East Midlands Ambulance Service NHS
NHS Trust

Our pledge to you

Our Quality Account

Our Quality Account
2012/13

Contents

We asked our Foundation Trust members to describe in one word how they view EMAS. The above shows what they said - the size of each word is in proportion to the number of times members used it.

Executive Summary

This Quality Account reviews our performance in 2012/13 and sets out our key priorities for quality improvement for 2013/14.

In 2012/13, EMAS continued to improve the quality of care provided. Last year we identified the following quality improvement priorities against the 3 'domains' of quality – patient safety, clinical effectiveness and patient experience.

Patient safety	Priority 1: Improvements in response to staff survey key questions and Performance Development Reviews (appraisals)
Clinical effectiveness	Priority 2: Continue to improve the processes for call handling, clinical assessment and the deployment of resources
	Priority 3: Existing clinical performance indicators to be improved and new indicators to be developed taking into account regional priorities
Patient experience	Priority 4: Continue to engage with stakeholders across local communities to enable patient experience to influence service improvement and development
	Priority 5: Develop a training package linked to a new Domestic Violence Policy to equip frontline staff with the knowledge to recognise and deal effectively with victims and perpetrators of Domestic Violence

Delivering against the above priorities have yielded a number of benefits for patients:

Priority 1: Improvements in response to staff survey key questions and Performance Development Reviews (appraisals)

The Staff Survey undertaken in October 2012 had an overall response rate of 37.6%. The average response rate for the 6 'Picker' ambulance trusts was 38.9%.

In relation to the 6 other Ambulance Trusts that use Picker, our results are:

Significantly BETTER than average on 22 questions
Significantly WORSE than average on 7 questions
The scores were average on 62 questions

The atreas that the Trust has significantly improved on are:

No training in how to handle confidential information
No training in how to deliver a good patient / service user experience
Not able to do my job to a standard am pleased with
Opportunities to show initiative infrequent in my role
Not involved in deciding changes that affect work
Dissatisfied with freedom to choose own work method
Do not know who senior managers are
Communication between senior management and staff is not effective
Senior managers do not try to involve staff in important decisions
Discrimination from patients/service users, their relatives or other members of the public

The Trust has a current 50.2% completion rate for PDR's based on a rolling annual cycle as at January 2012.

Priority 2: Continue to improve the processes for call handling, clinical assessment and the deployment of resources

We have made significant additional investments in the expansion and development of our clinical assessment team, which has led to more appropriate management of non life-threatening calls via telephone-assessment and referral to local community services, and consequently fewer conveyances to an emergency department. The introduction of additional dispatch capacity also means that we have been able to utilise our resources more effectively.

Priority 3: Existing clinical performance indicators to be improved and new indicators to be developed taking into account regional priorities

We improved our performance against a number of national clinical performance indicators and implemented improvement plans to target areas where further improvement was needed. We have seen static performance in some areas and these are now subject to targeted improvement plans. Additionally we have developed two new internal indicators for Chronic Obstructive Pulmonary Disease (COPD) and Fractured Hip to enable us to continually improve the quality care we deliver to our patients above and beyond that required nationally.

Priority 4: Continue to engage with stakeholders across local communities to enable patient experience to influence service improvement and development

The Trust has developed a Stakeholder Engagement Strategy to guide our priorities around patient and service user engagement, foundation trust membership engagement, engagement with patient and condition management groups and business engagement in terms of working with the Clinical Commissioning Groups and Local Area Teams.

The Trust has held a number of Membership Engagement Groups focussing on patient safety, experience and clinical effectiveness and has undertaken a range of patient surveys to ensure that the services we provide are meeting patient needs.

Involvement in vehicle design and equipment reviews has resulted in some key changes in response to patient feedback and we continue to work alongside Learning Disability, Deaf Awareness and Dementia care groups to name but a few in response to user feedback.

The Trust has recently undertaken a significant public consultation exercise to launch our Being the Best programme. This included over 100 public events and consultation meetings across each county to engage locally on pour plans for the future.

Priority 5: Develop a training package linked to a new Domestic Violence Policy to equip frontline staff with the knowledge to recognise and deal effectively with victims and perpetrators of Domestic Violence Whilst it is estimated that twenty five per cent of women will experience domestic violence at some point in their lives, the crime remains severely under reported and under recorded (NHS South Gloucestershire, 2010). Changes to the landscape of the domestic and sexual violence sector have gathered pace and the definition of violence to women and children has expanded to include other forms of violence such as Honour Based Violence, Forced Marriage and Female Genital Mutilation. More recently the evolving agenda places more emphasis on the recognition of abuse to men and those in same sex relationships. Violence and abuse is an inexcusable contribution to gender inequality and is currently central to a range of agencies priorities, including crime prevention, safeguarding children and vulnerable adults and the physical, mental and sexual health agenda. Through the provision of education, procedures and a communications campaign staff have been supported to deal with domestic violence; enquiring into the circumstances of each injury presented and that the explanation offered or otherwise is noted clearly. Procedures and awareness campaigns include narrative on when to refer the injury to other agencies and to ensure survivors and/or perpetrators of Domestic Abuse are signposted to the most appropriate agency for support allowing an interdisciplinary multi-agency response to families at risk of harm including the consideration of risk, need to escalate and the impact of the abuse on the family.

In 2013/14 we will continue to drive forward our quality improvement initiatives to enhance patient safety, patient experience and clinical outcomes for patients. Our priorities have been developed with our staff, service users and the public and are shown below

Clinical effectiveness	Priority 1: Produce a cardiac arrest strategy and implementation of developments across a range of areas to improve cardiac arrest outcomes
Patient safety	Priority 2: Implement a strategy to reduce slips, trips and falls amongst patients and staff (based on the West Midlands Ambulance Service Model)
	Priority 3: Education and training plan for 2013/2014 includes: Essential Education: Values, attitudes and behaviours; Suicide and Self Harm including MH; Maternity/Obstetrics; Newborn assessment and resuscitation; Slips, trips and falls – staff and patients; Equality and Diversity; IPC; Conflict Resolution; HSE Workstation set up; Clinical Updates: Resuscitation; JRCalc updates;

	C-Spine Assessment CPD: ECG Updates; Equipment Updates; IT training. In addition to opportunities through LBR and JIF funding.
	Priority: Improving response times through the following: Reduced time to process calls through changes to CAS and script KPIs for dispatchers Reduced on scene time through clinical engagement Targeted turnaround time to reduce delays at acute sites
Patient experience	Priority 5: Engage with frontline staff to identify and share good practice/ improvements in patient experience
	Priority 6: Improving communications with stakeholders (Alan)

A brief overview of our Trust (what we do)

Introduction

East Midlands Ambulance Service NHS Trust (EMAS) currently provides Emergency and Urgent Care for the six counties of Derbyshire, Leicestershire, Rutland, Lincolnshire (including North and North East Lincolnshire), Northamptonshire and Nottinghamshire. Additionally we provide Patient transport service in North and North-East Lincolnshire and supporting Nottingham University Hospitals.

We employ over 2,700 staff at more than 70 locations, including two Emergency Operation Centres at Nottingham and Lincoln, with the largest staff group being accident and emergency personnel. Our overall annual income budget for 2012/13 was £145 million.

Our accident and emergency crews respond to over 586,000 emergency calls every year, that is one call every 54 seconds, while our Patient Transport Service (PTS) and volunteer ambulance car drivers provide care and transport on large numbers of journeys to and from routine appointments each day in North and North East Lincolnshire.

We rely on our volunteer staff to help us provide a quality service. These include Community First Responders, LIVES responders, Voluntary Care Drivers, St John Ambulance, The Red Cross and our own staff who respond as Medical First Responders in their own communities. We also utilise EMICS (East Midlands Immediate Care Scheme) doctors who respond to emergencies to support us. All doctors in EMICS are volunteers who attend emergency incidents at the request of and in support of staff from the EMAS. These doctors are all very experienced and fully trained in trauma work and are equipped to perform life-saving interventions at the scene of an incident such as an industrial or road traffic accident or a rail crash. They carry with them a wide range of specialist equipment to deal with the serious trauma and other emergencies that might be encountered in their day to day emergency work. The positive partnership EMAS has with our volunteer organisations is particularly valuable in supporting timely responses to patient in more rural areas.

We also work closely with two air ambulance charities: Lincolnshire & Nottinghamshire Air Ambulance, and the Air Ambulance Service.

What can you expect from us when you call 999?

When you call 999 and ask for an ambulance, you will be immediately connected to one of our highly trained ambulance control centre teams. They will ask you for your location, the telephone number you are calling from and details of the main problem. While you are talking to our control team, appropriate help has already started to be arranged.

If the illness or injury is life-threatening, we instantly pass the information we have been given to the nearest available ambulance vehicle so that they can get to the location as quickly as possible. In many cases we will send a fast response car or a community first responder, where they can get to the scene more quickly than a conventional ambulance and start to provide care immediately.

Whilst help is on the way, our control team will offer advice on how to help the patient and they will usually remain on the phone until the vehicle arrives.

On arrival, the patient's condition is assessed and treatment is given. Where necessary the patient is quickly transported to a hospital A&E department or, where appropriate, to a centre which specialises in the treatment of head injuries, heart attacks or stroke.

In non life-threatening cases, a 'blue light' emergency response from an ambulance is not always needed but if we decide to dispatch an ambulance, crews will often provide treatment at the scene. If we decide an ambulance response is not needed (based on the information given to us by the caller) an advisor will call back, carry out a full clinical assessment of the patient's condition over the phone and then suggest the best treatment - such as being cared for at home, being referred to a GP, pharmacy or community based care service.

On 1 April 2011, the Department of Health introduced new national targets for ambulance services. The Category A life-threatening call target of responding to 75% of all cases within 8 minutes of the call being received was unchanged (these are now called Red calls) whilst other calls were split into a set of 4 less urgent groups . However, eleven new Clinical Quality Indicators were introduced for non-life threatening calls. This means we are measured on how we treat patients and the outcomes of the treatment rather than just on timeliness. By monitoring performance in this way, we are able to identify good practice and any areas which need improvement. As an organisation keen to develop and improve, EMAS welcomed this change. Examples of the new quality measures are:

- ✓ Outcome following a heart attack
- ✓ Outcome following stroke
- ✓ Proportion of calls dealt with by telephone advice or managed without transport to A&E (where this is clinically appropriate)
- ✓ Unplanned re-contact from the patient within 24 hours of discharge of care (i.e. where patient not transported but has received telephone advice or treatment at the scene)

The following table identifies how the timeliness of our response to 999 calls is measured:

How we respond to 999 calls at-a-glance guide

Call	**999 call received** and assessed by Emergency Operations Centre using AMPDS or NHS Pathways				
	Category A (Red)		**Category C** (Green)		
Assessment	**Red 1** Life-threatening requiring defib All echo codes	**Red 2** Immediately life-threatening All other category A	**Green 1** Serious but non life-threatening Serious clinical need	**Green 2** Serious but non life-threatening Less serious clinical need	**Green 3** Non life-threatening Non-emergency	**Green 4** Non life-threatening Non-emergency
Response	Face-to-face ambulance response		Face-to-face ambulance response	Face-to-face ambulance response	Telephone assessment: a) Alternative pathway referral b) Upgrade to Red/Green 1/2 c) Advice given and call closed	Telephone assessment: a) Alternative pathway referral b) Upgrade to Red/Green 1/2 c) Advice given and call closed
Performance	Within **8 minutes** of call received (19 minute transport standard)		Within **20 minutes** of call received	Within **30 minutes** of call received	Within **20 minutes** of call received	Within **60 minutes** of call received
	Quality of care given to the patient and the difference that made All patient care given is assessed using 11 Clinical Quality Indicators - including outcome of cardiac arrest, ST elevation myocardial infarction, stroke, service experience and telephone advice given - to measure type, quality and outcome of treatment					

Patient Transport Services (PTS)

EMAS provides a non–emergency transport service for eligible patients across North and North East Lincolnshire and some support to Nottingham University Hospitals. This is for patients whose medical condition is such that they cannot travel by public or private transport and their needs are best served by non-emergency ambulance staff. PTS services across the rest of the East Midlands are no longer provided by EMAS.

What does the Trust Board Do?

Our Trust Board have overall corporate responsibility for the running of our ambulance service. The main role of the Trust Board is to guide the overall strategic direction of EMAS including planning for our current challenges and future priorities – ensuring that we can set and meet our objectives.

