NHS
Yorkshire
Ambulance Service
NHS Trust

Risk management, Safety and Quality Compliance Report 2018-19

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Improvements

2018 - 2019

NHS
Yorkshire
Ambulance Service
NHS Trust

1119
compliments received and processed in 2018-19

Launch
of intelligence based security portal to inform staff of identified threats to staff safety

105
PTS vehicles now equipped with Pro-Move slings to reduce the amount of moving and handling injuries to staff

257
new CorPulse defibrillators deployed onto frontline ambulances

84%
would recommend Yorkshire Ambulance Service NHS Trust to friends and family if they needed similar care or treatment

10
new QI Fellows started in 2019 with the 8 previous fellows graduating

243,791
ePRs completed since its launch

131 staff trained in 'Bronze' level QI training
67 staff trained in 'Silver' level QI training
11 staff trained in 'Gold' level QI training

17%
increase in the number of Bright Ideas submitted in 2018-19 vs 2017-18

328
patients survived following an out-of-hospital cardiac arrest. This is more lives saved than any other year

50
new urgent care Pathways

55%
reduction in staff injury claims since 2015-16

Section 1.0

Introduction

1.1 Purpose

The purpose of this report is to

- Provide a summary of Trust developments in relation to risk management, safety and quality in 2018-19 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 management, 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.

Patient and staff safety are key priorities 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, Safety & Clinical teams. By analysis investigation of incidents, analysis of themes and trends, feedback to operational Directorates 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.

Historically, *High Quality Care for All* (2008) 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. In January 2019 the *NHS Long Term Plan* (2019) was published, setting out key ambitions for the service over the next 10 years. This plan recognised the requirement to maintain and improve the three well recognised key dimensions of quality:

- Patient safety
- 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* 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. As this strategy drew to a close at the end of 2017-18 we have developed new strategies to ensure we remained focused on delivery of high quality, patient focussed care.

The four Sign up to Safety work streams, which were completed in 2018-19 allowed YAS to make improvements in relation to understanding human factors and the impact they have within 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 which aims to reduce both patient and staff injuries that occur during patient movement.

We met the following CQUIN requirements in full.

- Ambulance Mortality review
- Respiratory Care
- End to end review
- Health Eating 1b
- Non-Conveyance

We partially met the following CQUINs

- Health and Well-being 1a
- Health and Well-being part 1c (Influenza Vaccination)

It is not anticipated there will be any financial implications due to the partial achievement. 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 were re-launched in 2017 and supported by the new Trust strategy which was launched at the Leadership Summit during October 2018. This strategy is supported by the Quality Improvement Strategy and new Clinical Strategy, both developed following listening events and engagement with staff and patient groups. These two critical strategies will shape our clinical development and quality improvement activity over the next 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 philosophy, practices and business processes rather than be viewed or practiced as a separate 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 2018-19

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 2018-19 two Internal Audit reviews of the Trust's risk management procedures were conducted. One review looked at risk management procedures in general, the other examined risk management practice in particular teams. Both reviews provided a good level of assurance that the Trust has in place sound risk management arrangements, that risks are identified and managed effectively, and that there is a high level of compliance with the control framework.

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 the Risk and Assurance Group (RAG) which meets on a monthly basis. This comprises scrutiny of Strategic and Operational risks with a current risk score of 12 and above, based on the YAS risk matrix (below), assessment of gaps in control, appropriate mitigating actions and progress in delivering these. The RAG is chaired by the Associate Director of Performance Assurance and Risk.

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 Head of Risk 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 risks. There is a monthly cycle of review of the CRR and the Board Assurance Framework (BAF) via the RAG and the 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. During 2018-19 an Internal Audit review provided substantial assurance that the BAF contributes well to the governance of the Trust and that the controls applied in respect of the BAF are effective.

Some of the principal risks set out in 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 continues to analyse and interpret data arising from incidents, complaints, claims and 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 2018-19 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, handover challenges, and delivery of national drivers such as the Ambulance Response Programme. These risks remain on the risk register into 2019-20.

2.1.5 Looking ahead - key priorities for 2019-20

The following priorities have been set for 2019-20:

- Continue to embed and enhance effective performance management of risk throughout the Trust
- Review and update the Trust's Risk Management and Assurance Strategy
- Implement and embed an upgraded risk management information system (Datix Cloud IQ)
- 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 the delivery of strategic objectives are 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 partners to collaboratively manage system-wide risks.

2.2 Information Governance

Information Governance concerns the way organisations manage information. It covers both personal information, i.e. relating to service users and employees, and corporate information, e.g. financial and accounting records. Yorkshire Ambulance Service (YAS) is committed to maintaining the highest standards of Information Governance and data security, and has processes in place to ensure its use of data is lawful, secure, justifiable and proportionate.

The Senior Information Risk Owner (SIRO) during 2018-19 was the Executive Director of Governance, Quality and Performance Assurance and Deputy Chief Executive. The SIRO is a Board Member who has ownership of the organisation's information risk policy, acts as champion for information risk on the Board and provides written advice to the Accountable Officer on the content of the organisation's Governance Statement for information risk.

The Caldicott Guardian during 2018-19 was the Executive Medical Director. A Caldicott Guardian is a senior person responsible for the protection of the confidentiality of patient and service-user information and has oversight of arrangements for proportionate and justifiable information-sharing.

The Trust's Data Protection Officer during 2018-19 the Trust Solicitor and Head of Legal Services. The role of the Data Protection Officer is to ensure compliance with the Data Protection Act 2018 and the General Data Protection Regulation (GDPR).

The GDPR came into force in May 2018 as part of the new Data Protection Act 2018 bringing substantial amendment to the legislation governing the processing of personal data, with changes to data subjects' rights and data controllers' obligations. In preparation for the GDPR, the Trust completed a thorough review of its systems, processes, policies and documentation to ensure that all are commensurate with the requirements of the new legislation. This review was led by the Trust's Information Governance Working Group reporting to the Trust Management Group.

The Trust reports its compliance with information governance and data security legislation as part of the annual Data Security and Protection Toolkit (DSPT) managed by NHS Digital. The DSPT replaced the IG Toolkit in 2018-19 and is modelled on the National Data Guardian's Data Security Standards.

The purpose of the assessment is to enable NHS organisations to demonstrate their compliance against the law and central guidance and gives an indication as to whether information is handled and processed correctly, protected from unauthorised access, loss, damage and destruction. The assessment rating scheme is simply either 'Met' or 'Not Met'. The Trust was able to report compliance and supply evidence against all mandatory requirements for 2018-19.

The Trust has a dedicated Information Governance Team that leads the annual information governance work programme along with a network of Information Asset Owners within each service. In 2018-19, YAS has taken the following actions to identify and mitigate information governance and data security risks and strengthen our assurance:

- A review of all policies, procedures and contractual arrangements was undertaken in readiness for implementation of the GDPR in May 2018, along with implementation of an updated Data Protection Impact Assessment (DPIA) process;

- The Trust Publication Scheme was updated to reflect GDPR requirements including privacy notices and fair processing arrangements;

- Continued engagement and development of our established network of Information Asset Owners (IAOs) through a well-embedded risk review process which allows us to undertake information governance and data security checks within IAOs respective business areas and identify areas for improvement;

- We have revised our Data Security Training for staff and volunteers in line with national content, Caldicott Principles, GDPR and the National Data Guardian's 10 data security standards;

- Information Asset Registers and Records of Processing Activities (ROPA) have been reviewed in accordance with regulations and to determine the lawful bases for processing of data;

- Staff training in the use of YAS systems that support the provision of care has included messages regarding the importance of security and accuracy of data;

- The annual clinical audit programme includes audits that measure YAS adherence to the health records keeping standards and best practice in line with the Health Records Keeping Standards guideline;

- We have maintained robust archiving and destruction of records in accordance with our Records Management Policy and retention and destruction schedules.

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

In 2018-19 the GDPR changed the requirements of previous IG SIRI guidance to report certain types of personal data breach to the Information Commissioners Office. The Trust already had robust and embedded incident reporting processes in place based on previous guidance, this enabled a straightforward transition to the updated requirements.

The Trust monitors its information and data security related incidents to identify themes and trends to mitigate risk and ensure continuous improvement of its governance arrangements. The Caldicott Guardian reviews all data breaches involving patient data and duty of candour is considered as part of this process.

All staff are required and proactively encouraged to inform the Trust's incident reporting system of all data-related incidents via Datix. Themes and trends from these reports are analysed and reviewed by the Information Governance Working Group to inform changes to policy and process. Lessons learned ensure that the organisation puts in place measures to prevent recurrence.

There have been no serious incidents (SI's) relating to information governance and data security reported during 2018-19.

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 2018-19	
Breach Type	*Total*
Corruption or inability to recover electronic data	1
Cyber Security	3
Disclosed in Error	70
IG Other	24
Lost in Transit	3
Lost or stolen hardware	1
Lost or stolen paperwork	25
Non-secure disposal - paperwork	3
Technical security failing	8
Unauthorised access/disclosure	11

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 2019-20

Following the appointment of a new Information Governance Manager who commenced employment in July 2019, a revised IG Work Plan will be drawn up to cover the required areas such as information sharing, records management, and training across the Trust.

Work will continue to embed and enhance effective management of Information Governance risk throughout the Trust. The IG team will continue to support Information Asset Owners to develop their IG knowledge and expertise, including providing a higher level of training for them as our IG experts within the Trust.

The Information Governance Manager will work collaboratively with ICT colleagues to complete and submit the Data Security and Protection Toolkit to ensure YAS' continued compliance throughout 2019-20.

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 2018-19 there have been no changes to health and safety legislation which have had a significant effect on the Trust however, there are some general changes to note.

During 2018, legislation was drafted which would ensure that "European Union derived health and safety protections will continue to be available in UK law after the UK leaves the EU". The legislation is called the "Health and Safety (Miscellaneous Amendment) (EU Exit) Regulations 2018" and will come into force on the EU leave date.

New sentencing guidelines for manslaughter have been published which will mean that jail sentences are much longer than they were before when someone has been convicted of gross negligence manslaughter, an offence often connected to more serious health and safety breaches.

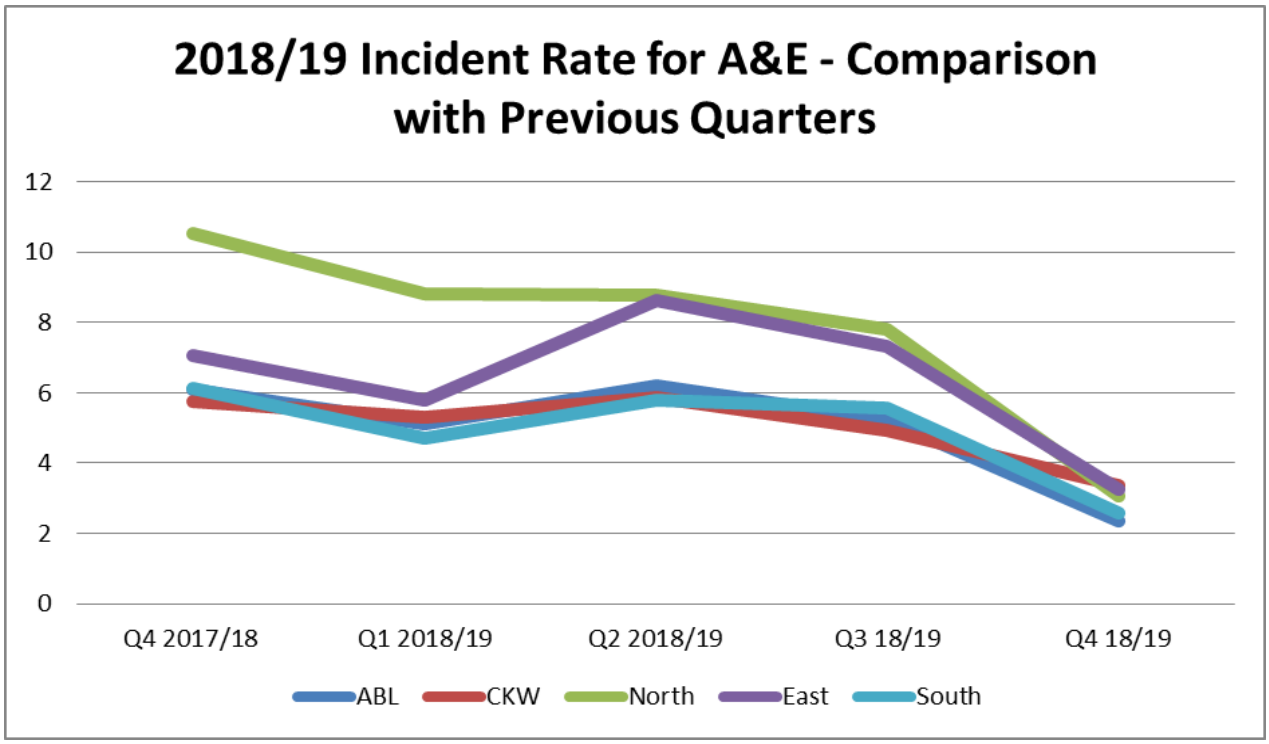
2.3.2 Incident reporting

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

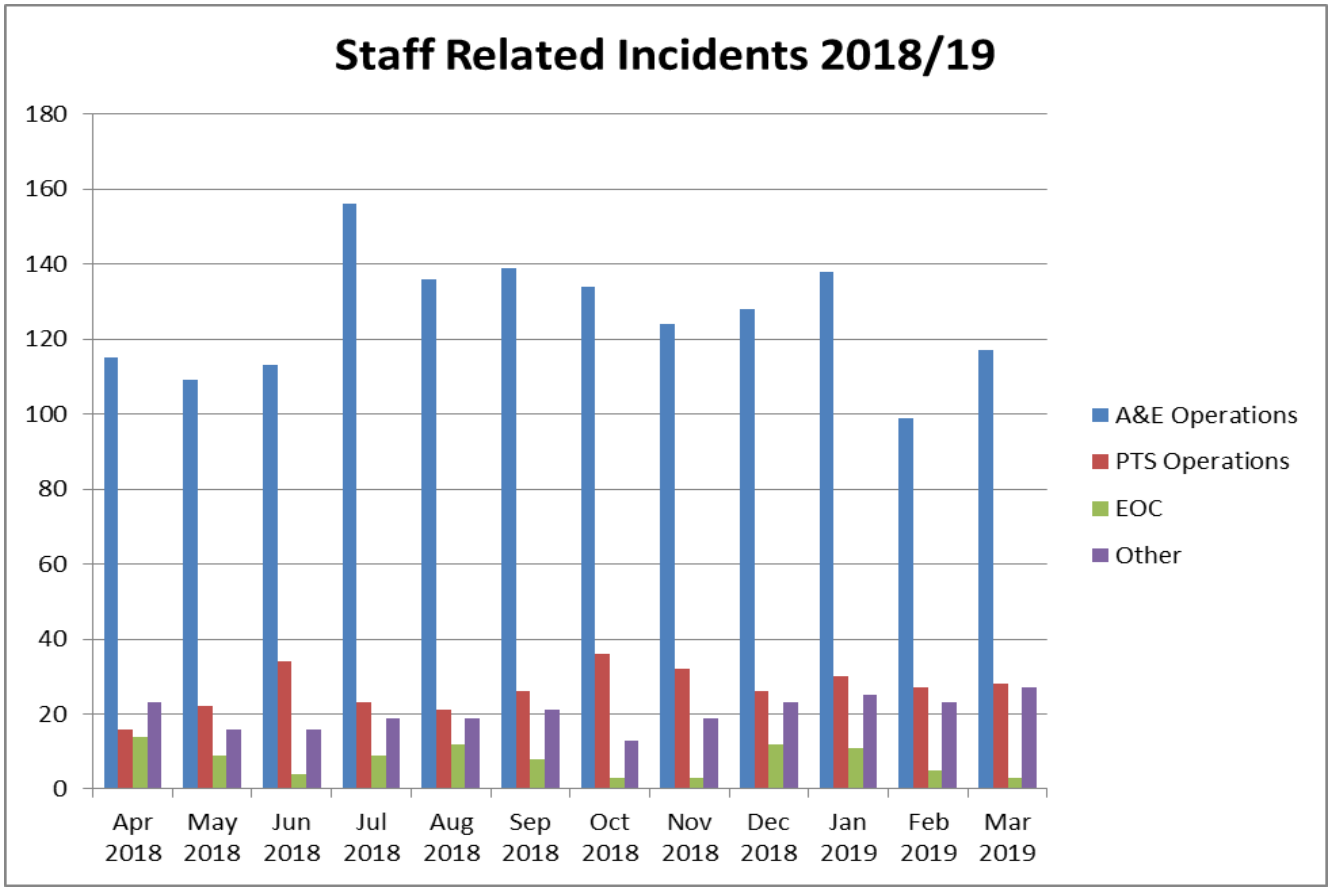
PTS incidents remained static for the first quarter of 2018-19 but then a significant rise was noted from Q2 to Q3 (nearly 50% increase). Incidents remained at this higher level for the remainder of 2018-19. This was a reflection of significant work done within PTS to increase incident reporting due to historic under reporting in that area.

For A&E, whilst incident rates have varied across the areas over the year *(No. of incidents per 1000 responses)*, as can be seen in the graph below the incident rate trend has been for downward movement. All areas have experienced a significant reduction with North

region ending the year on a par with other operational areas after a prolonged period with a rate of over 10 when compared to other regions. The number of incidents reported over the year has not varied greatly from the year before therefore; the reduction in this incident rate is attributed to an increase in the number of responses we make as a service.

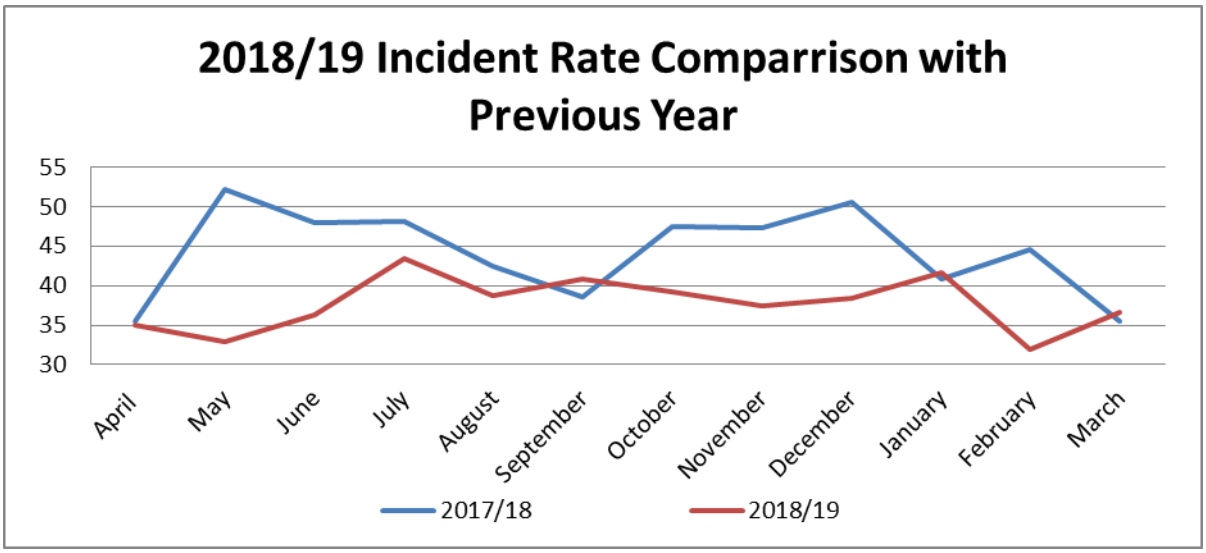


The graph below shows the number of staff related incidents reported in 2018-19.



