East Midlands Ambulance Service NHS
NHS Trust

Developing our Clinical and Quality Strategy

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Approved by: EMAS Trust Board

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Clinical and Quality Strategy 2014-2019

Contents

1. Executive Summary

The purpose of the strategy is to support the delivery of the integrated business plan where we have set out what we want to deliver to our patients, and how we want to deliver it

. The strategy clearly sets out our approach to the national clinical priorities which are emergency care, urgent care, mental health, the frail elderly, long term conditions, end of life care and public health and prevention.

To ensure that there is a clear strategy to support the delivery of a high quality service that is safe, effective and patient focussed, we are we clearly setting out our aims and aspirations for our patient experience, patient safety and clinical effectiveness. This strategy clearly sets out our aspirations for all our services to ensure that we are providing patient centred care and ensuring that **service users are receiving the right care, with the right resource, in the right place and at the right time.**

Specifically our aims are :

- To ensure that all services are clinically sound and well governed and developed in partnership with our patients and stakeholders.
- To meet the requirements of the national context, specifically the recommendations from the two Keogh reviews -of Urgent and Emergency Care; and of high Standardised Mortality rations; , The Berwick review of Safety, and Clwyd review of Complaints.; and the recommendations from the Francis report
- To meet the national ambulance quality indicators and the clinical performance indicators and continue with the improvement plan to ensure that we continue to deliver safe effective care.
- To continue to work with all our clinicians to ensure they have the skills and attributes to not only deliver high quality, clinically effective patient care, but also the unrelenting desire to deliver a positive patient experience.
- To safeguard the delivery of these aims, we will ensure that our clinicians are supported in their provision of care by effective clinical leadership at every level, incorporating well developed, clinically effective structures.
- To ensure a focus on patient safety, including sign up to the national safety campaign which will allow the Trust to build detailed plans on the reduction of avoidable harm.
- To encourage reporting of incidents , with our commitment to be open honest and transparent.
- To ensure that we have robust mechanisms to learn from complaints and compliments and that are responses are patient centred and that we learn from mistakes and are open and transparent in our communications with patients, families and stakeholders.
- To fully embrace patient engagement to work collaboratively with all patient representatives and patient forums and groups, so that we can truly say our patients are involved in our service developments and that we work in partnerships to deliver the care and services that meets the needs of our local populations.

Effective governance is central to the delivery of this strategy and we will ensure that there is effective measurement and reporting of key quality indicators ;to ensure that we understandthe quality of our services ;that we are sighted on the services that are delivering a high quality care and those that need to improve ;and to be assured that those improvements are agreed delivered and monitored.

This strategy is central to the delivery of our Integrated Business Plan, and is interdependanton the Workforce, Fleet , Estates and IMT strategies

The patient has to be the centre of all our services and the focus of all our efforts, central to all our strategies is the understanding and the desire to deliver high quality compassionate and effective care for our population .Iin order to deliver that the Trust has to work in full partnership and collaboration with

our staff, our patients, our patient representatives, our stakeholders and the general public. This theme runs through all our strategies as we endeavour to deliver a better patient care programme.

2.Context

National Policies

Several key reports outline the recommendations that Trusts need to adopt to ensure that they are delivering patient focussed, safe and effective care.

Keogh Review of Urgent and Emergency Care

The review of urgent and emergency care, undertaken by Sir Bruce Keogh 2013, sets out a vision of a system where patients with urgent but non -life threatening needs have access to highly responsive, effective and personalised services outside of hospital, which are delivered in or a s close to patients' homes as possible. Additionally, for those patients with serious or life threatening emergency needs, the vision is for their treatment in centres with the best expertise and facilities in order to reduce risk and to maximise their chances of survival and a good recovery.

- **Emergency Care** - Continuing to improve the clinical care for patients with life threatening conditions remains a fundamental priority for ambulance services.
- **Urgent Care** - Ambulance services need to work in partnership with other health care providers to help deliver a coherent 24/7 urgent care service. Ambulance services should become and be seen as community based mobile urgent treatment services rather than solely a means of transportation

This is a critical review process which we will need to consider carefully and ensure our strategy is focusses upon delivery of a service model which meets the opportunities it provides

Keogh Review into the quality of care and treatment provided by 14 hospital trusts in England .

- The main focus of the report was to ensure that the Trust board and patients and the public had access to accurate insightful and easy to use data about quality at service line level.
- Patients and carers and member of the public are treated as equal and vital partners in the design and assessment of their local NHS. They should feel confident that their feedback is being listened to and see how it impacts on their own care and the care of others.
- No Trust however small or remote will remain an Island and professional, academic and managerial isolation will be a thing of the past.
- Staffing will be monitored and skill mix will appropriately reflect the acuity and dependency of the patients that they are caring for.
- Organisations' will ensure that they are engaging and supporting staff and understand the impact of staff satisfaction has on the patient experience and patient outcomes.

Berwick Report on Patient Safety

The Berwick report A promise to learn and a commitment to act Improving the safety of patients in England (2013). The report focussed on the following key principles to ensure the delivery of a safe and effective service

- The report focussed on the need for the NHS to ensure that patients remain the focus of all services and that patient safety is seen as the keystone dimension of quality.
- There is a strong patient and carer presence in the organisation and that patients' are present and powerful within all levels of the Trust. The patient voice has to be heard and heeded at all times.
- To place the needs of patients, families and carers at the centre of all of the work of the Trust, treating them with courtesy and respect .and ensuring that we treat colleagues with the same dignity and respect.
- Acknowledge when care goes wrong and to be an open honest and transparent service.
- The Trust needs to recognise with clarity and courage the need for systemic change
- Abandon blame as a tool and trust the goodwill and good intentions of the staff

- Reassert the primacy of working with patients and carers to achieve health care goals.
- Use quantitative targets with caution, such goals do have an important role en route to progress but should never displace the primary goal of better care.

Francis report on Mid Staffordshire Foundation Trust

The report focussed on the common themes arising from the inquiry which focussed on the failings in the care provided at the hospital and the delays in this being reported and acted upon.

- There were negative aspects of culture.
- A lack of openness to criticism
- A lack of consideration for patients and a defensiveness.
- A willingness to look inwards instead of outwards,
- Secrecy
- misplaced assumptions about the judgements and actions of others
- A failure to put the patient first in everything that is done.