Our Trust Board is led by our Chairman and comprises of Executive Directors and Non-Executive Directors (see opposite). Non-Executive Directors have roles and responsibilities outside EMAS. This allows them to bring an alternative viewpoint and draw upon external experience when discussing and agreeing upon the direction of our Trust – bringing an important balance to the Board.

How does the Trust Board assure itself on Quality?

EMAS has "Delivering High Quality, Patient Focused Services" as its first strategic aim and the trust is structured to deliver on this aspiration through the Quality Strategy. This high level strategy brings together all of the key strategies that underpin the Trust approach to delivering and assuring quality. Progress on this strategy is monitored by the Quality and Governance Committee and reported to the board by exception. The Board receives an integrated board report of quality metrics, made available to the public through our board papers, against which we judge our delivery against key quality goals. This is used to challenge the current performance and drive quality improvement. Additionally the Board receives key reports from outside agencies linked to quality such as the Care Quality Commission.

There is a Board approved structure of committees and support groups designed to look at the quality of the service we provide. The two committees which are primarily concerned with quality are the Audit Committee and Quality Governance Committee reporting directly to the Trust Board. In 2010 the Trust's governance arrangements were externally reviewed (Audit Commission, Dame Elizabeth Fradd) and all recommendations made have been implemented. The Executive Directors are jointly responsible for Quality of care with the key responsibilities sitting with the Director of Nursing & Quality and Medical Director.

Quality considerations are at the heart of the Board decision making process however the board has been caught out in the past, for example the impact of operational performance management on infection, prevention and control measures, and has used this as a learning opportunity to develop its processes to understand quality impact with a key initiative this past 12 months being the Quality Impact Assessment process. This ensures that all change plans, service developments or cost improvement plans have to undergo a formal process to assess the potential impact of the change on the quality of care that we deliver. Where the risk is considered to be higher the assessment is subject to scrutiny by a direct sub-committee of the Trust board.

Linking to frontline staff concerns about Quality is crucial and all Board members carry out at least one Patient Safety Visit each year – all Divisions are covered in the process. Additionally at least twice a year the Board undertakes a "Deep Dive" into a Division with the whole Board going out into one county to meet staff and find out how what happens at the Board becomes reality at the frontline of clinical care. This year the Board members have been to Lincolnshire and Derbyshire.

It is very important that the patient is brought into the Board room so the board members feel connected to the people we serve. The Board regularly receives Patient Stories, usually with the patient or their relative present to tell their story, and agrees actions which drive improvements in the quality of care provided, for example the revision of the complaint response letter, as well as strengthening the impact of the quality agenda at a senior level.

Our Quality Account
2012/13

Part 1

An introduction to our Quality Account - your definitions of quality

We have compiled this document to provide readers with information about EMAS' past, present and future activities in relation to the important subject of quality.

In 2010, the Department of Health (DoH) mandated that all NHS provider Trusts published a Quality Account on an annual basis. The purpose of the Quality Account is to demonstrate our commitment to quality and for others to hold us to account. Quality is broken down into three domains:

- ✓ Patient safety
- ✓ Clinical effectiveness
- ✓ Patient experience

This Quality Account reviews our performance for 2012/13 and sets out our key priorities for 2013/14.

To make our Quality Account useful to all readers, we asked a broad range of organisations and people how we could make the three domains of quality meaningful to them. The table below summarises the responses we received and these are updated annually:

What does quality mean to you?

Area	We asked	Respondents said
Patient Safety	What would make you feel safe?	✓ good and effective communication between professionals, between care agencies and others ✓ treatment in a clean environment ✓ being given reassurance, made to feel calm and less anxious ✓ an appropriate response being provided ✓ Appropriate personal protection ✓ Ability to control wheel chairs safely
Clinical Effectiveness	What would you expect from us when we treat your ailment or condition?	✓ prompt response times ✓ prompt and up-to-date care delivered by knowledgeable, calm, capable staff ✓ well maintained vehicles, with up-to-date equipment. ✓ Treatment is fast and effective ✓ Personal data is protected ✓ Resources are used effectively ✓ Staff are identifiable

Patient Experience	How would you like to be treated by the Ambulance Service?	✓ with care, compassion and dignity ✓ polite, friendly and professional staff ✓ a service that focused on patients. ✓ Staff who are knowledgeable, polite and understand the needs of a diverse group of patients. ✓ Patients are listened to

Board assurance statement

The EMAS Trust Board has been involved in identifying the quality indicators, agreeing the content and endorsing the content of this Quality Account. Our quality priorities and indicators have been developed in conjunction with our stakeholders and our staff. Non-Executive Directors continue to play a pivotal role in providing challenge and scrutiny, assessing our performance and contributing to our future strategy.

The Trust received a visit from the CQC in September 2012. The purpose of the inspection was to review compliance against outcome 12, requirements relating to workers. The CQC wanted to ensure that improvements to recruitment procedures had been made since their last visit in July 2011. Following the visit in September 2012, the CQC concluded that the Trust was compliant with outcome 12, adding that effective recruitment and selection processes were in place to ensure people employed to work with the service are of good character, are suitably skilled, qualified and experienced to perform the work.
This section will need to be updated before the document is published as we are expecting a visit from the CQC before 31 March 2013.

Statement of Directors' responsibilities in respect of the quality account

NHS Trusts are required under the Health Act 2009, National Health Service (Quality Accounts) Regulations 2010 and National Health Service (Quality Account) Amendment Regulation 2011 to prepare Quality Accounts for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporate the above legal requirements). In preparing our Quality Account, the Trust Board has ensured that:

- the Quality Account presents a balanced picture of the Trust's performance over the period covered;
- the performance information reported in the Quality Account is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and
- the Quality Account has been prepared in accordance with Department of Health guidance.

The Directors of the Trust Board confirm to the best of their knowledge and belief that they have complied with the above requirements in preparing this Quality Account. This has been confirmed through a resolution of the Trust Board.

Chief Executive's quality statement

Welcome to East Midlands Ambulance Service's (EMAS) fourth annual Quality Account which provides:

- ✓ a summary account of our performance against selected quality metrics (measures) for last year
- ✓ details of our quality priorities for the forthcoming year.

This report is for the public and we want it to be an honest and transparent view of our quality performance, it shows what we are doing well, where we need to make improvements and what our priorities are for the coming year to deliver the service you deserve.

Quality Accounts are intended to show how NHS services are truly putting quality at the top of their agenda. Their introduction in 2010 marked an important step forward in putting quality on an equal footing with finance. NHS Trust Boards are ultimately responsible for quality of care provided and they must ensure that Quality Accounts:

- ✓ demonstrate commitment to continuous, evidence based quality improvement;
- ✓ set out to patients where improvements are required;
- ✓ receive challenge and support from local scrutiny;
- ✓ enable Trusts to be held to account by the public and local stakeholders for delivering quality improvements.

After joining EMAS as Chief Executive in December 2011, I have spent a great deal of time visiting our committed and talented staff across the East Midlands and seeing how our many departments work. I continue to be impressed by the pride, professionalism and friendliness of everyone I meet and their determination to improve the quality of our services and care.

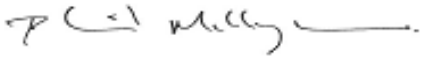
At EMAS our vision is to be a leading provider of high quality and value for money clinical assessment and mobile healthcare with our number one priority is to maintain and improve the quality and safety of the service. We strive to deliver the right care, in the right place, at the right time through being clinically-led and patient focused. Working in partnership with our service users ensures that improvements in care are not only evidence-based but are responsive to need, reflecting the issues that patients tell us are important to them.

In 2012/13, EMAS has continued to make significant improvements in the quality of services we deliver however we still need to do more to improve our response times against the background of ever increasing demand on the service. A major focus for next year will be starting the implementation of our "Being the Best" programme, designed to improve our performance across response times and a range of other quality areas, we intend to ensure that you are kept up to date with our progress on this area.

To the best of my knowledge, the information contained within this Quality Account is accurate and reflects a balanced view of EMAS' current position and future ambitions. I hope you enjoy reading this report and share in the pride I have in the services we have been able to provide for our patients in the last year, and will continue to provide in the future.

The Quality Account celebrates our hard work and achievements. I would like to congratulate staff for providing outstanding care to patients whilst ensuring the Trust remained financially sound. This would not have been possible without the hard work of everyone who works for and supports the Trust.

Thank you.



Chief Executive

Our Quality Account
2012/13

Part 2

Priorities for improvement
(where we need to improve)

In association with patients, staff and other stakeholders (see Part 3 – How we developed our Quality Account) we have identified a number of key priorities for 2013/14. These priorities have been developed in line with the views of our stakeholders and are of equal importance:

Need to add in rationale, measure, target, Lead, by when and outcome for each of the below

Clinical effectiveness	Priority 1: Produce a cardiac arrest strategy and implementation of developments across a range of areas to improve cardiac arrest outcomes
Patient safety	Priority 2: Implement a strategy to reduce slips, trips and falls amongst patients and staff (based on the West Midlands Ambulance Service Model)
	Priority 3: Education and training plan for 2013/2014 includes: Essential Education: Values, attitudes and behaviours; Suicide and Self Harm including MH; Maternity/Obstetrics; Newborn assessment and resuscitation; Slips, trips and falls – staff and patients; Equality and Diversity; IPC; Conflict Resolution; HSE Workstation set up; Clinical Updates: Resuscitation; JRCalc updates; C-Spine Assessment CPD: ECG Updates; Equipment Updates; IT training. In addition to opportunities through LBR and JIF funding.
	Priority: Improving response times through the following: Reduced time to process calls through changes to CAS and script KPIs for dispatchers Reduced on scene time through clinical engagement Targeted turnaround time to reduce delays at acute sites
Patient experience	Priority 5: Engage with frontline staff to identify and share good practice/ improvements in patient experience
	Priority 6: Improving communications with stakeholders (Alan)

Priority 1:

	Priority	Rationale	Lead	Outcome Measure
Clinical Effectiveness	Produce a cardiac arrest strategy and implementation of developments across a range of areas to improve cardiac arrest outcomes	EMAS Cardiac arrest outcomes have remained static for some time. In order to see improvement it is crucial to implement a change in approach. It is recognised that that the public see this as a high profile issue.	JG	Strategy production and evidence of delivery of key elements of it linked to increased regional awareness. Whilst there is a large national variation it is hoped to see an increase in ROSC and survival with time as the strategy is implemented

Priority 2:

Patient Safety	Priority	Rationale	Lead	Outcome Measure

	Implement a strategy to reduce slips, trips and falls amongst patients and staff (based on the West Midlands Ambulance Service Model)	Slips, trips and falls continue to be one of the highest categories of incidents reported. Work undertaken by WMAS demonstrates that significant reductions in the numbers of incidents are achievable. This priority would benefit both patients and staff.	KG	Run a communications campaign during 2013/14 promoting the strategy. Outcome will be measured by a reduction in the numbers of slips, trips and falls during 2013/14 compared to 2012/13.

Priority 3:

Patient Safety	Priority	Rationale	Lead	Outcome Measure

	Education and training plan for 2013/2014 includes: Essential Education: Values, attitudes and behaviours; Suicide and Self Harm including MH; Maternity/Obstetrics; Newborn assessment and resuscitation; Slips, trips and falls – staff and patients; Equality and Diversity; IPC; Conflict Resolution; HSE Workstation set up; Clinical Updates: Resuscitation; JRCalc updates; C-Spine Assessment CPD: ECG Updates; Equipment Updates; IT training. In addition to opportunities through LBR and JIF funding.	The Trust has a robust education planning process that takes into account organisational priorities; compliance standards; outcomes from PDR/IPR; education request process; and staff feedback (eg via the Quality Account).	DF	% of staff attending/completing programmes and where assessment is necessary achieving required level of competence

Priority 4:

Patient Safety	Priority	Rationale	Lead	Outcome Measure

	Improving response times through the following: Reduced time to process calls through changes to CAS and script KPIs for dispatchers Reduced on scene time through clinical engagement Targeted turnaround time to reduce delays at acute sites	Reduced time to obtain information from caller and shortened script allows call to be transferred quicker and dispatch to be done earlier. In addition KPIs are being introduced for dispatchers to improve times. RFID rollout will assist with turnaround	SC	Reduction in call cycle and improvement of performance through releasing hours back for crews

Priority 5:

Patient Experience	Priority	Rationale	Lead	Outcome Measure

	Engage with frontline staff to identify and share good practice/ improvements in patient experience	Improving patient experience has been identified as a priority by patients and other stakeholders. During quality visits and team briefings frontline staff have identified that there are examples of best practice that could and should be shared across the organisation. This approach will also ensure that work continues with regard to frontline staff engagement which also remains a priority for the organisation.	KG	Run at least one campaign during 2013/14 using the Patient & Family ECHO web platform provided by Clever Together. Use the findings from the campaign to identify and spread good practice across the Divisions. Outcome will be measured by improvement in patient satisfaction survey results. Staff will also report that they feel more engaged.