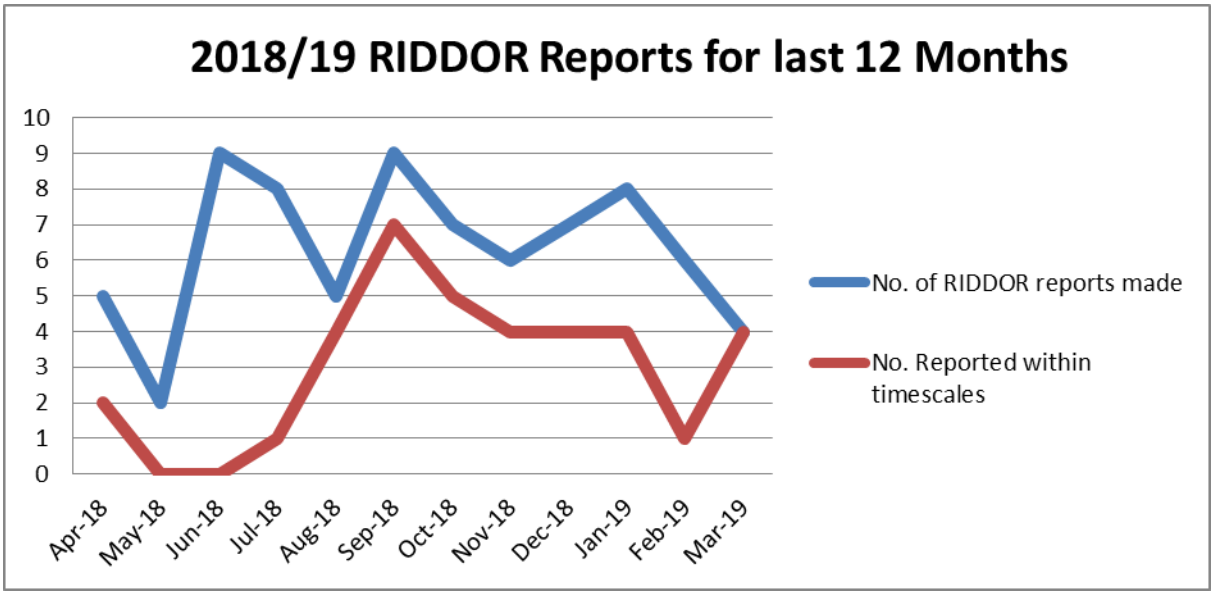
Of the staff related incidents reported in 2018-19, 4.79% were graded with a severity of moderate or above (See table below for monthly breakdown). This is an increase from the previous year (4.61%)

The staff incident rate *(No of incidents per 1000 FTE staff)* ended in March 19 at almost the same level as it was in April 18 (35.0). However, the figure has been consistently lower for the rest of the year showing an almost inverse pattern to the previous year. The yearly average is 37.9 down from 44.2 in 2017-18 with a peak of 43.5 in July (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 2018 - 2019

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

Incident Type	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019	Total
Fall from a height	1	1	1	0	1	0	0	0	0	0	0	0	4
Hit by a moving, flying or falling object	1	0	1	0	1	2	0	0	2	0	1	1	9
Hit something fixed or stationary	0	0	0	0	1	0	0	2	0	0	0	0	3
Injured while handling, lifting or carrying	3	1	6	1	3	2	4	2	0	4	3	1	30
Other kind of accident	0	0	0	1	0	0	0	0	0	0	0	0	1
Physically assaulted by a person	0	0	1	2	1	2	1	0	2	1	3	1	14
Slipped, tripped or fell on the same level	0	1	0	0	0	0	2	1	3	3	1	2	13
Biological Agent - Known Exposure	0	0	1	0	0	3	0	0	0	0	0	0	4
Biological Agent - Unknown Exposure	0	0	0	3	0	0	0	2	0	0	0	0	5
Total	5	3	10	7	7	9	7	7	7	8	8	5	83

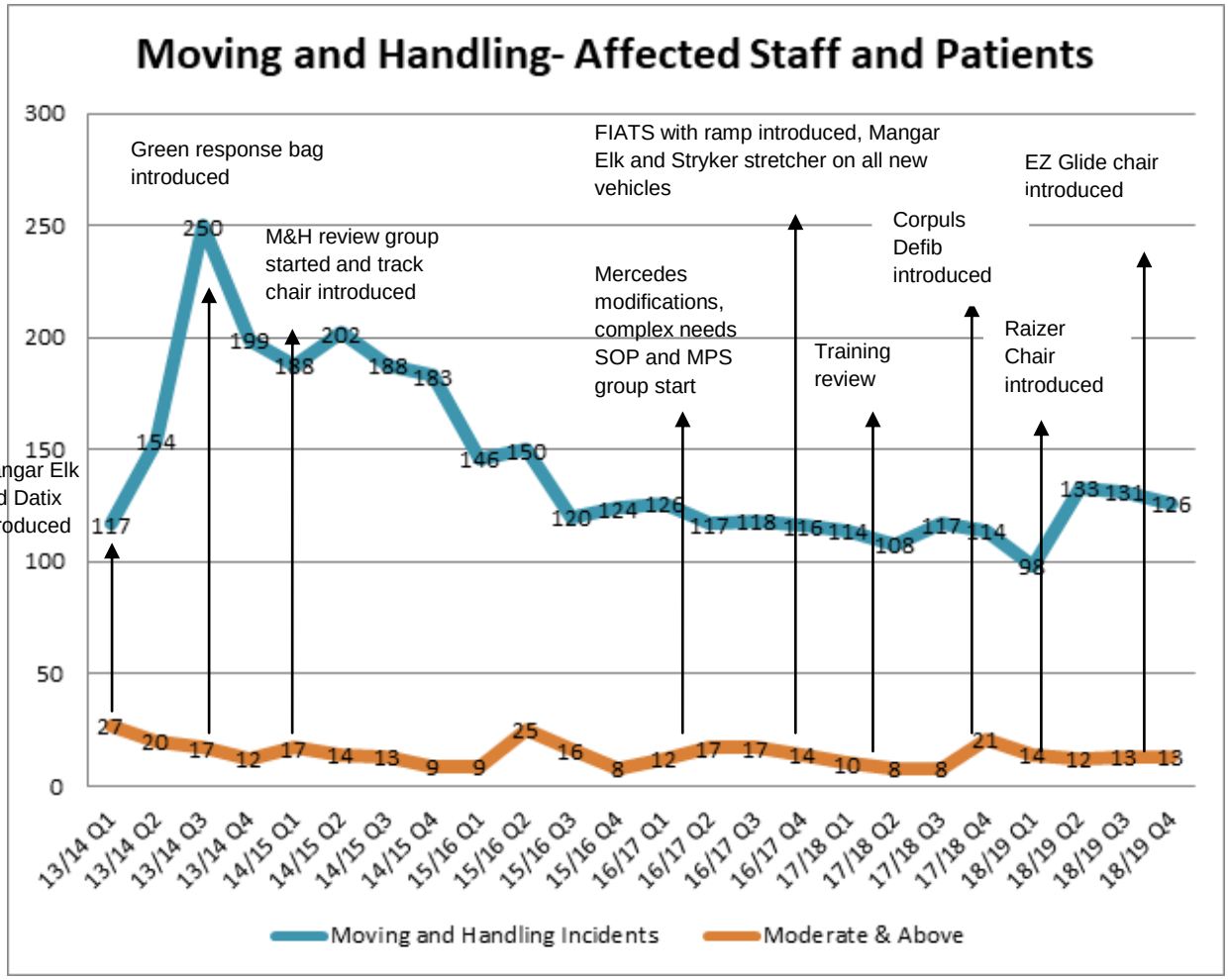
These figures show that the highest number of harm incidents relating to staff are occurring from injuries sustained during moving and handling. Slips, trips and falls and injuries from physical assault are also common and therefore RIDDOR incidents are consistent with the Trusts' top 3 reported incidents. Addressing these areas of harm is a priority for the Trust and 2018-19 work plans 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

It is clear that moving and handling incidents have significantly reduced over time, thought to be due to initiatives such as the introduction of the new green response bag and the track carry chair and modifications to the Mercedes vehicle tail lifts, introduction of the Fiat vehicles and the wider availability of the Mangar Elk and improved stretchers. As a general direction, equipment used by crews is being upgraded to have bariatric capability as standard and the weight of new equipment is being reduced where possible e.g. new lighter weight defib. New lifting equipment is also being introduced such as the Raizer chair and EZ Glide. However, MSK incidents remain a key theme in reporting and, as the graph shows, the rate of improvement has slowed in recent times Therefore, reducing the risk of MSK injuries to staff remains one of our key work-streams in 2019-20 with significant work planned.

The following graph shows moving and handling incidents tracked back to Q1 2013-14 with significant changes to Trust practices highlighted.



2.3.3 Delivery of Work Plan for 2018-19

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 2016-17 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 2017-18 with the provision of IOSH accredited Leading Safely training to all members of TEG and TMG and IOSH accredited Managing Safely training provided to a select group of managers and supervisors drawn mainly from the Fleet, Estates and Facilities Directorate.

Work was started towards the end of 2017-18 on the design of an internal non-accredited Health and Safety Training Course for all other managers and has continued throughout 18/19. The course was originally going to be classroom based but is now in the process of being transferred to e-learning in order to provide more flexibility and facilitate a quicker delivery.

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 2018-19 and make progress with its moving and handling work plan.

Key achievements made by members of this group have included a comprehensive review of the Trust's standard operating procedure for wheelchairs and the introduction of 2 new pieces of moving and handling equipment for PTS (EZ glide and Pro-move). In addition, work has been undertaken to evaluate the Trusts' need for better access to specialist moving and handling advice and work on the results of this will continue into 2019/2020.

The second key piece of work for 2017-18 was the continuing partnership working on moving and handling improvement with the Health and Safety Executive (HSE) and National Ambulance Risk and Safety Forum (NARSF).

The joint working has mainly focussed on identifying and capturing common moving and handling risks across the ambulance sector and has resulted in the completion of a joint risk assessment for an ambulance carry chair, with and without track. Agreement was also made to begin work on further assessments for other common moving and handling equipment.

Premise Inspections

The Inspection 4 Improvement (I4I) programme, which ensures that all YAS premises are inspected and assessed for compliance with Health and Safety, Security, Information Governance, Infection Prevention and Control and Risk Management Standards, was sustained throughout 2018-19.

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.

As part of a review of the I4I process, a number of I4I inspectors were provided with IOSH accredited Managing Safely training to enhance their health and safety knowledge and therefore their confidence when conducting inspections.

Health and Safety Consultation with Employees

The implementation of the guidance document regarding health and safety consultation has continued in 2018-19. All local health and safety committees in operational areas (North, South, East and West) are meeting quarterly, the Fleet, Estates and Facilities meeting has been re-instated and a new local health and safety committee for EOC, 111, PTS Logistics and Support Services has now been established.

By the end of 2018-19, all necessary local health and safety committees were up and running regularly.

Personal Protective Equipment (PPE)

A new work stream added to the health and safety work plan for 2018-19 was in relation to personal protective equipment (PPE) which included the completion (or review) of risk assessments in order to inform a review of boots, helmets, RPE and eyewear provision.

The RPE (Respiratory Protective Equipment) assessment was the first to be reviewed and it informed a significant change in provisions for A&E frontline staff.

Taking into account the level of respiratory risks to staff and legal advice provided by the Health and Safety Executive, in 2018-19 the Trust made the decision to moved away from the provision of disposable tight fitting RPE (which requires face fit testing and is not suitable for everyone), to re-useable loose fitting RPE (which does not require face fit testing and can be worn by anyone). This was to ensure that suitable RPE protection is available to all necessary staff regardless of their facial characteristics. Procurement of the new RPE started in 2018-19 and roll out will commence in 2019-20 on a vehicle issue basis.

The second assessment to be completed was for helmets provided to A&E frontline staff.

The assessment showed that, whilst the current head protection in place at YAS provides adequate protection to staff, it is no longer the most suitable. There is now a more comfortable type of head protection available which also provides better freedom of movement and improved verbal communication whilst still providing adequate protection from the identified hazards.

The Trust has therefore made the decision to move towards the provision of head protection which complies with EN 16473 - Fire fighter technical rescue. Procurement of the new helmets started in 2018-19 and roll out will commence in 2019-20 on a new starter / replacement basis.

Finally, in January 2019, the Trust created a Uniform and Personal Protective Equipment steering group (USG) chaired by the Deputy Director of Operations. The USG was established as part of the Trust's procurement activities to ensure effective clothing, footwear and associated equipment are purchased with staff health and safety implemented across the Trust. It is responsible for reviewing all items relating to Uniform and PPE for the Trust and therefore now incorporates the PPE work stream detailed in the health and safety work plan.

Air Quality and Diesel Emissions

Another new work stream added for 2018-19 was the review 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.

In July 2018, monitoring work was undertaken by an Occupational Hygienist at Leeds Ambulance station and again in October at Unit M. No legal exposure limits were found to be breached on either occasion however; some issues with ventilation were identified. These were rectified along with improvements made to the management and checking of all local exhaust ventilation systems (LEV) within Fleet workshops.

Slips, Trips and Falls

Slips, trips and falls are 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 had been identified previously in relation to slips, trips and falls and therefore, personal issue torches were rolled out to staff in April 2018.

In addition, the provision of safety boots which is a key control measure for slip, trip and falls, is now under review as part of the Uniform and Personal Protective Equipment steering group (USG) which was detailed earlier.

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 continued to be made in 2018-19 with the implementation of the 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.

Risk - 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 issues 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 in 2018-19 and the continued improvement of the Fiat ambulance saloon design taking into account ergonomic factors.

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 looked at by the Moving Patients Safely Group and a key piece of work helping to address this has been

the evaluation of the Trusts' need for better access to specialist moving and handling advice.

2.3.5 Looking ahead – priorities for 2019-20

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

Arrangements will be made to ensure that the IOSH accredited training has been delivered to all of the Trust senior management and work will continue to develop the e-learning 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 now meet 4 weekly instead of 6 weekly. Work will also continue with the HSE and NARSF in 2019/20 along with the progression of a business case for the appointment of a subject matter expert for moving and handling (a result of the evaluation work done on the Trusts' need for better access to specialist moving and handling advice).

A new work stream added to the work plan for 2019-20 is in relation to First Aid.

A comprehensive risk assessment of First Aid Provision within the Trust will be conducted and management arrangements put in place as necessary. The risk assessment will start with higher risk areas such as Fleet and a First Aid training programme will be implemented as necessary.

The goals for 2019-20 include:

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

2.4 Violence Reduction and Security

2.4.1 Introduction

Security management throughout 2018-19 was overseen by an accredited Local Security Management Specialist (LSMS). One of the major changes in this period was the dissolution and subsequent removal of national governance and support around security management within the NHS.

This aside, work has been happening at a national level to develop revised violence reduction/security management standards, in line with the violence reduction strategy announced by the Health and Social Care Secretary in late 2018, and the Trusts LSMS has been involved in an advisory capacity in this development.

2.4.2 Incident reporting

Throughout 2018-19 the Risk Team have reviewed, mapped and endeavored to improve the way in which incidents are managed around violence reduction.

As mentioned, there is no national governance around security or violence reduction, and as such no national requirements for reporting. However we have continued to collate and provide statistics on assaults to the national ambulance security group, which has in turn provided these to the Quality, Governance and Risk Directors (Q-GARD) as part of the national reporting structure.

The process of internal investigation and support for a victim of a crime, whilst simultaneously supporting a police investigation, is complex, and has been challenging to map, however this work has now been completed, and a new Criminal Incidents Policy, has been developed and has since been approved at the Trust Management Group.

This Policy sets out the trust position on investigating crime within the trust, including violence against staff, and provides a comprehensive process to enable the management of a reported incident to progress, whilst ensuring the criminal side of the investigation is supported fully, and any opportunities for sanctions and redress are maximised.

The Conflict Resolution Training (CRT) offering from the trust is currently being reviewed, with an aim to provide a revised and updated version to be delivered until the national package covering the entirety of violence reduction is completed.

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. A quarterly Safer Responding Group is set up with a comprehensive terms of reference, and agreed governance structure. This group is chaired by the LSMS.

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.

The current Data Flag policy and associated process is under review and this work is being led by the Head of Risk.

2.4.4 Site Security

Following the completion of site security assessments, various papers have been produced and considered through a quarterly Executive Security Review process, where the different elements which make up site security have been discussed, such as access control, CCTV, and lockdown ability.

Further to this, key areas of work have been identified and are being progressed.

1- Reviewing, developing and where necessary re-tendering the contracts held for CCTV, Access control and CD room monitoring.

2- Reviewing and planning the organisations ability to respond to key security threats both nationally and locally.

This work is on-going and will continue to be developed further over the forthcoming year, however significant progress has been made in driving it forwards and we are in a good position in this area to ensure that further development occurs, and that the trust receives the most appropriate systems and processes whilst ensuring that value for money is maximised.

2.4.5 Looking Ahead – Priorities for 2019-20

The following are identified as priorities within the 2019-20 period:

- To continue to lead on the development of the national package of violence reduction measures in the ambulance sector, and to ensure that this work is aligned to national best practice in the use of restrictive interventions and supported nationally.

- To continue to develop the team's ability to actively support victims of crime, and maximise investigative opportunities, ensuring appropriate sanctions and redress are obtained whenever possible.

- To improve and accurately obtain evidence of sanctions, along with criminal investigation outcomes and key risk data, feeding this back into clinical practice via training, policy development and staff updates.

- To complete ongoing work in relation to CCTV and access control.

2.5 Infection Prevention and Control

2.5.1 Report from the Director of Infection Prevention Control

In 2018-19 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 Deputy Director of Quality and Nursing, The Head of Safety will take on the IPC Lead Nurse role in 2019-20.

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, Patient Transport Service, Fleet, Estates and A&E 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 2018-19

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

The 2018-19 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 2018-19 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 IPC 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 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 2018-19 the following policies and guidance documents have been reviewed:

    - Aseptic technique and Invasive devises guidance
    - Norovirus management guidance
    - Hand Hygiene policy

Full review of the information included in YAS IPC policies has been undertaken with a specific view to ensure all information is robust and meets the Health and Social Care Act 2012 requirements. This was undertaken to ensure all service lines have access to the correct information to be able to support staff to make decisions around personal protective

equipment and decontamination of vehicles following possible occupational exposure to a communicable disease. Standard Operating Procedures for common microorganisms are being strengthened for advisory staff and others who act in this advisory capacity out of hours.

- The Patient Safety and Nurse Development Manager and Head of Safety undertake validation audits of vehicle cleanliness and hand hygiene at relevant Emergency Departments to ensure that compliance with hand hygiene and vehicle cleanliness is maintained.

- Infection prevention and control elements for station are assessed during 'Inspections for Improvement'. Improved compliance with IPC related elements has been demonstrated across the annual inspections during 2018-19 largely down to the collaborative work undertaken with internal stakeholders and the introduction of the Ambulance Vehicle Preparation project (AVP).

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

- Collaborative working with Health and Well Being Lead is on-going; this has included input to the revised Trust Health Surveillance matrix and support provide for the Trust flu campaign.

2.5.4 IPC audit

The clinical audits for hand hygiene, vehicle cleanliness and premise cleanliness are carried out monthly in each clinical business unit (CBU) 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. Overall total YAS service line compliance for premise, vehicle and hand hygiene averages between 98-99%.

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 and hand sanitiser.

IPC audits are communicated through to station level and are visible on the compliance notice boards. Compliance and audit with this standard is monitored and captured via 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, compliance with PPE and common errors staff make when using sharps. 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.

Where there is non-compliance with the deep cleaning schedule and the vehicle breaches the 35 day cleaning window the DIPC will issue a letter, to apply the vehicle off road policy to facilitate deep cleaning. This ensures a sustained improvement with the assurance associated with the deep cleaning programme.

Ambulance vehicle preparation (AVP) has been introduced across the Trust to standardise cleaning and stocking of ambulance vehicles, this provides an enhanced use of resources and supports IPC practices. The programme is now operational in Wakefield, Huddersfield and Leeds, with Doncaster expected to go live in early 2020.

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.

2.5.5 IPC training

IPC 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 IPC training continued to increase in 2018-19 and at year end was at 95%. 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	2014-15	2015-16	2016-17	2017-18	2018-19
Clinical/Medical Sharp Injury	61	46	50	56	53
Contact with communicable infection	29	28	38	70	54
Contact with Blood/Bodily Fluids	25	27	36	43	57
Cleanliness Issues	5	2	16	22	20
Availability of PPE	2	3	5	0	0
Bite	6	5	7	6	15
Lack of availability of Equipment	2	0	3	2	3
Waste Disposal	3	3	3	4	1
Failure to follow YAS Procedure/Protocol	5	3	5	0	0
Vaccinations/Immunisations	0	0	2	1	1
Totals	138	117	165	204	204

Incident reporting overall in 2018-19 has remained comparable to reporting in 2017-18. This remains positive which may be due to the sustained awareness of reportable infection prevention and control incidents and the focus on the value of reporting incidents. There has been an increase of incidents related to contact with blood or bodily fluids and bites, a number of the incidents are directly linked to violence and aggression. Work is ongoing with the Local Security Management Specialist (LSMS) to address the increase in incidents and initiatives such as spit kits made available to frontline staff to support identification and prosecution of perpetrators.

Staff coming in contact with communicable infection incidents has seen a decline in 2018-19 but notifiable infections such as tuberculosis, measles, and whooping cough have seen an increase. The IPC Practitioner works closely with operational staff, Public Health England and Occupational Health Advisors to ensure timely support and treatment is given to these staff members. Clinical or medical sharps injuries have seen a decline in 2018-19 due to robust training and effective communication. The theme of many of these incidents is injury during cannulation and is suggestive that staff are not following the correct procedures when a failed attempt occurs. During 2018-19 we will continue the work with cascading best practice.

Staff have a greater awareness of the infection risks posed when delivering care supported by training, best practice events and CPD events. During 2018/19 we will continue to have a strong focus on' protecting yourself' by undertaking a dynamic risk assessment and utilising the correct personal protective equipment (PPE). Additional PPE, Respiratory Protective Equipment (RPE) has been purchased by the Trust to protect our staff from risk of infections.

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.

A risk remains on the risk register relating to Trust responsibilities outlined in the Green Book 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 as full compliance requires active support from a range of external partners.

The lack of correct and complete records for immunisation status of staff remains on the risk register. This is a joint risk with IPC Practitioner and the Health and Well-being Lead. At the end of the Occupational Health Contract for the current provider in 2018-19 this was not resolved and the new Occupational health service is continuing this work

The risk of inadequate FIT testing compliance across the organisation remains a recorded risk. Due to the nature of FIT testing, where beards or stubble are contraindicated, the possibility of this risk being removed from the register is minimal. Therefore the decision was made to procure Respiratory Protective Equipment (RPE) for staff and protect them against infectious disease, this would replace the need to FIT test, subsequently removing the risk to the organisation. The equipment is intended to be delivered and rolled out to frontline staff in 2019-20.

2.5.8 Next steps for 2019-20

- Continue audit work to embed and review practices in relation to bare below the elbow and issue of new fob watches.
- 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.
- Continue IPC work to reduce blood stream infections (BSI's) with the initial focus on Escherichia coli (E.Coli).
- Develop online IPC learning.
- Distribute the RPE and provide training and guidance for use.

