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Monday, 2 March 2015

OSC Scrutiny Officer
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Dear

Re: East Midlands Ambulance Service draft Quality Account 2014/15, version 1.0

Each year we send to your committee a draft copy of our Quality Account - an annual report that providers of NHS healthcare services must publish in June to inform the public of the quality of the services they provide.

The Account also allows us to demonstrate our commitment to provide the best quality services for people in the East Midlands.

As you are aware, May 2015 will see the General Election take place. As a result, we were asked in February by a couple of Health Overview and Scrutiny Committees to provide the draft Account earlier this year to avoid purdah which starts on 30 March 2015.

To assist, we have brought forward the production of the Account by two-months and I am happy to enclose with this letter our first draft Quality Account for 2014/15. In doing so, I ask you to note the following:

- The Quality Account is for 2014/15 and this current performing/financial year will not conclude until 31 March. Therefore the enclosed document is missing some information which will be added early April after year end (we have included up-to-date figures where possible). We will be sending version 2 - the updated draft version - of this report to other stakeholders in April for review and comment. If you would like to receive a copy of version 2 we will be happy to forward it to you. Alternatively, we will ensure you receive a copy of the final version which will be published on the NHS Choices and EMAS websites (www.nhs.uk and www.emas.nhs.uk) before 30 June 2015 (as per national guidelines).
- Once final comments and changes have been received by the EMAS Trust Board in May 2015, we will have the document designed to include some photograph images and graphs where appropriate. Given the amount of detail we have to share, this will aid the reader by breaking-up the text heavy document. Unfortunately, in reviewing this first draft and working to the revised production timescales you will not have the aesthetic benefit of the images or graphs.
- Whilst we are a regional service, we will ensure county based data is included for our performance and the compliments and complaints received, allowing people to see how we perform in their local area.



In the enclosed draft we have been able to demonstrate where we are doing well and where we need to make improvements. The Account features our priorities for the coming year (2015/16) and details how we have progressed against the priorities identified for 2014/15.

The past year has been a very challenging time for all UK Ambulance Services and the NHS in general, with many of the challenges being promoted via national and regional media.

I am pleased that EMAS representatives have been able to visit your committee recently to update you on our vision and future plans. From those recent discussions you will know that despite the increase in demand, hospital pressures which impact on the ability of Emergency Department colleagues to accept a clinical handover from our ambulance crews, and challenging winter weather at times, we have continued to improve the care and services we provide to local people.

We still have a lot of work to do and we don't always get it right. However, our Listening into Action staff engagement programme and new substantive Trust Board is seeing a change in culture and 'the way we do things' at EMAS. Our colleagues are working incredibly hard and this, together with the continued support from the NHS Trust Development Authority and our Commissioners, will see us continue to make significant steps to develop and improve our services.

Your organisation is invited to make comment on the enclosed version ahead of purdah on 30 March. As in previous years, official responses submitted to EMAS via rebekah.marong@emas.nhs.uk will be included in the final version of the document.

If you would value a representative of EMAS attending a meeting of yours during May or June 2015 to present the final version of our Quality Account, we would be happy to arrange for an Executive Director and / or county-based General Manager to attend. To take up this opportunity, please make your request in writing and send it to rebekah.marong@emas.nhs.uk.

Yours sincerely

A handwritten signature in black ink, appearing to read 'Judith Douglas', enclosed in a light blue rectangular box.

Judith Douglas
Director of Nursing and Quality

Enc



Our pledge to you

Our Quality Account 2014/2015

Production note: The final version of this Quality Account will include end of year figures (1 April 2014 to 31 March 2015) and will be produced in an attractive format to aid the reader by breaking-up the text with the use of patient experience photographs (where consent has been obtained) and stories.

Our Quality Account

2014/15

Contents	Page
Introduction and declaration of accuracy	3
About us	4
Review of quality improvements for 2014/15	7
What we want to do better in 2015/16 – our priorities	12
Evidence of quality improvements for 2014/15	17
What we have done to improve patient safety	23
Evidence for improvements in clinical effectiveness	26
What we have done to improve patient experience	34
Improving the care environment	44
Appendix 1 – Workforce	45
Appendix 2 – IG Toolkit	49
Appendix 3 – Research & Development	50
Appendix 4 – Care Quality Commission	57
Appendix 5 – Third Party Statements	58
Appendix 6 – EMAS Trust Board	59
Glossary	62
Contact details	65

Introduction

Production note: this Quality Account relates to the 2014/15 performance year which concludes on 31 March 2015.

Due to the General Election in May 2015, it has been necessary to produce this draft two months early (to comply with national guidance and share with OSCs before purdah starts on 30 March).

As such EMAS does not have end of year figures to include in the document at this stage, and this introduction piece will be written once the year end position is clear.

The Chief Executive's introduction is therefore to be inserted here in April 2015.

Declaration of accuracy

I confirm that to the best of my knowledge the information presented in our Quality Account is accurate.

add signature here when document complete & all statistics included

Sue Noyes
Chief Executive

About us

East Midlands Ambulance Service (EMAS) provides emergency and urgent healthcare on the move and in the community.

EMAS Vision and Values

It is our vision to play a leading role in the provision, facilitation and transformation of clinically effective urgent and emergency care delivered by highly skilled, compassionate staff, proud to work at the heart of their local community.

We are on a journey transforming from a mainly emergency focussed service, reliant on a single Accident and Emergency contract (e.g. providing blue light responses to 999 calls), to an organisation that provides the most appropriate and effective response to patients, for example providing care directly, sign posting or referring patients to the best service to support them in their homes and the community, and reducing admission to hospital where appropriate. We will do this by working closely with primary, community, social care, mental health and secondary care services.

This will allow the NHS to deliver more with less and allow EMAS to move into new business areas. We want to be able to deliver a locally focussed service, with regional resilience.

Our Values support everything we do.

Respect: *Respect for our patients and each other*

Integrity: *Acting with integrity by doing the right thing for the right reasons*

Contribution: *Respecting and valuing the contribution of every member of staff*

Teamwork: *Working together and supporting each other*

Competence: *Continually developing and improving our individual competence*

Our Values help us provide our patients with access to high quality clinical care and services to ensure the best experience and clinical outcome.

People we serve

The East Midlands is undergoing similar demographic changes to the rest of the country, with a growing and aging population with ethnicity and health differences.

There are specific local area differences and challenges, such as student populations and areas with specific concentrations of young families or retirees, and significant variations in population densities.