Priority 6

	Priority	Rationale	Lead	Outcome Measure
Patient Experience	Improving communications with stakeholders (Alan)		AS	

EMAS captures patients' experience in a variety of ways. One way is by inviting patients and carers into our Trust Board meetings to tell their story. We have included 2 examples below – one where we have done well and one which shows we need to improve:

Patient Story

We heard from a 16 year old gymnast who suffered multiple open fractures to his left arm after an accident on a piece of gymnastic apparatus (the 'high bar'). He attended the Board with his parents to discuss the complaint that they submitted in February 2012 in which they raised concern about:

- *The time it took for the ambulance to arrive (over 1 hour),*
- *The categorisation given to the 999 call (initially Green 2); and*
- *The unwillingness of the call takers in the Emergency Operations Centre (EOC) to give any information regarding the estimated time of arrival (ETA) of the ambulance.*

Despite these concerns the family did wish to raise some positive elements to the care received including:

- *The clinical care provided by the crew*
- *The helpful and professional approach taken by the Investigation Officer appointed to handle the complaint*

What we did:

We passed on the families praise and thanks to the crew and the Investigation Officer involved. We also identified a number of priority actions to improve the delivery of services across all A&E categories including:

- Introduction of a Resource Management Centre to maximise resource utilisation to meet demand
- Review Emergency Operations Centre processes to improve efficiency and productivity
- Proactively address hospital turnaround delays through partnership working with Acute Trusts and PCT Commissioners
- Reduce sickness absence of internal workforce
- Increase clinical assessment of calls to ensure timely access to the most appropriate care
- Review of fleet and estates facilities to optimize deployment of resource

In addition the Board are currently revisiting the approach to information provision to callers specifically to consider whether call takers should provide an estimated ambulance arrival time. The Trust Board agreed in November that a controlled pilot would be undertaken to determine the feasibility of adopting this as a future course of action

Carer Story

We heard from a gentleman (Mr W) whose wife; an ex-nurse suffered Atrial Fibrillation (a heart problem) on in August 2012. Mrs W was attended first by a paramedic in a Fast Response Vehicle (FRV) backed up shortly afterwards by a Double Crewed Ambulance (DCA) and taken to Chesterfield Royal Hospital. Following the event, Mr W contacted the Trust as he felt compelled to pass on his thanks to the crew and to ensure that the Trust management received feedback about his family's positive experience. Mr W was particularly impressed by:

- *The calm and efficient manner of the call taker*
- *The timeliness of the ambulance service response*
- *The competence of the FRV paramedic*
- *The skills, manner, gentleness and sense of humour of the DCA crew*
- *The teamwork demonstrated by all of the crew in attendance*
- *The way in which the crew not only looked after Mrs Ward but also other family members, explaining at all times what was happening and offering reassurance*

This story illustrates the importance of combining technical and interpersonal skills in order to provide a positive experience to patients and their families.

What we did:

As a result of this story we have:

- Provided the staff involved with positive feedback and thanked them for their continued hard work and professionalism
- Shared this story with Organisational Learning for use in Essential Education. A 'real-life' story can convey a very powerful message.
- Key messages from this story were included in the Chief Executive's bulletin (a weekly bulletin sent to all staff) in November 2012

Extracts from letters of thanks sent to EMAS

The community paramedic was absolutely brilliant in this time of deep sadness and treated my mother and our family with respect and kindness. His professionalism and empathy was greatly appreciated and will be forever remembered.
Mr P, Derbyshire

My son spoke about him the next few days in hospital and I really think that both the ambulance crew and tex (technician) made my sons and my daughter's experience a lot easier to handle.
Mrs T, Lincolnshire

Dave and Jackie who are a credit to your organisation, no complaints only compliments for their kind words and help provided.
Mrs P, Northamptonshire

Please tell everyone that I love them and thank you so much for making me feel better.
Mrs G, Nottinghamshire

Extracts from could do better letters sent to EMAS

On Monday 19th November at approximately 11.30am an ambulance was called to attend a 92 year old man who had fallen and suffered a large cut to his head outside Derby Station. The paramedics arrived 1 hour and 15 minutes later after 4 separate calls were made to the operator, each expressing concern over the welfare of the elderly gentleman. The medical treatment and care provided on arrival was exemplary, however the information provided to us by various operators prior to the paramedics arrival was inconsistent causing further distress to the injured gentleman.
Mr B, Derbyshire

The two members of ambulance crew proceeded to walk my husband down the stairs and out of the house into steady rain in just his pyjamas, dressing gown and carpet slippers. They performed no tests or examination before moving him despite being faced with an 89 year old man experiencing severe difficulty in breathing. They also ignored my request to dress him in a coat.
Mrs C, Leicestershire

How disgusted we are with the ambulance service. My mother had a fall on 1st December and was laying on concrete on a frosty afternoon and it took nearly two hours to come to her aid, she has a fracture in her back. She has never needed an ambulance before in 98 years and then she gets this response. I know they were very busy but her age should have been taken into consideration.

Quality Management Systems
(how we will support improvement)

Being the Best

Estates Reconfiguration

Delivery of the aims of 'Being the Best' requires changes to the way the Trust operates and to the facilities from which it delivers its services. The Estates Reconfiguration has 'Being the Best' at its heart and is designed to improve both patient care and staff working lives.

The majority of the Trust's existing ambulance stations (or reporting bases) have been in place since a time when local councils were responsible for service provision. The context of service provision has changed and local councils are no longer responsible for their geographical areas. As a result, the locations of reporting bases within the EMAS geographical area are not optimal for current service provision, and this impacts upon performance. Additionally, a large proportion of the Trust's current estate is in need of major repairs and refurbishment and this has been estimated to cost approximately £15 million to undertake.

A Strategic Outline Case (SOC) has been developed which describes the process that the Trust followed to reach decisions about the development of its estate, which have been agreed following careful consideration of the needs and views of frontline staff, stakeholder groups and the public. The SOC has been prepared using principles of the five case model, in line with Department of Health guidelines. It is anticipated that the SOC will be approved at the March 2013 Board meeting and that implementation will take place over a the following 3 to four years but with the majority of the benefits to patients being delivered in the first year.

The primary objectives for change to the estate are as follows:

- Provide suitable facilities in locations that support an improvement in operational performance, measured by improved response times and give greater equality of service between geographies served by the Trust.
- Provide facilities which support the efficient management, training and deployment of resources within each Division, including appropriate provision for fleet maintenance and 'Make Ready'.
- Provide facilities that support and motivate staff and enhance the public image of the Trust.
- Provide a range of flexible and sustainable accommodation that will support changes in demand, future Trust operational strategy and the Trust's environmental aspirations.
- Develop an investment programme that is deliverable within acceptable time and cost parameters, making best use of existing assets.

The preferred option as at the time of writing (March 2013) includes a mixture of new build and refurbishment of current ambulance station facilities and new build on new sites where this was considered an optimum location to deliver performance. The 9 Hubs and 19 Ambulance Stations will be supported by 108 Community Ambulance Stations.

Within the counties of Nottinghamshire (1), Derbyshire (1), Leicestershire (2), Lincolnshire (3) and Northamptonshire (2) there would be 9 purpose built hubs that also include fleet services. These 9 Hubs would be supported by a further 19 smaller Ambulance Stations that will have make ready but not fleet services. Additionally, the new Estates Configuration will include occupational health, fitness suite, educational space, and cultural diversity space in appropriate locations.

Three Tier model

The proposed service model has 3 levels of ambulance vehicle response:

• Level 1 – Urgent Care Ambulance crewed by Emergency Care Assistants (ECA) for patients who require conveyance but do not have a life-threatening condition
• Level 2 – Paramedic Fast Response Vehicle (FRV) or Ambulance crewed by a Paramedic and ECA/Technician for patients who require an immediate response and / or conveyance
• Level 3 – Emergency Care Practitioner (ECP) in an FRV for patients who are likely to need on-scene treatment or assessment but not conveyance

This model deploys EMAS staff more appropriately to ensure that patients receive treatment that is most suitable for their clinical need. The model will require the following to achieve performance:

• an increase in ECPs
• an increase in ECAs
• nominal change to student numbers or Technician posts

The new service model will ensure that patients receive treatment that is most appropriate for their clinical need, use the skills of EMAS staff more appropriately and ensure that the most appropriate type of ambulance vehicle is deployed.

Rota Changes

The current rotas across the East Midlands Ambulance Service were reviewed in 2010 and in some areas changed as required to meet changing patterns of demand upon our service. Since 2010 demand has increased and national performance standards have been strengthened with a greater emphasis on clinical outcome for our patients resulting in the need for further change.

The key drivers for change are a need to:

• Direct and locally deliver services which meet the needs of the patient, ensuring appropriate care at the right time and in the right place.
• Create capacity within the workforce, enabling delivery against higher call demand
• Support continuous improvement
• Improve the quality of care and performance provision in line with national standards
• Achieve consistently against national performance standards
• Support a suitable meal break agreement
• Reduce unnecessary costs associated with not having the right staff in the right place at the right time
• Allow for appropriate resilience for end of shift cover.

As a result, a further review of the rotas was required to ensure that our levels of cover are sufficient at the times when they are needed the most. As a patient centred organisation, we are required to regularly consider any changes that are needed to ensure our operational model of delivery meets the needs of the patients, service and regional activity.

Management Restructure

The Operations Management Restructure consultation document outlines EMAS proposal to restructure Operations Management to ensure that it is able to deliver quality service to patients and is fit for purpose.

The proposal supports EMAS' intention to establish the Trust as an organisation that provides high quality care, delivers its performance and people objectives and operates within the funds available.

The key principles are to implement an operational management structure that;

- Embeds clinical leadership at every level, ensuring that quality is our first priority
- Has the fewest number of managerial layers, to ensure the most effective communications and decision making
- Has clear accountability for the delivery of key performance indicators, where each individual knows what they are accountable for
- Adopts a model of devolved responsibility In the form of service line management
- Supports an environment of Health and wellbeing

The proposal document outlined a proposed operational management structure that will support the Trust in achieving its strategic objectives through robust frontline and middle management roles within the operations directorate.

Planning and Developing the Workforce

Over the last 2 years we have experienced quality, financial and performance challenges which have necessitated a review of the current service model and operational management structure. The aim of this change is to ensure the delivery of high standards of clinical care coupled with the achievement of performance standards. The new model provides a greater degree of flexibility and responsiveness to local and national developments across healthcare, and is affordable. This involves significant workforce transformation to ensure we have the right staff, with the right skills, in the right place at the right time, at the right price. The key focus for the Workforce Directorate over the next few years is to support and deliver workforce transformation to enable implementation of the new service model and operational management structure.

The new service model and operational management structure emphasise the importance of clinical leadership (see Figure 3 below) and a devolved approach to decision making and accountability through service line management; establishing a flatter structure of operational management below board level – the division, the locality and the team. Effective teamwork and good communication channels underpin the new model to ensure principles of working together, supportive management, involving and valuing the contributions of all underpin the way we will operate. This will require a new relationship between the corporate body and operational management, and alignment of corporate departments to support the divisional structure.

We will also see change across our frontline workforce as our new model of service delivery is implemented. Through this change programme we aim to ensure that clinical skills remain at a high level, and that all staff work in a team environment, have regular appraisals, an individual development plan and regular contact with their team leader, through an environment where staff are valued, recognised, empowered and nurtured through supportive management behaviour and increased opportunity for involvement and participation.

Consolidation of the divisional structure will see the development of local hubs where local managers can have contact with clinical staff and where team leaders can provide supervision and support. A key aim is to improve the communications between the organisation and individual clinicians and to ensure that an experienced colleague can be available to support individual clinicians at the end of a tough day or after a difficult incident.