2.6 LEGAL SERVICES

The Legal Services Department deals with all requests made for disclosure of information under the Data Protection Act 2018, 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 numerous schedules within the Data Protection Act 2018, for 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 2018-19 are shown below, in comparison to previous years.

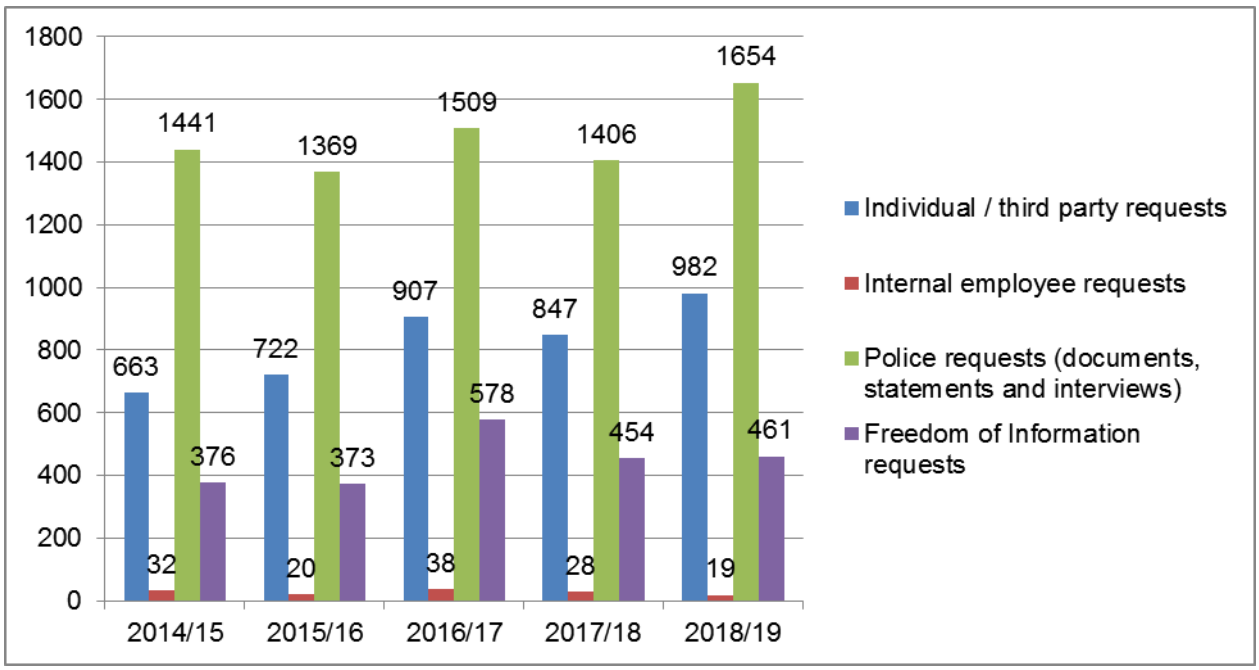


Figure 1: Total number of information requests received by year

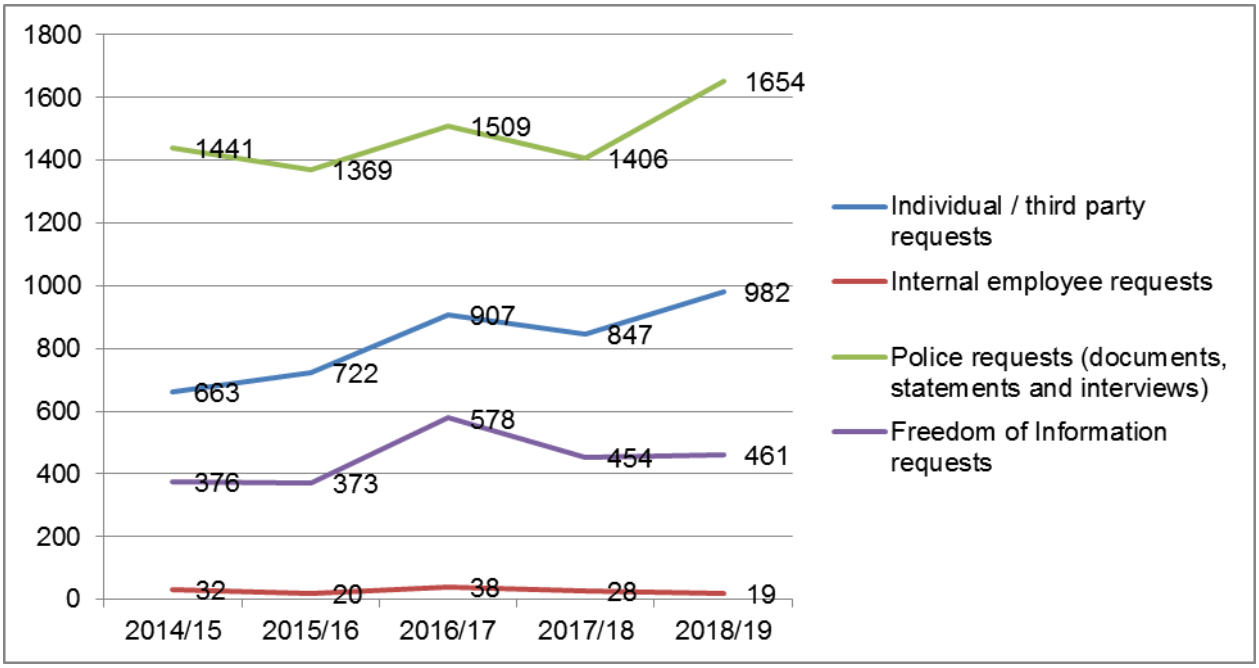


Figure 2: Trend of information requests received by year

The volume of information requests dealt with by the Legal Services Department remains consistently high year on year. There has been a decrease in internal employee requests whilst individual/third party and policy requests have seen marked increases.

These figures include two months of processing under the old Data Protection Act 1998, with any requests received post 25 May 2018 being processed under the new Data Protection Act 2018 which dovetails with the General Data Protection Regulation 2016.

This change impacted on the organisation as a whole, but specifically in relation to subject access requests for information there were 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 changes outlined above have had an effect upon the numbers of information requests and these are expected to increase. Structural changes within the department has also had an impact upon the requests for information; however permanent members of staff are now embedded within the department with measures put in place to continue to improve compliance rates.

Work is planned for 2019-20 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.

The Trust is not aware of any complaints made to the Information Commissioner's Office ("ICO") around the handling of requests for information.

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

The Legal Services Department actively manage all HM 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 598 new Coroner requests and employees gave evidence (oral or written) at 288 inquests. There are a further 255 cases that are still awaiting a hearing date (these are all open inquests not just for the previous year).
This year, the amount of requests had continued to increase and has seen the highest amount of requests at 598.

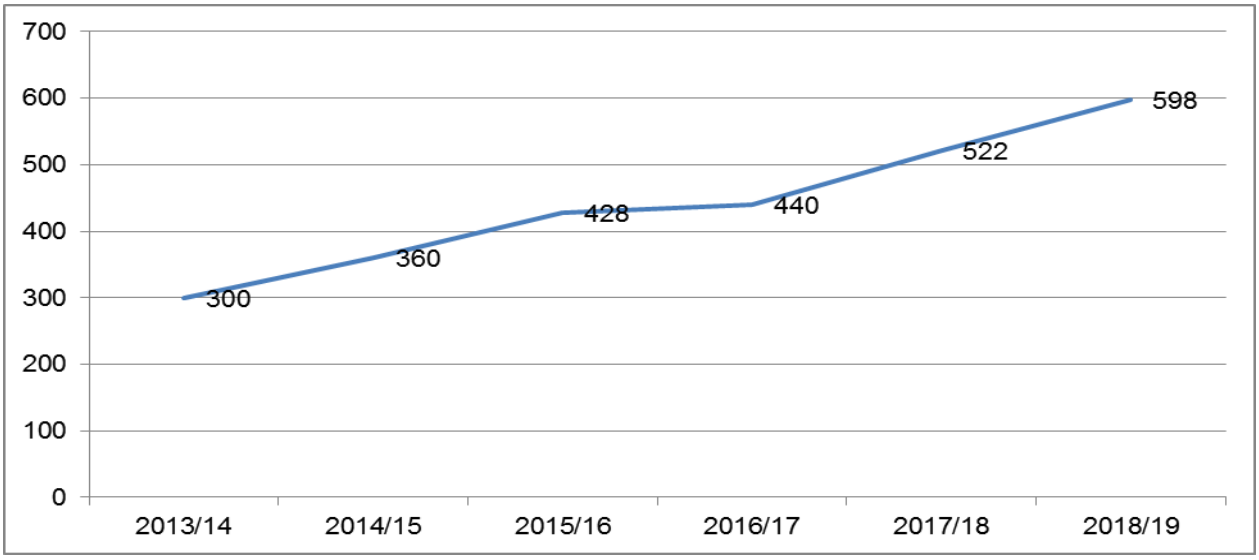


Figure 3: Trend of HM Coroner's requests received by year

An initial review determines the Trusts response to the request and other written or oral evidence will need to be provided by the Trust.
The amount of inquests the Trust has provided evidence to (written or oral) has consistently remained high over the years (between 200 and 300).

During 2018-19, 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. Other areas of a lesser frequency surrounded the non-conveyance of patients, the interface with secondary mental health services, processing of calls within NHS 111 and the protocols with dynamic risk assessments pertaining to standing off.
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.

At the end of the financial year, the DATIX record management system was used wholly for the recording and management of inquests, having moved from being spreadsheet based. This move to DATIX will greatly assist with theme and trend analysis.

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 2018-19 YAS did not receive any PFD reports however the Trust has considered relevant PFD reports from other ambulance services and has implemented a process to regularly review these reports.

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 Department and individuals and departments across the Trust who are involved in producing statements or investigation reports for the Coroner. The Legal Services Department 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 Department 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 Department 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 2018-19 there were 127 open claims, with 107 new claims being

reported. The data shows a continued decrease in the amount of claims received by the Trust and this is testament to the measures put in place by the Trust to reduce the likelihood of claims. The use of the low value claims portal ensures that claims are investigated and a decision on liability made much more quickly than previous years and as can be seen, there is a marked reduction in the amount of open claims at the end of the financial year.

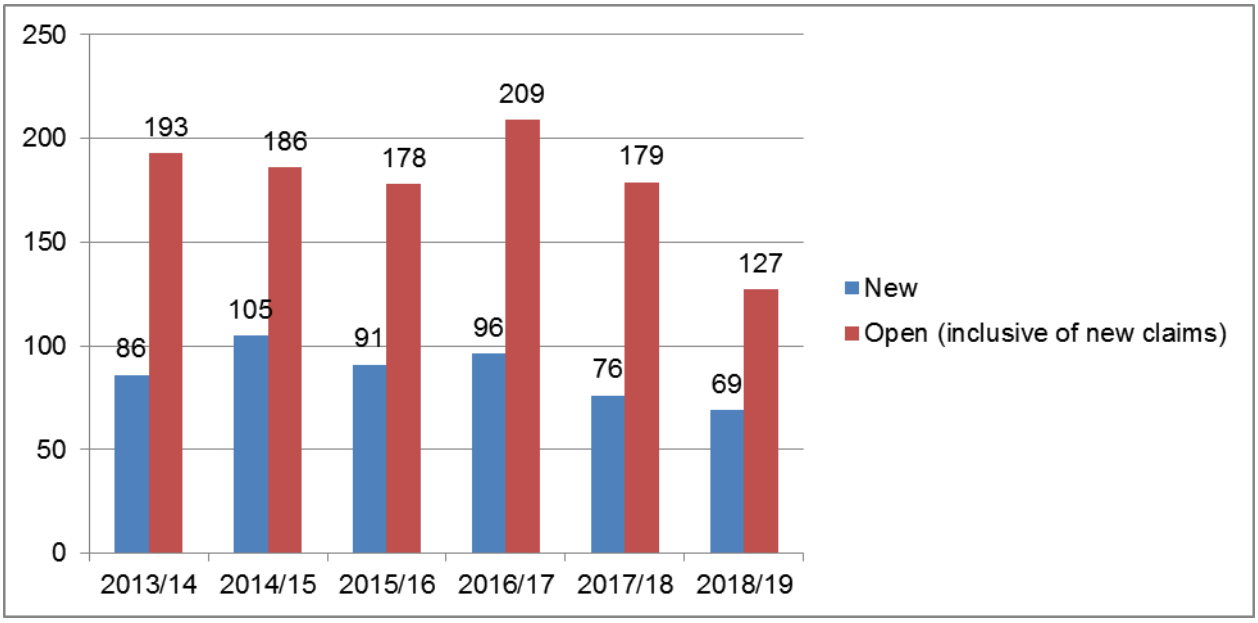


Figure 4: Total number of new and open claims by year.

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.

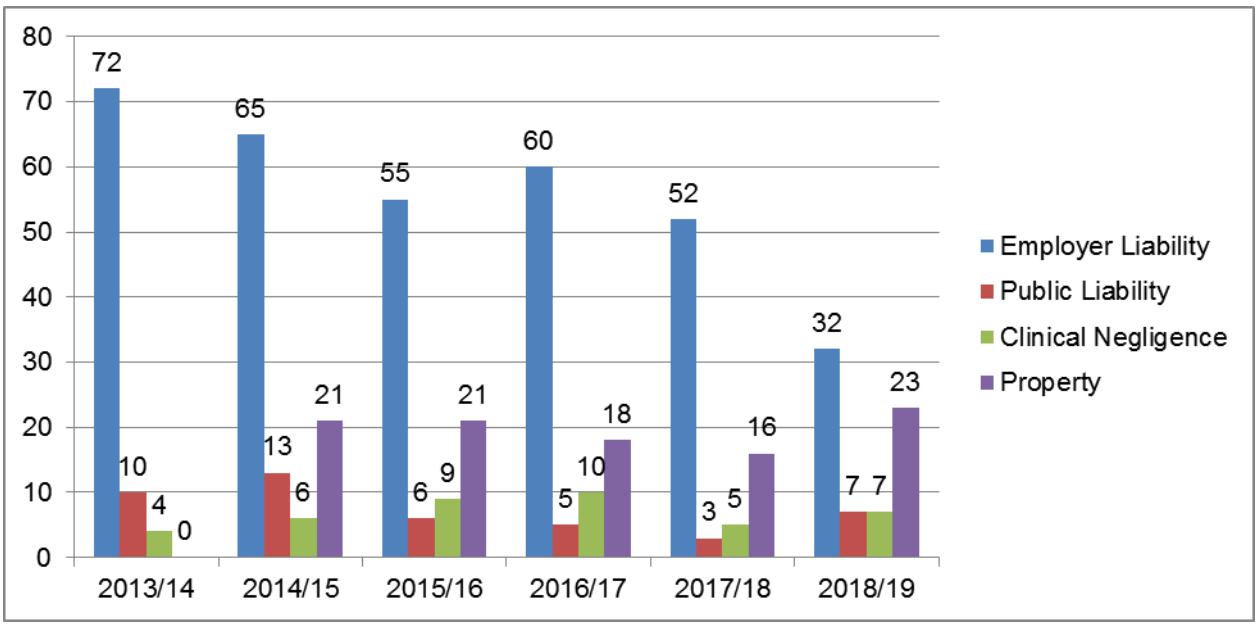


Figure 5: New claims reported (EL/PL/CNST/Property)

Employer Liability (EL) Claims

Employer Liability claims continue to be the main focus of claims workload within the Legal Services Department; 32 new claims were reported in 2018-19, a decrease from the previous year. The main focus of the claims within this category continues to be moving and handling with 9 new 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 new claims (7 claims) which mainly consist of injuries from tail lifts and ramps.

The continuing 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 2018-19 there were 7 new PL claims reported, which is a slight increase from the previous year. The relative low numbers of claims demonstrates a positive patient safety culture within the Trust. The majority of these claims involve being moved onto or from Trust vehicles, predominantly with Patient Transport Services ("PTS").

Clinical Negligence (CNST) Claims

In 2018-19 there were 7 new CNST claims reported which is a slight increase from the previous year. These claims by their very nature are potentially very high value claims with reputational impact on the Trust.

The key themes within these new claims are in relation to alleged delays in providing treatment to the patient and clinical assessment on scene.

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

Looking ahead – priorities for 2019-20

- 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. With a new Legal Services Manager in post, it is planned for him to contribute at CBU management meetings / groups.

- 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. Training sessions regarding attendance at inquests is planned to be rolled out to CBU management and cascaded amongst operational staff.

- 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 optimisation 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 2018-19 the Accountable Officer for Controlled Drugs has been the Executive Medical Director. 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.

2.7.2 Medicines Management Work plan

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.

1. The new medicines process pilot has been approved and a project team has been set up to complete the work.

2. The diazepam storage has been reviewed after a security incident. Diazepam has been removed from the medicines cupboards in the emergency departments and placed in the controlled drug safes in the station. The process for storing within the vehicle has not changed.

3. A Drugs and Therapeutics committee which is a multidisciplinary team composed of doctors, pharmacists, paramedics and nurses has been formed. The committee reviews medications and selects drugs to be included in the YAS formulary based on safety and

how well they work. The selected drugs are limited to use within an Urgent Care environment, i.e. they require to be prescribed urgently to meet patients' clinical needs. The YAS Drugs and Therapeutics Committee are responsible for compiling, maintaining and updating the formulary. The group works together to work together to promote clinically sound, cost-effective medication therapy and positive therapeutic outcomes.

4. The medicines supplies and logistics process has been much improved over the last year, with a more streamlined system in place to ensure hospital cabinets and stations are kept adequately stocked with much more efficient rotation of medicines system in place. This has also allowed the procurement team to have improved stock control up to the point the medicines are put into the hospital cupboards. The new medicines process pilot will continue the improved stock control and medicines visibility.

2.7.3 Medicine Optimisation update

PGD's

The PGD suite has been reviewed and updated. Specialist paramedics have had codeine added to their formulary, but currently it is only being used by the rotational staff until a new process can be confirmed to allow all other SPs to efficiently withdraw and return it at the beginning and end of each shift.

New patient group directions for the critical care paramedics have been approved:

A. Hypertonic saline solution 5% for the emergency management of raised intracranial pressure and developing cerebral herniation in patients with traumatic brain injury.

B. Magnesium sulphate 20% for:

- Severe / Life-threatening asthma unresponsive to 1st line therapies
- Anaphylaxis unresponsive to 1st line therapies
- Eclampsia (Seizure Management)
- Tachyarrhythmia's unresponsive to 1st line therapies

Change to documentation

The expiry and tag check sheets have been reviewed and made into a register to allow easier access and reporting. The previous process used single sheets kept in a folder within the car, a new register has been produced to be kept with the medicines register. The aim is to improve the quality of the expiry recording, and reduce the number of medicines with inaccurate or missing expiries. It was a suggestion made through the staff forum, discussed at Medicines Optimisation Group and implemented.

New safe

A new controlled drug safe has been fitted at Rotherham station, due to the change in process with regards to diazepam. The increased contents of the safe was leading to errors and damage to the medicines. A request was made to add an extra safe to store the diazepam. This has been implemented.

Integrated and Urgent Care

The 111 Formulary principles, maintenance and antimicrobial prescribing handbook has been produced by the formulary team and approved at Medicines Optimisation Group and Clinical governance. The formulary team are working with NHS England to become a prescribing centre. The Trust Pharmacist will also take on the role as the Non-Medical Prescribing Lead.

Gosport Enquiry

The Medicines Optimisation Group have reviewed the Gosport enquiry, after discussion with safeguarding lead, and the lead for Freedom to Speak Up and duty of Candour it was decided that as a Trust we were currently adhering the Gosport recommendations in relation to medicines.

Medicines Issues

A serious issue was raised by another ambulance trust pertaining to adrenalin 1:10000 adrenaline pre-filled syringes. During a shift a sealed pre-filled syringe was opened to administer to a patient, it was found to be empty. On further inspection 26 sealed syringes were found to be empty. Two different batch numbers were affected. The ambulance trust informed both manufacturer and the ambulance pharmacist network, who informed the MHRA. YAS did not have any of the specific batches but it was decided that the packs of syringes should be weighed as they entered the service before they were distributed to the medicines cupboards. A clinical alert was put out to alert staff to the risk, and gave information on what to do if they found an empty sealed syringe.

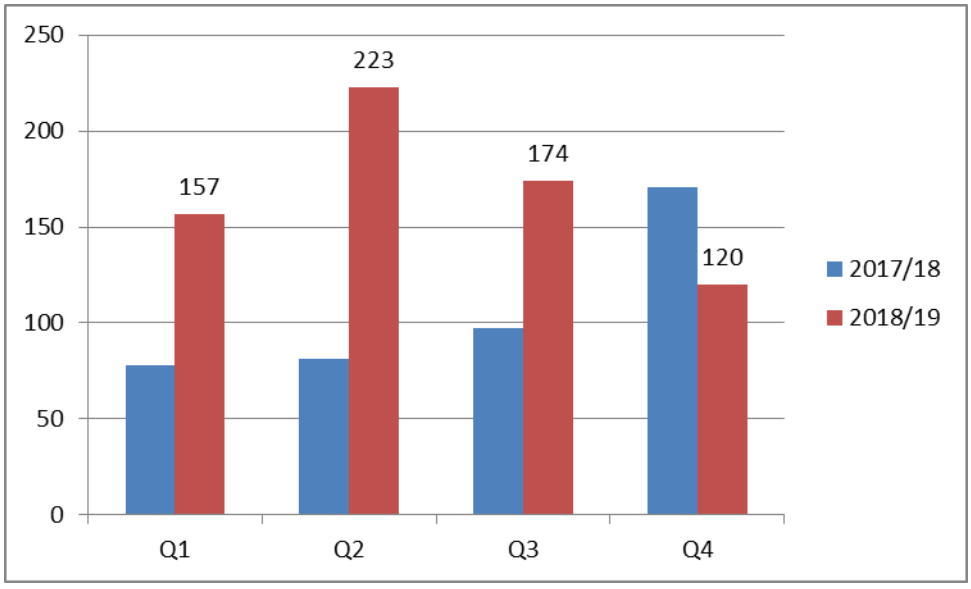
EU Exit

There has been continued work on the EU exit strategy relating to medicines. A formal procedure has been put in place, a business continuity exercise has been completed including the procurement and logistics team. This has led to specific medicines cards added to the Business continuity documentation. The Ambulance Pharmacist Network, are working together to ensure that Ambulance Services are kept informed and are engaged with the national strategy.