Historically the region's population has been growing faster than nationally and this looks set to continue over the next decade, which will put pressure on our existing and new services. Health inequalities are marked across the region, with generally poorer levels of health in the urban centres as evidenced through Public Health England data.

It must be our priority together with our commissioners to ensure equality of service provision to all patients.

The area we cover

We provide emergency 999 and urgent care services for a population of approximately 4.86 million people within the East Midlands region.

The region, which covers approximately 6,425 square miles, includes the counties of Derbyshire, Leicestershire, Lincolnshire, Nottinghamshire and Northamptonshire and Rutland.

There are large differences in population density across the East Midlands, from the highly concentrated urban areas and more dense population corridor along the M1, to the low density rural areas to the east.

There are several airports within our region, with the largest being East Midlands Airport, serving over 4.2 million passengers each year.

The M1 motorway serves all of the region's county towns with the exception of Rutland and Lincoln.

Two of the UK's mainline railways serve the region, providing regular high-speed services, and there are currently plans to bring a new high-speed rail line through the East Midlands as part of the High Speed 2 project.

The East Midlands is home to numerous entertainment venues including major sporting venues, national parks and forests, the East Coastline, music festivals and venues, the National Space Centre, and holiday and caravan parks.



Our services

Our annual turnover is £154million (2014/15) and we are commissioned (paid) to provide services by 22 Clinical Commissioning Groups (CCG) based across the East Midlands. We deal directly with the A&E contract lead in NHS Erewash CCG which represents the other CCG's in the region.

We employ over 2,700 colleagues, with the majority being frontline Accident and Emergency ambulance personnel.

Patient Transport Services (PTS) are currently provided for people who have routine (non-urgent and scheduled) clinic appointments across North and North East Lincolnshire and parts of Nottinghamshire. Other counties in the region are served by private PTS companies commissioned by the CCGs.

We operate from more than 65 locations across the East Midlands, including two Emergency Operations Centres (EOCs) in Nottingham and Lincoln, which host our call handling function and over 60 ambulance stations across the East Midlands where our colleagues report on and off duty.

Every day we receive approximately 2,155 calls from people dialling 999 and from other healthcare professionals making urgent transport requests.

During 2014/15, we dispatched response vehicles to [enter end of year figure here] calls using our fleet of 530 vehicles.

We also use 32 Patient Transport Service vehicles and in 2014/15 invested in Community First Responder vehicles.

In addition to our core services, we provide a range of other key services including:

- Specialist transfers: inter-hospital transfers that include adult critical care or for specialised surgery, paediatric and neo-natal care.
- Bariatric transfers: specialist services and equipment to transport bariatric patients (our bariatric ambulances can transport patients up to 50 stone).
- Emergency Preparedness and Business Continuity (Regional Resilience): a service that ensures we are prepared to deal with a range of civil contingencies and major incidents. It works closely with the six Local Resilience Forums across the region, each of which includes Local Authorities, Police and Fire services. This also ensures business continuity in the event of a civil contingency or other adverse event that affects normal operations.
- Hazardous Area Response Team (HART): a dedicated team providing specialised cover for civil contingencies, major incidents and Chemical, Biological, Radiological and Nuclear (CBRN) incidents.
- Events Support: a commercially available team that provides support to special events which include sporting, musical and athletic showcases across the region.
- Admission Avoidance Schemes – through a number of schemes across the East Midlands including Falls Partnership Services and GP in a car.
- Cycle Response Units – carry the same essential life-saving equipment as a fast response car and can reach patients even faster in congested areas. Often patients can be treated on the scene by the Cycle Response Units meaning our ambulance vehicles can be deployed to other life threatening emergency calls.
- Community Access Automated External Defibrillators (AED) – we have placed life-saving equipment in local communities across the East Midlands. AEDs are used when someone has gone into cardiac arrest (i.e. when the heart stops pumping blood around the body). The defibrillator gives the heart an electric shock to allow effective cardiac rhythm to be re-established.

Review of quality improvements for 2014/15

This quality account demonstrates our achievements for the year 2014/15 and what we are aiming to achieve in the coming year.

We are 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.

Our 2014/15 priorities

We identified the following quality improvement priorities against the three domains of quality, these being,

- **Clinical effectiveness**
- **Patient safety**
- **Patient experience**

Priority 1: Consolidation and further development of EMAS' role in the management of long term conditions working in partnerships with the various health communities across the East Midlands.

Priority 2: Development of an organisational succession plan aligned with the Leadership and Talent Management Framework.

Priority 3: Implementation and evaluation of a staff engagement strategy using the Listening into Action methodology.

Priority 4: Improving response times through more effective use of resources resulting in reduced conveyance to hospital by:

Priority 5: Development and implementation of a programme of public engagement activities focusing on hard to reach/vulnerable groups with a view to using feedback to improve our services

In this Quality Account we evidence how these priorities have been met and are progressing.

Commissioning for quality and innovation (CQUIN)

A proportion of EMAS's income in 2014/15 was conditional on achieving quality improvement and innovation goals agreed between EMAS and Erewash Clinical Commissioning Group (our lead commissioners).

The CQUIN schemes are an opportunity for us to provide services that focus on quality improvements. The benefits of the schemes can be validated and if successful will be provided through the commissioning process.

EMAS signed up to deliver the following 10 schemes and have provided evidence of how these schemes have impacted on the quality of care that we provide as well as how the work will continue to be supported going forward.