Key features of the workforce transformation include:

- Implementation of the new service model based on 3 levels of response: an urgent care ambulance; a front line A&E ambulance; and an ECP service. This will be supported by increased clinical skills in the Emergency Operations Centre to support increased clinical assessment, Hear and Treat, and Hear and Refer.
- Complete restructure of divisional management teams with reduced number of operational staff and managers.

- Ensuring increased clinical leadership within divisions with the introduction of Consultant Paramedic roles supporting Divisional Directors.
- Ensuring an effective team based approach is embedded within the new structure.
- Ensuring team leaders have the capacity and capability to do the job effectively.

Planning and developing our workforce is fundamental to ensuring security of supply as well as attracting staff that can develop the appropriate knowledge, skills and attitudes through high quality education and training to meet the needs of patients and changing service models. Over the last two years we made significant progress in developing our internal workforce planning processes. However, moving forward, the onset of national changes to the workforce planning infrastructure with the introduction of Health Education England and Local Education and Training Boards, as well as the redesign of our operational service model requires even greater emphasis upon developing workforce planning systems and processes, and partnership working with internal and external stakeholders to ensure data and intelligence is available to support effective workforce planning and ensure the right workforce capacity to deliver high quality patient care.

Education and development

The service has experienced significant change and increasing diversification over recent years. A shift from transferring all patients to Emergency Departments to one that now has greater responsibility for patient assessment, treating and clinically managing patients at home, and referring through alternative healthcare pathways ensuring patient care is responsive and appropriate to patients needs. This highlights the changing role of the ambulance practitioner who needs a greater range of competences, skills and underpinning knowledge whilst maintaining the vocational nature of their training. Registration with the Health Professions Council, and the College of Paramedics curricula and subsequent review processes has moved the minimum entry requirements for registered professionals to Diploma or Foundation degree with entry through duly accredited Higher Education programmes, which provide the foundation for professional practice. Continued commitment to education, training and development, and further education to support the introduction of new care pathways is essential to ensure all our staff have the right skills and qualifications to do their job safely and effectively.

Growing and supporting our own staff to be leaders and/or develop into functional/specialist roles is important and a more systematic approach to nurturing talented individuals within our workforce needs to be developed. It is also imperative to ensure a succession plan is in place to enable workforce risks to be proactively managed, creating a talent pool that will increase the speed to appointment to all roles and give assurance that successors have been established for key roles in the Trust.

Staff support and wellbeing

The report on NHS Health and Wellbeing by Dr Steven Boorman clearly sets out the rationale for the improvement in health and wellbeing across the NHS, and its findings confirm that where organisations prioritise staff health and wellbeing, they achieved better performance, improved patient satisfaction, stronger quality scores, better outcomes, higher levels of staff retention and lower levels of sickness absence. The current focus on staff health and wellbeing in EMAS is primarily based on reactive occupational health services through line manager or self referral, access to counselling support and physiotherapy. Furthermore, we are experiencing a prolonged period of high sickness absence (6.74% 2011/2012). Sickness absence targets of 5% for 2012/2013 and 4% by 2013/2014 have been agreed. It is important that we focus on reducing the rate of sickness absence and improving our health and wellbeing offering focusing on prevention and health improvement; by providing efficient support for staff who present with ill health; by being proactive in tackling the causes of ill health (both work and lifestyle related); and, where there are clear benefits, by providing early intervention services.

Absence Management

The Trust has seen an overall reduction in absence this year when comparing absence rates during 2011/2012 and 2012/2013. This is illustrated in the table below:

Month	YEAR ON YEAR	
	2011-2012	2012-2013
	%	%
April	7.01%	5.40%
May	6.06%	5.96%
June	6.82%	5.75%
July	7.02%	6.03%
August	6.99%	5.90%
September	6.95%	5.52%
October	7.52%	6.21%
November	7.81%	6.00%

Source: ESR

Absence Management continues to be a key priority for the Trust and we have a number of key initiatives this year to ensure a proactive and robust approach including:-

- Implementation of the Health and Wellbeing Strategy will be supported with early intervention and rehabilitation programmes for staff with long term conditions (muscular-skeletal and mental health). A range of Health Promotion Days across all divisions are planned to take place during the months of February and March.
- A new approach to employee engagement supported by the roll out of the reward and recognition schemes across all areas is being planned as the management structure is rolled out. This will ensure responsibility for engagement is seen as a core part of manager's roles in a planned and coordinated way.
- As a result of the last deep dive exercise and feedback received from staff, a new Attendance and Wellbeing Group has been set to take forward the Health and Wellbeing Strategy. Work has already been carried out by members of the group including a health and wellbeing survey and various health and wellbeing initiatives have been discussed including introduction of Cardio Vascular equipment on stations, and physical competency assessment. The next meeting of the group will be held on 29th January 2013. A paper will be submitted to the Executive Team in March 2013 outlining the wellbeing initiatives and recommendations in detail.

Equality Delivery System

Equality & diversity must be embedded as core components within the Trust's business portfolio. As well as being central to legal and regulatory requirements, equality and diversity is being embedded within contract requirements and specifications. We need to enhance workforce capability and confidence around equalities through better awareness, ownership and involvement; increase diversity of workforce composition; deliver services that effectively respond to and meet the needs of diverse communities; embed equalities within the staff engagement strategy especially in areas that support the development of special interest groups; identify and engage with national/regional equalities initiatives that nurture talent and support career development especially from under-represented staff; and identify innovative and creative ways to improve collection and use of equalities data to improve our equality performance.

Leadership

The Trust recognises that it will continue to face challenges in future years. In a economic climate it must seek to increase productivity through innovation and

development, whilst continuing to improve service quality and deliver performance standards.

Strong leadership from the Board remains crucial to drive the culture and facilitate organisational development. Leadership needs to be prevalent at all levels. The introduction of service line management and efficient and effective locally based decision making sits at the core of the new service model and is vital to secure continual improvement in quality, productivity and operational delivery.

Clinical leadership is not just about those in senior positions but needs to be embedded throughout the organisation and across all clinical roles. In order to achieve the strategic goals, members of staff act as clinical leaders within their role and support the high standards of clinical care that the Trust strives to deliver. At the frontline, clinical leadership is paramount to the continuing professionalisation of the service. The new service model, aligned with an operational management structure that embeds clinical leadership at its core, will ensure that the clinical needs of the patient are met by the most appropriate clinical response.

This will be achieved through:

- A strong and effective clinical directorate which is visible to staff and communicating effectively with the frontline
- Clinical leaders across the Trust, both as clinical champions for specific areas of service strategy but also as links within their local community
- Well established clinical mentorship and supervision for staff helping to drive up clinical standards
- An operational model of devolved responsibility and service line management
- A structure that is team focused with clarity of team and individual accountability.

Transformation Board

The group is responsible for ensuring that the Trust is supported and enabled to develop and implement the Transformation and Service Improvement programmes to deliver the new model of service delivery. In particular the Transformation Board aims to:

- Agree service delivery models and oversee implementation
- Agree strategies, policies, processes and procedures as necessary
- Agree the Programme plans, setting deadlines and allocating tasks
- Agree the finances and resources to support programme processes
- Agree the overall transformation and service improvement programme budget which reflects those finances and resources identified within the individual PIDs from each individual programmes
- Agree strategies, for example the relevant consultation strategy, communications strategy, etc.

The Transformation Board will advise the Trust Executive Group that each Programme of work is being managed and delivered in accordance to agreed timescales and will highlight any issues that affect the delivery of the Programme to the Trust Executive Group.

.Innovation

The Care Quality Commission and the NHS Litigation Authority set out essential standards of quality and safety that we must demonstrate and evidence in order to demonstrate compliance and provide assurance of the delivery of high quality patient care. Compliance with legislation, supporting staff and driving quality through organisational and workforce development strategies

are integral to these standards, and the contributions and objectives of the Workforce Directorate have been articulated throughout this document. However, in addition there is further work to do to ensure appropriate means of measurement are developed to ensure we can demonstrate the contribution to quality; encourage innovation; ma ute to cost improvement plans; and inform decision making.

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Learning

EMAS has an embedded system of sharing learning across the organisation through our established Divisional and Strategic Learning Review Groups (SLRG). SLRG members review the feedback and take steps to communicate the learning outcomes across the Trust. Learning is identified from a wide range of sources including serious incidents, complaints and patient experience surveys.

Serious Incidents

During 2012/13 the Trust identified XX Serious Incidents (SI) requiring investigation.

General themes relate to:

- Delayed response to green category calls
- Incorrect coding of calls
- Vehicle incidents
- Care management

Learning from SIs:

All SIs require completion of a Root Cause Analysis (RCA) which seeks to identify contributory factors, root causes, learning for both individuals and the organisation and to provide recommendations to prevent reoccurrence. Action plans are completed following each SI RCA and actions are closely monitored until closure.

Complaints

During 2012/13 the Trust identified XX Formal Complaints (FCs) requiring investigation.

General themes relate to:

- Delayed response to green category calls
- Staff attitude
- Patient assessment
- Call management

Ombudsmen Requests

During 2012/13 the Trust received X requests for information from the Ombudsmen. Of these X were upheld.
Learning from FCs:

All FCs require investigation which seeks to establish the facts of the case and identify learning for both individuals and the organisation and to provide recommendations to prevent reoccurrence. Action plans are completed following each FC investigation and actions are closely monitored until closure.

General approaches to learning from SIs and FCs include:

- Communication of key learning points through education, training and awareness, including the use of the Trust's monthly Clinical Update email as a method of communication
- Clinical case reviews and reflection of the practice by individuals
- Development of clinical risk assessments to ensure identified risks are managed through the Trust's clinical risk management process.
- Amendment to policies, procedures and practices
- SIs and their themes are reviewed by the Trust's Learning Review Group which consists of multi-disciplinary membership

Patient Experience Surveys

The Trust conducts quarterly postal patient experience surveys for all emergency call categories and patient transport services. Approximately 12.5% of patients are surveyed and response rates average around 30%.

The surveys all include the Net Promoter Score (NPS), known as the 'Friends and Family' Test. The NPS is obtained by asking patients the question 'On a scale of 0 to 10 how likely would you be to recommend East Midlands Ambulance Service to family and friends?' where 10 is' extremely likely' and 0 is 'not at all likely'. Based on their responses respondents are categorised into one of three groups 'Promoters' (9-10 rating); 'Passives' (7-8 rating) and 'Detractors' (0-6 rating). The percentage of Detractors is then subtracted from the percentage of Promoters to obtain a Net Promoter Score (NPS). NPS can be as low as -100 (everybody is a detractor) to +100 (everybody is a promoter). An NPS that is positive (i.e. higher than zero) is felt to be good, and an NPS of +50 is excellent (scoring methodology taken from NHS Midlands and East's Position paper December 2011).

EMAS has continued to receive excellent scores for both accident and emergency and Patient transport services. However we are not complacent and recognise that there is always room for improvement. The results are analysed by call category and Division and actions are identified to bring about continual improvements.

Service Improvements

A number of improvements have been identified as a result of learning from a wide range of sources including serious incidents, complaints and patient experience surveys. Some examples are shown below:

- Improvement in the quality of completion of IR1 (incident reporting) forms
- Issue of a clinical bulletin changing the way in which paediatric hospital pre alerts are given
- Improved documentation of cannulation
- Development and provision of a Domestic Violence Abuse (DVA) training package delivered through Essential Education
- Provision of a discreet DVA card that crews can give out to patients they suspect may be victims of domestic violence
- Issue of guidance to staff on the use of oromorph as a first line analgesic
- Introduction of the Clinical Coordinator role to support frontline crews in accessing alternative pathways for patients
- Recategorisation of Road Traffic Collisions as Green 1 from Green 2 thereby improving response time
- Issue of clinical bulletin relating to ambulance staff role in identifying and reducing risk of pressure ulcer development
- Introduction of divisional patient safety visits
- Introduction of on vehicle CCTV
- Introduction of local Clinical Performance Indicators
- Development of "easy read" patient survey which is currently being trialled at the "Big Health" days across the East Midlands region
- Provision of bespoke customer care training for call handlers
- Recruitment of additional Dignity Champions and development of Dignity Pledges

- "Being the Best" consultation underway to reconfigure EMAS estate and redesign service delivery model to improve response to all call categories
- Ongoing work with Acute Trusts and Commissioners to address hospital turnaround delays. EMAS hosted a Turnaround Summit on 7th September, led by the Director of Nursing and Quality. An overarching turnaround program toolkit has now been developed which includes actions arising from the summit, a post-handover action plan and a number of discrete projects including RFID, process mapping and recovering acute penalties.
- Following a review of the Clinical Assessment Team Framework all 999 calls for immediately life threatening conditions (Red1 and Red2 codes) received from High Volume Service Users are immediately passed (Hot Transfer) to a member of the Clinical Assessment Team for further assessment to ensure the patients' needs are met.
- Welfare checks have been introduced for green call delays and where no contact can be made these calls are automatically upgraded as a safeguard
- All calls received from Police Control are now processed through AMPDS to ensure the appropriate response is allocated
- Review of Bariatric capabilities (specifically Nottinghamshire). PTLs involved in recent incidents have been invited to sit on the working group looking at the future of EMAS bariatric services. Cascade training and refreshers for Megasus Stretcher and Viking Hoist to ensure staff are current in their understanding and usage of both

Staff Survey

The annual Staff Opinion Survey was conducted by the Picker Institute on behalf of East Midlands Ambulance Trust (EMAS). Picker also administered the survey for 6 other Ambulance Trusts enabling us to have some comparative data ahead of the Department of Health report due in March 2012 which details our results against all other Ambulance Trusts and other parts of the NHS.