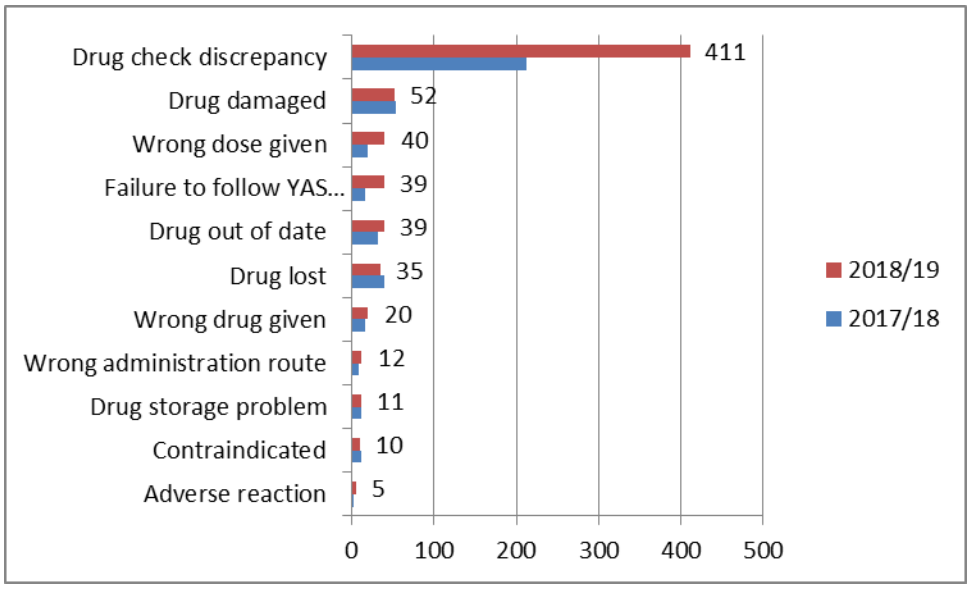
2.7.3 Review of Incidents Relating to Non-Controlled Drug Medication

There have been a total of 427 non-controlled drug related incidents reported to Datix during 1st April 2017 and 31st March 2018.

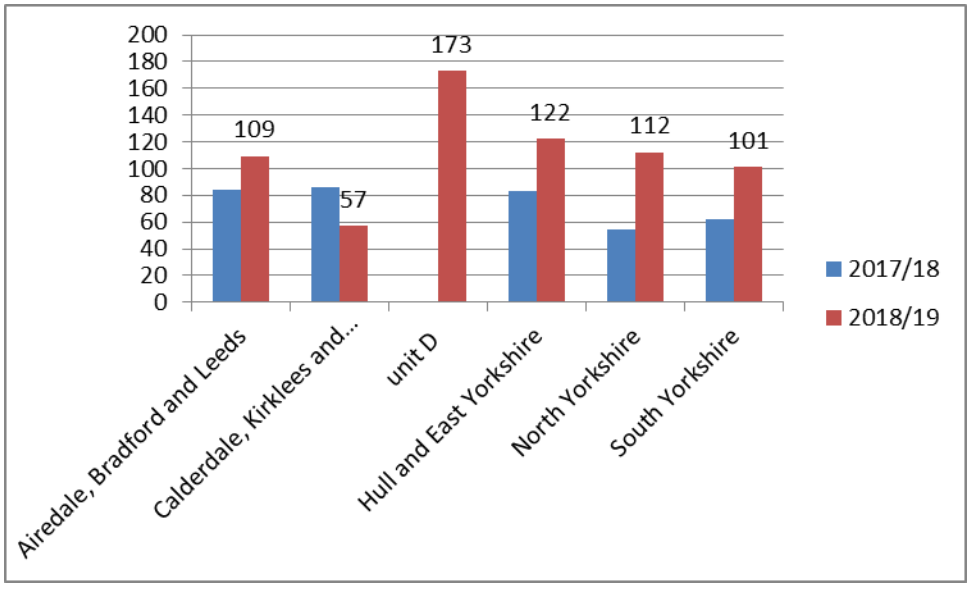
There were a total of 674 Non-Controlled Drug related incidents reported to Datix during 1st April 2018 and 31st March 2019. The reason for such a marked increase is the introduction of incident reporting by the procurement team in Q4 2017-18, this increased the number of stock discrepancy reports by a considerable amount. The procurement team reported any discrepancy found in any of the ED and station medicines cabinets.
The following chart shows all of the Non-controlled Drug incidents that happened during 2018-19, broken down by quarter, compared to the same quarter in the previous year.



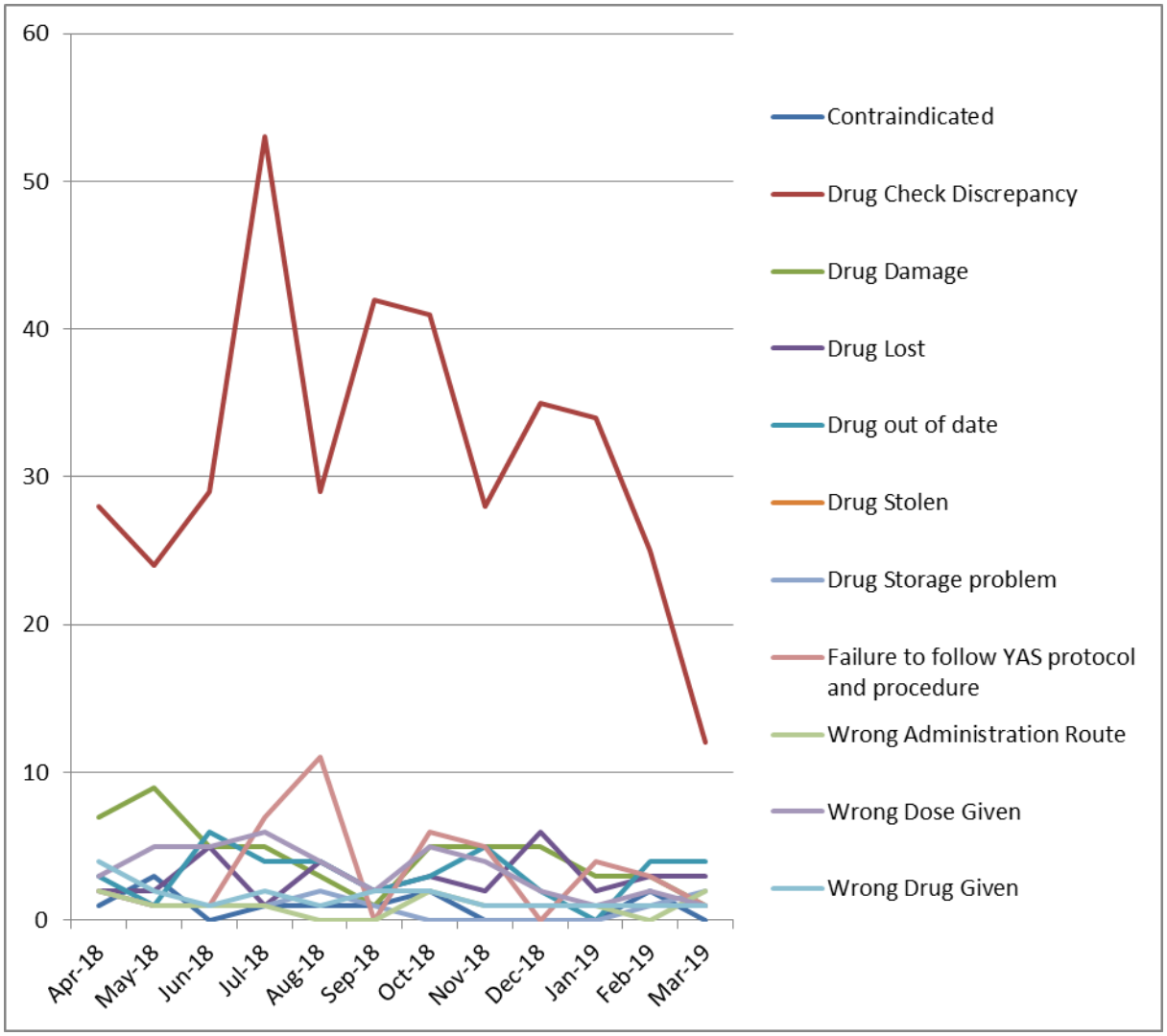
The following chart shows the Non-controlled Drug incident that occurred during 2018-19 compared to 2017-18 broken down by Sub-Category. The graph shows that the only significant difference in the values is in the drug check discrepancy section. There has also been a 100% increase in the number of wrong dose administered; this has been due to an increase in the number of external errors reported through DATIX. This is a positive increase as it indicates that paramedics are looking at medicines not only the ones that we administer but also those that are dispensed/administered by external stakeholders. All the external incidents reported are also submitted to the responsible authority via a service to service concern.



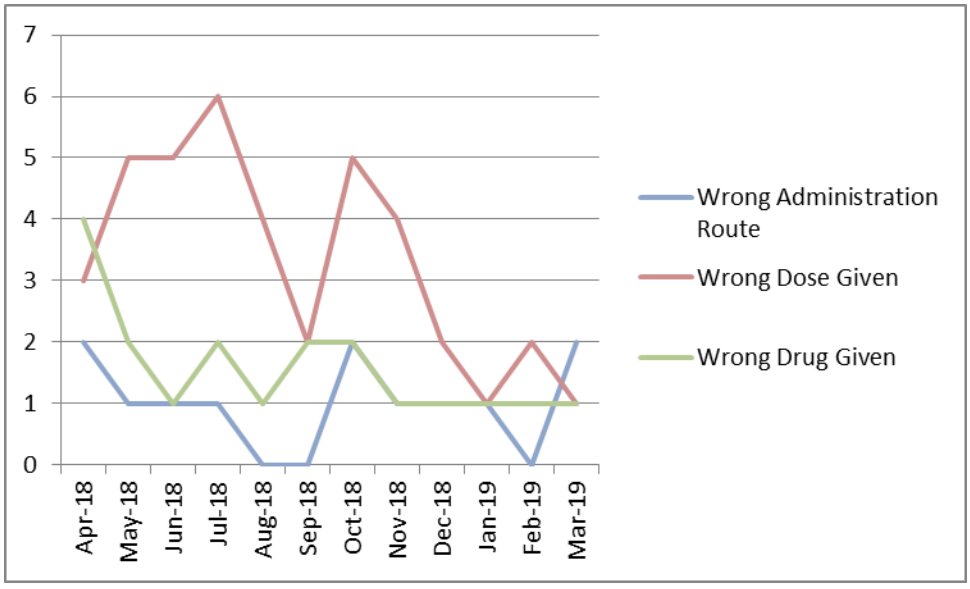
The following chart shows the Non-Controlled Drug incident that occurred during 2018-19 compared to 2017-18 broken down by Geographical Area. The Unit D value is part of the discrepancy, the others are spread across the CBU's, depending on what is recorded on DATIX.



The following chart looks at all of the non-controlled drug related incidents that have occurred since 1st April 2018 and the 31st March 2019. These allow any trends to be identified.



The graph below shows incidents relating to clinical errors that should be avoided: wrong route, wrong dose, and wrong drug.



2.7.4 Monitoring Usage of Controlled Drugs

Controlled Drugs Serious Incident

The controlled drug SI has been completed and a number of changes have been actioned and recommended:

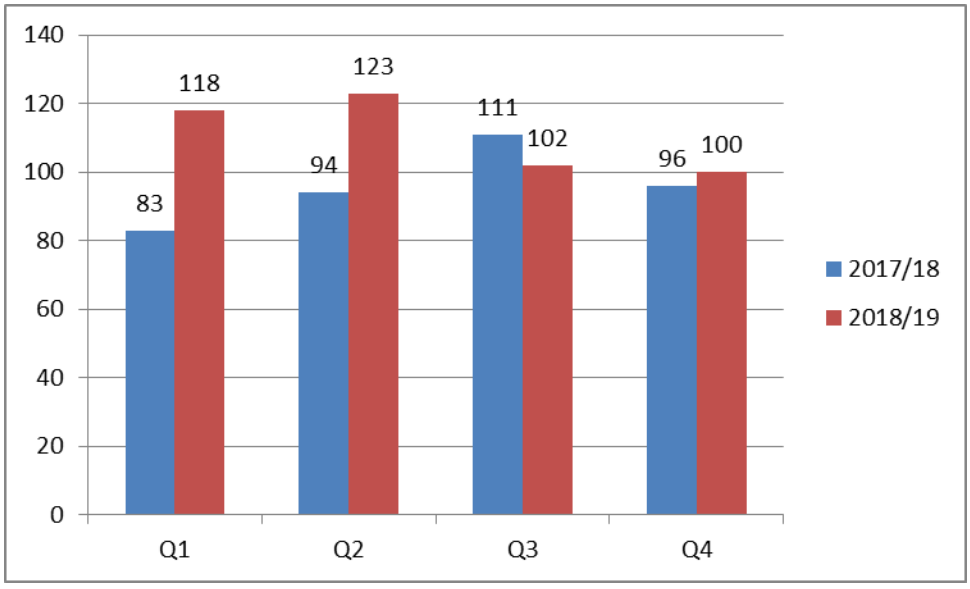
1. A full audit of the withdrawals and returns of morphine was undertaken at each station by the Clinical Managers, this was presented at MOG and CGG. No concerns were highlighted. It has been recommended that the LM for each station performs the same audit to review the withdrawals and returns, each station must be audited within a 3 month period. Looking at a minimum of one weeks documentation. This should allow the LM to have oversight of staff who change their use or do not use morphine at all. Any unusual activity will be investigated further.
2. The Supplies team have reviewed the maximum and minimum levels in each station and are monitoring the stock. A monthly report will be presented at the Medicines Optimisation Group (MOG), any anomalies will be investigated.
3. Morphine administration that is collected on the EPR will be presented in a report for monthly MOG meetings. This will be discussed at the next MOG to determine the format and information required.
4. The internal audit team have been tasked with performing a full audit on the CD process.

Controlled Drugs Incidents

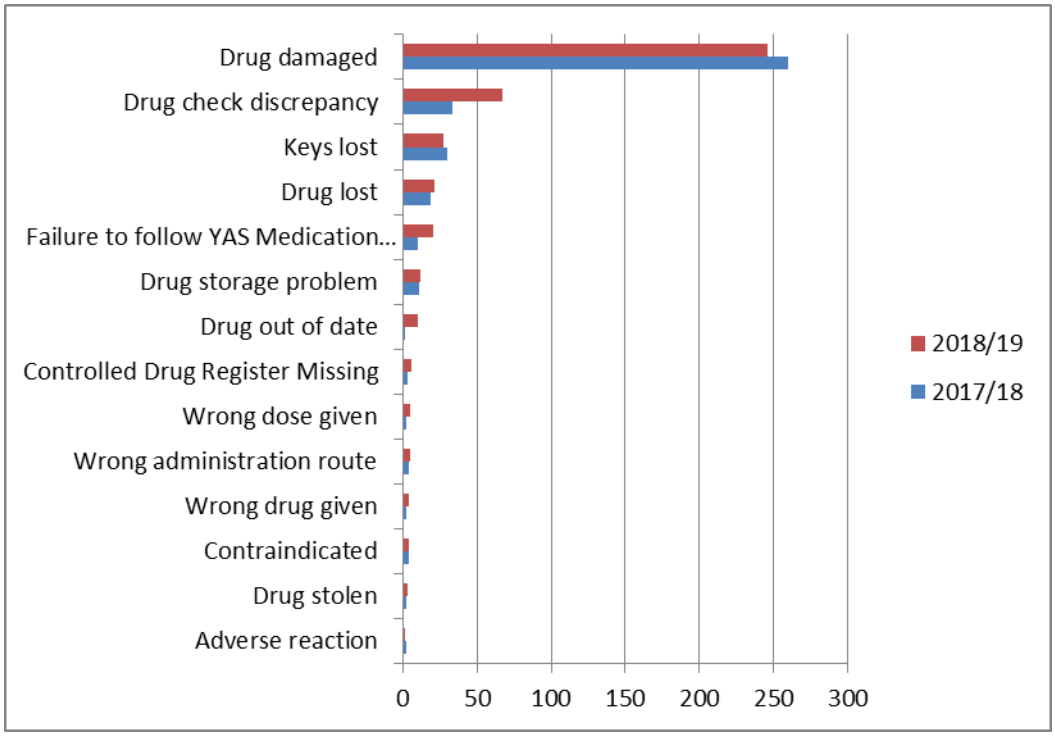
The investigation into a serious incident relating to the misuse of controlled drug incidents are analysed and broken down by sub-category, geographical location and severity for the Quarter to assess any trends.

The following charts break down the 2018-19 Controlled Drug related incidents compared to 2017-18 incidents.

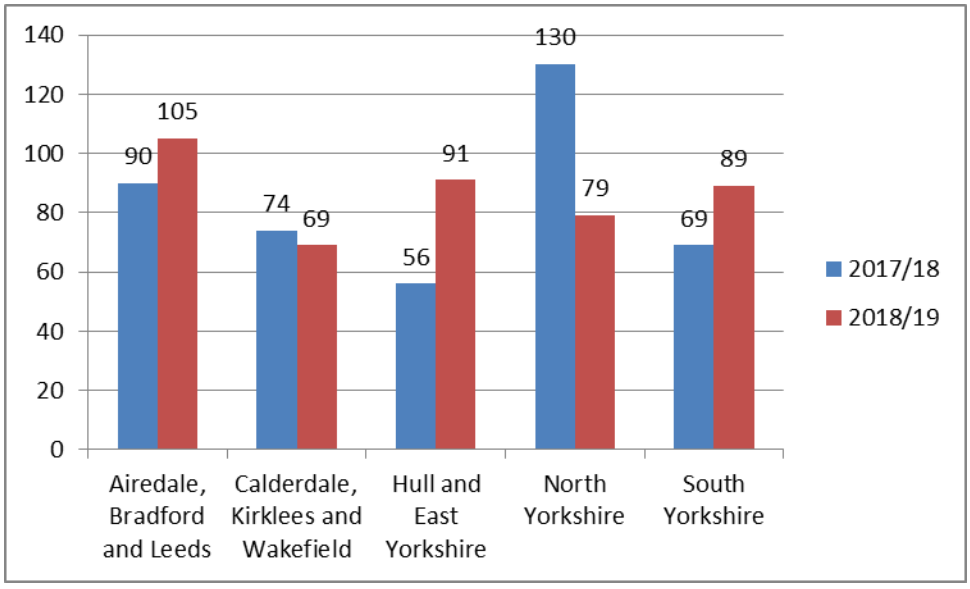
There were a total of 433 Controlled Drug related incidents reported to Datix during 1st April 2018 and 31st March 2019.