- **Paramedic Pathfinder:** This electronic triage (assessment) tool has been rolled out across our service to allow our ambulance crews on scene to access the most appropriate health service for the patient. This has led to an increase in the number of patients that can have care delivered in their own home or place of residence. The initiative is planned to be continued through next year as a further CQUIN to ensure the tool is fully embedded and evaluated.
- **Risk trigger tool:** Introduced in 2010 this tool recorded whether key observations had been documented by our clinicians when assessing and treating patients. We reviewed the performance of the trigger tool and found it was no longer giving a true representation of triggers for harm in the patients we serve. We took action and developed a new objective tool with clear indicators for harm. It was introduced at the end of quarter 3 and applied to all data obtained at that time. As a result, the new indicators of potential harm are clearly based upon current evidence or link to likelihood of harm. This has reduced subjective and varied reporting and allows us to focus our audit processes, together with colleague feedback, on high impact areas of patient care. Current trigger tool performance indicates approximately 95% of patient report forms evidence no triggers for potential harm. It is important to note that this may not indicate actual harm.
- **Mental Health Steering Group:** This new group has been set up to improve the service we provide to patients with a mental health illness. It will also allow us undertake more partnership working, such as the successful Mental Health Car initiative which runs in Lincolnshire.
- **Dementia:** A dementia assessment tool has successfully been rolled out across the service. It has enabled the attending crews to assess whether a patient is potentially suffering from dementia and to refer that patient to appropriate services to allow a comprehensive assessment and diagnosis of dementia. This piece of work will be continued through our new Mental Health Steering Group. We have held an awareness communication campaign internally and provided face-to-face education. A leaflet was developed with a trigger question to promote early intervention for those with dementia. We have further supported this work with the recruitment of dignity champions that will promote both the dementia, and the EMAS dignity and respect campaigns and work plans.
- **Clinical Assessment Team (CAT):** We have improved patient care by making significant changes to our Clinical Assessment Team. The team of registered nurses and paramedics are based in our Emergency Operations Centre. They undertake detailed assessment of a patient's needs and use an electronic directory to ensure those who are not reported to be in an emergency or urgent condition, are directed to a more appropriate, alternative health service. We have recruited more clinicians to the team and this has led to a reduction in the number of people we take to hospital. This means we are able to leave more patients safely in the comfort of their own home, or in the care of a community based service, and have reduced unnecessary admissions to busy emergency hospitals. Changes to the team have also allowed us to concentrate on education and training and provide a robust service that will continue to develop and improve.

- **General Practitioner in CAT:** A general practitioner is based in our CAT during peak times allowing our CAT paramedics and nurses to refer patients to the GP for a more detailed medical assessment or further medical opinion. As well as substantially enhancing the quality of care we provide, this has allowed us to share case studies for educational purposes, and provide more clinical supervision to our colleagues. We are exploring the employment of dual qualified nurses – particularly looking at those with midwifery and mental health expertise - to further develop our CAT by increasing skill mix without increasing costs.
- **High volume service users:** Our commissioners wanted to understand current issues in their area in regard to the number of people calling 999 on a regular basis for help. By having the bigger picture, commissioners aim to explore the potential to develop alternative care pathways for this group of patients. We provided data for the top 'high volume users' showing the location of the patient at time of call, number and type of calls made, number of telephone or face-to-face responses given (e.g. ambulance travelling to scene) and number of times the patient was taken to hospital or a treatment centre. As a result, care plans have been put in place to provide these patients with better access and support from local health and social care teams.
- **Serious incidents and high level concerns:** The learning undertaken from serious incidents and high level concerns has ensured that all at EMAS are sighted on the level of incidents, the outcome of the investigations and, importantly, the lessons learnt. To strengthen the process we will deliver a learning event for colleagues and key stakeholders in May 2015 and have made a commitment for this to be an annual event.
- **Formal complaints:** We took a 'deep dive' on the formal complaints and PALS (queries that come into our Patient Advice and Liaison Service) received at EMAS. This has enabled us to scrutinise the lessons learnt. We will further work to ensure we strengthen processes and all opportunities to learn lessons and that patient engagement and feedback remains central to all our services.
- **Friends and Family Test:** We rolled out of the national Friends and Family Test to colleagues and patients asking: 1) Would you recommend this service to your family and friends, and 2) Would you recommend us as an employer to your family and friends? The feedback allows us to monitor results internally, act on the findings and benchmark our results, including response rates, against other NHS organisations.

New services and innovation

As detailed earlier in this report, EMAS' vision is to play a leading role in the provision, facilitation and transformation of clinically effective urgent and emergency care. This means that together with our commissioners and other healthcare services, we need to continually explore new ways of providing better care to our patients. Here is an example of more of the initiatives that have taken place during 2014/15 to help improve the quality of care we provide to our patients.

Telehealth pilot: During March 2015 we will launch this new pilot scheme. Using existing technology, the pilot will allow us to help people with long-term conditions (eg. chronic obstructive pulmonary disease, diabetes, dementia etc) residing in care homes. Telehealth equipment allows us to proactively monitor the health of the patient(s) by measuring their blood pressure, blood glucose levels or weight. Providing this proactive support to patients and colleagues in Care Homes can reduce the number of times our paramedics need to visit. Care Home staff and / or the patient is taught how to do the tests themselves and the measurements are automatically transmitted to a secure facility at our Emergency Operations Centre (control). Our control paramedics and nurses can monitor the patient's condition on a daily basis and can proactively talk to the Care Home and / or patient over the telephone to raise any concerns and provide reassurance and advice.

Joint Ambulance Conveyance Project (JACP): This was launched after Lincolnshire Fire Service secured funding to extend the current co-responding scheme which has been running for many years. Their co-responders continue to attend medical incidents, but now, in an ambulance vehicle while our paramedic also responds in a Fast Response Vehicle (car). Our paramedic will assess if the patient needs to go to hospital and if so, will travel with the patient in the ambulance providing any necessary treatment en route.

Community Ambulance Stations (CAS): We are introducing CAS in each county across the East Midlands to help us provide more locations for our ambulance crews to have comfort breaks (including drink making facilities and toilets). Providing more locations allows our crews to stay in the community rather than having to return to their station base. Many CAS are shared facilities with other public sector organisations meaning we save costs and build on our relationship with these organisations.

Mental health initiative: We are working with a team of mental health nurses and Lincolnshire police to provide better care for people with mental health issues. The scheme involves the healthcare teams travelling around the county responding to calls from 999 operators, A&E crews and Police services who think a person they are dealing with would benefit from mental health support. The scheme reduces demand on A&E resources, as well as reducing the number of people with mental health issues arrested or put into custody.

Enhancing quality improvement and assurance

During 2014/15 we have continued to improve our quality and assurance processes. Through a variety of ways we have talked with and listened to our colleagues and patients to identify areas for improvement and to help share best practice.

We reviewed how we measure the standard and quality of care provided and have adopted a 'quality roadmap' tool which is aligned to the Care Quality Commission outcome standards and key lines of enquiry, and other pertinent legislation or clinical initiatives.

Quality Everyday is our new programme to ensure we are focussed on quality at every opportunity, and that everyone at EMAS understands their responsibility and contribution to deliver a high quality service. The programme provides ambulance crews with a comprehensive, up-to-date range of standards which can be measured and allow for timely and accurate feedback.

Four strands are included in *Quality Everyday*.