Picker have provided us with an Executive Summary of the results earlier than anticipated as well as a copy of our full survey results. Early inspection has identified some anomolies in the target population data, which are currently being reviewed in conjunction with Picker, prior to being able to confirm the accuracy of the final data. Once resolved, the full report will be made available.

EMAS's response rate was 37.6%. The average response rate for the 6 'Picker' Ambulance Trusts was 38.9%.

Top 3 areas of improvement on last year

These are the areas that showed the greatest improvement in the score:

- Training in how to deliver a good patient/service user experience (15% improvement).
- Communication between senior and staff is not effective (15% improvement).
- Senior managers involving staff in important decisions (11% improvement).

A summary of all areas of improvement can be found on page 5 of the Executive Summary.

Top 4 areas of deterioration on last year

These are the areas that have most significantly deteriorated:

- My job is not good for my health (12% deterioration).
- Felt unwell due to work related stress in last 12 months (11% deterioration).
- In last 3 months, have come to work despite not feeling well enough to perform duties (7% deterioration).

- In the last month, saw errors, near misses/incidents that could hurt patients (7% deterioration).

A summary of all areas of deterioration can be found of page 5 of the Executive Summary.

Top actions taken to improve 2011 survey results

- New Service Model and Operating Model.
- Operational Management restructure to support staff health and well being and line management accessibility.
- Supportive Management Training programme launched.
- Survey Monkey introduced quarterly and recent survey focused on additional questions for staff survey.
- Recognition Scheme launched for all staff groups as well as an Annual Awards event to recognise staff's achievement.
- Chief Executive communication to managers via video link and weekly bulletins.

These actions seem to have had a positive impact on scores relating to communication with staff and staff involvement in important decisions.

Next Steps

Engagement with staff on the results of the survey will be managed through the Staff Engagement Framework and Implementation Plan. One of the actions from the Board Governance Assurance Framework was that Staff Opinion Survey improvement plans should be integrated into the Staff Engagement Framework and Implementation Plan. This framework was developed to ensure that employee engagement activity is co-ordinated, comprehensive and integrated, and to assist those who lead on employee engagement to do so in an informed and manageable way. Please refer to Appendix One for details on the framework action categories

Staff will be made aware of the 2012 staff survey results via Pulse at the end January, and through highlights in the Chief Executives bulletin. The executive summary and full report will be available on INSITE. The CQC report, which compares our Trust to all other Ambulance Trusts, will be available in March. This report will also be available through INSITE and staff will be made aware of it through the Chief Executives bulletin.

At an organisational level, the problem scores will be grouped under the action categories in the Staff Engagement Framework. Organisational level actions to address these problem areas will be agreed at Executive level and communicated to the Senior Leaders Team through strategic sessions and to operational managers through workshops in February 2012.

The full results, organisational problem scores and staff engagement implementation plan will be disseminated to divisions and departments during February. Divisions/Departments will be asked to identify their problem scores and three priority areas under the high level action headings identified in the Staff Engagement framework. Each division/department will have to establish a 'forum' or a 'road show' to communicate the results in their areas /division.

In order to contextualise the results focus groups in divisions and departments will be conducted to specifically establish what actions would staff like to see that would make a difference in response to the problem areas identified. This will include actions to be taken at the group and individual level in accordance with the framework. These focus groups will be led by HR Business Partners and Divisional Directors/Deputy Directors/Heads of Department.

These actions will be monitored through the Workforce Governance Group and feedback to staff will be on a bi-monthly basis through Chief Executives Bulletin. A detailed staff engagement communications plan to include feedback on the Staff Opinion Survey is currently in development.

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Our current quality performance
(what we did and how we improved)

We have reviewed all the data available to us on the quality of the care we have provided to our patients. The following information identifies what we did during 2012/13 to monitor and assess our quality performance outcomes.

The factors listed below demonstrate that we have made good progress in many areas whilst acknowledging that we can make further improvements in 2013/14.

What Issue we addressed	What we did and how we improved
We identified that compared to other ambulance Trusts we had lower then average levels of incidents reported (particularly for incidents with no harm (near misses) or those with low harm.	We developed and implemented an action plan to improve reporting rates which included the provision of a telephone reporting line, issuing of further guidance to staff, a staff survey to identify barriers and facilitators, improved feedback to staff following incidents. As a result we have seen a significant improvement in both our overall numbers of incidents reported and an increase in the percentage that are low or no harm. We are now comparable to our peers. We hope to further improve our reporting rates by extending the telephone line to 24 hours a day, seven days a week and rolling out a web based reporting system.
We also identified that we receive relatively low response rates to our patient satisfaction surveys.	We developed and implemented an action plan to improve response rates. We consulted with our Patient Safety & Experience Forum (a group made of Foundation Trust members with a specific interest in patient safety and experience) and they helped us to revise our patient surveys to make them more user friendly. We also increased our sample sizes and began issuing our Patient Transport Service surveys out by hand. We have seen an improvement in our response rates and plan to build on this in the coming year by introducing online surveys, trialling telephone and face to face surveys and providing crews with cards to issue to patients explaining how they can share their feedback.

We recognised that our staff required support to be able to access the most appropriate care pathway for their patients which is not always attendance at A&E.	We provided a clinical assessment guide to support staff in their assessment and clinical decision making. We also introduced the role of Clinical Coordinator into our Emergency Operations Centre which provides a resource for frontline staff to contact if they require advice and support. In addition Continuing Professional Development sessions have been put on for staff and access to the Pre Hospital Assessment and Disposition (PHAD) course has been facilitated.
A theme merging from our Serious Incidents was the poor recognition and management of potential spinal injuries.	We undertook a thorough review of the cases to identify the root causes and contributory factors and used this to develop and implement an action plan to reduce the number of incidents. This included issuing a bulletin to staff and developing a training podcast for use in education. To continue to embed this knowledge we are including spinal assessment and management in our 2013/14 Essential Education programme and developing a quick reference pocket guide for staff.
We needed to ensure that our staff received the nationally mandated training for PREVENT, counter terrorism awareness.	We included the training in our Essential Education during 2012/13. We have received positive feedback from staff who have attended the training and also from the Strategic Health Authority as part of our Adult Safeguarding Annual Assessment Framework review for the progress made in this area.
We recognised that we needed to improve the level of engagement with frontline staff on quality issues.	We expanded the scope of the visits undertaken by our Board members to include staff feedback on issues relating to all aspects of quality (patient safety, experience and clinical effectiveness). We also used the opportunity to ask staff about ideas for service improvement and cost improvement programmes including any concerns they may have about the potential adverse impact of programmes on quality. In addition the Clinical Quality Managers started undertaking local Divisional visits in July 2012. We also introduced twice yearly full board visits where all members of the Board between them visit all locations in a single Division on one day. A rolling action plan is maintained to implement the priority actions arising from the visits.

Participation in Clinical Research

Clinical Audit is led by the Clinical Audit department which reports to the Clinical Governance Group and is led by the Head of Clinical Governance, Audit and Research and Supported by the Associate Clinical Director for research.

The clinical audit department develops the Trust's clinical audit by ensuring that all necessary support for the undertaking of clinical audit are readily available to staff and that progress on all audits are monitored for correct procedure.
The Clinical Audit topics are divided into 4 main types:

- Mandatory
- Discretionary
- Performance driven
- Staff initiation

Clinical audit topics are selected according to priorities which may include some of the following considerations:

1. Is the area concerned of high cost, volume or risk to patients or staff
2. Is there evidence of serious quality problems e.g. patient complaints or high incident rates
3. Is there good evidence available to inform standards i.e. national clinical guidelines
4. Is the problem concerned amenable to change?
5. Is there potential for impact on health outcomes?
6. Is there opportunity for involvement in a national audit project?
7. Is the topic pertinent to national policy initiatives?
8. Does the topic relate to a recently introduced treatment protocol? Are there any potential collaborators who could contribute to the project workload?
9. Subjects raised by Risk Management and Untoward Incident Reporting system

The department has a pivotal role in ensuring that recommendations from clinical audit are distributed out to our frontline staff to ensure improvement in clinical practice and is used to drive the continuous quality improvement aims of the trust. Areas that can be evidenced would include review of cannulation rates showing low levels of inappropriate insertion, review of oxygen usage against British Thoracic Society guidelines and use of intra-osseous cannulation (direct into the bone when the blood vessels are not an option). The Trust also contributes to the development of clinical audit in ambulance services nationally by participation in national audits and clinical performance indicators as well as being a member of the National Ambulance Clinical Quality Steering Group and the Ambulance Service Association/JRCALC (Joint Royal Colleges Ambulance Liaison Committee) clinical effectiveness Committee.

In addition to clinical audit the trust has a significant research department with collaboration in a number of nationally externally funded studies which are at the cutting edge of research into pre-hospital care management and also include studies that are about quality change such as the Ambulance Service Clinical Quality Initiative

(ASCQI) which has directly led to quality improvements in Stroke and cardiac care and lessons learned from implementation have been fed into quality change initiatives in other areas such as asthma. The Service is part of the National Ambulance Research Steering Group.

Following the publication of 'Innovation, Health and Wealth, Accelerating Adoption and Diffusion in the NHS' (Department of Health, 2011), EMAS developed an Innovation strategy .This strategy aims to promote the spread and adoption of innovation across the organisation to ensure transformational change and the delivery of quality and productivity improvement. The strategy also focuses on the need to strengthen the contribution of Health Research and Development to promote the Trust as a centre of excellence for health and healthcare-related research and development. EMAS' Research and Development Strategy supports both regional and ambulance sector innovation. The approach aims to increase the quantity and quality of health and healthcare-related research and development through:

- Enhancements in collaborative working
- Innovative approaches between sectors (particularly health, universities and industry)
- Promoting continual improvement in everything that we do.

The research community in EMAS is a key part of the innovation landscape and many joint initiatives are underway as a result of our partnerships. EMAS is linking closely with the emerging Academic Health Science Networks to ensure the high level and quality of research is being maintained.