To change there has to be a relentless focus on the patient's interests and the obligation to keep patients safe and protected from substandard care. This means the patient must be first in everything that is done, there must be no tolerance of substandard care, frontline staff must be empowered with responsibility and freedom to act in this way under strong and stable leadership in stable organisations

Conclusions on national context

These reports have informed and shaped the Trust quality agenda and to ensure that the care that is delivered is safe, effective and patient focussed, that there are clear links between front line services and the Board and that the Board has a clear sight of the services that they are delivering and the patient experience and patient outcomes. We have benchmarked against elements of these key reports to ensure that we fully integrate the principles and recommendations into our strategy and to ensure that we continue to drive forward the quality in care. However there is more work to be done to ensure that we deliver all of their recommendations

. In addition, we will need to ensure we deliver the relevant recommendations from the Saville report , in order to to protect all patients and staff and to ensure robust safeguarding and whistleblowing polices are in place and that honesty and openness is supported, encouraged and championed.

Organisations need to show that they are continually listening, learning and improving services to deliver the highest standard of care consistently. It is therefore essential to ensure all voices are heard e.g. deaf and hard of hearing, blind or sight impaired, learning disability, mental health, language or cultural, religious observance, sexual identity etc. That lessons are learnt in a no blame culture and that we openly honestly admit when care goes wrong to patient relatives and staff and ensure that lessons are learnt and changes result from that experience.

3. EMAS Vision & Strategic objectives

3.1We are a healthcare provider. We provide healthcare on the move and in the community, and our vision is for EMAS ***to play a leading role in the provision, facilitation and transformation of clinically effective urgent and emergency care delivered by highly skilled, compassionate staff, proud to work at the heart of their local community***.

We believe this will support CCGs and other health and social care providers across the East Midlands in the delivery of a long-term, sustainable healthcare system.

The five-year plan maps our transformation journey from a mainly emergency focused service in 2014/15 to a future operating model whereby the organisation sits at the centre of the urgent and emergency care system.

This means it is our ambition for EMAS to act as the co-ordinating NHS organisation at the centre of the system, either providing care directly (e.g. over the phone or on the scene) or signposting/referring

patients to the best service to support them in their homes and the community, reducing admissions to hospitals where appropriate.

This model is designed to ensure the most appropriate and effective response to meet the needs of our patients and/or the referring clinicians. Put simply:

"…..supporting delivery of the right care, with the right resource, in the right place and at the right time."

3.2 Future Operating Model

Our current Integrated Business Plan (IBP), completed in June 2014 and covering the five year period 2014-2019, articulated that, in order to realise we will:

Years One and Two (2014-2016)

The current service model is based upon core clinicians (paramedics) operating on frontline vehicles and the dispatch of the nearest available resource to attend to patient care irrespective of the clinical need.

This model involves the deployment of our most skilled staff in all circumstances, and makes no allowance for case mix. Additionally, the majority of patients are transported to the nearest Accident and Emergency facility with little opportunity for our skilled staff to exercise the full range of their clinical judgement.

Whilst this model is effective at one level, in that patients are seen and treated promptly, we regard it as being unsustainable in the longer term where demand is increasing within a decreasing financial envelope.

In developing options for the future, we (working with our Commissioners) are clear we will want to retain elements of the model that support delivery of consistent operational performance and financial sustainability, whilst operating at the centre of a more integrated urgent and emergency care system.

- Focus on continued delivery of performance, delivering at a county level on a sustained basis.
- Further develop our Clinical Assessment Team to increase hear and treat and support our teams in the field in the use of alternative pathways and admission avoidance services (supported by Paramedic Pathfinder), utilising all local health and social care providers.
- Work in partnership with CCGs, acute trusts, community trusts, local authorities, private providers and the voluntary sector to develop and implement integrated admission avoidance services (e.g. Falls, Discharge services, Acute Visiting Services etc.).
- Build our capacity and capability to support future integrated strategic developments (e.g. eDoS, Paramedic Pathfinder and Telehealth & Remote Monitoring).
- Support delivery of the right care, with the right resource, in the right place and at the right time.
- Deliver excellence in patient experience and outcomes.

Years Three to Five (2016-2019)

Our proposed future operating model has, at its core, a whole system approach to urgent and emergency care, with EMAS acting as the co-ordinating entity at the centre of the system, either providing care directly or signposting to other services.

This model ensures the most appropriate and effective response to meet the needs of our patients and/or the referring clinicians. Put simply:

"…..supporting delivery of the right care, with the right resource, in the right place and at the right time."

- Be at the centre of the urgent and emergency care system, generating efficiencies across the healthcare system (e.g. multi-skilled staffing, better use of admission avoidance schemes, reduced conveyance to emergency departments).
- Provide a regional platform for an efficient and sustainable integrated urgent and emergency care system (e.g. integrated care records, coordinated assessment services, care plans, direct booking into services etc.).
- Identify gaps in the system, facilitating improvements, managing demand and pressure regionally.
- Aim to provide a significant portion of the patient transport services in the region, so we will be a provider of transport services across the whole spectrum of urgent, emergency and planned care.
- Aim to be a partner in 111 services, developing strategic partnerships and working more closely with other providers.
- Provide other services and new models of care as opportunities arise.
- Continue to support on-going delivery of the right care, with the right resource, in the right place and at the right time.
- Continue to deliver excellence in patient experience and outcomes.

In summary the EMAS strategy over the five years of this plan is to transform ourselves into an organisation that is able to achieve key performance and quality standards, supporting reductions in emergency admissions, in a consistent and sustainable way (years one and two).

From this position, we seek to expand our service offering, building on our unique position as a regional provider with core skills, infrastructure, capacity and capability in call centre management, clinical assessment and provision of transport, to position ourselves as the platform upon which the urgent and emergency care system in the East Midlands can become sustainable (years three to five).

Please see appendix two for a further breakdown the range of services and call category for ambulance Trusts.

We recognise that successful delivery of our strategy will be dependent on the achievement of a number of strategic objectives. We recognise that a key objective is the delivery of a quality service, and that we need to build a reputation among stakeholders as an organisation that can deliver a quality service. By quality, we mean delivering consistently within all three domains of quality: patient safety, patient experience and clinical effectiveness. In order to build a strong reputation, we will need to develop innovative service offerings that help to address the current and future challenges in the urgent and emergency care system in the East Midlands, and we will do this through working with partners to provide and facilitate greater integration. This will be delivered through skilled and motivated staff working within an effective and efficient organisation.

We have, therefore, identified six strategic objectives. These elaborate on the vision and strategy overview and provide a more detailed focus on how the vision will be delivered:

Our Quality: We will respond to our patients with a high quality service which consistently meets national ambulance targets quality indicators

Our Reputation: We will be recognised nationally as a reliable provider of high quality out of hospital and community based care across the East Midlands

Our Innovation ambition: We will be recognised nationally as a leading innovator in out of hospital and community based care

Our Integration approach: We will work in partnership with our local health care, social care, and voluntary sector partners to deliver and enable integrated patient services and care pathways across the East Midlands

Our People: We will consistently develop and support our people to be highly skilled, highly motivated, caring and compassionate professionals

Our Efficiency: We will make the most effective use of all our resources, delivering upper quartile performance on our indicators for money, staff, premises, and fleet.