- Central inspections (audits)
- Monthly quality visits
- Quality newsletter
- Quality station / base noticeboards

The inspections will be undertaken by the station management teams to ensure compliance with key areas, for instance infection control, medicine management, vehicle and station inspections. Together with the monthly visits, they will provide a rag rated action plan to ensure that any identified concerns are addressed, and areas of good practice are recognised and shared throughout the service.

The *Quality Everyday* noticeboards and newsletter will help improve communication and engagement with colleagues, via the sharing of key messages, patient feedback, lessons learned from incidents and discussions at our local and strategic Learning Review Groups (protecting the identity of those involved), and local clinical updates and performance standards data.

What we want to do better in 2015/16

We are ambitious at EMAS and we are all working hard to bring about significant improvements to the services we provide.

By talking with and listening to our colleagues, patients and stakeholders we are able to learn and act on things that did not go well and from those that had a good outcome (it is important to learn from both the bad and good).

As in 2014/15, we have identified three domains of quality:

- **Clinical effectiveness**
- **Patient safety**
- **Patient experience**

Against those we have set five quality improvement priorities for 2015/16:

Clinical effectiveness

Priority 1: Develop the paramedic pathfinder algorithms to support ambulance colleague clinical decision making with patients suffering falls, general frailty/social care situations, end of life care and Chronic Obstructive Airways Disease.

During 2015/16 particular focus will be on the following:

- To increase the number of services that we access via the Pathfinder Programme to support patients to stay at home rather than go to hospital when admission is not required.
- Work in partnership with the Clinical Commissioning Groups and Community and Acute providers in the East Midlands to improve the management of these conditions and presenting symptoms.
- To reduce unplanned admissions and to provide care closer to home through the use of innovation underpinned by clinical safety.
- To use our 'hear and treat' (provided by our Clinical Assessment Team) and 'see and treat' (provided by our ambulance crews) services appropriately.

Lead: Medical Director

Priority 2: Develop a frail elderly steering group and action plans to deliver unilateral trust wide schemes with locally agreed pathways to ensure integrated support to individuals who are frail.

During 2015/16 particular focus will be the following:

- To work in partnership with the Clinical Commissioning Groups, Community and Acute providers within East Midlands to improve the management of the frail elderly to enable these patients to be assessed to ensure that they can access the services that promote independence and wellbeing.

- Delivery of a trust-wide falls service
- Effective use of our 'hear and treat' (provided by our Clinical Assessment Team) and 'see and treat' (provided by our ambulance crews) services to reduce inappropriate admission to hospital
- To work collaboratively with residential and nursing homes to ensure that the residents can access care and support and reduce inappropriate hospital admissions

Lead: Medical Director

Priority 3: Having signed up to the National Mental Health Crisis Concordant, we will work collaboratively with local commissioners and relevant stakeholders to implement the agreed priorities within the mental health action group.

During 2015/16 particular focus will be the following:

- Concentrate on the implementation of the Mental Health Triage Car (currently operational in Lincolnshire) across the East Midlands.
- To ensure that there are mental health workers in our Clinical Assessment Team and Emergency Operations Centres.
- To produce and agree mental health awareness and education sessions to support our colleagues.

This will require cross boundary working and collaboration across Clinical Commissioning Groups and other key stakeholders.

Lead: Director of Nursing and Quality

Priority 4: Following the continued improvement of our ambulance card quality indicator 'Return of Spontaneous Circulation (ROSC)' outcomes, we will continue to explore further innovative ways to build upon these achievements.

During 2015/16 particular focus will be the following:

- Completion of 'Pit Crew Concept' training for the management of cardiac arrest
- Increase the presence of frontline clinical supervision to all active resuscitation attempts
- Conclude the evaluation of Mechanical CPR (cardio pulmonary resuscitation) devices and determine future use
- Enable the 'hot debrief' of clinicians following attendance at a cardiac arrest call to support continued improvement

- Work with partner Trusts to increase access to Heart Attack centres for patients with pre and post return of spontaneous circulation (ROSC) and high risk Acute Coronary Syndrome.

This will require continued collaborative working across all directorates within EMAS to ensure these improvements can be delivered whilst maintaining our ability to provide core services.

<p>Patient safety</p>	<p>Priority 5: Having enrolled on the national Sign Up To Safety Campaign, we will work to reduce avoidable harm in mental health, maternity and adverse events in the Emergency Operations Centre with particular focus on delayed responses.</p> <p>In 2015/16 the priority will be:</p> <ul style="list-style-type: none"> • To collect the baseline data in each of these areas to determine the level of reduction required. • Using this data, identify key actions for year one (of a three year programme) that we will implement, monitor and report on. • To deliver a 50% reduction in harm over the three years of the programme <p>Lead: Director of Nursing and Quality</p>
<p>Patient experience</p>	<p>Priority 6: Develop a robust patient forum group and strategy that will ensure that we are working with all of our local communities.</p> <p>During 2015/16 this will include:</p> <ul style="list-style-type: none"> • Recruit inclusively across our local communities to ensure we have a broad range of patients and carers join our patient forum • To have clear terms of reference and an agreed work plan to strengthen patient engagement throughout EMAS. • Deliver a programme of patient engagement events throughout the year • To have patient representation in key EMAS meetings and the patient forum to be the internal resource to ensure that patients are fully consulted on service improvements <p>Lead: Director of Nursing and Quality</p> <p>Priority 7: Use the EMAS 'Listening into Action' staff engagement forums to enhance the delivery of compassion in practice and ensure we are promoting and rolling out schemes that will enhance the care we deliver and ensure colleagues are patient focussed.</p> <p>During 2015/16 we will:</p> <ul style="list-style-type: none"> • Support the continued implementation of the national #hellomynameis campaign, designed to remind healthcare staff about the importance of introductions in the delivery of patient care. • Relaunch and promote our Dignity Champions role, recruiting

more champions and sharing case studies to demonstrate the difference the Champions can make to patient care and our services.

Lead: Director of Nursing and Quality

Evidence of quality improvements for 2014/15

This section details progress made against our 2014/15 priorities.

Priority 1: Consolidation and further development of EMAS' role in the management of long term conditions working in partnerships with the various health communities across the East Midlands.