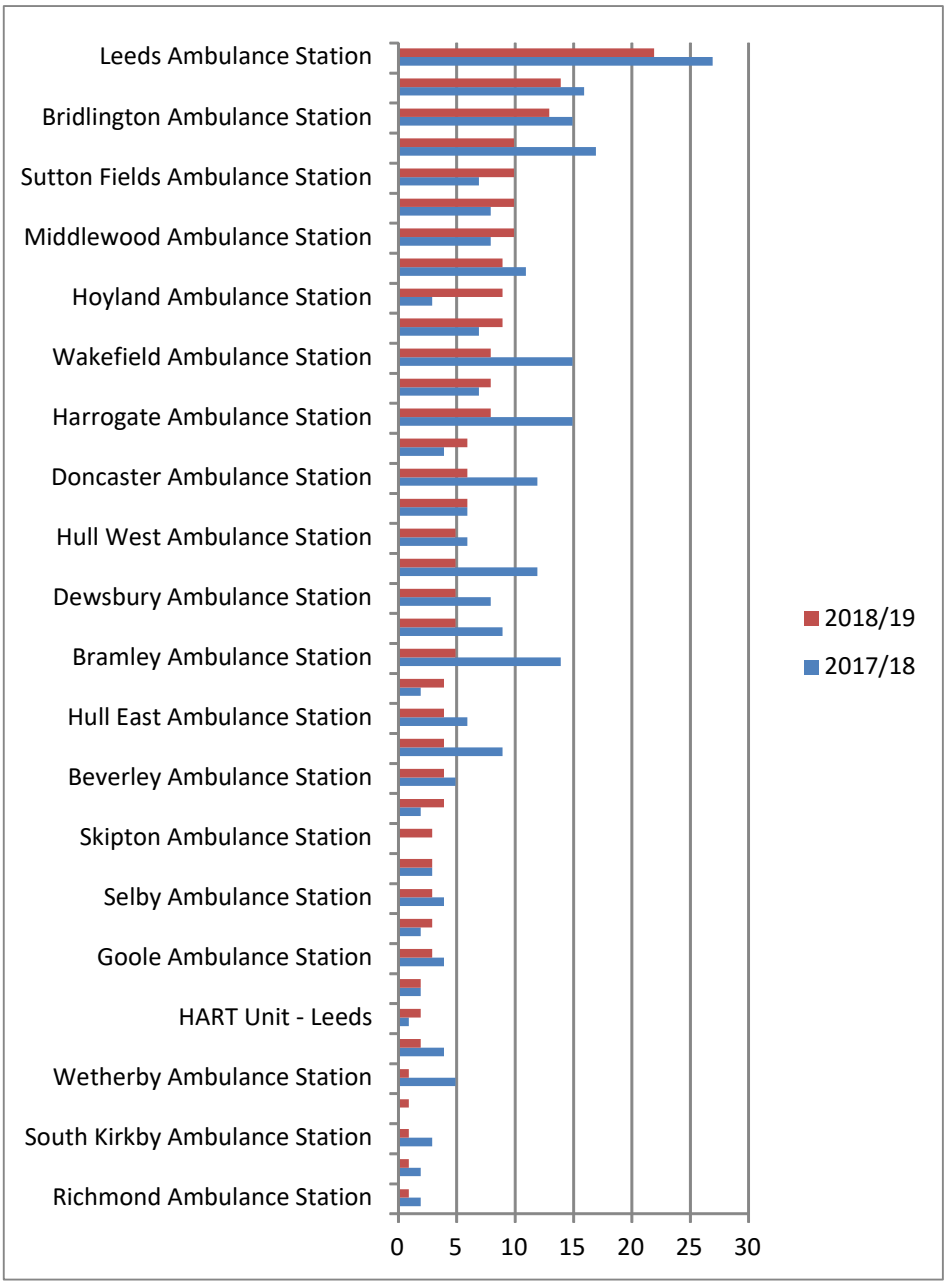
The following chart shows the Controlled Drug incidents occurring during 2018-19 and 2017-18 broken down by Sub-Category. There has been a further reduction in key loss, in the last 2 years there has been a 50% reduction in key loss from 55 to 27. However there has been a marked increase in drug check discrepancy, this is mainly due to documentation errors that occur during the completion of the register. One way to potentially improve this would be by moving to an electronic recording system. There has been double the amount of out of date medications identified, this is mainly due to diazepam now being treated as a CD, which took place during the second half of 2018-19.



The following chart shows the Controlled Drug incident that occurred in 2017-18 and 2018-19 broken down by Geographical Area.



This graph shows drug damaged in 2017-18 compared to 2018-19 broken down into location.



2.7.5 Risks

Fraudulent Medicines Directive – on the risk register

For YAS to adhere to the European FMD legislation we should have gone live by February 2019, however the uncertainty around the EU Exit has led to a stall in the process. NHS England have recommended that Trusts look at options and have funding in place. The Trust Pharmacist, Procurement Leads and IT have been looking at options, capital funding to upgrade the IT around medicines management has been approved.

EU Exit – on the risk register

Medicines shortages are already occurring, the clinical directorate business continuity plan has been reviewed and updated to include action cards for medicines shortages. The procurement lead for medicines and the Trust Pharmacist have got a medicine shortage escalation process in place. The Trust Pharmacist receives the national information around all medicines shortages and also liaises with the Ambulance Pharmacy Network to discuss issues arising.

2.7.6 Looking ahead - key priorities for 2019-20

The Medicines process improvement plan will be implemented during 2019-20 a pilot is planned for York and the AVP sites across the region. This will be paper based initially but will move towards an electronic system in the future with scanning from the point the medicines enter the trust to the administration to the patient.

As part of the Integrated and Urgent Care contract YAS are required tol become a prescribing centre during 2019-20, with electronic prescribing in the 111 centre. There are currently a number of pharmacists and Nurses working within 111 who have an independent prescribing qualification. The plan to include paramedic prescribing into the 111 centre will be implemented. YAS are working with Health Education England to support to national framework for paramedic prescribing

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.

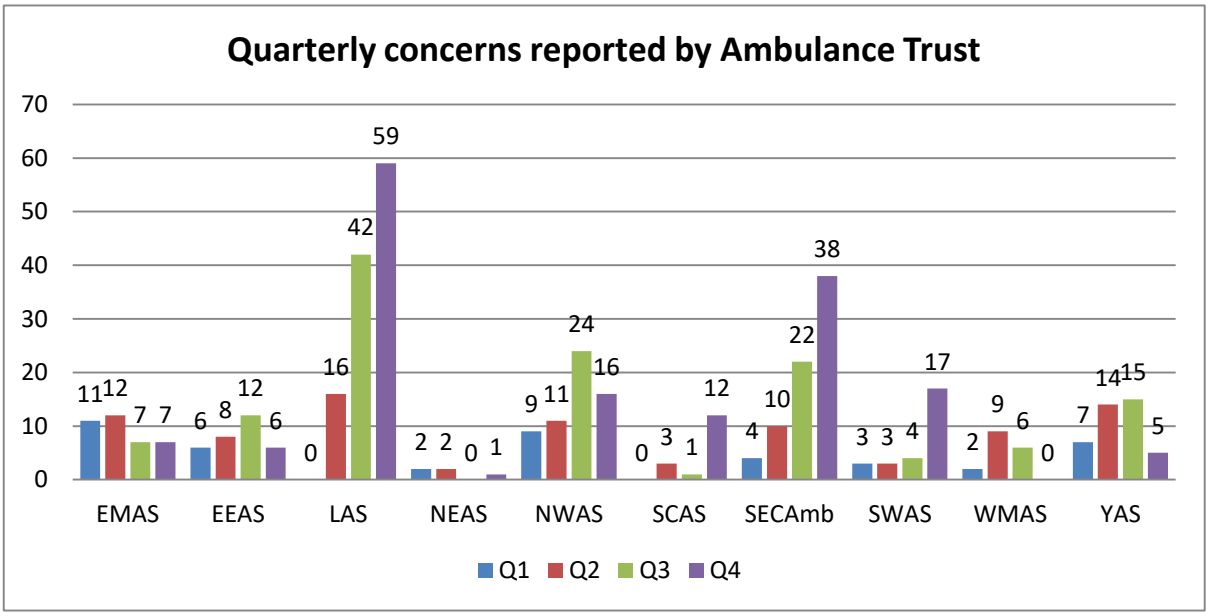
2018-2019 developed this further with the launch of the Freedom to Speak Up Strategy, embedded within the Trust's People Strategy. This outlines our commitment and vision for FTSU over the next 5 years. A Board self-assessment was also conducted in year to understand areas of improvement required and to frame how we progress as an organisation in our continuous implementation of an open, reporting culture.

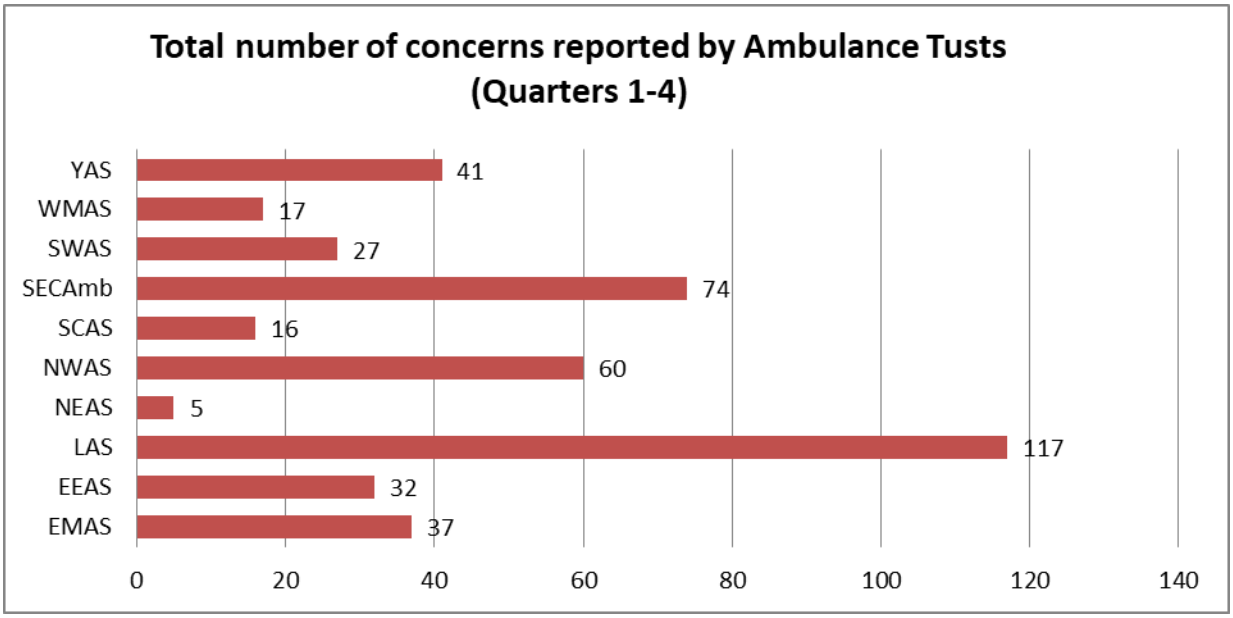
2.8.2 Recording of Concerns

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 2019. This concluded the second 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 Trusts are at different stages in their development of FTSU therefore data varies.

The two charts below indicate the number of FTSU concerns reported by quarter and in total from April 2018 – March 2019.

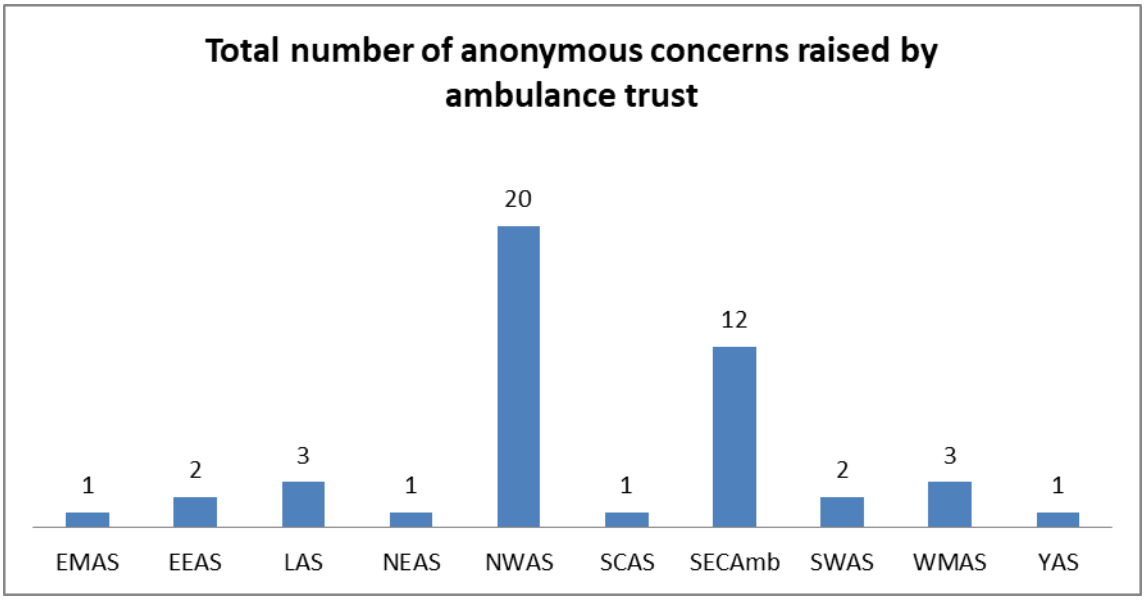




The NGO also requests data on the number of concerns:

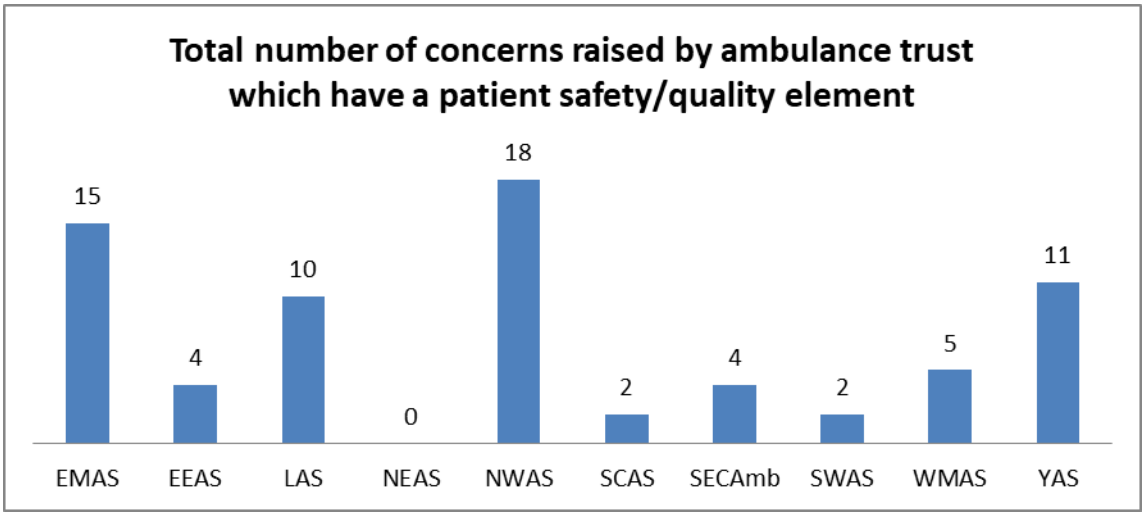
- Reported anonymously
- Which are believed to have an element of patient safety/quality
- Which are believed to have an element of bullying & harassment
- Where the reporter believes they are suffering detriment as a result of speaking up

The following charts indicate the responses from the ten ambulance trusts over the twelve month reporting period in relation to the NGO requirements above.

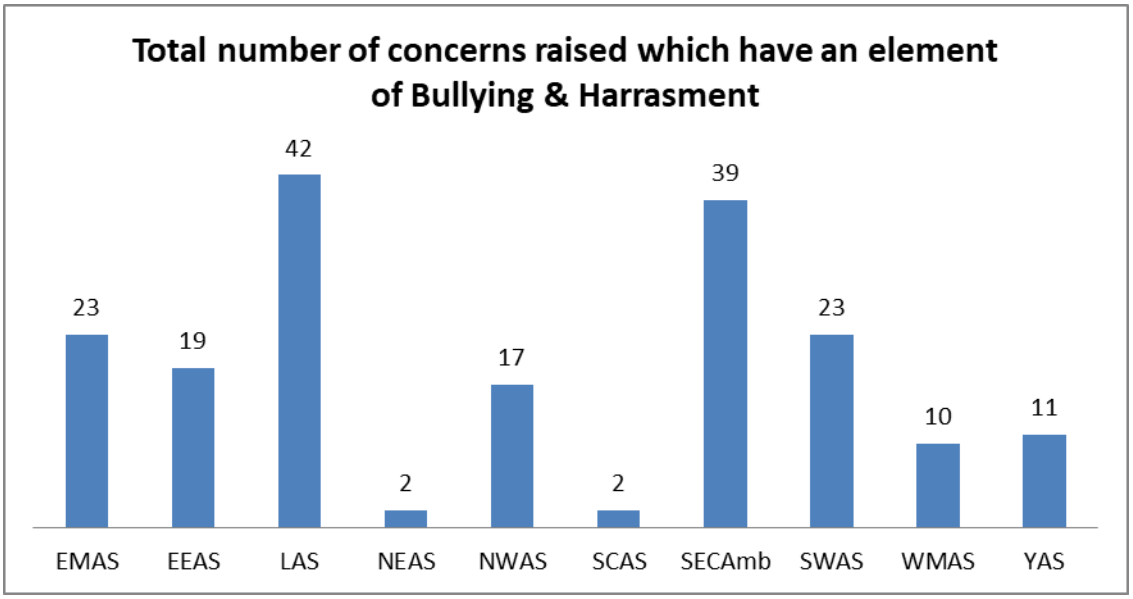


"Anonymous cases are those where the individual speaking up is unwilling to reveal their identity to you or to others i.e. you do not know who they are.

The number of anonymous cases received may be an indicator of the level of trust workers have in the speaking up culture in the organisation." [NGO 2018]

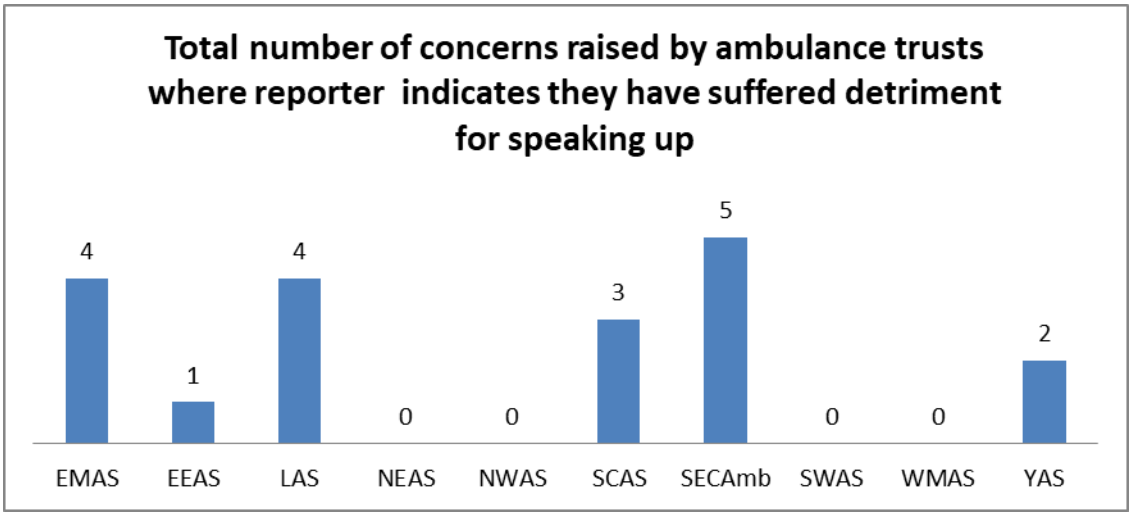


"Any case that includes elements that may indicate a risk of adverse impact on patient safety or the quality of care. Where it is not clear whether there is an impact on safety/quality without further investigation, but the individual raising the case believes that there is, then the case should still be recorded in this category." [NGO 2018]



"Any case that includes an element of bullying or harassment. Where the individual raising the case believes that there is an element of bullying or harassment then the case should be recorded in this category.

The NGO advises that the terms should be interpreted broadly and that the focus should be on the perceptions of the individual bringing the case." [NGO 2018]



"Detriment can be described as any treatment which is disadvantageous and/or demeaning and may include being ostracised, given unfavourable shifts, being overlooked for promotion, moved from a team, etc.

You should record the number of cases brought to you where an individual feels they have suffered detriment as a result of speaking up. In addition, should details of a case reveal elements of detriment as described, these should also be recorded even if the individual bringing the case does not identify detriment." [NGO 2018]

To improve the rigour of the FTSU process a concern tracker document was introduced in 2017-2018. 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 – 20
- EOC – 8
- Fleet & Estates – 2

- IUC – 3
- Corporate – 2
- Community Resilience – 3
- Other - 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 previous YAS FTSU Guardian Co-chaired this group up until February 2019 which meets every 3 months. In addition to ourselves the members include:

- 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 and at local inductions. 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

National engagement events attended by the FTSU Guardian included:

- National Ambulance LGBT Conference
- National BME Conference
- NHS Expo Conference

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

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

2.8.4 Learning from FTSU

The most noticeable theme to emerge from the concerns raised at YAS during the year involves recruitment and selection processes. A review of such processes within the HR function has taken place during the year with additional guidance and policy developed where necessary.

Two policies relating to standardising processes in HR which occurred during 18-19 are below.

Recruitment and Selection: Management Guidance – This was introduced to the Trust in February 2019 to assist managers in complying with the principles outlined in the recruitment and selection policy.

Recruitment and Selection Policy – This was reviewed and updated in February 2019. The purpose of this policy is to deliver the Trusts People Strategy through an open, fair and effective recruitment and selection process.

2.8.5 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 Trust is confident in its robust processes that are in place and are assured at the consistent volume of concerns that continue to be raised, representing an open and transparent culture.

2.8.6 Next steps for 2019-20

During 2019-20 the Trust will appoint a new Guardian into post following the three year tenure of the current post-holder elapsing. This will provide an opportunity to build upon the excellent work already in place and to continue to champion YAS at a national level for the drive towards culture change.

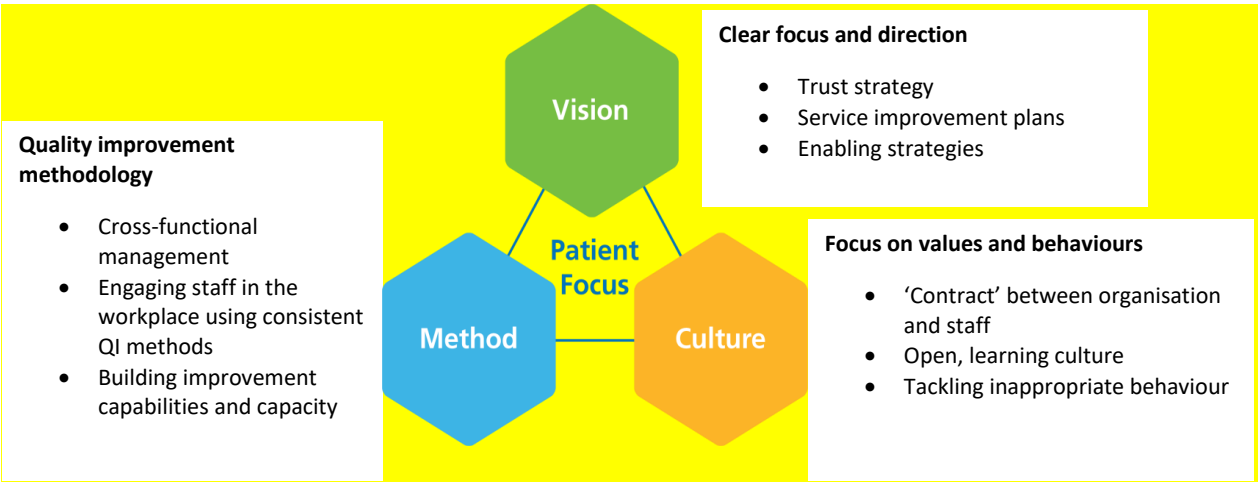
Section 3.0

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. Extreme staff engagement is supporting the development of a new Clinical Strategy, which will be published in 2019.