The IBP identified that the development of our strategy would be underpinned by a series of supporting strategies, one of which is this Clinical and Quality strategy. The IBP also recognised that each of these supporting strategies would be reviewed to ensure they reflect, are consistent with and support the strategy and future operating model detailed in our plans.

Our IBP includes a future operating model that reflects the fact we know, in years one and two of our plan, we must place significant emphasis on:

- The delivery of core performance at a county level
- The delivery of clinical indicators
- the provision of a sustainable service

4. Implementing our strategy – Outcomes and Performance Indicators

Ensuring we are delivering our clinical and Quality strategy will require us to consider a variety of outcomes and indicators.

4.1 Ambulance Quality Indicators ('AQI's)

We publish our quarterly clinical effectiveness report detailing our performance against the national Ambulance Quality Indicators (AQIs) and Clinical Performance Indicators (CPIs). These are a nationally agreed set of clinical metrics essential to review the quality of clinical care delivered.

The current AQI/CPI topic areas are as follows:

- National CPIs
- Asthma
- Falls in elderly patients (commencing 2014)
- Febrile convulsion
- Single limb fracture

In addition there are monthly indicators which we monitor :

- Cardiac arrest – return of spontaneous circulation (ROSC) and survival outcomes.
- STEMI – patients transferred for primary percutaneous coronary intervention (PPCI) within 150 minutes.
- Stroke care
- Face, Arm, Speech, Time (FAST) test positive stroke patients, potentially eligible for thrombolysis within local guidelines, transferred to a hyperacute stroke unit (HASU) within 60 minutes.

Locally agreed CPIs

- Exacerbation of COPD
- Suspected fractured neck of femur

4.2 Clinical audit

Our clinical audit team reports all CPIs and AQIs internally every month, to enable closer monitoring than the national programme allows. This detailed information, including county-level breakdowns, is disseminated to stakeholders each month. In addition this data analysis allows for the development of services, care and individuals in order to improve care delivery.

We are committed to illustrating the clinical effectiveness of its interventions and as such will continue to support and educate clinicians in these care bundles, build the structures and increase the awareness of the positive impact that focusing on these interventions will mean to patient care.

Future developments in respect of Clinical Performance will focus towards a greater emphasis on clinicians 'owning their performance' with greater accessibility of an individual clinicians own delivery against these measures. Forming part of each staff members' annual review and ensuring each paramedic and ambulance clinicians has a complete understanding of their delivery against established evidence based practice

4 .3 Commissioning for Quality – ' CQUINNS '

Requires form of words to be agreed with commissioners

4.4 Regulation – Care Quality Commission

The Care Quality Commission is our regulator who ensures that Providers meet essential standards of quality and safety within a well governed and financially robust framework.

Our most recent inspection has resulted in a programme for improvement and progress against these standards is monitored through the Better Patient Care Programme that reports directly to the Trust Board

The approach for ambulance trust inspection is currently undergoing change and our approach towards ensuring we meet the requirements for satisfactory compliance will be updated and refreshed as this strategy develops

4.5 Specific areas for improvement

4.5.1 Cardiac Arrest

We have been keen to focus our attention upon the improvement of successful Return of Spontaneous Circulation (ROSC) rates in cardiac arrest. The gathering of AQI data has illustrated this is a worthy emphasis and as such the organisation developed a cardiac arrest strategy, aimed to deliver these advances. Following publication of the strategy, we have invested heavily in the delivery of a more clinically effective means to care for these critically ill patients. This has included the provision of mechanical CPR, the adoption of the 'pitstop strategy' or managing cardiac arrest, ensuring cardiac arrest attempts are streamlined with the provision of a number of interventions intended to support ambulance clinicians in these stressful situations. Early indications are illustrating a positive impact from these interventions but we are keen to ensure this growing momentum is built upon. Subsequent developments will work to provide clinical leadership at the scene of incidents of this nature, focusing on the most appropriate care needs of the patient and supporting clinicians through a positive team-based approach. (Please see cardiac strategy in appendix one for further details.)

We have a robust essential education programme that ensures that staff are sensitive to the needs of the population that it serves and that our policies and procedures are fully compliant with the equality and diversity legislation and best practice. We must ensure that it has strong links with our local communities to ensure joint planning in place to meet the needs of our local population

4.5.2 Mental Health - Mental Health patients are often overlooked, and it is our desire to give parity of esteem to those who are in crisis. Calls to mental health patients are common presentations to 999 and urgent care settings at times of crisis and can result in frequent calls from some patients

.We aim to provide a high level standard of education to our clinicians and a robust pathway for patients who are presenting with mental health issues and for that reason we recognise this is a clinical priority area

.We have recently formed a mental health steering group to ensure that current and proposed work streams that fall under the remit of mental health can be discussed and there are clear governance arrangements and reporting process for new initiatives and projects that allow EMAS to improve the services that it currently provides to this group of patients

EMAS has signed up to the national mental health crisis concordant and is meeting with each multi professional locality to agree the plans that will radically change the care of patients who at their most vulnerable dial 999, to ensure that our response is measured patient focussed and ensures that patients can access the most appropriate service to meet the presenting complaint. Part of this response is the mental health triage car that has been piloted in Lincolnshire and has dramatically improved the care of these patients and ensured that they can access mental health services rather than the local A/E. .

4.5.3 The Frail Elderly and Falls- Falls are one of the most common primary presenting complaints to ambulance services and we appreciate the fact that we have an ageing population placing additional demands upon services. The frail elderly commonly present to ambulance services and represent a large proportion of acute admissions to hospital. NICE (2013) state that the over 65's have the highest risk of falling, with 30% of people older than 65 and 50% of people over 80 falling at least once a year. Given that ambulance services are commonly the first point of contact following the falls episode; opportunities for improvement in care are significant. EMAS has a falls service which aims to assess patients and agree a care plan that ensures that they can remain at home rather than being conveyed to hospital when they require no medical intervention

4.5.4 Long term conditions - Patients with long term conditions should have a personalised care plan and along with carers and relatives be supported in how to manage their own condition. However, many people may be undiagnosed or have an exacerbation and feel it necessary to access emergency or urgent care. EMAS needs to recognise this need and work with partner providers to manage these patients' more effectively within a community based setting.