Aim	What we did	What we have achieved	Quality Indicators
To work with other healthcare providers to allow us to provide better advice and treatment when responding to people with a long-term condition, and to direct patients and carers to the most appropriate support networks, helping them find people to share their experiences with and to access the right care.	<p>During 2014/15 we worked jointly with the regional stroke network to facilitate greater alignment of the various stroke admission protocols across the acute hospital service providers to ensure equity of access to care.</p> <p>We worked with partner providers to introduce pathways to broaden the scope of access specialist care at Heart Attack Centres.</p> <p>A reductive triage tool (Paramedic Pathfinder) was introduced to assist ambulance clinicians in determining which patients can be safely managed within the community without the need for transport to Emergency Departments.</p>	<p>We have aligned our pathways for stroke services to reduce confusion and provide a more streamlined process, right across the region.</p> <p>An algorithm was developed to enable access to primary percutaneous coronary intervention (PPCI) services for patients in cardiac arrest.</p> <p>Comparatively more patients are being managed within the community and less transported to the Emergency Departments.</p>	<p>Ambulance Care Quality Indicators. EMAS consistently performs in the top 4 of ambulance services when accessing Hyperacute Stroke Units and PPCI Catheter Laboratories in line with the stroke 60 and STEMI 150 standard.</p> <p>A significant % increase in 'see and treat' referrals to community based providers.</p>

Priority 2: Development of an organisational succession plan aligned with the Leadership and Talent Management Framework.

Aim	What we did	What we have achieved	Quality Indicators
To ensure that EMAS has the leadership capacity and capability to deliver transformation and continual improvement.	<p>We developed the EMAS People Capability Framework, founded on the values of the NHS Constitution.</p> <p>The framework articulates the required abilities, attitudes and behaviours required across EMAS. It defines the capabilities required at manager (first line, middle & senior), executive and board level.</p>	<p>The framework supports our values based recruitment programme. It has also been integrated into the 2015 Appraisals and Talent Management System.</p> <p>Leadership and management development plans are now being produced for implementation in 2015</p>	Appraisal findings e.g. actual achieved versus target achieved

Priority 3: Implementation and evaluation of a staff engagement strategy using the Listening into Action methodology.

Aim	What we did	What we have achieved	Quality Indicators
To use the staff engagement feedback and evaluation, and demonstrate improvements for both patients and staff.	<p>Through the 2014 staff engagement programme Listening into Action (LiA) we aimed to mobilise and empower colleagues to lead and drive change both locally and at an organisational level, and embed LiA as ‘the way we do things around here’.</p> <p>A number of listening events were held across the region together with station and ‘pass it on’ events providing opportunities to listen, engage, involve and communicate change and celebrate success.</p>	<p>A wide-range of ‘quick wins’ were achieved, including (but not limited to):</p> <ul style="list-style-type: none"> • Improved access to charitable funds to improve facilities for colleagues at stations • Re-establishment of the Ambulance Technician role • ‘No Change’ Fridays • Appreciation letters being placed on colleague personal files <p>There are more LiA improvement examples in the Workforce section of this Quality Account (appendix 1)</p>	NHS Staff Opinion Survey results, NHS Friends and Family Test results, recruitment and retention and sickness rates, through the EMAS appraisal system, reports to EMAS Trust Board, and via LiA year 2 feedback

Priority 4: Improving response times through more effective use of resources resulting in reduced conveyance to hospital by:

Aim	What we did	What we have achieved	Quality Indicators
<p>To improve the speed of response to emergency and urgent 999 calls, whilst recognising the assessment, treatment, experience and clinical outcome for each patient are vital too.</p>	<p>The progression of our robust improvement plans continue to see us make steps in the right direction for our patients, local communities and our colleagues.</p> <p>Our plans include the:</p> <ul style="list-style-type: none"> • Effective use of our control paramedics and nurses in the Clinical Assessment Team to give more 'hear and treat' advice, reducing unnecessary journeys • Implementation of Paramedic Pathfinder (an assessment tool to support decision making) and an electronic Directory of Services to give better sign posting of services and allow more treatment in the community • Working in partnership with Clinical Commissioning Groups to identify and work with care homes with high conveyance rates to better manage patients in the home • Introduction of regular GP sessions in the Emergency Operations Centre 	<p>We are getting to more patients faster than ever before.</p> <p>EMAS is no longer the worst performing Ambulance Service to sitting mid-table when compared to all other UK services based on year to date performance figures (as at 26/02/15). We are also one of the best performing non-Foundation Trust Ambulance Services based on year to date performance figures (as at 26/02/15, and continue to work hard to bring further improvements.</p>	<p>National Performance Standards and Clinical Quality Indicators – published by the Department of Health</p>

- Improved care planning for high volume service users.

More details on these initiatives can be found in this Quality Account.

Priority 5: Development and implementation of a programme of public engagement activities focusing on hard to reach/vulnerable groups with a view to using feedback to improve our services

Aim	What we did	What we have achieved	Quality Indicators
<p>To obtain feedback and use the experiences of the people we serve, to continue to improve our services.</p>	<p>Incorporated a patient experience section to the EMAS 2014 Reputation Audit conducted across the East Midlands during July - September.</p> <p>Revitalised the Patient Experience Forum which is now chaired by the Director of Nursing, and is attended by patients and their carer.</p> <p>Successfully secured funding from the EMAS Charitable Funds Committee to hold a series of focus groups across the region to actively engage with our patients including those in 'seldom heard' groups.</p>	<p>Better patient engagement and enhanced feedback received from our patients and other members of the public, allowing us to address areas of concern and praise colleagues where positive experiences and good outcomes have been reported.</p> <p>More opportunities to promote and share best practice throughout the Trust.</p>	<p>Improvement in patient feedback metrics such as Friends and Family Score and EMAS 2014 Reputation Audit results.</p> <p>Improved relationships, greater public involvement in initiatives and advocacy of services.</p>

What we have done to improve patient safety

Learning from incidents, experiences and feedback

We have an open and honest approach at EMAS and encourage and support colleagues to report good and bad practice so we can identify learning and take steps to either replicate things that work well in other areas or reduce the risk of an adverse incident happening again.

At EMAS we identify learning from a wide range of sources such as untoward incidents or serious incidents, compliments and complaints, patient surveys and discussions at focus groups or community events.

We share learning across the organisation through our established Strategic Learning Review Group (SLRG). SLRG members, which include senior representatives from all divisions and teams within EMAS review the feedback and learning and promote the learning outcomes across the service.

Quality Visits

Our quality visits allow us to provide Trust Board members with the opportunity to observe and evidence patient safety, experience and clinical effectiveness.

All Executive Directors and Non-Executive Directors should undertake at least two quality visits each year and these should take place in the county for which they are the lead.