Research

CURRENT STUDIES – NEEDS UPDATING PRIOR TO FINALISING

PROJECT	EMAS LED OR HOST SITE	TYPE & STATUS	PROJECT SUMMARY	CHIEF INVESTIGATOR & FUNDING ORGANISATION
Patient reported Outcomes for Vascular Emergencies (PROVE): Interview study of patients and practitioners for developing PROVE (IS-PROVE)	EMAS Led	NIHR Portfolio Research	The study's main objective is to develop an understanding about what aspects of care and outcomes are important to patients accessing the emergency services for stroke and heart attack. The completed study has shown features of pre-hospital care that improve outcomes and experience for patients. These include communication, holistic care, appropriate treatment and smooth transition from home to hospital. The results are being used to inform development of PROMS (Patient Reported Outcome Measures) and PREMS (Patient Reported Experience Measures)for stroke and heart attack.	Niro Siriwardena Funded by: HF

Developing new ways of measuring the impact of ambulance service care	EMAS led	Research	The programme aims to develop new ways of measuring the impact of care provided by the ambulance service to support quality improvement through monitoring, audit and service evaluation. The programme is currently in progress.	Prof Niro Siriwardena Funded by: NIHR
Pre hospital Pain Scoring and Linked management System (PSALMS)	EMAS Led	Research	The aim of the study is to gain an understanding about pain assessment and management in the pre-hospital environment which would be used to inform the development of a pain management tool. Phase 1 is complete with suggestions to improve pre-hospital pain management including addressing barriers, modifying the available drugs and developing a pre-hospital pain management protocol supported by training for staff. The second phase is expected to produce a pain management tool ready for validation and testing.	Funded by: RDS and EMAS
Barriers and facilitators to evidence based assessment of asthma: exploring the perceptions and beliefs of ambulance paramedics to the assessment of asthma	EMAS Led	Research	The aim of the study was to understand the factors which prevent or enable ambulance assessment guidelines for asthma being followed. The study has now been completed and has identified issues relating to clarity of ambulance guidelines, conflicts between training and guidance, misconceptions about the importance of objective assessment and over- reliance of non-objective assessment. Our findings have informed improved systems of care and training for asthma, and have led to improvements in asthma indicators.	Deborah Shaw Funded by: NIHR, RDS
Closing the Gap: Ambulance Service Quality Improvement Initiative	EMAS Led	Quality Improvement	A two year funded study looking at the use of quality improvement initiatives to improve the delivery of the stroke and heart attack care bundle across all English Ambulance Services. Preliminary results show significant improvements in care for heart attack and stroke across ambulance services in England. We have also developed a model to improve pre-hospital care which is transferable to other conditions.	Niro Siriwardena Anne Spaight Funded by:HF
Engaging Ambulance Clinicians in Quality	EMAS Led	NIHR Portfolio Research	The study aims to achieve a measure of Quality Improvement (QI) leadership behaviour, culture and methods used in ambulance	Niro Siriwardena

Improvement (QI) Initiatives			services in England. The study also aims to identify potential barriers to achieving and maintaining clinician engagement. Data is currently being collected and analysis will shortly begin.	Funded by: HF
Strategic Reperfusion Early After Myocardial infarction (STREAM)	Host Site	Industry Research	The aim of the study is to compare the outcomes of pre-hospital patients presenting with a heart attack who receive either: Early (pre-hospital) thrombolysis (clot busting treatment) followed by cardiac catheterisation or; Primary Percutaneous Coronary intervention (immediate balloon and stent treatment to open the blocked artery in the heart). EMAS participation in the study has now finished and EMAS will await the final conclusion.	Prof Gershlick Funded by: Boehringer Ingelheim
Acute Medicine Interface Geriatrician Outcome Study (AMIGOS)	Host Site	NIHR Portfolio research	The study's overall aim is to conduct a randomised controlled trial based at Queen's Medical Centre, Nottingham to assess the impact of the interface geriatrician compared to usual care of older people attending the acute medical unit. EMAS' participation in the study involves gathering data about the ambulance resources used by patients who have consented and been recruited to the study.	Prof John Gladman Funded by: NIHR
Trial of a Medical and Mental Health unit for Older People	Host Site	NIHR Portfolio Research	The aim of the study is to evaluate whether a specialist multidisciplinary Medical and Mental Health Unit for older people with confusion admitted to general hospital as an emergency is associated with better outcomes than standard care. EMAS' participation in the study involves gathering data (with consent) about the ambulance resources used by patients recruited to the study.	Prof John Gladman Funded by: NIHR
Better Mental Health Development Study	Host Site	NIHR Research	The main objective of the study is to describe and measure the health problems of older people who are admitted as emergencies to general hospital and who additionally have mental health needs. The study also aims to measure the management of patients and their outcomes to facilitate the development and of a specialist in-patient unit for the management of such older patients. EMAS' participation in the study involves gathering data (with consent) about the ambulance resources used by patients recruited to the study.	Prof John Gladman Funded by: NIHR
Care of older people who fall: evaluation of the clinical and cost	Host Site	NIHR Research	The principle objective of the research is to assess the benefits and costs for patients and the NHS of new protocols allowing paramedics to assess and refer older people who have fallen to community based	Prof Helen Snooks Funded by: HTA

effectiveness of new protocols for emergency ambulance paramedics to assess and refer to appropriate community based care (SAFER 2)			care. Patients who have suffered a fall are being assessed by paramedics and where appropriate are being referred to a community falls services reducing Emergency Department attendances	
Evaluating High Quality care for All: Quality and Safety in the NHS (QSN)	Host Site	Research (Portfolio Study)	The overall study aim is to identify clinical team processes and how these are linked to patient care. The study also aims to assess how the team working processes impact on decisions made about the quality and safety of patient care. All NHS trusts have been invited to participate in the study. Study in progress.	Professor Michael West Funded by: NHSPR
Rapid Intervention with GTN in Hypertensive Stroke Trial	Host Site	Research	The aim of the trial is to determine whether it is possible to conduct a trial in stroke patients in the first few hours after onset by using the ambulance service to assess, consent, randomise and administer medication. The trial is complete and has demonstrated the feasibility of pre-hospital invention studies in hyper-acute stroke. This is being used to inform future studies.	Professor Philip Bath Funded by: Nottingham University Hospital Trust
Evaluation of three digit number (3DN)	Host Site	Research	The learning outcomes of the project are expected to be around: (1) whether the three digit number simplifies the process of accessing urgent care (2) whether the new service results in increased satisfaction of service users; (3) the impact of the three digit number on other services; (4) the costs and consequences of the new service (5) The advantages and disadvantages of different models of provision to identify lessons on the best ways of developing the service and rolling it out.	Janette Turner Funded by: DH
Avoiding Isolation: A study of relationships between NHS Commissioners and Providers	Host Site	Student Research	This study will examine the relationship between commissioners and providers in the NHS and what can be done to improve this. This has recently been approved in the Trust and is yet to begin.	Peter Cross Funded by: Self funded
Investigating whether any barriers affect	Host Site	Student Research	The study aims to identify whether staff face or are aware of any barriers in the provision of services to ethnic minority consumers. The	Shena Parthab Taylor

ethnic minority consumers' (EMCs) take-up of Products or Services designed and delivered in UK			study is also looking at how an inclusive design solution could benefit stakeholders which may lead to time-cost savings. The study is at the analysis stage and an interim report is currently being written.	Funded by: Loughborough University and self funded

Clinical Audit – Update prior to finalising

2012/2013 AUDIT	TYPE	TIME-SCALE/ STATUS	NOTES
MINAP	National	Quarterly ONGOING	MINAP (National Myocardial Infarction Audit Project) data is collected by hospitals to look at how quickly patients suffering with a heart attack receives clot busting drugs. This allows us to evaluate where ıd has led to improved processes for evaluation and alert of hospitals.
National Clinical Performance Indicators	National	Continuous ONGOING	This reviews the care given to patients with STEMI (a group of heart attacks), stroke, hypoglycaemia (low blood sugar) and asthma. As well as reporting on these CPIs nationally every 5 months, data from the Electronic patient report form system has been collected within the Trust and validated local monthly reports have been produced from these allowing better tracking of progress. The results of these audits have been distributed to clinical staff and actions for improvement put into place which has improved care for patients
National Ambulance Quality Outcome Indicators	National	Continuous ONGOING	This is a group of new indicators which services report on nationally where data is collected and analysed for all patients with stroke, cardiac arrest, or STEMI. The outcomes are then reported and fed-back to clinicians and specific improvement work has been put into place to improve patient outcomes in these areas
PRF Compliance	Local	Quarterly ONGOING	This audit reports on the compliance of Patient Report form (PRF) completion. The results from the audit are fed-back to clinicians so that improvements on the recording of the patient's assessment and treatment can be made ensuring that when care is passed to either a GP or hospital that they have all the information available to give the right on-going care.
Oxygen Guidelines	Local	Annual COMPLETE	Audit of the accuracy of oxygen guidelines being followed since they were changed nationally. Where the guideline was not followed, the most common point of failure was that the patient did not require, but had still received, oxygen (40 patients). This suggests that old practices of oxygen administration still persist and has led to discussion with staff to target those not complying to ensure the best care for patients.
Stroke Care	Local	Annual COMPLETE	This Audit was focussed around the times spent at the various stages of the patients journey when a call was made for a suspected stroke. It identified potentially prolonged on-scene times and this has been communicated to staff with work to try and improve this position.

STEMI Care	Local	Annual ONGOING	This Audit was focussed around the times spent at the various stages of the patients journey when a call was made for a suspected STEMI (type of Heart attack). It is yet to report
Intubation/use of supraglottic airways in patients	Local	Annual COMPLETE	This audit compared the rate of survival when a supraglottic (a type of airway management device) airway (LMA) was utilised compared to endotracheal intubation (ETT). During the five month period examined, far more intubations were performed using an ETT (88%) than using an LMA (12%). There was little or no difference found in survival between the two methods. With the introduction of a new LMA this will be reviewed again.
Evaluation of the Clinical Safety of downgrading Red 2 calls	Local	Quarterly ONGOING	This audit was designed to support the introduction of telephone assessment for some of the red calls (potentially life-threatening) where it was felt they may have been over-prioritised by the computer system utilised in the control room. This demonstrated a 93% safety and areas where safeguards could be put in place to further improve the process which have been implemented.

Our local improvement priorities (what we pledged to do)

A proportion of EMAS' income in 2012/13 was conditional on achieving quality improvement and innovation goals agreed between EMAS and EMPACT (East Midlands Procurement and Commissioning Transformation) (our lead commissioners) through the Commissioning for Quality and Innovation payment framework. Further details of the agreed goals are available on request (see the end of this document for contact details). The CQUINs relate to 4 quality domains; Safety, Effectiveness, Patient Experience and Innovation

Through use of the Commissioning for Quality and Innovation (CQUIN) framework, the total value of our CQUIN indicators was £3.2million. Our CQUIN Goals for 2012/13 are provided in the following table.

Goal Name	Description of Goal	Value	Quality Domain
Directory of Services	Development of 999 access to electronic Directory of Services (eDoS) across East Midlands PCT clusters to inform patient care signposting and treatment via alternative care pathways, as appropriate.	£ 500,000	Effectiveness
NHS Pathways	Implementation of a Regional enhanced triaged tool (NHS Pathways) for people ringing 999 for an ambulance	£ 200,000	Effectiveness
Patient Revolution	a) To ensure that providers have real time systems in place to monitor patient experience b) To demonstrate improvements in patient experience c) Demonstrate Board to Crew commitment	£ 300,000	Patient Experience
Response to Commissioners Clinical Concerns	a) Demonstration of a system to capture clinical commissioner concerns b) Response to concerns of X% in X days c) An improvement plan based on a thematic review	£ 200,000	Patient Experience
NHS Safety Thermometer	This CQUIN incentivises the collection of data on patient harm using the NHS Safety Thermometer.	£ 199,949	Safety
Independent Review	Implementation of Independent Review internal recommendations	£ 500,000	Effectiveness
Local Schemes	Development of Patient pathway schemes and integration with CCG's	£1,300,000	Effectiveness

What others said about us: Care Quality Commission (CQC)

This section will need to be updated before publication as we are expecting a visit from the CQC before 31 March 2013.

The Trust received a visit from the CQC in September 2012. The purpose of the inspection was to review compliance against outcome 12, requirements relating to workers. The CQC wanted to ensure that improvements to recruitment procedures had been made since their last visit in July 2011. Following the visit in September 2012, the CQC concluded that the Trust was compliant with outcome 12, adding that effective recruitment and selection processes were in place to ensure people employed to work with the service are of good character, are suitably skilled, qualified and experienced to perform the work.

What people told the CQC

As part of the inspection undertaken in July 2011 the CQC reviewed patient survey results which showed very high levels of satisfaction with the accident and emergency and the patient transport service. The vast majority of people said the service met or exceeded their expectations. People said the staff had explained their treatment, involved them in decisions and assessed their pain. They felt reassured and safe with the staff and most people said staff members were caring and professional.

What we found out about the standards we reviewed and how well Trust was meeting them

Outcome 4: People should get safe and appropriate care that meets their needs and supports their rights
People receive safe and appropriate care treatment and support which meets their needs.

Outcome 7: People should be protected from abuse and staff should respect their human rights
People are protected from abuse or the risk of abuse because staff know how to identify and respond in accordance with local procedures.

Outcome 12: People should be cared for by staff who are properly qualified and able to do their job
Effective recruitment and selection processes were in place to ensure people employed to work with the service are of good character, are suitably skilled, qualified and experienced to perform the work.