4.5.5 End of Life Care - Ambulance services may be involved at any stage of a patient's care towards the end of life. Planned journeys include transferring patients who are approaching the end of life, for example from acute setting to preferred place of death. Unplanned involvement is common when a patient has a sudden crisis or deterioration, worsening symptoms and anxious carers and family members call 999. Paramedics are frequently at the scene at or shortly after the point of death, and have to make decisions on whether resuscitation is required or if it would be futile, often based on limited knowledge of the patient or their end of life plan at this point. EMAS has signed up to the leadership alliance for dying and is ensuring that it is working across all communities to ensure the sharing of information that allows all patients to access appropriate services and assistance to enable them to remain in their preferred place of care. EMAS needs to continue to ensure that we are culturally sensitive and knowledgeable about the values and faiths of the communities that we serve.

4.5.6 Public Health & Prevention - Ambulance services can make significant contributions to the public health agenda. Ambulance clinicians are routinely in situations and in patient's homes where they can identify health care prevention issues such as lack of heating, social care needs, mental health needs and the recognition of vulnerable adults. This information needs to be shared with other health and social care partners and more referral pathways developed .Engaging with health partners and networks and participating in collaborative health improvement initiatives is an essential and very important

engagement activity for the Trust. If we do not do retain the capacity to effectively work with our stakeholders, this will compromise the Trust's credibility effectiveness and reputation

5.0 Strategy Stakeholder Engagement

Requires this section to be expanded

5.1 The strategy has been developed and will be shared across all departments and clinical areas to ensure that it is shared and everyone has an opportunity to comment on the content.

5.2 It will be shared with our external stakeholders our patients' and Public including our patient forum, health watch and our commissioners.

5.3 Through the equality and diversity manager to ensure that we reach the hard to reach and vulnerable members of our community

5.4 Shared through the communications team to ensure that it is communicated internally and externally through the agreed channels.

6. Enabling Quality Improvement

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6.1 Ensuring Patient safety

Patient safety is the priority for all health care organisations and is the priority in all aspects of the care delivered by all staff and is part of the framework that underpins decision making within the organisation.

We need to ensure that we have a no blame culture and a comprehensive whistle blowing policy to ensure that patient and staff are confident that they can report concerns and ensure that they are dealt with fairly and with a no blame culture.

It is essential that we have a robust patient engagement strategy and a clear strategy for patient participation that ensures that we have a strong and effective patient voice on all service improvement initiatives and committees to ensure an equal and valued partnership.

We will need to develop a carer's strategy that ensures that we are listening and valuing the contribution that carers can make to the focus and development of services.

We will also need to ensure that are patient involvement is not tokenism but is a key facet of all our care and is respected and valued.

The Trust has to meet its statutory requirements including those dictated by Health and Safety legislation.

EMAS is following the NPSA seven steps to patient safety and Manchester Patient Safety Framework (MAPSAF) methodology.

The Trust has in place a Strategic Learning Review Group, supported by Divisional Learning Review Groups which facilitate learning across the whole trust and encourage service improvement for patient safety.

These initiatives will be tracked through the Better Patient Care Programme to ensure that we are delivering our key strategic aims.

6.2 Effective Risk management

It is essential that if we are to deliver a safe service that we have a robust risk management framework and that we manage risk and that we have a process in place to learn from incidents and reduce harm.

This is with the sole aim of preventing avoidable harm by identifying risks and mitigation against harm, to ensure robust learning when harm has occurred and that there is a process to ensure that the Board is assured that the Trust has the correct processes and procedures in place.

EMAS has a robust method of recording incidents through the ULYSSES system and reports incidents in line with the national standards and format. The data is reported through the clinical and operational governance structures through to the board and has robust action plans and monitoring in place. There are also Strategic and Divisional Learning Review Groups in place to ensure that identify lessons learnt and ensure that we continue to learn and develop services.

Quarterly thematic analysis takes place to ensure that we complete deep dives and investigation for any reoccurring themes and these are shared across the organisation.

This is monitored internally through the Better Patient Care Programme, Clinical Governance Group, Quality Governance committee and the Trust Board. It is shared externally with the Quality and Governance Commissioning Group.

Serious Incidents represent a failure of process or care delivery, and EMAS has a responsibility to ensure that there is a culture of reporting incidents in order to ensure that learning takes place. The SI reporting/learning is shared externally with the Commissioners and the Trust Development Agency patients and families to ensure we are open, honest and transparent.

6.3 Creating an open and transparent reporting environment

As part of the Trust incident reporting system incidents which caused moderate harm or had the potential to cause moderate and/or significant harm to patients are also investigated thoroughly and undergo root cause analysis to ensure that learning takes place.

Assurance is provided to the Board on the embedding of risk management and quality processes at a local level via the quality audit and safety inspections programmes.

We have launched a 'HOT' internal campaign that stands for being Honest Open and Transparent to encourage the reporting of incidents and near misses to ensure that we have a culture of reporting incidents and improving our safety culture.

We have also signed up the National sign up to safety campaign which means that we have agreed to pledge to reduce harm over the next three years in the following areas:

- Pressure ulcers
- Mental health
- Delayed response
- Patient Injury

The Trust will collect baseline data against each of these and ensure that we agree a robust action plan that will ensure an agreed reduction in incidents relating to these four areas.

6.4 Creating the right Health and Safety environment

All organisations have a responsibility to ensure that the health and safety of their employees and others affected by their activities.

Staff are trained and competent to carry out their jobs safely and are fully aware of their responsibilities in relation to health and safety.

Staff are fully aware of and understand the risks associated with their work activities and the control measures that are in place to reduce and manage them. This is facilitated by a Trust wide risk assessment programme which ensures are roles, premises and equipment including vehicles are adequately risk assessed.

Staff are fully consulted and engaged with in relation to ensuring their own health and safety and as well as that of others affected by the Trust activities. This is achieved by through the Divisional Health, Safety and Security Groups and the Risk, Safety and Governance Group.

All untoward incidents including RIDDOR incidents are reported in a timely manner and the number of incidents are reduced, by ensuring lessons are learnt and that risks are monitored and managed.

All untoward incidents including patient safety incidents and RIDDOR are reported internally through the Clinical governance framework and are reported through to Quality and Governance Committee and the Trust Board.

We conduct an annual self-assessment against the NHS Employers Health, Safety and Wellbeing Partnership Group Standards for Health and Wellbeing to ensure they meet the legislative requirements relating to health, safety and wellbeing.

6.5 Ensuring we safeguard Vulnerable Children and Adults

All organisations and individuals have a responsibility to help protect the most vulnerable in society.

Staff understand and act in accordance with their roles and responsibilities in relation to safeguarding and promoting the welfare of children, young people and vulnerable adults.

Staff are trained and competent to safeguard vulnerable children and adults effectively

Senior managers are committed to the welfare and safety of children, young people and vulnerable adults and we work closely with Local Children Safeguarding Boards to ensure shared learning and best practice.