The following areas are visited as part of our quality visits:

- Hospital emergency departments
- EMAS Emergency Operations Centre
- EMAS Training Centres, and Headquarters (HQ) including divisional HQs
- Ambulance Stations
- Other Trust sites e.g. Fleet and Logistics, Hazardous Area Response Team HQ

The purpose of quality visits is to:

- Show meaningful visible leadership
- Engage with colleagues and if possible patients and their carers
- Triangulate information
- Obtain assurance
- Identify issues/barriers and ideas for solutions
- Communicate key messages

A total of 23 visits have been undertaken in EMAS during 2014/15 **[as at 27 February]**. These visits have proved successful in engaging frontline staff in the safety agenda and providing a constructive way for EMAS Board members to demonstrate visible leadership.

A template is completed by the Board member to record feedback which is collated into a report and actions addressed. The information collated during 2014/15 tells us:

What's good?

- Crews were observed to be caring and compassionate to patients and family members and they were treated with dignity and respect.
- The crews were observed to wear their uniform smartly and were professional in their approach to caring.

- Staff seemed more positive about the use of Electronic Patient Report Form in some areas.
- Observed good team working despite increased workload pressures and service demands.

What could be improved?

- The Team Leader/Clinical Team Mentor (CTM) role.
- The availability of vehicles and reliability of vehicles.
- Communication and sharing additional information between Emergency Operations Centre and frontline staff regarding nature of the emergency they are travelling to.
- Career progression - especially Emergency Care Assistant to Paramedic opportunities.

What ideas do staff or patients have for improvement?

- Better understanding of the Emergency Care Assistant (ECA) role
- Robust development opportunities of ECA's
- Better education of the public on appropriate use of ambulance and 999 calls
- Ensuring staff numbers and skill mix meet the demand of the service
- Build resilience amongst the workforce and ambulances

Serious incidents (SI)

Our transparent approach sees us proactively encourage colleagues to report patient safety incidents in line with a mature safety culture. Reporting allows us to analyse what happened and identify and put in place actions to reduce the risk of recurrence. [enter number at year end%] of all patient safety incidents (including SIs) reported during 2014/15 resulted in low or no harm which indicates a healthy reporting culture. During the year, EMAS identified [enter number at year end%] serious incidents requiring investigation. The general themes related to:

- Care management
- Delayed response
- Incorrect coding of calls

[these may change at year end]

The EMAS Trust Board regularly receives an update on the number and type of serious incidents reported. Again supporting our open approach, the Board meeting papers are made available to the public approximately a week before each monthly meeting via www.emas.nhs.uk/about-us/trust-board/

As part of the Serious Incident Investigation process a Root Cause Analysis (RCA) meeting takes place at which the root cause, contributory factors and learning for both individuals and the organisation are established; recommendations and Action Plans are also put in place to prevent reoccurrence. The actions are closely monitored on a monthly basis until closure. A review of learning and implemented actions is completed every 6 months by the SLRG to provide assurance that the learning and actions are embedded practice and have resulted in service improvement.

Safeguarding

We continue to prioritise safeguarding as a critical part of providing high quality care. Our approach to safeguarding is based on promoting dignity, rights and respect, helping all people to feel safe and making sure safeguarding is 'everyone's business'. Over the years the safeguarding agenda has continued to grow across EMAS from Board to frontline staff.

Safeguarding in EMAS is well embedded and encompasses:

- Prevention of harm and abuse through provision of high quality care
- Effective responses to allegations of harm and abuse

- Seeking responses that are in line with local multi agency procedures
- Using learning to improve service to patients

Improving patient safety with safeguarding

To aid a more joined up approach to safeguarding, streamline process and increase patient safety, we introduced SystmOne into the safeguarding team in early 2014. NHS Connecting for Health is delivering the National Programme for IT to bring modern computer systems into the NHS which will improve patient care and services. SystmOne is the local service provider; it links to the national spine and allows users to access the patient demographic service, summary care record and reporting.

To protect patients and colleagues a *VIP, Celebrity and Media Visitor Access Policy* has been produced in response to a recommendation made by the independent oversight of NHS and Department of Health investigation into matters relating to Jimmy Savile. The policy has been ratified by the EMAS Clinical Governance Group.

Safeguarding reporting remains an important component of patient safety management. Towards the end of 2014 the line management responsibility of the Safeguarding Triage Team, formerly known as the Clinical Assessment Support (CAS) desk, has been transferred to the EMAS Safeguarding Team within the Nursing and Quality Directorate.

The small but experienced Safeguarding Triage Team provide a 24/7 telephone safeguarding referral telephone service for frontline staff to make their safeguarding referrals/care concerns.

The Child Protection - Information Sharing (CP-IS) project is a national programme to help protect children and young people particularly those who are subject to a child protection plan and who are looked after. This programme allows the sharing of child protection information from Local Authorities to the NHS with a return message indicating that a child has been seen in an unscheduled care setting. The CP-IS stores only minimal information on a restricted set of children and the NHS number is being used as the unique number. Our Director of Nursing for EMAS has signed up to this project and it will be piloted in Nottingham.

Evidence for improvements in clinical effectiveness

Part of ensuring clinical effectiveness is through scrutiny of our clinical care against best practice, in other words 'clinical audit'. This provides the means by which we ensure quality clinical care, by making individuals accountable for setting, maintaining and monitoring standards. It is focussed around the three domains of quality - clinical effectiveness, patient safety and patient experience.

Each year the Clinical Audit programme is agreed and the audits completed according to the plan.

For 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 and therefore forms part of the Trust's Board Assurance framework and risk register?
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?
9. Subjects raised by Risk Management and Untoward Incident Reporting system

Recommendations from clinical audit are a) distributed to frontline staff to ensure improvement in clinical practice and b) used to drive EMAS' continuous quality improvement aims. We also contribute 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.

So what has been happening in Clinical Audit over the past year?

Each year our requirements for clinical information continue to increase together with a number of national audit requirements.

As well as providing our Clinical Ambulance Quality Indicators (ACQIs) data (stroke, STEMI and cardiac arrest) to NHS England, and participating in the full national programme of Clinical Performance Indicators (CPIs) – these include asthma, febrile convulsion, hypoglycaemia and lower limb fracture - we maintained and further developed our local programme of clinical audit work, thus reviewing and ensuring clinical effectiveness wherever possible.

We now produce monthly reports on all the AQIs and national CPIs, as well as our local CPIs (exacerbation of chronic obstructive pulmonary disease and suspected fractured neck of femur), which are shared with clinical and operational colleagues. The CPIs are also presented as a quarterly report, which compares performance by locality.