The Quality Improvement Strategy was launched in January 2019, to support the Trusts overall Strategy and complement the Clinical Strategy and the People Strategy. This Strategy supports the delivery of the Trusts strategic objectives by providing a clear focus and direction in line with the Trust's vision and values that has a sharp focus on values and behaviours, which is underpinned by the rigorous use of a consistent, quality improvement methodology. All elements are needed in equal measure for successful and sustainable transformation.



3.1.1 Progress against the Clinical Strategy for 2018-23

Patient Safety: Managing Clinical Risk – Zero Avoidable Harm:

Development of an early warning score for adults NEWS2 has been embedded in 2018-19 and now forms business as usual advocating a system to standardise the assessment and response of patients presenting with acute illness and ensuring an appropriate response to support care. A review of compliancy and use of the NEWS2 scoring system will take place in 2019-20.

Investigations and Learning training promotes incident and near miss reporting. RLDatix was procured in 2018-19, a new Datix cloud IQ system which supersedes generic incident reporting and provides the means to provide a deeper level of incident analysis. Within this new platform development is underway to provide a simplified form for near miss reporting, this is expected to be available for staff in 2019-20.

Evidence based Schwartz rounds were successfully launched in 111 in 2018-19. The purpose of rounds is to understand the challenges and rewards that are intrinsic to providing care. Rounds can help staff feel more supported in their jobs, allowing them the time and space to reflect on their roles. Evidence has shown that staff who attend rounds feel less stressed and isolated, with increased insight and appreciation for each other's roles. The underlying premise for rounds is that the compassion shown by staff can make all the difference to a patient's experience of care, but that in order to provide

compassionate care staff must, in turn, feel supported in their work. Work will continue to establish rounds in other service lines in the organisation.

During 2018-19 the Quality and Safety team have reviewed staff support during serious incident investigations and work to develop a second victim programme and support network is underway. The 'Just Culture' guide has been relaunched and has further promoted the openness and transparency to report. The Freedom to Speak up process also supports the open learning and 'Just culture' within the organisation.

The end to end review process for incidents is well established, where different services have inputted to the care delivery and something has gone wrong within that patient pathway. This is continuing to provide 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.

In 2018-19 safety huddles have been established and delivered regularly in EOC, PTS and A&E. All staff have been trained in safety huddles as a short multidisciplinary briefing process. The huddles have centred on safe care being delivered and involve agreed actions, informed by visual feedback of data and have provided the opportunity to celebrate success in reducing harm. These have been well received across the organisation with key risks emerging that have been addressed immediately. Development further will include the impact of human factors on incidents and review learning to make sustainable improvements.

3.2 Patient Safety

Moving Patients Safely

The Moving Patient Safely Group's main focus in 2018-19 was to review risk assessments for equipment used to move patients and utilised by PTS and A&E. Key equipment risk assessments completed with stakeholders of the group include:

- Pro-move slings
- PTS winch
- EZ Glide Chairs

Ongoing work to complete risk assessments for the Incident Support Unit's (ISU) complex moving equipment will be the key focus for 2019-20 and the effective deployment of the ISU for use with complex mobility patients. Continual reviews of new equipment is 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.

The MPS group has reviewed staff feedback, incidents and case studies related to moving patients and where appropriate implemented any learning identified from debriefs or incidents involving the movement of patients with complex mobility needs, such as bariatric patients. These are referenced with incidents highlighted by safety huddles and addressed swiftly.

The group ensures that policies and procedures; protocols and guidelines are in place to support YAS to achieve its responsibilities for ensuring the safe movement of patients. Key stakeholders of the group represent operational staff and this engagement supports that any anomalies in practice related to moving and handling can be addressed immediately through dialogue and agreement. The group provides support for operational staff, to mitigate risk and reduce potential harm to staff from moving patients whilst working in the

pre-hospital setting. The group has continued to provide expert advice to the Trust Procurement Group on suitable equipment for moving patients. It provides assurance to the Strategic Health and Safety Committee that the MPS group is taking all reasonable steps to support staff operationally when they attend incidents which pose a challenge in terms of mobility for the patient and staff.

In 2019-20 the moving patient safely group will participate in further dialogue with frontline staff through a Quality Improvement based initiative, a Breakthrough Series Collaborative to establish how moving and handling techniques can be improved in challenging pre-hospital scenarios, this will span 12 months and deliver findings in 2020.

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 2019-20 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.

3.2.1 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.

During 18-19 a total of 8,039 incidents were reported averaging at 670 incidents per month. This was a slight decrease against the previous year but this was expected due to the data cleansing as part of the re-launch in 2017 and the quality of the information contained in the system is much higher. Information obtained in the staff survey result reports positive improvements in relation to safety culture with more staff reporting that they feel they are

treated fairly when they report an incident, and having more confidence that the organisation will take action.

Support is provided to managers through the set-up of dashboards. 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. A Quality Improvement project was carried out during 2018-19 to identify areas for improvement to assist managers in this duty and this learning has been embedded into practice in some areas following completion of this project in March 2019. Further work with the Operational Management team in 2019-20 will aim to embed the best practice more widely across the Trust.

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).

A total of 2,457 patient incidents were reported in 2018-19 this was an increase on the 2,379 reported in 2017-18. The data demonstrates that the culture of reporting is being embraced within the organisation providing greater visibility of incidents and the development of learning to address these. 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% and for 18-19 this was 1.5%.

3.2.2 Number of Adverse Incidents for 2018-19

The breakdown of incidents can be seen below

	A&E Operations	EOC (Emergency Operations Centres)	PTS (Patient Transport Service) - Operations	NHS 111 & LCD	Other	Total
Apr 2018	367	58	69	44	34	572
May 2018	409	47	81	60	20	617
Jun 2018	341	43	110	52	48	594
Jul 2018	488	40	106	57	59	750
Aug 2018	457	44	84	54	55	694
Sep 2018	424	41	82	61	58	666
Oct 2018	427	19	130	65	61	702
Nov 2018	410	25	122	65	51	673
Dec 2018	421	58	91	74	43	687
Jan 2019	501	64	90	67	58	780
Feb 2019	348	38	95	71	34	586
Mar 2019	478	41	97	64	38	718
Total	**5071**	**518**	**1157**	**732**	**559**	**8039**

Keeping our staff and patients safe is the primary focus across the organisation as well as ensuring that the highest quality of care is delivered to patients consistently. This year we have seen an overall decline of incidents which supports the positive impact of learning from incidents and creating a positive reporting culture. One initiative utilised is 'Just Culture' as advocated by NHS Improvement, we are actively working with culture of

fairness, openness and learning from incidents that supports staff to feel confident when speaking up when mistakes occur.

Within 2018-19 the highest category of themes related to violence and aggression incidents to staff, response related incidents within the emergency service and Trust vehicle related incidents.

The Trust has robust processes in place for the monitoring of excessive responses to 999 calls whereby excessive responses of the following criteria are reviewed to identify patient harm. This was strengthened in December 2018.

The standard operating procedure within the Trust is for the Business Intelligence team to extract data which meets the below criteria:

- Response time is beyond the below threshold:
    - Category 1: 10 minutes +
    - Category 2: 40 minutes +
    - Category 3: 120 minutes +

and

- The patient is declared deceased or is transported to hospital with blue lights and sirens following attendance at the scene.
The review of these cases identifies that in the majority of cases, no harm is caused to patients.

Violence and Aggression remains in the top 3 reported categories of incident at YAS and the highest category of 'Affected Staff' incident. The category V&A includes physical assault; spitting, biting, punching and kicking, sexual assault, and verbal abuse; swearing, threats, racial and homophobic.

Conflict Resolution Training is being delivered face-to-face to frontline operational A&E Ops and PTS staff. The focus is on de-escalation techniques, the National Decision Model as part of the Safer Responding procedure, dynamic risk assessment and breakaway techniques as well as relevant legislation and theory. The Risk Team are working with the YAS Academy to review this package and develop training packages for other staff groups, including communication centres in 111, PTS and EOC.

Work continues to strengthen the support provided to staff, both the victim and their immediate line management team, to support staff in the most appropriate manner and increase numbers of sanctions applied. The Data Flag Review Group continues to review approximately 50 cases per month, scrutinising statements, intelligence from Police and other agencies in order to apply a warning marker to relevant patient information systems. The Security Manager writes to perpetrators advising of their unacceptable behaviour and the warning marker in place. We work with the Frequent Caller Case Officers where a patient is on their caseload and is verbally abusive in order to jointly manage the message regarding behaviours.

A Task and Finish Group has worked to formalise processes to support staff who are victims of violence and aggression, to apply a full range of sanctions and to pursue redress for damage to Trust assets. The Group includes representation from A&E Operations, Staff Side, and our Freedom to Speak Up Guardian, Legal Services, Fleet Department, Frequent Caller Team, and Health and Wellbeing, the LSMS and is coordinated by the Risk Team. A staff support booklet and managers' checklist has been developed and was launched

during Q4. The group has also agreed processes between corporate support functions who work in the pursuance of redress for damage to Trust assets; usually vehicles and equipment and the prosecution process.

Incidents Relating to Patient Care 2018-19

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

	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019
A&E Operations	76	79	74	86	72	71	72	80	94	146	70	137
EOC (Emergency Operations Centres)	27	24	25	26	21	23	9	14	33	45	27	25
PTS (Patient Transport Services) -Operations	28	26	45	40	39	34	54	47	37	28	32	45
NHS 111	33	53	40	60	46	51	57	50	59	57	54	49
Other	3	2	1	6	2	2	5	1	4	4	1	6
Total	**167**	**184**	**185**	**218**	**180**	**181**	**197**	**192**	**227**	**280**	**184**	**262**

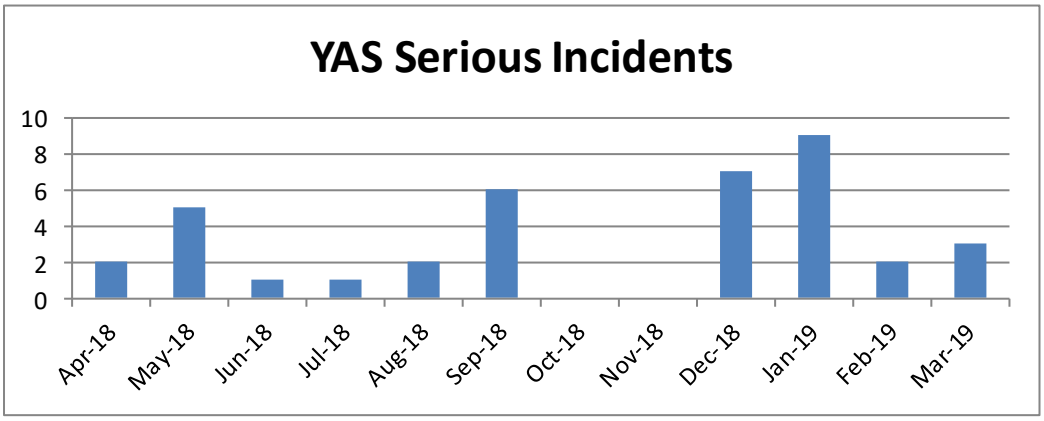
YAS continues to monitor incident rates against 3 key harms; falls whilst in receipt of YAS care, injury whilst in receipt of YAS care and medication errors whilst in receipt of YAS care. These are tracked on a daily, weekly and monthly basis using the “harm free care days” methodology utilised in the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

The safety thermometer ensures that frontline staff members are informed of the level of incurred harm in their patient group during care delivery for these 3 indicators. It supports the open and honest ‘Just Culture’ reporting 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 of cases reported may increase; however having now run the Patient Safety Thermometer for five years it is likely that we have reached an average baseline from which we can work to reduce these incidents, thereby reducing harm to our patients. Medicine errors are a good indication of progress that has been made within this sphere with incidents now falling year on year and evidence of reductions being sustained and best practice being applied.

Falls, injuries and medication errors make up a small proportion of reported patient related safety incidents, with rates being consistently below 0.05% harm. There is however patient harm that Yorkshire Ambulance Service has zero tolerance for. This has been aligned to the YAS strategic objectives and a zero avoidable harm work plan has been established spanning 2018-23. Key areas of this work concentrate on the procurement of the Datix Cloud IQ software, which will provide a further streamlined incident and near miss reporting system and will support the ability to provide an enhanced analysis of patient safety data and learning. Promotion of safety huddles is continuing across the trust with key areas adopting the process, initial feedback received is positive, in particular from EOC and PTS. Frontline A&E areas are initiating safety huddles in the North and these will be evaluated once established.

3.2.3 Serious Incidents

The Trust reports Serious Incidents in line with the National SI Framework and during 18-19 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	0	2	0	0	0	2	0	0	3	4	1	2
EOC	1	0	1	0	0	1	0	0	1	3	0	0
PTS	1	0	0	0	0	1	0	0	1	0	0	0
111	0	1	0	0	1	1	0	0	1	1	1	1
LCD	0	0	0	0	1	1	0	0	1	1	0	0
Other	0	2	0	1	0	0	0	0	0	0	0	0
TOTALS	**2**	**5**	**1**	**1**	**2**	**6**	**0**	**0**	**7**	**9**	**2**	**3**

f

3

38 SIs were reported in 2018-19. This compares with 37 SIs in 2017-18 and 51 reported in 2016-17. 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 2017-18 and 2018-19 in relation to the ambulance response, but these provided a sharper focus on identification of key learning.

During 2018-19 the cardiac arrest refresher training including ALS simulation commenced in the annual clinical refresher following a theme identified from SIs in 2017-18.

During 2018-19 the national Healthcare Safety Investigation Branch (HSIB) launched their maternity investigations. From December 2018 the HSIB undertake investigations independently where there has been a maternal death, a neonatal death, an intra-partum stillbirth or severe brain damage caused to a baby within the first 7 days of life. During 2018-19 YAS received notification of two cases where involvement was had in the handling of an obstetric emergency. Two of these cases were reported as SIs by YAS. Learning was identified from these cases in relation to confidence of clinicians in managing obstetric emergencies, in particular neonatal resuscitation. This will feature in the annual clinical refresher commencing in October 2019.

3.3 Safeguarding

The Safeguarding Team continue to build positive relationships both internally and externally with partner agencies to safeguard children, young people and adults at risk from harm or abuse. 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, volunteers and sub-contractors to identify safeguarding priorities to ensure quality patient care.
The key priorities for the team include:

- ensuring all staff are aware of their role and responsibilities in protecting the unborn, children and adults at risk from harm.
- the development of effective and appropriate safeguarding policy and associated guidance which accurately reflect statutory and mandatory safeguarding requirements.
- the review and development and delivery of effective training packages, to include face to face training for all substantive staff and volunteers.
- developing effective systems for the safeguarding referral processes
- investigating incidents and allegations against staff through robust root cause analysis methodology and reporting findings.
- working in partnership with external agencies and multi-agency partners, sharing appropriate and relevant information that contributes to safeguarding enquiries and case reviews.
- ensuring learning is shared across the organisation.

3.3.1 Memorandum of Understanding (MOU)

- A Memorandum of Understanding (MOU) is in place between 13 adult and 13 children safeguarding boards, 22 CCGs and Yorkshire Ambulance Service (led by NHS Wakefield CCG as the commissioner of YAS), to ensure multi agency working and clear lines of accountability across the geographical area of the Yorkshire Ambulance Service.
- The Children and Social work Act 2017 gained Royal Assent on 27.4.2017 and replaces Local Safeguarding Children Boards (LSCB) with new local safeguarding arrangements, led by three safeguarding partners (local authorities, chief officers of Police and CCGs). It also places a duty on child death review partners to review the deaths of children normally resident in the local area. The transitional period to Local Safeguarding Partnership arrangements were included in the MOU for 2019 -22, which was finalised in Q4.

3.3.2 Multi-agency working

The Safeguarding Team has contributed to Serious Case Reviews, Safeguarding Adult Reviews, Learning Lessons Reviews and Domestic Homicide Reviews across the Yorkshire region; provided reports to Child Death Overview Panels. Cases and associated action plans are monitored to completion via the YAS Incident Review Group (IRG) and approved for closure by Executive Director Lead for Safeguarding.

3.3.3 Safeguarding Training Compliance

The Trust is achieving its target for Safeguarding Children Level 1 and Level 2 compliance. Level 2 safeguarding has been developed in the YAS Volunteer workbook during autumn 2018.

Training	Q1	Q2	Q3	Q4	Delivery Method
Children Level 1	96.1%	94.6%	91.8%	95.0%	Workbook
Children Level 2	80.2%	85.8%	90.7%	93.0%	E-Learning
Adult Level 1	95.6%	94.5%	90.2%	94.0%	Workbook
Adult Level 2	58.3%	64.0%	79.7%	93.0%	E-Learning
Prevent Basic Awareness	91.2%	91.7%	91.2%	95.0%	Workbook / E-Learning
Annual Prevent Update	N/A	N/A	N/A	N/A	Staff Notice March 2019
WRAP (Trust Wide)	88.1%	87.6%	88.3%	89.8%	Face to face
WRAP A&E			88.5%	89.8%	Face to face
WRAP PTS			88.2%	89.9%	Face to face

Roles and Responsibilities face-to-face training, facilitated by the YAS safeguarding team complements the eLearning Level 2 product and promotes case based and scenario discussions. Staff in A&E Operations and PTS receive a two-hour classroom based session as part of their statutory and mandatory training.
All staff are required to have completed the eLearning course before attending the 'Roles and Responsibilities' classroom session. Train the Trainer model for NHS 111 has been strengthened.

The Workshop to Raise Awareness of Prevent (WRAP) continues to be delivered by tutors with Home Office facilitator numbers. NHS England has recently developed an eLearning course that meets the requirements of Level 3 WRAP and consideration of using the eLearning course will take place during 2019.

3.3.4 Level 3 Safeguarding Adults and Children

The Adult Safeguarding: Roles and Competencies for Health Care Staff, First Edition was published in August 2018 and the Safeguarding Children and Young People Safeguarding: Roles and Competencies for Health Care Staff, Fourth Edition was published in January 2019. It is proposed that face to face Level 3 Safeguarding Training, targeted to specific staff groups (**as appropriate to role**), requiring multi professional attendance delivered by Safeguarding experts, is to commence in 2019. This has been agreed and progressed via the Non Clinical Portfolio Governance Board and Trust Management Group.

3.3.5 Safeguarding Referrals

- Safeguarding Children Referral Form
- Safeguarding Adult Referral Form (Adult at Risk)
- Referral for a Social Care Assessment

During 2018-19, **16518** safeguarding referrals were made to adult and children social care teams. This is an increase of 11% from the year 2017-18.