Outcome 16: The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care
The Trust takes steps to try and ensure that people receive safe, quality care and treatment.

What others said about us: Local Involvement Networks (LINKs)

To be sort from the LINks following the agreement of the document content

What others said about us: Overview and Scrutiny Committees (OSC)

To be sort from the OSCs following the agreement of the document content

What others said about us: Our Lead Commissioners

Statement from our Lead Commissioner -
To be sort from the Commissioner following the agreement of the document content

Data Quality

Good quality information underpins the effective delivery of patient care and is e
quality of care are to be made.

EMAS relies upon this quality information to carry out its various duties and resp
deliver the highest possible level of patient care. The EMAS Business Intelligen
role in supporting the Trust in achieving these aims.

The A&E activity performance data provided in this Quality Account has been provided by the BIU. Data relating to other activity areas has been validated by experts in each particular area ensuring that what has been provided is relevant and accurate prior to its inclusion within this document.

Based on proper checks and controls we have in place relating to data collation and reporting, the BIU can confirm data accuracy and surety and also that data complies with the Department of Health's KA34 guidelines and our Ambulance Services Annual Return for period 2012/13.

EMAS was not subject to the Payment by Results clinical coding audit during 2011/12 by the Audit Commission. (this part was included in last years report – not sure if it is still relevant)

Information Governance Toolkit attainment levels

EMAS' Information Governance Toolkit assessment overall score for 2012/13 was ??? (figure will be available on 31st March) and was graded satisfactory. The Information Governance Manager is responsible for maintaining the evidence to support the Information Governance Toolkit for the Trust. Assurance on the process to collect the evidence is overseen by the Information Governance Group, chaired by the Senior Information Risk Owner (SIRO), which is accountable to the Operational Governance group.

Our Quality Account
2012/2013

Part 3

How we developed our Quality Account (what you said)

How we developed our Quality Account (what you said)

This section shows activity that EMAS has undertaken this year to develop our Quality Account our stakeholders. Feedback received was used to inform the Trust Board when determining priorities for the next Quality Account:

Public Engagement

- The Quality Account featured at the EMAS Annual General Meeting. Members of the public were invited to share their ideas regarding next year's priorities
- Priorities for the Quality Account have also been determined by triangulation of information from a range of patient feedback sources such as patient surveys, formal complaints and PALS concerns. Patient safety incidents have also be analysed along with clinical outcome measures.
- The Foundation Trust membership has proved to be a valuable reference group for a range of activities across the Trust. One such activity is gaining feedback from members regarding Quality Account priorities.
- Health Overview and Scrutiny Committees and LINks across the region have been invited to offer their suggestions for next year's Quality Account

Feedback from the Public

Key themes which emerged from our public feedback was as follows:

- Improve response times to patients
- Improve communication between EMAS and other organisations so that information is shared effectively to inform patient contacts
- Promote dignity and respect in care
- Encourage feedback from patients to improve services
- Be aware of and act on communication barriers eg those with hearing or visual impairments and language barriers
- Ensure patient friendly information
- Involve carers in developing services for patients

Staff Engagement

In 2012/13 we invited staff to comment on our Quality Account through a number of mechanisms.

- We invited comments though the CEO Bulletin in August, signposting staff to an on-line survey posted on INSITE.
- Ideas for next year's priorities were also sought via a desktop on all EMAS laptops.
- The Quality Account remains part of the Trust's Essential Education programme. The Organisational Learning Team invite staff to suggest priorities for the following years Quality Account and feedback key themes to the central team.
- Local engagement in divisions has been driven via the Clinical Quality Managers and Assistant Directors of Operations. Feedback has been collated locally to allow key themes to be identified for submission to the central team.
- Frontline staff provide ideas for service improvement in response to the Clinical Update email and through local listening events conducted by Divisional Assistant Directors.

- An analysis of the staff opinion survey will also be undertaken to isolate themes for continuous quality improvement Staff Opinion Survey results from the 2012 staff opinion survey will be available in January 2013. HR will advise once the subsequent analysis has been done.
- Board members currently undertake a minimum of one Quality Visit per month. Feedback from the visits provides a rich source of information across the quality domains. Analysis of the proformas has been undertaken to ensure quality themes are used to inform future quality priorities.
- Quality has been a focus of the staff consultation events which commenced in September in relation to 'Being the Best'.

Feedback from staff

Key themes which emerged from our staff feedback was as follows:

- Increasing education and training opportunities
- Increasing frontline staff and availability of vehicles
- improving working relationships with GPs and out of hours providers
- educating the public in the appropriate use of 999
- improving staff engagement
- developing an in house Extended Care Practitioner course
- reviewing use of various drugs for Paramedic staff
- improving access to mental health crisis teams
- developing alternative care pathways

Review of quality performance
(how we did last year)

EMAS is required to achieve a range of performance outcomes specific to the nature of the services we provide to the public. In addition, we are required to achieve many other organisational responsibilities as laid down by the Department of Health.

The following information provides evidence that EMAS is performing very well in relation to certain quality measures and that, compared to other ambulance trusts, we are making significant progress in the areas where further improvement is necessary for EMAS to achieve its aims.

Our priorities in 2011/12 were:

Priority	Quality measure
Patient safety	Priority 1: Improvements in response to staff survey key questions and Performance Development Reviews (appraisals)
	Priority 2: Continue to improve the processes for call handling, clinical assessment and the deployment of resources
Clinical effectiveness	Priority 3: Existing clinical performance indicators to be improved and new indicators to be developed taking into account regional priorities
	Priority 4: Continue to engage with stakeholders across local communities to enable patient experience to influence service improvement and development
Patient experience	Priority 5: Develop a training package linked to a new Domestic Violence Policy to equip frontline staff with the knowledge to recognise and deal effectively with victims and perpetrators of Domestic Violence

Priority 1: Improvements in response to staff survey key questions and Performance Development Reviews (appraisals)

Aim	What we did	What we have achieved	Quality Indicators
Obtain staff views on Patient and staff Safety and experience	Included 3 questions on patient safety and experience in the 2012 staff survey: 1) What can EMAS do to improve patient safety?	968 staff have given us feedback on these areas which is currently being analysed to identify any specific actions the Trust needs to	Staff Survey results

	2) What can EMAS do to improve staff safety? 3) What can EMAS do to improve patient experience?	implement to improve patient and staff safety, and patient experience.	
Improve communication with staff and staff involvement	• Developed and implemented a new Service and Operating Model supporting improved communication channels. • Developed and implemented new Operational Management restructure to support staff health and well-being and line management accessibility. • Developed Staff Engagement Strategy in partnership with staff. • Supportive Management Behaviour programme launched to support improvement in management behaviour. • Introduced quarterly 'temperature check' surveys to gain staff views and improve opportunities for engagement. • Recognition Scheme	Staff survey questions in the 2012 survey showed significant improvement in the following areas: -Communication between senior managers and staff is not effective (15% improvement). -Senior managers involving staff in important decisions (11% improvement).	Staff Survey results

	launched for all staff groups as well as an Annual Awards event to recognise staff's achievement. • Chief Executive communication to managers via video link and weekly bulletins.		
Performance Development Review	• Introduced new Individual Practice Review that is web based for contemporaneous reporting. • PDR activity monitored through performance management framework. • Included PDR in Manager KPIs • Education and training - Supportive Management Behaviour programme launched.	Clinical roles using the new system.	Staff Opinion Survey IBR Education Activity Reports

Priority 2: Continue to improve the processes for call handling, clinical assessment and the deployment of resources

Aim	What we did	What we have achieved	Quality Indicators
Provide a timely response to Category A Red and Category Green emergency calls.	Increase in capacity and scope of the Clinical Assessment Team to ensure that the patient receives the correct response	Commenced assessment of Red 1 calls to ensure correct classification of calls. Additional CAT	Monthly increase in percentage of calls assessed. Increase in see and treat activity. Fewer

		clinicians enabled increase Red and Green assessment and ability to make welfare calls. Added a crew referral telephone line within the CAT team to aid "See and Treat" activity of crews.	transports to ED.
	Introduction of dedicated 3rd party dispatcher in EOC every day	An increase in the utilisation of 3rd party resources ensuring utilisation for maximum patient benefit. Added a dedicated VAS / PAS dispatch desk for non 999 transport activity.	Unit hour utilisation of 3rd party resources (54% against 35% nationally)
	Increased utilisation of CFRs to ensure that all patients able to receive timely care regardless of location and introduction of automated texts for CFRs	An increase in the capacity of the CFR desk has resulted in an average 46% increase in dispatch of CFRs. Increase CFR desk dispatch capacity from 252 hours per week to 420 hours to increase mobilisations.	Number of incidents to which CFRs are dispatched. Each division increase by 8 mobilisations per month.

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Priority 3: Existing clinical performance indicators to be improved and new indicators to be developed taking into account regional priorities

Aim	What we did	What we have achieved	Quality Indicators
EMAS will improve our performance against the Clinical Performance Indicators (CPI) are national indicators developed to allow clinical skills and patient outcomes to be	Improved scrutiny via monthly validated reports from the Electronic Patient Report Form with data developed down to practitioner level to allow accountability for	EMAS has delivered improvement across the Clinical performance Indicators although seeing little change in the results for Return of Spontaneous	Measured from ambulance patient records and submitted to a national database for comparison with other UK ambulance services.

measured rather than timeliness of response alone. The measures cover: ✓ STEMI (ST elevation myocardial infarction) ✓ Asthma Care ✓ Coronary care (heart attack) ✓ Stroke ✓ Diabetes ✓ Cardiac Arrest and ROSC (return of spontaneous circulation, following resuscitation) Additionally EMAS will develop new internal indicators	clinical performance. Use of statistical process charts to ensure true improvement is measured rather than a single temporary change Checklists on all vehicles to remind staff of the elements of the care bundles Introduction of fortnightly clinical update email for general clinical issues but also targeting these areas Targeted interventions to support staff in understanding the rationale for the changes Deep dives into areas of concern to get to the root cause particularly around measurement of oxygen levels in asthma patients Development of two new internal indicators for Chronic Obstructive Pulmonary Disease and fractured hip	Circulation (ROSC) in Cardiac arrest or measurement of oxygen levels in asthma patients . EMAS uses monthly performance data from the electronic patient report form to monitor progress, recognising there will be some variation month on month but looking to improve the average over time. The latest results for the care bundle performance are shown below (note scale variation).	Local indicators measured and reported on internally to monitor improvement We will benchmark our performance against the results achieved by other UK ambulance services for the national indicators whilst focussing on improvement on our current performance and improving it.

Priority 4: Continue to engage with stakeholders across local communities to enable patient experience to influence service improvement and development

The Equality Delivery System (EDS) is the national performance framework for the NHS to demonstrate progress on equalities; identify and improve equality performance and objectives that address inequalities and deliver positive outcomes for patients.

Implementation of the EDS and external engagement will enable stakeholders to grade our current equality performance and influence the development of equality objectives to support the Trust's goal to improve equality performance.

Aim	What we did	What we have achieved	Quality Indicators
Ensure stakeholder engagement is representative of seldom heard groups; and members from protected characteristics (identified in the Equality Act) to ensure meaningful grading activity is conducted to measure current equality performance. .	In 2012 we held an event to which we invited representatives from all the Local Involvement Networks (LINks) in our region to assess EMAS against the NHS Equality Delivery System (EDS) by telling us what they thought we do well and where we could do better in relation to equalities, particularly in relation to better health outcomes and improved patient access and experience. We also held workshops in each division for EMAS members who wished to be involved. Following various engagement activities, feedback from stakeholders and informed involvement with NHS Equality Delivery System developments, **the following** have been identified as priority equality objectives for East Midlands Ambulance Service to meet the 6th April 2012 Equality Act deadline:	The intention was that EDS grading captured from across each of the counties or divisional areas covered by East Midlands Ambulance Service could be validated by LINKs, as is required in the EDS national framework. It was however highlighted that many NHS Trusts are finding this challenging, with some still to secure terms of reference and membership for EDS panels or forums. Whilst EMAS is engaged across these developments, most are at embryonic stages of development. Despite this, EMAS is driving forward and successes include working in collaboration with NHS and Voluntary Organisations in Derbyshire to establish the robust Derbyshire Community Health Inequalities Panel (DCHEP).	One Annual EDS Grading Event to be held per county during the year. . EDS objectives developed in conjunction with community groups by 6 April 2012 prior to Board submission

Continued

Aim	What we did	What we have achieved	Quality Indicators
	1. Review workforce data collection systems to ensure all equality "protected Characteristics" are covered in a systematic and regular process and the data is monitored and analysed to provide a timely and effective response to issues/gaps identified.	1. An analysis of workforce data collection was undertaken and gaps were identified are now being addressed via an action plan to ensure capturing of this data.	
	2. Embed requirements of the Equality Act 2010 and the NHS Equality Delivery System into the Trust Community Engagement Strategy to ensure required standards of targeted engagement are maintained.	2. The requirements of the Equality Act 2010 and the NHS Equality Delivery System have now been reflected in the relevant Trust Strategies.	
	3. Establish an Equality Delivery Assurance Framework and Equality Delivery Action Plan to deliver equality objectives (that are established and informed by stakeholder engagement) and ensure continuing improvement in equality performance.	3. An EMAS Equality Assurance Strategy has been agreed and a supporting Equality & Diversity workplan (2012-2014) is in place to deliver and monitor actions.	
	4. Maintain and enhance the Trust EDS Group to further the aims of the EDS to identify barriers and initiate effective responses.	4. The work of the Trust EDS Group has been incorporated into the Trust's Diversity and Inclusion Group who are now monitoring this within the Equality & Diversity workplan.	
	5. Develop case studies for each of the "protected characteristics" in relation to EDS Goals and Outcomes to inform service design and planning.	5. Case studies have been undertaken in relation to LGBT (see below) and BME Groups. Case studies for Age and Religion & Belief are currently being commissioned.	