The projects described on the Clinical Audit & Service Monitoring Plan 2014/15 are complete (or are a continuous requirement and are up-to-date). As part of this, we produced audits/evaluations on major trauma, the safety of downgrading Red 2 calls (life-threatening 999 calls), and the usage and management of controlled drugs.

The team regularly provides clinical information and reports for a number of unplanned, ad hoc requests. Some examples from 2014/15 are:

- Prolonged waits evaluation
- End-tidal carbon dioxide (ETCO₂) monitoring in intubation
- Non-conveyance (patient can be assessed and treated at the scene and does not need taking to a hospital or treatment centre) evaluation
- Freedom of Information requests
- Patient report form requests

As well as producing the initial reports, on-going monitoring for two of these topics: ETCO₂ and prolonged waits, are now provided in two new monthly reports.

We also publish the quarterly Clinical Effectiveness Report, which brings together all EMAS' clinical metrics in one summary document.

National Clinical Performance Indicators (CPI)

The National CPIs have seen changes in the preceding twelve months as new National CPIs are developed for single limb fracture and febrile convulsions. The report gives more prominence to the data, and in particular the care bundles for each national CPI.

Data Collection and reports

The eleven ambulance trusts in England submit data to the National CPI co-ordinator who produces a cycle report using various analytical techniques. The reports that are produced are distributed to the National Ambulance Service Medical Directors (NASMed), as well as to each individual ambulance service. Each CPI has a number of indicators based on best practice and as described below.

The four current National CPIs are as follows:

Hypoglycaemia

The aim for this CPI is *'Improved assessment and management of hypoglycaemic patients'*

"If blood glucose levels are too low (<4.0mmol/L), hypoglycaemia must be reversed through pre-hospital care to avoid permanent brain damage or death."

To assist in the care this CPI has four elements which are monitored;

- | | |
|----|---|
| H1 | Blood glucose assessed prior to treatment |
| H2 | Blood glucose assessed after treatment |
| H3 | treatment for hypoglycaemia administered |

H4 Direct referral made to an appropriate health professional.

This CPI was one of the original CPI's introduced with good compliance for all the elements with H1, H2 and H3 all having a national mean of over 97%. H4 has a national mean of 70% following the most recent cycle; this is lower due to not all pathways and referral options being available to pre hospital care colleagues.

Asthma

"on average, 4 people per day or 1 person every 6 hours dies from asthma. It is estimated that approximately 90% of asthma deaths could have been prevented if the patient, carer or health care professional had acted differently."

The CPI has five elements

- A1 Respiratory rate assessed
- A2 PEFr assessed prior to treatment
- A3 SpO2 recorded
- A4 Beta 2 agonist administered
- A5 Oxygen administered

The above CPI was one of the original CPIs introduced with good compliance for all the elements with A1, A3, A4,A5 all having a national Mean of over 97% by the end of the most recent cycle. A2 has a national mean of 78% which is improving from cycle 1 where it was 49.4%

Single limb fracture

"Extremity fracture is commonly seen in pre-hospital care. They demonstrate a wide variety of injury patterns which depend on the patient's age, mechanism of injury and premorbid pathology"

The CPI has the following four elements

- F1 Two Pain scores recorded (pre and post treatment)
- F2 Analgesia administered
- F3 Immobilisation of limb recorded
- F4 Assessment of circulation distal to fracture site recorded

Febrile Convulsions

"A febrile convulsion is a seizure associated with fever occurring in a young child. Most occur between six months and five years of age. Febrile seizures arise most commonly from infection or inflammation outside the central nervous system in a child who is otherwise neurologically normal"

This CPI has five elements

- V1 Blood glucose
- V2 SpO2 recorded (prior to O2 administration)
- V3 Administration of anti-convulsant if appropriate
- V4 Temperature management recorded

V5 Appropriate discharge pathway recorded
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There is a set cycle in which these indicators are audited and the reports presented for inclusion in clinical improvement plans.

Here we share the Clinical Audit and Service Monitoring Plan for 2014/15, showing the status of each of the audit subjects.

Clinical Audit & Service Monitoring Plan 2014/15

Audit	Type	Timescale	Notes	Status at end 2014/15
Myocardial Ischaemia National Audit Project (MINAP)	Mandatory - national audit requirement	Continuous requirement	<ul style="list-style-type: none"> ✓ Provision of audit information to acute trusts upon request. 	<ul style="list-style-type: none"> ✓ Requirements met throughout the year
National Clinical Performance Indicators (nCPIs)	Mandatory - national audit requirement	As per nCPI programme	<ul style="list-style-type: none"> ✓ Hypoglycaemia, asthma, febrile convulsions, single limb fracture. ✓ Data collection as required. ✓ Analysis of local and national data, report / template preparation and dissemination. 	<ul style="list-style-type: none"> ✓ EMAS is responsible for co-ordinating the data from all English ambulance services and producing the reports according to the cycle requirements.
Ambulance Clinical Quality Indicators (ACQIs)	Mandatory – national performance monitoring	Monthly	<ul style="list-style-type: none"> ✓ Cardiac arrest (ROSC and survival). ✓ Stroke (care bundle and arrival at hyperacute stroke centre in 60 minutes). ✓ STEMI (care bundle, PPCI/thrombolysis within 60 minutes). ✓ Analysis, report preparation and submission to Department of Health/Unify. 	<ul style="list-style-type: none"> ✓ Requirements met throughout the year and published on a monthly basis. They are then collated into the quarterly Clinical Effectiveness Report, which is presented to the Clinical Governance Group and Quality Governance Committee before dissemination to

				clinicians.
Local Clinical Performance and Quality Indicators (LCPIs)	Discretionary – local clinical audit project	Monthly	<ul style="list-style-type: none"> ✓ Topics include asthma, hypoglycaemia, COPD, suspected fractured neck of femur, stroke, STEMI, stroke/HASU 60 mins, STEMI/PPCI 150 mins. ✓ Based on all patients for each topic, broken down by EMAS division. ✓ Data collection as required. ✓ Analysis, report preparation and dissemination. 	<ul style="list-style-type: none"> ✓ Requirements met according to the cycle throughout the year
PRF compliance and Trigger Tool monitoring	Monitoring – performance monitoring, required for IG toolkit / NHSLA	Quarterly	<ul style="list-style-type: none"> ✓ PTL-led PRF completion compliance audit. ✓ Data collection. ✓ Data analysis / report preparation. 	<ul style="list-style-type: none"> ✓ This audit is completed for NHSLA and CQUIN requirements, as well as to ensure good patient care documentation. The audit is completed at station level to encourage immediate feedback to clinicians. The reports are presented at Clinical Governance Group after which the report is widely disseminated to clinicians.