Safeguarding helpline to be supported and managed directly by the safeguarding team to ensure good support and supervision is available to the staffs working on the helpline.

There will be continual review of current practice against national reports, and publications to ensure that we implement all recommendations, and good practice indicators, within safeguarding.

The continual review of current practice following external visits and assessments to ensure robust practices are in place and the service continues to develop and implement recommendations.

6.6 Effective Infection and Prevention and Control (IPC)

Infection prevention and control is a key part of patient safety and EMAS is committed to achieving and maintaining a consistently high standard.

IPC is everyone's responsibility and will continue to be embedded as such within the organisation.

Full compliance and maintenance of high standards in relation to the Hygiene code, the Health and Social Care Act 2008.

We will review of current practice against National and local initiatives and policy to ensure that we implements all recommendations and best IPC practice.

To ensure that EMAS can respond to communicable disease activity whether this be on a global, national or local level, thus protecting staff and patients, we will work in line with best IPC practices. (Examples being hand hygiene, PPE and employee vaccination and immunisation programmes.)

An annual programme of IPC quality inspections is maintained to ensure monitoring of practice and policy and give compliance assurance. The programme includes vehicles premises and staff compliance and targets for this are agreed with commissioners.

Monitoring of the vehicle deep cleaning programme as provided by the ambulance support team will provide assurance that operational vehicles of all types meet IPC standards.

6.7 Learning from Patient Experience

Patient experience is captured through multiple sources, focus groups, patient surveys, patient stories, complaints, compliments and the reporting incidents process. We will take steps to ensure feedback is captured across seldom heard or hard to reach groups.

It is essential that if we continue to collect and analyse patient feedback to ensure that we continually learn from this feedback and ensure that patients remain the focus of our services

Our continued development and growth will only occur successfully if we ensure that patients are central to our service. As part of the Trust Board cycle patient and staff stories are presented on a regular basis. This needs to reflect our local population and ensure there is a robust process to ensure that all our patients have an opportunity to present their story at Trust Board and that we have the support in place to assist patients and carers.

There will need to be a plan to engage more collaboratively and strengthen our relationship with the EMAS patient forum and this will be accomplished by the Director of Nursing and Quality becoming the chair of this forum. The long term aims and objectives of the group will be determined by the group.

Membership will be reviewed to ensure that is a true reflection of our local populations and the long term strategy is to ensure a patient presence and membership at key meetings to ensure the service developments have a strong user voice. High profile complaints are shared at the board and the actions lessons learnt are reviewed.

We will also roll out of the Friends and Family test in line with National guidelines.

Internal surveys of patient groups to ensure that improvements identified through the national surveys make the intended changes to the patient experience.

In line with the Clwyd Review, we will focus on ensuring our complaint responses demonstrate that EMAS is open honest and transparent and ensures that we provide compassionate, patient focussed responses. This will also include how accessible the process is for equalities groups i.e. learning disabilities, sight impairment and language.

It is imperative that we ensure that all patient feedback is listened to and there is a mechanism for ensuring that feedback changes and refines services and that will be monitored through the patient forum which will be the way that we are held to account by our patients and stakeholders to ensure that we are responding, listening and acting on those patient concerns and views to ensure that we are a patient focussed service that puts patients at the centre of all our services.

We have to work collaboratively and in partnership with patient carers and the public and to do this we need more patient involvement and a clear strategy to deliver a patient focussed service. Our progress will be monitored through the patient forum, to the better patient care programme and report to the Trust board.

To ensure we learn from our patient experience there will be regular integrated learning reporting and “deep dive” analyses into emerging themes.

We will also continue to monitor improvement against national and local targets in our response times to complaints and PALS queries and concerns

Robust action plans in place and monitored effectively that address the national and local survey results to ensure that we address patient experience concerns and views of EMAS. This will be reported through to the Quality and Governance committee and the better patient care programme

We undertake annual self-assessment of our patient experience processes using the Trust Development Authority Patient Experience Development Framework

6.8 Developing our clinicians and Clinical Leaders for the future

Paramedics continue to develop from their historical role of delivering first aid and transportation to hospital, towards a greater emphasis on decision-making, and our staff can now make a fundamental contribution to unscheduled and urgent care

There is significant potential for further development of the paramedic role to enable an enhanced clinical service for the benefit of patients. The future approach will include a move towards a professionalised paramedic workforce with enhanced clinical capabilities, clinical leadership and clinical decision making skills, to work autonomously with the support and recognition from other professional colleagues.

The paramedic evidence based education project (PEEP) published in August 2013 reviewed the existing evidence to support the future direction of paramedic education and training. It recognised that local training currently being delivered differs dependent on location, and therefore provides trainees with different experiences and levels of support. The report proposed the introduction of a national education and training framework for paramedics. The recommendations in the report are now being reviewed by Health Education England.

As this agenda develops EMAS will play its part as a leading employer of paramedics to ensure that not only effective and fit for purpose education for paramedics at the start of their career but also ensure there is a structured educational development plan for learning beyond registration.

Clinical leadership is regarded as a process by which an individual influences others to set standards, accomplish objectives and directs the organisation to greater consistency. Leaders are generally identified by a number of key characteristics; knowledge, skills and attributes. Therefore clinical leadership that covers a range of areas will encourage clinicians to inform strategy, improve and drive quality, service design and resource utilisation.

Clinical Leadership development within our organisation will be designed to engage with the workforce, develop succession plans and inspire talent to become future organisational leaders.

There is a need to establish a tiered system of clinical leadership, throughout the organisation and to create an aspirational career pathway within the paramedic profession

There will be several key strands to our clinical leadership development approach :

- Developing and supporting the current and future workforce profile and skills mix. Working with the Local Education & Training Board to commission the programmes which will ensure our workforce has the skills and characteristics to more effectively manage the patients we see.
- Work with clinicians, commissioners and clinical leaders to introduce decision making support tools (such as Paramedic Pathfinder) to assist paramedics in streaming patients away from Emergency Departments into community based care closer to home.
- Increasing and improving the level of clinical support available to the front-line from the Emergency Operations Centre. Developing the Clinical Assessment Team to take a proactive role in managing service user's needs by working directly with operational clinicians through a region wide single point of access.
- A continuation and development of the current support through appraisal of clinical performance indicators, PDR reviews and operational performance.
- A network of clinical leaders across the Trust, educated over and above that of registrant level (academic level 6, 7 & 8). Providing a tiered system of clinical leadership to the practitioners working within the teams they clinically lead.