Figure 1 Trust Wide Summary

	Safeguarding Referrals 2017-18	Safeguarding Referrals 2018-19
Safeguarding Adult	5650	2921
Safeguarding Children	5744	6627
Social Care Assessment	3448	6970
Total Referrals	**14842**	**16518**

Figure 2 Referrals by Service Line

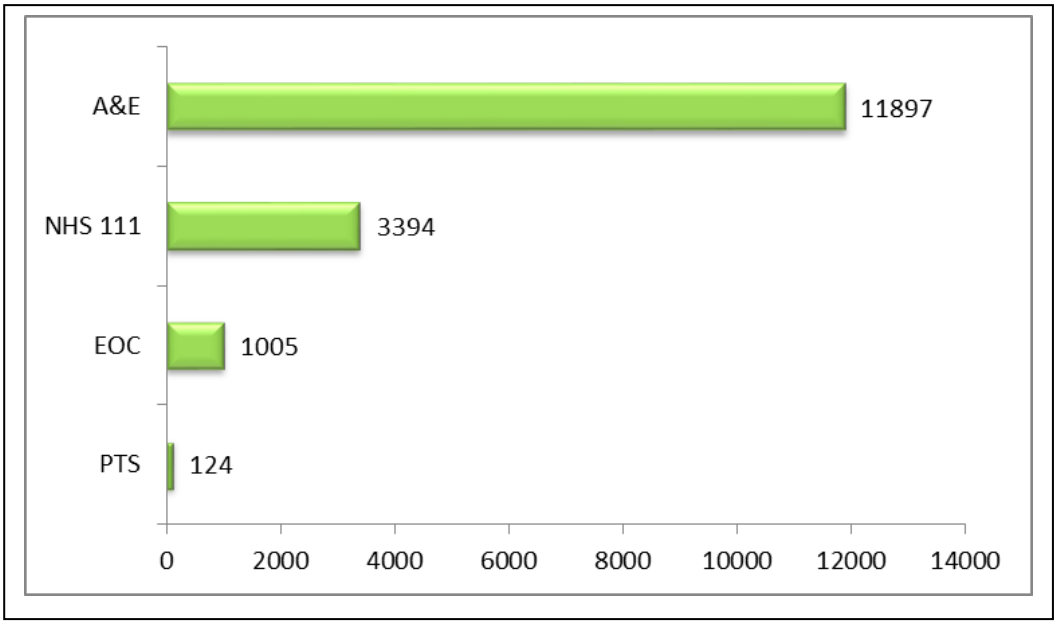
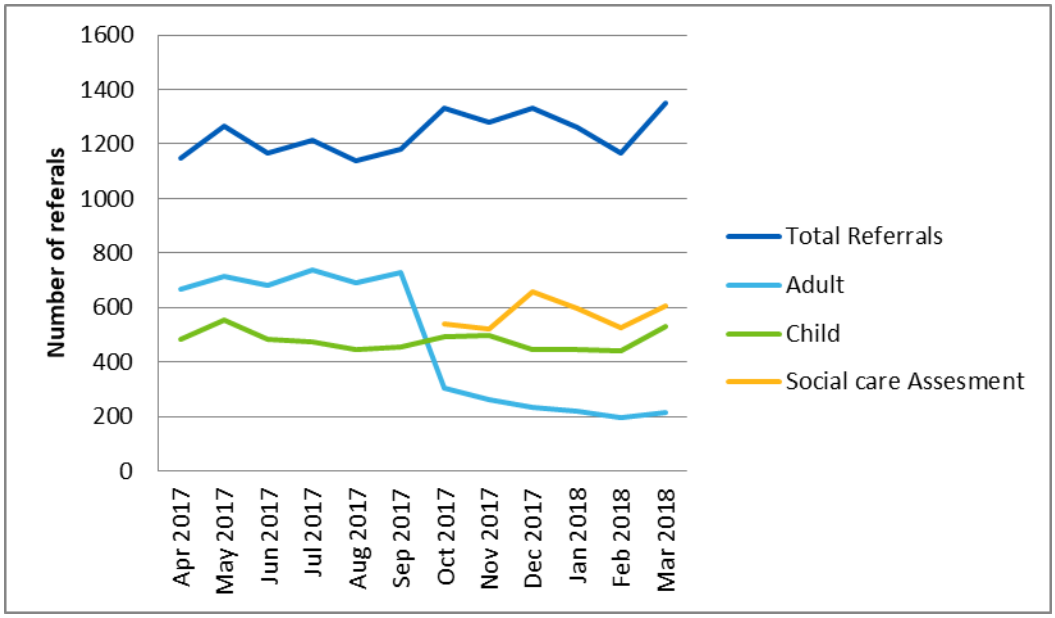


Figure 3 Request for Social Care assessments

Since the introduction of the request for a Social Care Assessment (SCA) in 2017 there has been an expected increase in the SCA and expected decline in the number of safeguarding adult referrals being made for abuse and neglect. This demonstrates the Safeguarding agenda is a priority in the delivery of high quality patient care and the importance of meeting our patients' holistic social care needs.



3.3.6 Safeguarding Audit

The Safeguard Module within Datix has been updated and refreshed to more accurately reflect the quality work completed by the Safeguarding Team that in turn informs the wider Safeguarding Children & Adult Agenda within YAS.

Trust wide Audit of Safeguarding referrals is complete and an action plan developed to address the gaps in the quality of safeguarding referrals. The safeguarding audit strategy for 2019-20 has been developed to continue to measure the quality and the impact of the revised safeguarding referral forms and the Safeguarding training products.

Themes identified through audit include:

It is evident that Yorkshire Ambulance Services practitioners are identifying risks and making referrals for safeguarding concerns and social care assessments.

There is an improvement in gaining consent for children's safeguarding referrals and the recording of where the child or other children are at the time of referral.

The Situation, Background, Assessment Recommendation (SBAR) is allowing for clear, concise and complete recording and information sharing.

There are some recording errors within the safeguarding referrals, including consent, mental capacity assessment and making safeguarding personal fields not always being accurately completed. However many of these were noted to be transcription issues when call handlers receive the referral information on behalf of the practitioners taking information. The development of safeguarding referrals and requests for social care assessment to be built within ePR will allow for the practitioner to complete their own referrals, as part of the completion of the patient record. This will be introduced in 2019.

3.2.7 Dissemination of Lessons Learnt

YAS safeguarding team are continually updating training products to reflect local and national learning.

- February 2018 – Amendments to Local Care Direct SoP for babies under 6 months.
- Staff Update April 2018 – Consent for Social Care assessment.

- Safety Update April 2018 – Bruising Burns or Scalds in non-mobile Child.
- Operational Patient Leaflet to include National Domestic Abuse helplines.

3.3.8 Developments during 2018–19

Safeguarding Audit is now embedded with both quantitative and quality measures, working internally and with our multiagency partners.
We are working with partner agencies, including commissioners, social care and health providers to improve our systems and processes to modernise and continually improve the service we provide to YAS staff and our children and adult board partners.

- Information updates on the Internet and Intranet (PULSE) safeguarding pages.

- Development of Level 3 safeguarding training plan (as appropriate to role) for Ambulance staff in YAS Training Plan for 2019 – 2020.
- Development of Level 2 safeguarding training for call handlers within Training Plan for 2019 – 2020.
- New Trust Chaperone Policy – approved; sits within safeguarding library of policies.
- Development of Paediatric Liaison Frequent Caller 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. It is anticipated that the role will be introduced as a pilot during 2019.

3.3.9 Safeguarding Risk Register

Level 3 Safeguarding Training	1208	Moderate Risk - 12
Trust Wide Safeguarding Referral Process	1219	Low Risk - 6
Level 2 Safeguarding Adult and Children Training	825	Low Risk - 6

3.3.10 Looking ahead - key priorities for 2019-20

The following priorities have been set:

- Information governance: embed safeguarding practice within Safeguarding module Datix.
- Review and update safeguarding policies and guidance.
- Work closely with board partners during transition of Local Safeguarding Child Partnership arrangement (as per LSCB rearrangement).
- Support frontline staff to attend multi-disciplinary child death & strategy meetings.
- Implement safeguarding referrals and requests for social care assessment into ePR.
- Face to face safeguarding case focused training to all service lines

- Level 2 Train the Trainers for NHS 111
- Continue to increase compliance with Safeguarding Adults training
- Continue to develop Level 3 safeguarding training (as appropriate to role) for Ambulance staff
- Explore the development of a Trust wide approach to safeguarding supervision aligned to wider clinical supervision and the Clinical Leadership Framework to support staff with reflection, education, training and learning logs. This will be a pivotal requirement for Safeguarding Level 3 competencies self-declaration in year 2 and 3.
- Workshop to Raise Awareness of Prevent (WRAP) current classroom model to be transitioned to Level 3 eLearning national product on ESR.
- Refine the Trust wide model for Safeguarding Induction with YAS Academy.
- Introduce pilot Paediatric Liaison Nurse role.

3.4 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.

3.4.1 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 or their department manager.

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.

3.4.2 Progress in 2018-19

- In 2018-19 the average response time to complaints was 32 working days against a target of 25 working days*.
- 88% of complaints met timescales agreed with complainants against a target of 85%.
- Only 6 cases were referred to the Ombudsman for investigation and 0 cases were investigated by the Ombudsman during the year.

** During the year there have been delays in accessing patient care records which are a significant requirement for complaint investigations to proceed. The roll-out of the electronic patient care record programme will improve this and we anticipate shorter average response times in the coming year. Standard operational procedures are in place to monitor individual and team workloads and the overall compliance rates are reported to the Board.*

3.4.3 Number of Complaints, Concerns, Comments and Compliments received 2018-19

The table below shows the breakdown of feedback received across the year and within different service lines.

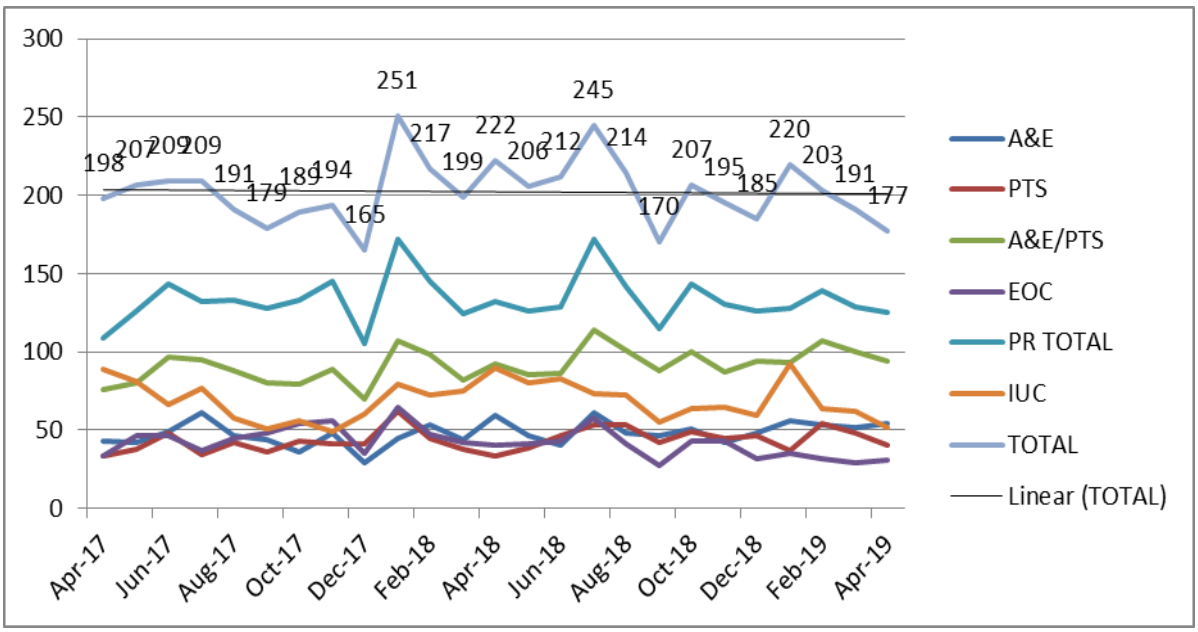
		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total 2018-19
EOC	Complaint	20	16	17	17	18	10	21	13	17	11	11	10	**181**
	Concerns	5	8	10	15	7	6	11	14	4	12	7	9	**108**
	Service to Service	15	17	15	26	13	11	11	14	9	9	14	8	**162**
	Comment	0	1	1	2	3	0	1	2	2	3	0	2	**17**
	Compliments	2	0	0	0	0	0	1	0	0	2	0	0	**5**
	Lost Property	0	0	1	0	0	0	0	0	0	0	0	0	**1**
	Patient Advice Liaison Services (PALS) Enquiries	3	2	2	1	1	0	1	0	0	0	0	0	**10**
PTS	Complaint	9	8	6	20	19	13	17	16	20	13	16	14	**171**
	Concerns	20	31	36	33	28	29	32	25	19	17	26	34	**330**
	Service to Service	18	18	32	23	32	25	20	28	18	17	20	16	**267**
	Comment	4	7	4	7	6	11	7	4	7	7	12	0	**76**
	Compliments	0	0	1	2	0	1	2	0	1	1	0	2	**10**
	Lost Property	3	2	2	6	4	2	5	3	5	1	6	8	**47**
	Patient Advice Liaison Services (PALS) Enquiries	2	6	6	4	3	4	4	3	0	0	5	1	**38**
A&E	Complaint	21	22	18	18	16	12	23	9	20	23	13	16	**211**
	Concerns	11	7	6	17	15	11	7	12	9	8	13	14	**130**
	Service to Service	17	17	12	26	11	13	21	12	13	16	18	17	**193**
	Comment	10	2	4	4	6	8	9	9	6	9	9	5	**81**
	Compliments	22	17	10	7	8	3	27	14	1	13	6	15	**143**
	Lost Property	13	25	35	33	36	28	31	15	30	34	26	23	**329**
	Patient Advice Liaison Services (PALS) Enquiries	8	9	17	18	22	11	13	9	8	2	7	15	**139**
NHS 111	Complaint	45	46	35	39	31	22	32	32	34	46	29	37	**428**
	Concerns	6	2	2	4	5	4	5	3	5	2	1	0	**39**
	Service to Service	34	32	43	30	31	29	27	28	15	38	30	20	**357**
	Comment	5	6	3	5	5	4	3	2	5	6	4	5	**53**
	Compliments	10	12	16	7	9	7	7	12	11	9	13	10	**123**
	Lost Property	0	0	0	0	0	0	0	0	0	0	0	0	**0**
	Patient Advice Liaison Services (PALS) Enquiries	0	0	0	0	0	0	0	0	0	0	0	0	**0**

3.4.4 Referrals to the Parliamentary and Health Service Ombudsman

In 2018-19, 6 complaints were accepted for investigation by the Parliamentary and Health Services Ombudsman (PHSO). During the year the PHSO completed 5 investigations – none of these were upheld.

3.4.5 Feedback by Area (2017-19)

Cases received (includes complaints, concerns, service to service (except PTS), comments, other NHS leading)

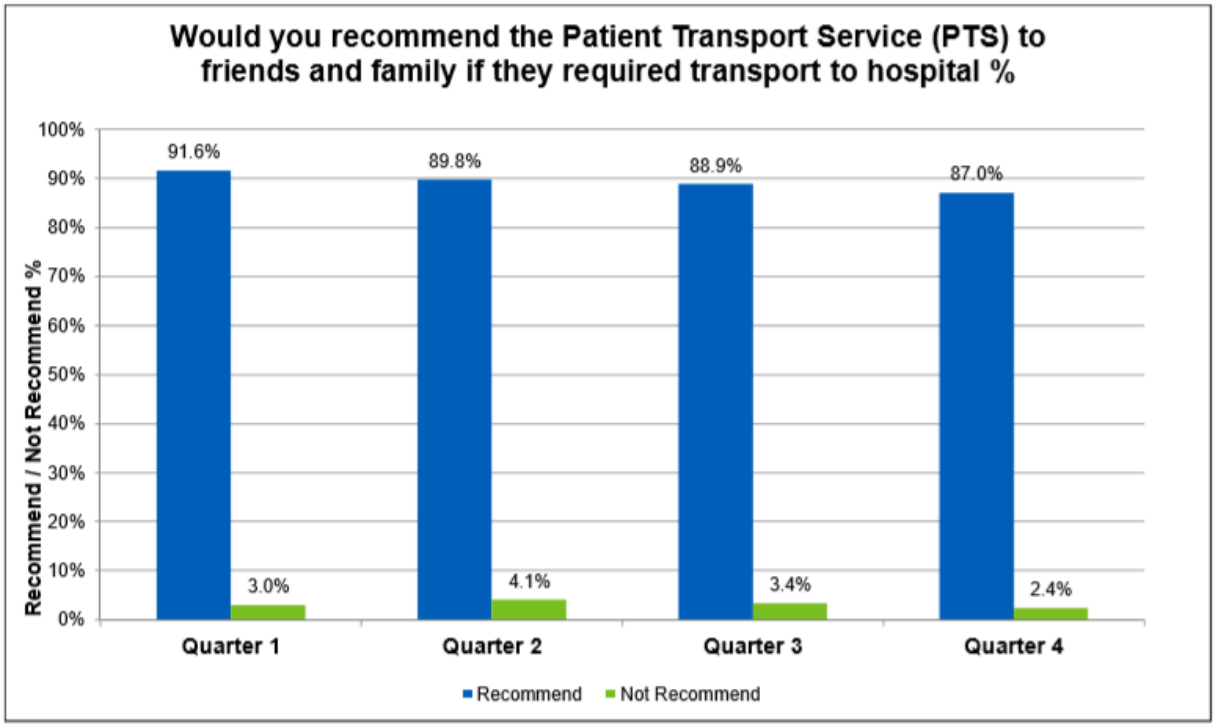


3.4.6 Cases responded to within agreed timescales (%) and average response timescale

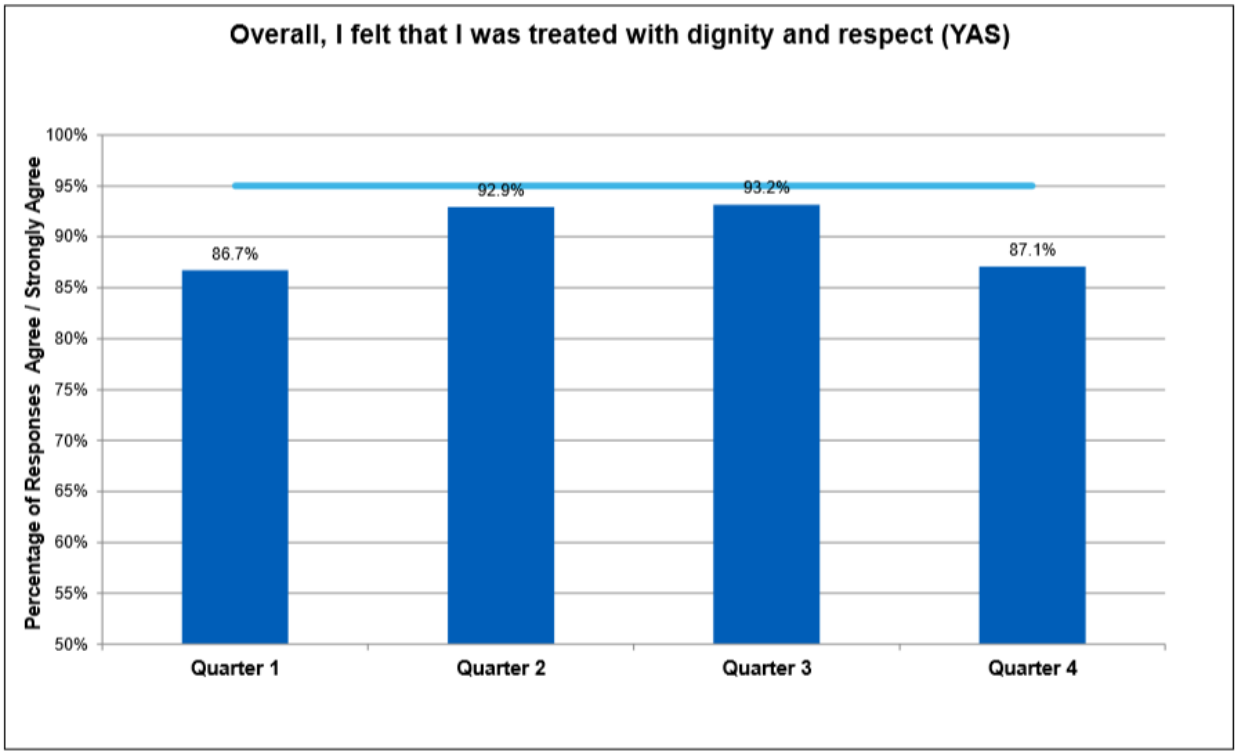
Month	% of responses meeting due date	Average response timescale (working days)
April 2018	92	34
May 2018	95	29
June 2018	95	36
July 2018	91	31
August 2018	83	31
September 2018	81	33
October 2018	90	33
November 2018	92	32
December 2018	82	31
January 2019	86	32
February 2019	89	34
March 2019	79	34

3.4.7 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.

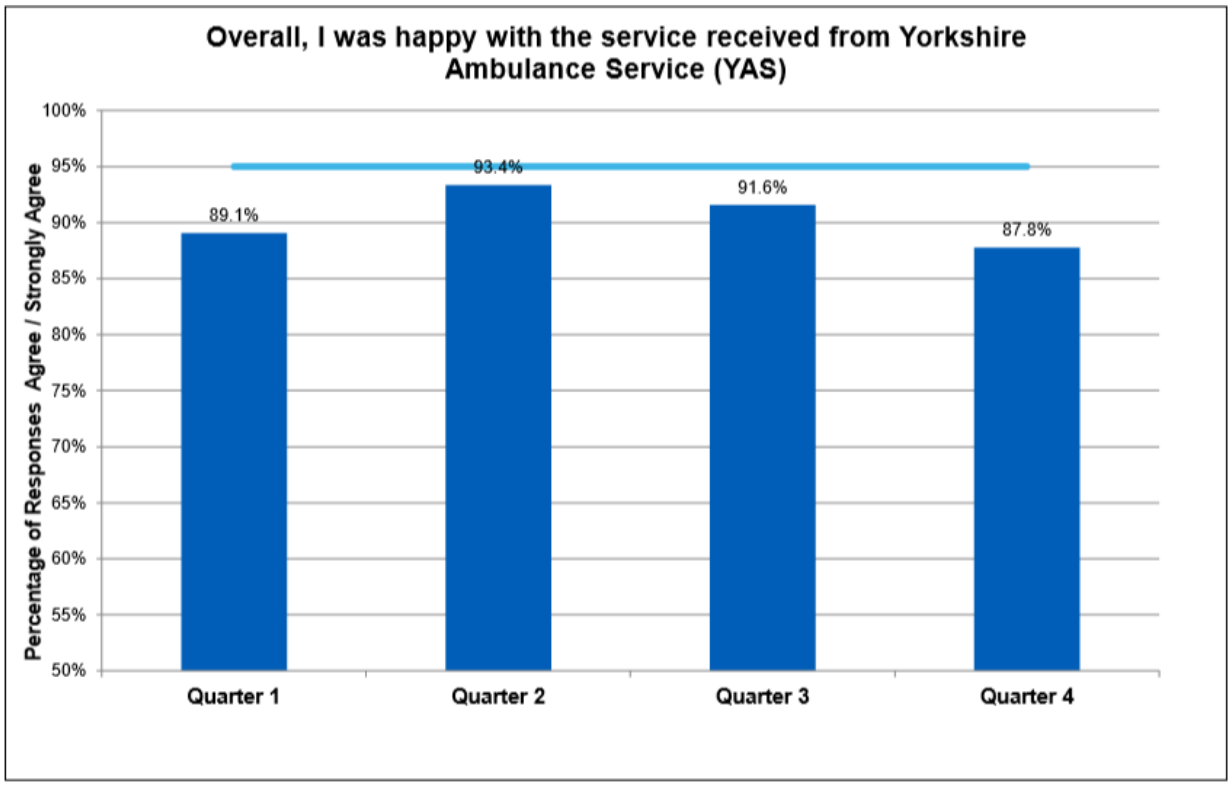


3.4.8 A&E Survey Results



Percentage of Responses Agree/Strongly Agree

3.4.9 PTS survey results



3.4.10 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.