Continued

Aim	What we did	What we have achieved	Quality Indicators
Through the above stakeholder engagement and influence, develop relevant equality objectives to support improvements in the Trust's equality performance in line with the priorities identified by seldom heard groups and members from protected characteristics	Lesbian Gay Bisexual and Transgender (LGBT) groups were identified as one of the protected characteristic groups (under the Equality Act 2010) that EMAS needs to improve engagement with. Therefore, we bid and were successful in getting Stonewall funding to support this agenda. In 2012 divisional community engagement events have been held in Leicester, Leicestershire and Rutland (immediately before the EMAS Annual General Meeting), Northamptonshire and Nottinghamshire (Community In Unity – CIU), ensuring that feedback on outcomes/actions taken following the 2011 were included, taking a 'You Said, we Did' approach. The Northamptonshire and Nottinghamshire events were held in November 2012 and included consultation on the EMAS 'Being the Best' Transformation Programme proposals. .	The Stonewall funding has enabled us to do a case study in relation to establish any potential equality issues for LGBT Groups in relation to access for the service. We also attended (with frontline support) annual Pride events in the region in Nottingham and Leicester to engage directly with LGBT Groups. As a direct result of a suggestion at a divisional community engagement event in Derbyshire, during 2012 our new ambulances (90) added to the fleet were installed with hearing loops and staff have been trained in their use. EMAS has launched a scheme recently in partnership with social services. This is around carers carrying a card to state that they are carers. Therefore, if we receive a call to attend carers we will have a number to call that will bring in a stand in carer whist the 'carer' patient is then conveyed to hospital. We have re launched the medicine bags scheme (November 2012). This is where we ensure that we take all medicines to hospital to ensure that the patient has the correct medication when they arrive at hospital.	

Continued

Aim	What we did	What we have achieved	Quality Indicators
		We continue to encourage our staff to become dignity champions and we currently have over 500 hundred of which 80% are frontline staff. Over the last year we have developed a set of Dignity Pledges in consultation with EMAS public members, service users and staff which will be launched on 1 February 2013 as part of National Dignity In Care Day on 1 February 2013. An EMAS pre-hospital communication guide (one per vehicle) produced in consultation with service users and staff will be launched in March 2013 for use when staff are communicating with people that require support in communication, for example patients with a Learning Disability. The guide will support EMAS compliance with the Mental Health Capacity Act and improved patient experience. We continue to work with partner stakeholders, including securing support and attendance at external engagement events. For example, Big Health Days for people with Learning Disabilities and ensuring that feedback is shared to support service improvement; attendance Nottingham City and Nottinghamshire County 2012 Big Health days where the Self Assessment Form were completed; Lincolnshire Show – partnership working with Lincolnshire Carers and Young Carers. Engagement at these events helps to raise awareness of the EMAS service in relation to expectations and appropriate use.	

Priority 5: Develop a training package linked to a new Domestic Violence Policy to equip frontline staff with the knowledge to recognise and deal effectively with victims and perpetrators of Domestic Violence

Aim	What we did	What we have achieved	Quality Indicators
Implement a Domestic Violence and Abuse Policy to ensure the adoption of a safe, consistent and quality approach.	Developed a Trust Domestic Violence and Abuse Policy for Staff and Services Users. The policy has been assured by external experts.	EMAS Domestic Violence & Abuse Policy	
To increase awareness and improve staff confidence in addressing Domestic Violence and Abuse through a module within our Essential Education programme and a Communications campaign	A Domestic Violence & Abuse education module was designed and assured in collaboration with external experts. This module forms part of the 2012/12 Essential Education Programme for all Frontline staff and includes awareness-raising for Support Staff. There has been a communications campaign which includes the dissemination of signposting information for survivors and perpetrators of abuse.	Domestic Violence & Abuse within Essential Education. Between April to November 2012 61% of Frontline staff have attended this education module. Staff continue to raise safeguarding referrals where there are concerns for adults and/or children following attendance for a Domestic Violence Incident Dissemination of Signposting Literature to support staff when responding to incidents of Domestic Violence & Abuse.	Number of Staff attending Essential Education Programme
To ensure that lessons learnt from Domestic Homicide Reviews (DHR's) are embedded into practice	Action plans from DHR's are monitored within the clinical governance framework.	Learning identified by EMAS reviews identifies the need for Domestic Violence Policy and Procedures including the need to ensure staff are able to recognise and appropriately respond. Information sharing is a key learning point and this is a focus for	DHR Action Plan monitoring

		the Trust for 2013/14 with the desired implementation of an IT solution such as SystmOne within the Safeguarding Team to improve processes and contribute to robust risk assessments of families.	

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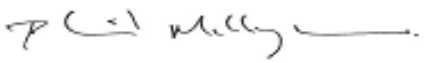
Conclusion

This quality account is intended to set out our ambitions for improving and sustaining quality during the 2013/14 performance year, we hope that readers will see that we have kept quality as our main priority and have taken action to improve where we can. We hope that we have been able to tell you that we know where we have further improvements to make and where we have not been able to make the progress that we had planned.

In producing this report, it has involved contributions from a wide range of stakeholders and I would like to pay tribute to their input, this has helped us to ensure that our ambitions for quality improvement match those who use, observe and/ or commission our services. Next year we will continue to work with our stakeholders so that we can ensure that our approach to quality is grounded in their expectations.



Chief Executive
East Midlands Ambulance Service NHS Trust

Glossary

A&E
Accident and Emergency – Accident and Emergency (A&E) is a hospital or primary care department that provides initial treatment to patients with a broad spectrum of illnesses and injuries, some of which may be life-threatening and require immediate attention. Also referred to as ED, Emergency Department.

AMPDS
Advanced Medical Priority Dispatch System – is a medically-approved, unified system used by EMAS to dispatch appropriate aid to medical emergencies including systematized caller interrogation and pre-arrival instructions.

Audit
A continuous process of assessment, evaluation and adjustment.

Board
EMAS Trust Board of Directors made up of Executive and Non-Executive members responsible for all that EMAS does.

CQC
Care Quality Commission – The Care Quality Commission (CQC) regulates all health and adult social care services in England, including those provided by the NHS, local authorities, private companies or voluntary organisation. It also protects the interests of people detained under the Mental Health Act.

CQI
Clinical Quality Indicators - These are a set of eleven indicators introduced to the ambulance service by the Government from April 1st, 2011 as measures of clinical quality.

CPI
Clinical Performance Indicator – A way to measure quality.

Commissioners
The NHS organisations who effectively purchase services from EMAS, based on the identified health needs of their local population. Derbyshire County PCT is the ‘lead commissioner’ for EMAS. That is, they (on behalf of all the PCTs in our area) negotiate what level of income EMAS will receive – and, alongside this, what quality measures we are expected to achieve as set out in our service level agreement.

CQUIN
Commissioning for Quality and Innovation (CQUIN) – The CQUIN payment framework makes a proportion of NHS service providers' income conditional on quality and innovation. Its aim is to support the vision set out in High Quality Care for All of an NHS where quality is the organising principle. The framework was launched in April 2009 and helps ensure quality is part of the commissioner-provider discussion everywhere.

CAD
Computer Aided Dispatch – Software used for ambulance dispatch.

DIVISION/S
Operational areas with autonomy to make decisions about the provision of local services under the umbrella of EMAS’ corporate vision, goals and objectives. Our divisions are aligned to the counties we serve (see below)

EMAS
East Midlands Ambulance Service – East Midlands Ambulance Service (EMAS) is part of the NHS and provides emergency and urgent care and patient transport services for the six counties of Derbyshire, Leicestershire, Rutland, Lincolnshire (including North and North East Lincolnshire), Northamptonshire and Nottinghamshire.

EMICS
East Midlands Immediate Care Scheme – Made up of a group of volunteer doctors who assist the Ambulance Service on emergency call-outs.

ECA
Emergency Care Assistant – Respond to emergency calls as part of an accident and emergency crew or at times as a first responder, using skills and procedures that they have been trained and directed to do.

ECP
Emergency Care Practitioner – The role of emergency care practitioners (ECPs) utilises the skills of paramedics and other professionals (such as specialist nurses with additional skills) to support the first contact needs of patients in unscheduled care. They are employed primarily by ambulance service trusts.

HPC
Health Professions Council – A UK health regulator. It was created by the Health Professions Order 2001 to protect the public by setting and maintaining standards for the professions it regulates.

IPC
Infection Prevention and Control – Provides specialist infection prevention and control support and advice for all clinical and support services.

IG
Information Governance – The way by which the NHS handles all organisational information - in particular the personal and sensitive information of patients and employees. It allows organisations and individuals to ensure that personal information is dealt with legally, securely, efficiently and effectively, in order to deliver the best possible care.

JRCALC
Joint Royal Colleges Ambulance Liaison Committee - its role is to provide robust clinical speciality advice to UK ambulance services and other interested groups

NHS
National Health Service - Established in 1948 to provide free state primary medical services throughout the United Kingdom.

NICE
National Institute for Health and Clinical Excellence – The health technology assessment body in the UK providing guidance to clinicians relating to authorised treatments, devices, diagnostics and techniques.

NHS Institute for Innovation and Improvement
Supports the NHS to transform healthcare for patients and the public by rapidly developing and spreading new ways of working, new technology and world-class leadership.

PALS

Patient Advice and Liaison Service – Offers confidential help, advice, support and information and are responsible for any compliments and complaints.

PPI

Patient and Public Involvement – Aims to support patient, user, carer and public involvement in health care.

PCT

Primary Care Trust – Part of the NHS responsible for the planning and securing of health services and improving the health of a local population.

ROSC

Return of Spontaneous Circulation - Following a period when the heart stops, providing life support is aimed at restoring the body's circulation.

SBAR

Situation, Background, Assessment, Recommendation - A structured communication tool used to share clinical information

SHA

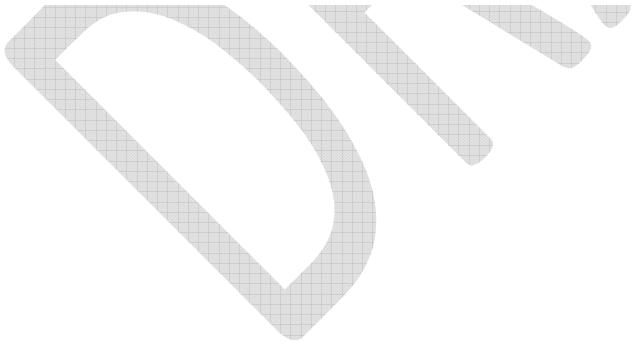
Strategic Health Authority – Responsible for developing plans for improving health services in its local area and increasing the capacity of local health services so they can provide more services.

STEMI

ST Elevation Myocardial Infarction - heart attack.

VCS

Voluntary Car Service – A group of volunteers within our Patient Transport Service who use their own car to provide a door to door service to medical appointments.



Our Quality Account
2012/2013

We welcome your comments about our Quality Account.
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