Whilst leading the clinical change across the frontline, all these extended role practitioners will practise at a level above that of base registrant with the ability of offer a greater degree of assessment, diagnostic, treatment and referral capabilities than that currently available. Possessing the ability to assess and treat conditions, reduce admissions to ED and ensure more patients are managed closer to home.

Additionally, and just as important is a greater ability to offer assessment, clinical decision making and intervention to serious and life threatening conditions with the focus upon reducing morbidity and mortality within this critical patient group.

Clinical Leadership will be a 'strategic enabler' and its effects and influence will be far reaching, linking with many other strategies and developments.

6.9 Research & Development

East Midlands Ambulance Service NHS Trust's (EMAS) reputation as a leader in pre-hospital research has increased over the past five years. The trust is now collaborating in more high quality externally funded studies and leads a prestigious £2 million National Institute for Health Research (NIHR) Programme for Applied Research: Pre-hospital Outcomes for Evidence Based Evaluation (PhOEBE) in partnership with the Universities of Sheffield, Lincoln and Swansea. One of the drivers for increased ambulance service research in England has been the National Ambulance Research Steering Group (NARSG), set up in 2007 with support from EMAS' Chief Executive, and chaired by EMAS' Associate Clinical Director, Prof Niro Siriwardena. The role of NARSG is to set a strategy and develop the pre-hospital research agenda for ambulance services in England.

Our success has enabled us to source funds for research in excess of £2.5 million since 2008. We are currently collaborating on, or leading a number of research studies, more than half are eligible for registration on the National Institute for Health Research Clinical Research Network Portfolio (NIHR CRN). A further four funding applications have successfully achieved funding from NIHR programmes.

We have good working relationships with our East Midlands NIHR Research Design Service, who provide extensive advice and support, through the East Midlands Ambulance Research Alliance (EMARA). EMARA is the strategic research group for EMAS supporting both in-house and external research that aims to develop EMAS as a centre of excellence for patient focused pre-hospital research and evidenced-based practice. Through EMARA we have developed strong links with higher education institutes and healthcare organisations, thereby ensuring all research undertaken complies with the Research Governance Framework for Health and Social Care.

To date there are 3 NIHR portfolio studies about to start in this financial year where EMAS is collaborating with other hospitals and universities in major research which will eventually have an effect on patient care. All these are between 3 -5 year projects. EMAS is also involved with a CLARHC (Collaboration for leadership in Applied Health Research and Care) Study where a hypoglycaemia pathway is being tested. This study will commence in January 2015 for 1 year. These studies will involve our clinicians.

Clinicians are encouraged to sign up to EMAS AIR (Active in Research). To date there are over 70 members who, when required, are called upon to become involved in studies. This is one way of integrating research into every day work, and provides an avenue for research interested clinicians to explore their research ideas and learn of new studies. As research becomes more high profile more clinicians will be encouraged to join EMAS AIR.

The research department will continue to explore not only research ideas in-house but also externally with partners in other NHS organisations and academia. Through these collaborations our clinicians can take part in major research initiatives and the Trust continue to build its reputation as a research organisation

7. Governance and Accountability

7.1 Structure and Process

7.2 Quality governance is the combination of structures and processes at and below board level to lead on trust wide quality performance including.

- Ensuring required standards are achieved
- Investigating and taking action on sub- standard performance

- Planning and driving continuous improvement
- Identifying sharing and ensuring delivery of best practice
- Identifying and managing risks to quality of care.

7.2 Accountability

The governance structure will hold each work stream to account and exceptions and risks will be monitored and reported through to the Trust board. Our patients' stakeholders will hold us to account through our patient forums and patient engagement events and by ensuring they are a member of key groups to ensure that there is a mechanism to allow them to challenge and hold us to account.

Progress is monitored through our quality accounts and risks will be highlighted and mitigated through the Risk register.

The Board has established a Quality and Governance Committee with delegated authority to oversee this agenda. This committee report to the Board at each meeting. The Nursing and Quality team is responsible for collating and analysing data relating to quality issues.

Board members undertake quality visits to Accident and Emergency Departments and the Emergency Operation Centres and accompany crews to obtain assurance on quality issues. Executive directors undertake four quality visits per year and Non- executives complete two quality visits per year.

The board programme includes regular patient and staff stories focussing upon continual improvement in relation to patient and staff experience.

7.3 Quality Accounts

Quality Accounts are reports to the public on the quality of services that the individual healthcare organisation provides with a focus on patient safety, experience and outcome.

Their purpose is to enable

- Boards or providers to focus on quality improvement as a core function.
- The public to hold providers to account for the quality of NHS healthcare services they provide.
- Patients and their carers' are able to make informed choices.

Our annual quality account sets out how we have engaged with the public in order to develop our quality metrics to ensure that they are meaningful to the people that we serve. The quality account includes six priorities which we have pledged to concentrate on.

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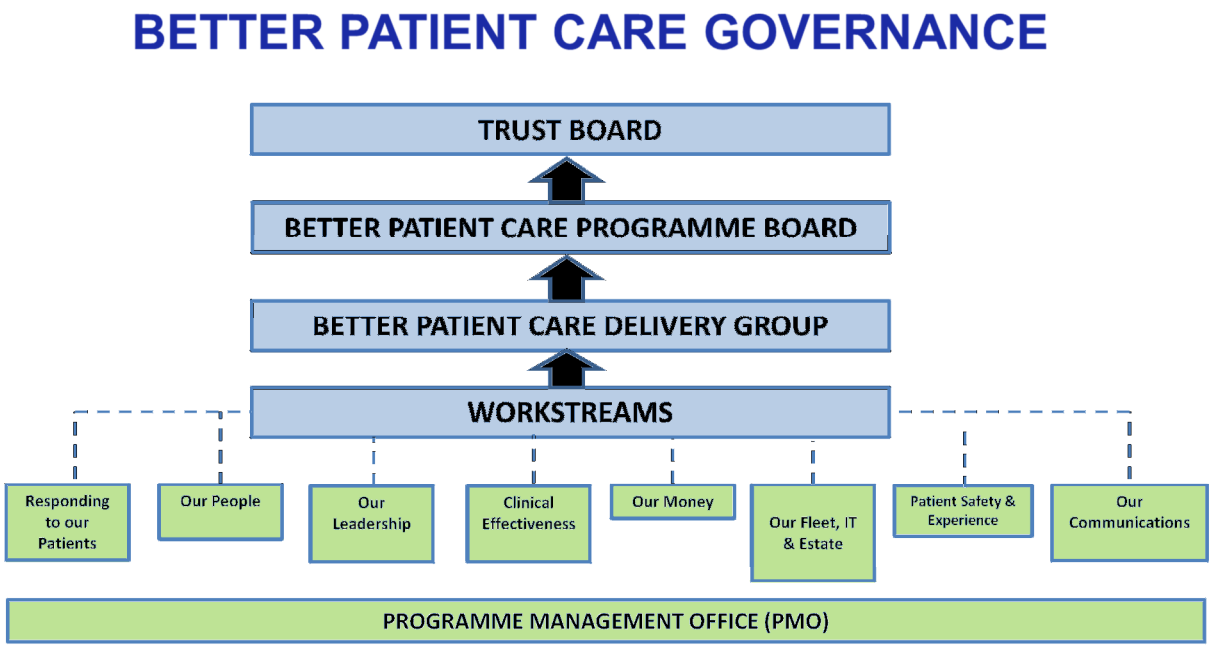
7.3 Better Patient Care Programme

7.4 The Better Patient Care Programme monitors and reports progress against agreed work streams and all work undertaken towards achieving the strategic milestones are risk assessed and monitored through this process. The group meets fortnightly to review progress and identify risks associated with the delivery of agreed actions.