A recurring theme arising from feedback received into the Trust is in relation to attitude and behaviours of operational staff. Often, communication skills play a part in this, in how information is communicated and/or received.

A particular theme for this was identified within South Yorkshire, in addition to other concerns raised within this area. During June-July 2018 workshops were held with Clinical Supervisors looking at the Trust Values and the YAS Behavioural framework. In addition, two “Professional Behaviour: A workplace Priority” 1 day programmes were arranged for April 2019 and June 2019 for Locality Managers and Clinical Supervisors which will be delivered with support from colleagues in East Midlands Ambulance Service. There will be potential for this to be cascaded further across the Trust should it prove successful.

One clinical treatment case was relating to a crew leaving a rhino clip on a patient’s nose too long and the patient being left in A&E not handed over to hospital staff. This complaint identified the need for guidance on the use of rhino clips and instructions are to be issued to crews.

One patient complained that a PTS crew transferred her from her home to the vehicle in her wheelchair. Her risk assessment states that she must be transferred in a carry chair due to the raised threshold and five stone steps to be negotiated. The patient was not harmed but felt unsafe and anxious. The investigation identified some learning needs for the crew and both crew members attended training school to retrain in moving and handling techniques and processes.

During Quarter 4 the service implemented a procedure that Clinicians review all 'attend ED' call outcomes for the appropriateness of the outcome. Also in Quarter 4 a Call Centre wide training day was held. Some of the topics covered were the use of DoS, and refreshers on SOPs including frequent caller process, call backs and CPR instructions.

3.4.11 Patient Stories

Throughout 2018-19, 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 in the Story to Board process have reported to have found it 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.

3.4.12 Duty of Candour – Being Open

During 2018-19 the Trust initiated the Duty of Candour process in relation to 56 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.
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.

3.4.13 Critical Friends Network (CFN)

YAS has a number of approaches to engagement with the public. The Critical Friends Network (CFN) was launched in 2016 and currently has 16 members from South, West and East Yorkshire. We continue to strive to increase the diversity within the group and two new members have been recruited that are from a BME background.

Throughout the last year the CFN has been a valuable forum for sharing ideas, gaining feedback and building the patient perception into our service developments. The CFN has provided feedback on a Quality Account, the National Ambulance Service Digital Strategy, the PTS wheelchair SOP, Project A and a Bright Idea submitted by a staff member within YAS. There has been CFN representation at the CQC mock inspections and on the panel for the Quality and Risk Coordinator interviews. Work has commenced on the Trust's first Always Event pilot, which has been co-designed with the CFN. One CFN member also helped to coproduce a training programme for staff members within the Clinical Hub as part of a Quality Improvement project by one of the Trust's QI Fellows.
During 2019 a representative of the CFN will also attend meetings of the Trust Quality Committee.

3.4.14 Always Events

During 2018-19 YAS launched its first Always Event within the PTS service. Always Events are defined by NHS England as “those aspects of the patient and family experience that should always occur when patients interact with healthcare professionals and the healthcare delivery system”. (NHS England, 2018).

NHS England in collaboration with the Picker Institute Europe, the Institute for Healthcare Improvement (IHI) and NHS Improvement have been leading the initiative to develop an approach where Always Events can be effectively implemented and embedded within frontline services.
Always Events is a co-production quality improvement methodology which seeks to understand what really matters to patients. Always Events should be agreed collaboratively between patients and staff and should not be professional standards, such as hand hygiene, which should be delivered anyway.
It was decided that a pilot would be beneficial within YAS to test the methodology and application of Always Events in an ambulance setting, and the decision was made to pilot this within the Patient Transport Service (PTS). This is due to having regular service users who frequently use PTS and are knowledgeable on what will help to improve their experience.
During October and November, intelligence was gathered by the Patient Experience Team through co-production to identify possible Always Events. This involved co-production with the CFN and PTS representatives, and visits to the Patient Reception Centres, as well as a review of the incident and complaint data from 18-19.
Through the intelligence gathered, a pilot Always Event has been agreed by the PTS management team and the Patient Experience Team. This is:
“The patient will always be briefed on the travel itinerary before they commence their journey”
The pilot began in February 2019 and will be reviewed in June 2019 with a view to roll out across the PTS service through 2019-20. The intention is then to design Always Events that can be utilised within the A&E and IUC service.

3.5 Clinical Effectiveness

3.5.1 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) a 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.

3.5.2 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)
- ROSC care bundle
- Outcome from cardiac arrest: survival to discharge – (Utstein group)
- Acute stroke care bundle
- STeMI care bundle
- Sepsis care bundle

Outcome from Cardiac Arrest

In 2018-19 Yorkshire Ambulance Service attended 3361 cardiac arrests, and achieved a Return of Spontaneous Circulation (ROSC) in 24.4% patients. The Utstein group showed a ROSC rate of 47.8%. (The Utstein group are patients who had resuscitation (ALS or BLS) commenced/continued by Emergency Medical Services (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 2018-19 is 10.2% for all cardiac arrests and 28.9% for the Utstein group. In 2018-19 a total of 328 patients survived to discharge following an Out of Hospital Cardiac Arrest.

The YAS 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	2018-19
ROSC	26.37%	27.4%	27.6%	24.4%
ROSC Utstein	57.14%	35.7%	47.2%	47.8%
Survival to Discharge	8.82%	10.1%	10.1%	**10.2%**
STD Utstein	37.05%	37.1%	27.7%	28.9%
Post ROSC care bundle *				36.8%

Post ROSC care bundle *

A new Ambulance Clinical Quality Indicator (ACQI) is the post ROSC care bundle. It outlines care expected to be delivered to those patients who have had a return of a spontaneous pulse following a cardiac arrest. Over 2018-19 the criteria in this care bundle has evolved over this year, with 2019-20 seeing the publication of an updated 'technical guidance' for all services to follow. This should result in the ambulance trusts being able to benchmark own and others practice with a common data set. YAS actions for improvement, over 2019-20 is the promotion of this and other care bundles, produced to station level performance for clinician awareness and for managers to use as motivation for improvement.

Outcome from Acute Stroke:

- Over 2018-19 the further development of ACQI for Stroke. For patients with a suspected stroke the focus on getting direct to scan benefits them in getting an early diagnosis and therefore treatment. The linking of ambulance data with the stroke sentinel audit programme known as SSNAP ensures trusts learn from the patients outcomes.
- The Stroke 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 2440 patients during May, August, November and February who were diagnosed with an acute stroke in 2018-19, 97% of patients received the full care bundle for acute stroke.

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 2018-19 YAS received 54,567 calls coded as chest pain and during April, July, October and January clinicians diagnosed 483 patients with ST elevation myocardial infarction (STEMI). Care bundle compliance was 67.7% at the end of 2018-19. 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.

During 2019-20 YAS are involved in national work to test the access to the National Institute for Cardiovascular Outcome Research NICOR to improve the share of outcome data. The aim is to develop themes and trends form this information to improve care and access to care for our patients

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 is now a new ACQI the components of this care bundle has changed over the period reported. During June, September, December and March YAS attended 2538 suspected sepsis patients, of which 51.6% received the best practise care bundle. Actions to improve involve the cascade to staff agreed set of standards in the care bundle which had not been agreed till recently.

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.

3.6 Local Audits

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

During 2018-19 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. YAS have been working with Mental Health trusts to improve access for our patients to community services with the aim of providing timely access to definitive care.
In 2019-20 YAS are supporting the development of a Mental Health Ambulance Quality Indicator. The primary objective is to provide trusts with a focus on accessing timely access for Mental Health assessment and treatments.

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 84,540 calls relating to falls during 2018-19, equating to approximately 6.5% of total calls received for the year. Just over 67% of falls calls involved patients in the over 65 high risk age category, according to CAD data.

Mortality

The monitoring of mortality within the health care system is widely used to provide an indicator for patient safety. Pre-hospital ambulance mortality reviews was until recently not clearly defined at a national level. However YAS has been proactive in developing its internal approach to mortality review and this has been in operation in the Trust, supporting learning and improvement, for the last 2 years. There is, under the new national guidance, now a nationally defined process for ambulance services to follow and the Trust has contributed significantly to the design of this process. The first reporting is expected in quarter 4 of 2019-20.

Clinical Documentation

In YAS, clinical documentation has been paper based for the last number of years. YAS generate over 2,450 forms in the course of a 24 hr period. Over 2018-19 we have introduced across the trust an electronic version of the existing paper form called YAS ePR. The ePR has been developed and a refined in house with significant input from front line staff.
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 2019-20 the YAS ePR will be further developed with new hardware being introduced in quarter 4 offering additional opportunities. These being access to patient's clinical records, e.g. GP or special records, increasing safety and informing decisions ensuring a right place first time model of care.

3.7 Quality Improvement

The Quality Improvement Strategy was promoted to staff via roadshows during January 2019 with an aim to increase knowledge and understanding of Quality Improvement throughout the organisation;

- For >20% of employed staff to have a functional level of Quality Improvement knowledge and experience by 2022;
- For Quality Improvement methodology to be embedded into Trust induction programmes and educational programmes;
- For Trust staff to have the confidence to make small scale changes within their teams and departments.

Quality Improvement Fellows

One of the main areas of focus during the 2018-19 period was the introduction of Quality Improvement (QI) Fellows. These QI Fellows would spend half of their employed time in their substantive role and half being supporting in learning and delivering QI. During 2018-

19, 8 QI Fellows were employed covering PTS, A&E Operations, EOC, 111 and Support Services. The QI Fellows received a number of training opportunities facilitated and supported by the Improvement Academy (IA). Initially, a five day induction programme was developed and delivered by the IA which provided trainees with an overview of Quality Improvement methodology and addressed some of the barriers that could be faced when embarking on a QI project. Silver Level QI training was then repeated in December 2018 to reinforce learning and the QI Fellows then completed the Gold Level QI training, enabling them to deliver the Silver Level QI training and aide the building of QI capacity throughout YAS.

The QI Fellows embarked on a number of ambitious projects throughout 2018-19 as detailed in the table below:

QI Fellow	Project	Outcome
Amy Ingham	Reduction in the use of paper for educational purposes	Time taken for educators to sign learner outcomes reduced from 3.5 hours to 0 hours. Time taken for learner packs to be complied reduced from 39 mins to 20 mins. Cost of printing (during test) reduced from £8.19 to £1.44. **OUTCOME:** To roll out across YAS Academy during 2019.
Carl Betts	Introduction of a mobile phone pack on front line ambulances	Project highlighted potential issues around phone access. Project now being co-lead by QI Fellow, Carl Betts and Head of Fleet.
	Barnsley District General Hospital Simulation suite pilot day for YAS staff	On-going
Craig Reynolds	Improving the time to final approval of incidents reported via DATIX	Reduced average time for approval from 57.8 days to 13.9 days. **OUTCOME:** To roll-out across YAS during 2019
	Improving the use of YAS TV	On-going
	QI app development	Complete. **OUTCOME:** To continue development in 2019-20

Gareth Sharkey	Reduce time to handover to clear	Deferred. Work being undertaken on larger scale
	Creation of a new training programme for paramedics in training in collaboration with the University of Bradford	Complete. **OUTCOME:** Delivered 2 x sessions to Bradford. Plans in place to work with Sheffield Hallam, Huddersfeld and Hull. To continue engagement with Bradford University
Jayne Bradbrook (Start date 01/10/18)	Reducing the number of falls in care homes in Sheffield	On-going into 2019-20 Testing Raizor Chairs and NaRT tool within care homes that frequently call 999 or NHS 111 in the Sheffield area.
John Porter-Lyndsey	Reducing MSK injuries for PTS staff by moving patients safely	Initial analysis concluded. **OUTCOME:** Analysis to inform larger scale project 2019/20 led by Iffa Settle – Head of Safety. Work to be taken forward as a Breakthrough Series Collaborative in 2019--20
	Working collaboratively with the Critical Friends Network and colleagues to create Always Events	Initial analysis concluded. **OUTCOME:** Analysis to inform Always Event project led by Rebecca Mallinder – Head of Investigations and Learning
Sakina Waller	Improving the self-care advice delivered during telephone triage	Training initiated through this project showed increase in confidence by an average of 10% and increase in understanding by an average of 30%. **OUTCOME:** Complete
	Improving collaborative working between the frequent caller team and the wider clinical hub	Introduction of a profroma reduced the time taken to log frequent caller information from 9:58 minutes seconds to 5:32 minutes. **OUTCOME:** Complete

	Reducing the interview time (and associated costs) for new recruits in EOC	On-going
Spencer LeGrove	Improving the receipt formal feedback on their clinical practice from acute NHS Trusts	Currently underway. Awaiting feedback.
	Implementation of the board of frustration	Implemented **OUTCOME:** To evaluate and roll-out across Hull & East
	Increasing the availability of crews awaiting a GP OOH phone back	Awaiting trial

The 2018-19 cohort of QI Fellows will become QI Advisors in 2019-20 and are taking a mentoring role for the new cohort. Each QI Fellow has been allocated one or two QI Fellows to mentor.

Core Quality Improvement Team

The core QI team and the PMO have been working closely together to align their skills and methodologies to ensure the most effective and efficient use of resources with regular bi-monthly meetings and joint working.

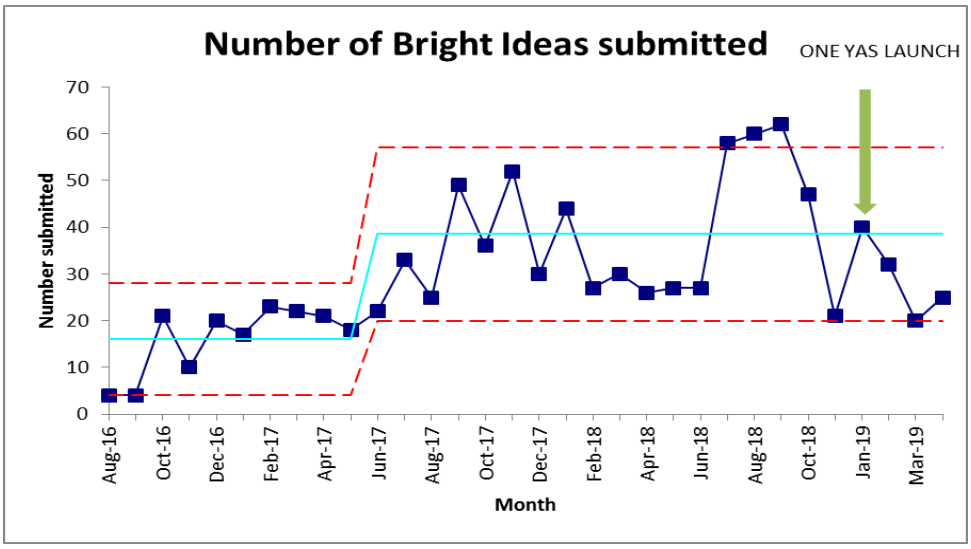
The QI App was launched on Pulse in January 2019. It contains information about the QI Team and project highlight reports from the projects being undertaken by the QI Fellows. Engagement with the Critical Friends Network has continued throughout the year with two further sessions focused around Quality Improvement having been delivered.

During 2018-19, several QI training sessions were held at Bradford University to student paramedics. Interest in this level of support from YAS has concurrently been received from Hull, Huddersfield and Sheffield Hallam Universities, who wish to be involved in this work in their next academic year.

The QI core team have been supporting #ProjectA, a programme of improvement for ambulance services with frontline staff and patients which is supported by NHS Horizons and AACE. The aim of the work is to allow front line ambulance staff and patients to have a voice in the improvement of ambulance services. The Head of Quality Improvement has been seconded to #ProjectA for one day per week to support the design of the workstreams. YAS are one of three ambulance services to have been selected to work with NHS Horizons.

Bright Ideas

The Bright Ideas Scheme continued throughout 2018-19 enabling all staff on an equal basis to propose ideas and suggestions. We have received a variety of Bright Ideas thought out the year covering a full range of YAS activity. The number of Bright Ideas submitted has continued to flourish and plans to further develop this method of staff engagement will continue into 2019-20.



Below is a selection of the ideas successfully implemented:

- Introduction of light blue epaulettes for student paramedics to distinguish their skillset from practising paramedics and the awarding of EMT1 & EMT2 epaulettes on completion of their course.
- Increased support for the emotional wellbeing of children who have witnessed a parent or sibling been given CPR, or even been doing CPR themselves. The 'child present at a cardiac arrest' suggestion has been discussed with the pathways and safeguarding teams. In addition, an amendment to the Resuscitation policy has been made with the decision that the child should be referred on to their GP for ongoing support.
- Replacement of SafetyGel with Absorbeze pads, a product designed to solidify liquids such as vomit to prevent spillage, reducing the risk of accidental ingestion by the patient and promoting patient safety.
- AEDs were placed on PTS vehicles to support crews in the rare event that they were required.

Priorities for 2019-20

- Continuation of the QI Fellow Programme with a second cohort in 2019-20
- Further development of the QI App including the creation of a QI toolbox aimed at providing staff with an overview of how to use QI tools.
- Strengthened Governance and project management is required as the number of QI focused projects grows.
- Development of further QI training opportunities for staff at all levels and the implementation of the QI Accreditation Programme.
- Initiation of training for student paramedics at Yorkshire Universities.
- Continued collaboration with NHS Horizons in #ProjectA.
- Focused workstreams introduced for 'Moving patients safely' and 'Measurement for Improvement'.
- Full evaluation of the Bright Ideas process, review and progress as necessary.
- Further embedding of QI approach across Trust functions to support delivery of Trust objectives.

Section 4.0

Assurance on Risk, Quality & Safety

4.0 Assurance on Risk, Quality and Safety

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.

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 Trust is highly likely to have a further planned inspection of services during 2019-20.

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 2018-19 in quarter 4 and launched during 2019-20. The refreshed version now utilises Statistical Process Control charts for which give greater clarity to performance trends and exceptions. 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 the 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 annual internal audit plan for 2018-19 focused on areas of key risk for the organisation. A total of 17 reports were produced with relevant assurance ratings, of which fourteen provided either 'substantial' or 'good' levels of assurance. One internal audit review reported a 'limited' level of assurance, and two reported a 'reasonable' level of assurance. These were as follows

• **Fixed assets (limited assurance)**: There was little evidence of a structured plan in place on how to verify assets (although significant work has been undertaken and the Trust has now verified **97.75%** of the £90,496k net current replacement costs on the fixed asset register). Other weaknesses related to some fixed asset procedures being insufficiently detailed or Finance not being notified of all disposals, albeit a number of robust mitigations have been put in place.

• **Attendance management (reasonable assurance)**: Expected processes were not being consistently followed when dealing with staff sickness, return to work interviews and special / carer leave. Documentation was not always present, fully completed or accessible to demonstrate expected processes had been followed. It is worth noting that we are in the process of introducing a new absence management system to support the attendance management process going forward.

• **Controlled Drugs Audit (reasonable assurance):** Some of our access and stock audit processes require improvement to ensure consistency of application and are being reviewed following the recent publication of this report.

These issues have been considered in the relevant management forums. Mitigation plans and actions have been agreed and are 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.
Overall, the annual opinion issued by the Head of Internal Audit provided good assurance that there is in place a sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. The Head of Internal Audit identified no significant control weaknesses.

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 2019-20

5.0 Looking Ahead to 2019-20

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 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 Quality Improvement 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.

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 Quality Improvement Strategy focusses on continuous improvement toward delivery of patient centred, high quality care. The QI strategy complements the individual work-plans through a coherent organisational approach to improvement, supported by both the Quality Improvement team and the Programme Management Office functions. Work-plans for each function have been developed and will be monitored through the existing management and governance arrangements in YAS.

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.

During 2018-19 an internal audit review gave a good level of assurance that risk management in the Trust is effective and that a good level of compliance is achieved. Work to further embed risk management in the organisation, leading to an even more mature and impactful function, remains a key priority. During 2019-20 the Trust's risk management and assurance strategic framework will be reviewed and updated. A development plan will be developed and implemented in order to strengthen key aspects of risk management policy, practice, governance, reporting and assurance. A significant activity will be migration to a new cloud-based enterprise risk management system as part of an upgrade to the Trust's suite of risk and incident management applications (Datix). This will deliver greater functionality and a more user-friendly system that is expected to support improved and more consistent risk management practice across the Trust.

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. Significant developments relating to leadership, organisational culture, staff engagement and well-being are being taken forward under the People Strategy (see YAS Annual Report). In addition, as part of the wider service transformation programme, the Trust will commence the implementation of a new Accountability Framework to establish clearer expectations regarding leadership

and management behaviours and responsibilities, and to support more effective decision-making and governance at all levels of the organisation.

During 2018-19 the Trust has continued to build on the solid foundations of safety, quality and governance established in previous years. There have been many achievements and innovations during the year across a wide range of functions and clear plans are in place to enable us to continue this positive development into 2019-20.