in line with national guidance, to further support and build on the findings from the internal review the Trust completed. The findings from the review broadly relate to three key priorities for improvement whilst acknowledging the good work that has already been delivered in these areas:-

- Develop a culture of accountability and greater delegation to the divisions and localities, through an accountability framework which clarify roles and responsibilities.
- Build stronger working relationships between the Board, the Executive Team and Management.
- Improve availability of high quality intelligence at a divisional and locality level, providing quality and performance information with clearer focus on exception based analysis, risk and decisions required.

Robust action plans are in place to support development in each of the key areas. These plans are integral to our ongoing annual Board Development Programme and the wider Service Transformation Programme. They will further strengthen our existing leadership and governance arrangements and ensure that we have in place the necessary capacity and capability to deliver our long term strategy.

# Section 5.0

# Looking ahead to 2018-19

## 5.0 Looking Ahead to 2018-19

The priorities described in this report reflect available guidance and best practice on key aspects of risk management, quality and safety; and are informed by learning from a range of internal reporting and feedback processes. Specifically these are aligned to the development of the new Quality Strategy and Clinical Strategy. These key enabling strategies will be shaped by national policy and guidance, statutory requirements, regional and local priorities; and also by feedback from patients, service users and staff. They will inform and support delivery of the overarching Trust strategy and the annual Operating Plan.

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

A key focus for the coming year will be on how we continue to build and sustain an inclusive, open, learning culture in all parts of the organisation. This will be a culture which emphasises staff engagement and well-being creating the maximum opportunity for staff and service users to be involved in quality and safety improvements. The new Quality Improvement Strategy, alongside wider leadership and staff engagement plans, will be a key element of this work. This will also complement the individual work-plans through a coherent organisational approach to improvement, supported by both the Quality Improvement team and the Programme Management Office functions.

We are committed to providing high quality urgent and emergency care across Yorkshire and the Humber, and providing greater equality for our communities ensuring that everyone has access to the healthcare they need, at the right time, in the right place. We are also committed to improving the health and wellbeing of our patients, focussing on a preventative approach, supporting them to keep mentally and physically well and to stay as well as they can to the end of their lives.

The Clinical Strategy concentrates on Evidence-based – Person-centred Care and puts the patient and clinician at the heart of the organisation, demonstrates our ambition for the future and provides the road map to support our ambition to become an integrated urgent and emergency care provider, driving improvements in patient outcomes, patient safety and clinical quality.

Further work to embed risk management in the organisation, leading to generic and mature risk management function is a key priority for 2018-19. The Trust will also continue to develop its leadership and governance arrangements in line with the national Well-Led framework to promote a strong foundation for the ongoing delivery of a safe, high quality service to patients and the public.