Any new work being undertaken by the teams are added to the Better Patient Care Programme to ensure that all initiatives and work plans are owned and delivered through this central programme. This process also ensures that any new initiatives are brought to this meeting and all aspects of the proposal and potential impact on quality can be discussed and a full assessment made.



8. Finance

Requires – Financial implications to be completed

8. Risk Management

8.1 Risk Analysis

We have robust, comprehensive and effective risk management systems in place to manage clinical, financial and business risks. Underpinning this is the Risk Management Policy and the Governance Strategy. Leadership is given to the risk management process by the Board and through Board Committees, which view risks from a variety of sources.

We have identified lead managers who monitor performance, compliance and assurance against a range of national standards.

The Board Assurance Framework is the key tool used by us to provide assurance of that risk and control mechanisms are in place and operating effectively. Through regular monitoring of the Board Assurance Framework and the operational risk registers, which underpin the risk management process, the Executive Team and EMAS Board ensure that current risks are managed appropriately and there are suitable arrangements for preventing and deterring risk. The Board reviews the Board Assurance Framework every two months. Each risk and its mitigating actions are reviewed and the risk score considered and amended as necessary.

8.2 Risk Registers

The Board Assurance Framework is a high-level register of the risks to the achievement of EMAS's strategic objectives. Controls to mitigate these risks and evidence of those controls are also included.

The Board Assurance Framework also includes risks that have been escalated to the Board from the operational divisions. The following committees review the Divisional Risk Registers and refer strategic risks to the Board:

- Quality and Governance Committee
- Workforce Committee
- Finance and Performance Committee
- Risk safety and Governance group
- Clinical Governance Group

Divisional and Local Risk Registers have been developed to ensure that risks, identified through the business planning process, are managed at a local level. Each Director is responsible for the risk registers within their Directorate. In addition, Directors are also accountable for specific risks in the Board Assurance Framework. The Board of Directors is accountable for controlling and mitigating organisational risk.

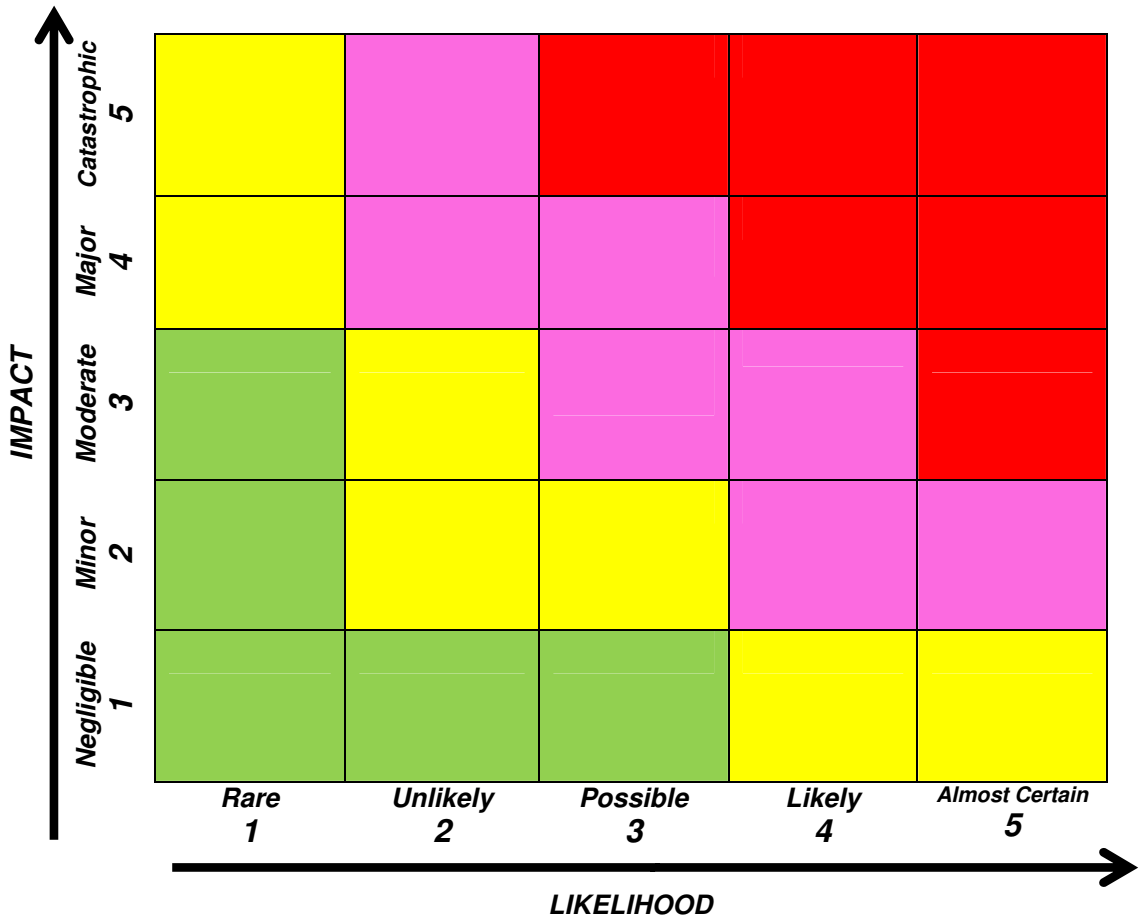
8.3 Key Risks

Please see enclosed risks as highlighted in the risk register

9.3 Risk log, scored and mitigated score

RISK REGISTER TEMPLATE

RISK REGISTER –



The risk that EMAS will not be involved in the development of clinical initiatives that would allow and support the development of services in line with national and local priorities Score: L [3] x I [4] = 12	[REF] 5 EMAS will not effectively review and fund the changes required to ensure the complaints process is inclusive and accessible for equalities group Score: L [3] x I [3] = [9]	[REF] 9. RISK DESCRIPTION Score: L [ ] x I [ ] = [ ]	[REF] 13. RISK DESCRIPTION Score: L [ ] x I [ ] = [ ]
[REF] 2.**Risk that EMAS will not meet the national ambulance quality indicators and will not see the increases in clinical effectiveness and patient outcomes** Score: L [3] x I [3] = [9]	[REF] 6.II RISK DESCRIPTION Score: L [ ] x I [ ] = [ ]	[REF] 10. RISK DESCRIPTION Score: L [ ] x I [ ] = [ ]	[REF] 14. RISK DESCRIPTION Score: L [ ] x I [ ] = [ ]

[REF] 3. EMAS will not effectively engage with the seldom hard to reach groups and ensure strong and effective patient engagement Score: L [2] x I [3] = [6]	[REF] 7. RISK DESCRIPTION Score: L [ ] x I [ ] = [ ]	[REF] 11. RISK DESCRIPTION Score: L [ ] x I [ ] = [ ]	[REF] 15. RISK DESCRIPTION Score: L [ ] x I [ ] = [ ]
[REF] 4. RISK DESCRIPTION Score: L [ ] x I [ ] = [ ]	[REF] 8. RISK DESCRIPTION Score: L [ ] x I [ ] = [ ]	[REF] 12. RISK DESCRIPTION Score: L [ ] x I [ ] = [ ]	[REF] 16. RISK DESCRIPTION Score: L [ ] x I [ ] = [ ]

CORPORATE RISKS Risk Register Management Lead – Director of Nursing and Quality								
Risk	**Risk Owner** **Latest Review**	**Source and Date**	**Score** **(L x I =)**	**Controls** **(Currently in place)**	**Planned Mitigating Action** **Implementation Date and Responsibility**	**Actions on Track (R/A/G) Comment**	**Residual Score** **(L x I =)**	**Sources of Assurance**
Objective: To ensure that EMAS will be at the forefront of the development of Clinical initiatives.								
[REF] 1. The risk that EMAS will not be involved in the development of clinical initiatives that would allow and support the development of services in line with national and local priorities	Risk Owner Judith Douglas Latest Review [10/08/15	Integrated business plan and clinical and quality strategy	[3] x [4] = [12]	Agreed Divisional structure with GM, Exec and Non exec lead to ensure that key strategic groups and working groups have EMAS representation. Attendance at key clinical forums to ensure engagement and leadership. Strong IBP that has been shared across the health economy to ensure that we are engaged and involved in urgent care centre involvement, falls services and mental health triage.	To ensure that we are involved in locality driven plans to reduce conveyance and ensure that EMAS has representation and is involved in service developments. Fed back through trust board and executives to ensure the key individuals are aware of progress and commissioning requirements Continued discussion re contracts and commissioning processes and awareness of tendering for services and full involvement of all departments to ensure a robust tendering.	Amber	[2] x [3] = 6 [ ]	Involvement in key groups, Tendering for services as the current arrangements expire.

CORPORATE GOVERNANCE RISKS (Risk Register Management Lead - Director of Nursing and Quality								
Risk	**Risk Owner** **Latest Review**	**Source and Date**	**Score** **(L x I =)**	**Controls** **(Currently in place)**	**Planned Mitigating Action** **Implementation Date and Responsibility**	**Actions on Track (R/A/G) Comment**	**Residual Score** **(L x I =)**	**Sources of Assurance**
Directorate Objective: To ensure that EMAS meets the national ambulance indictors								
EMAS will not meet the national ambulance quality indicators and will not see the improvements patient outcomes	Rashid Sohail	Clinical and Quality strategy. National Ambulance indicators	3 x 3= 9	Robust auditing of current practice and performance against quality indicators. Agreed improvement plans to ensure the adoption of the clinical pathways	CQUIIN payments related to this roust monitoring through clinical governance and trust board	Amber dependant on performanc e and current focus on operational duties of all staff	3x2=6	CGG QGC Trust board Robust data collection and analysis and governance
EMAS will not make the required changes to the complaints process to ensure that the complaint process ad responses are inclusive and accessible to equalities groups	Judith Douglas	Patient engagement strategy Clinical and quality strategy	3x3=9	Good patient engagement currently the understanding that this needs to be more robust and inclusive. Planned events too hard to reach groups are in process but funded out of charitable account	Engagement strategy, involvement with key stakeholders who attend trust board. Key public events and planned initiatives. Very active and committed equality and diversity manager who is very engaged with the strategy. Trust board and Executive team fully aware and agree the importance of a strong patient voice	RED No agreed funding or budget in place and not classed as a must do	3x3 =9	Monitored through the patient experience reports ad strategy that is reported to CCG, QGC and Trust board.

9.4 How risks will be monitored and implementation of mitigating actions

The risks will be owned and monitored by the Director of Nursing and Quality and the Medical Director where appropriate and reports will be presented at the Quality and Governance Committee and unresolved risks and concerns will be escalated through to the Trust board.

10. Appendices

Appendix 1 –Cardiac arrest strategy

See attached.

Appendix 2

Range of Services

Traditionally the role of the Ambulance service has been to take patients to hospital, whether for emergency, unscheduled or planned care. This role is changing as the health care needs of patients and the NHS in England change. The East Midlands Ambulance service is responding to these changing needs and ensuring all its frontline services are clinically focussed and delivering improved treatment for patients.

Emergency services

Emergency services operate 24 hours a day and are accessed through the 999 number. When a member of the public calls 999 in the East Midlands, they are first assessed by EMAS using the advanced medical priority dispatch system. (AMPDS) to determine the most appropriate response based on clinical need. These calls are categorised in the following way:

Red calls (R1 and R2) - immediately life threatening conditions which require a fully equipped ambulance vehicle to attend the scene.

Green calls (G1 and G2) - conditions which are not immediately serious or life-threatening but urgently require a face to face response.

Green Calls (G3 and G4) - non life-threatening conditions which require telephone clinical assessment by a paramedic or nurse where the patient will be referred to an alternative care pathway, given advice over the phone or upgraded to a more urgent call category.

Following categorisation the call is directed to the most appropriate care pathway for the patient.

Hear and Treat - advice is provided, generally for green calls, directly to the patient over the phone by a clinically trained member of staff (this may include identification of and referral to an alternative pathway).

See and Treat - A clinician attends and provides treatment to the patient on the scene, but there is no requirement to transport the patient to a healthcare facility.

See Treat and Convey - A clinician attends and provides treatment to the patient on the scene, before transporting them to a health care facility for further treatment.