R2 assessment	Discretionary – monitoring/ evaluation	Annual	<ul style="list-style-type: none"> ✓ Ongoing evaluation of the clinical safety of downgrading Red 2 calls. ✓ Data collection, analysis, report preparation and dissemination. 	✓ This audit was requested by the Medical Director and has been completed.
Trauma Audit & Research Network (TARN) Audit	Discretionary - national audit	Continuous requirement	<ul style="list-style-type: none"> ✓ Provision of audit information to acute trusts upon request. 	✓ Completed
Controlled drugs storage and management audit	Mandatory local service monitoring	6 monthly	<ul style="list-style-type: none"> ✓ Monitoring of correct storage and management of controlled drugs in line with misuse of controlled drugs regulations 	✓ This is completed by the Trust's Accountable Officer for Controlled Drugs and the report presented to Clinical Governance group before dissemination.
Controlled drugs usage audit	Mandatory local service monitoring	Annual	<ul style="list-style-type: none"> ✓ Monitoring the use of controlled drugs in line with the duties of accountable officers. 	✓ Completed.
Major trauma audit	Discretionary - local audit	Annual	<ul style="list-style-type: none"> ✓ Evaluation of the use of major trauma pathways. ✓ Data collection, analysis, report preparation and dissemination. 	✓ This is complicated and difficult audit to complete due to the many trauma definitions. The audit

				will be presented to Clinical Governance Group.
Suspected fractured neck of femur audit	Discretionary - local audit	Annual	<ul style="list-style-type: none"> ✓ Evaluation of the care of patients suffering from suspected fractured neck of femur. ✓ Data collection, analysis, report preparation and dissemination. 	This is now covered as part of local CPIs.

Learning and encouraging colleagues to become involved in Clinical Audit

Over this year results from clinical audit and the recommendations have been widely distributed to clinicians to ensure that clinical practice is affected. There have been a number of ways this has been done e.g. staff bulletins, the Clinical Up-date publication and face-to-face contact with staff as well as through the divisional and strategic learning review groups.

EMAS Research and Development

Our reputation as a leader in pre-hospital research has increased over the past five years. We are now collaborating in more high quality externally funded studies and lead a prestigious £2 million National Institute for Health Research (NIHR) Programme for Applied Research: Pre-hospital Outcomes for Evidence Based Evaluation (PhOEBE) in partnership with the Universities of Sheffield, Lincoln and Swansea.

One of the drivers for increased ambulance service research in England has been the National Ambulance Research Steering Group (NARSG), set up in 2007 with support from EMAS' Chief Executive, and chaired by EMAS' Associate Clinical Director, Prof Niro Siriwardena. The role of NARSG is to set a strategy and develop the pre-hospital research agenda for ambulance services in England.

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

Engaged in 5 portfolio studies, we topped the 2012/13 NIHR CRN national league table for ambulance services. A further four funding applications have been successful and received funding from the NIHR programmes during 2014/15.

Research studies eligible for inclusion in the NIHR CRN portfolio are supported by an NHS research infrastructure. The support available includes additional funding and training. To be considered eligible for adoption on the NIHR CRN portfolio a study must be a fully funded high quality research study. Some research is automatically eligible, for example, research funded by the NIHR, NIHR non-commercial partners (e.g. The Health Foundation) or other areas of Government. Other research (e.g. commercial collaborative research) may also be eligible but will need to undergo a formal adoption process to be considered. Audits, needs assessments, quality improvements and local service evaluations are not eligible for adoption or support.

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

Our research status to date for year 2014/2015 is detailed in appendix 3 of this Quality Account.

What we have done to improve patient experience

Compliments

During 2014/15, we received more than [enter number at year end%] expressions of appreciation from patients or members of the public. This is an increase/decrease from previous years. When the colleague can be identified by the information provided, the individual(s) are thanked personally by the Chief Executive in the form of a letter which accompanies a copy of the patient feedback. We are grateful to the patients and their relatives who have been happy to share their experiences at our public Trust Board meeting and with local and national media. We are tremendously proud to be able to promote the achievements of our colleagues in this way and it always gives a real boost to morale.

Formal Complaints (FC)

During 2014/15, EMAS identified [enter number at year end%] formal complaints requiring investigation; [enter number at year end%] related to our Accident and Emergency Services (x.xxx% in relation to journeys provided or xxx complaints from xxx,xxx journeys), and x to our Patient Transport Services (x.xxxx% in relation to journeys provided or x complaints from xxx,xxx PTS journeys).

Following investigation xx complaints were found to be justified and xx partially justified. The remainder were not justified or not applicable (e.g. the complaint related to a different service).

The general themes related to:

- Delayed response and non-conveyance to green category calls
- Staff attitude
- Care management
- Call management

[these may change at year end]

This table demonstrates how many compliments and complaints were received per county during 2014/15:

County	Compliments	Complaints
Derbyshire	tbc	tbc
Leicestershire & Rutland	tbc	tbc
Lincolnshire	tbc	Tbc
Northamptonshire	Tbc	Tbc
Nottinghamshire	Tbc	Tbc
Emergency Operations Centre	tbc	tbc
Not specific	tbc	tbc

All formal complaints require investigation to establish the facts of the case and identify learning for both individuals and the organisation. The investigation also allows us to provide recommendations to prevent reoccurrence. Action plans are completed following each investigation and actions are closely monitored until closure.

General approaches to learning from serious incidents and formal complaints include:

- Communication of key learning points through education, training, communication and awareness
- Clinical case reviews and reflection of the practice by individuals

- Amendment to policies, procedures and practices
- Themes being reviewed by our Learning Review Group which consists of multi-disciplinary membership

Ombudsmen Requests

During 2014/15, we received five requests for information from the Ombudsmen. Of these, the Ombudsmen confirmed four were not upheld, and one remains open [figures may change at year end 31 March 2015].

National review of NHS complaints system

In February 2013, the Francis Report into Mid Staffordshire NHS Foundation Trust was published. It included: *“A complaints system that does not respond flexibly, promptly and effectively to the justifiable concerns of complainants not only allows unacceptable practice to persist, it aggravates the grievance and suffering of the patient and those associated with the complaint, and undermines the public’s trust in the service.”* The Francis report prompted the Prime Minister and the Secretary of State for Health to commission a review of NHS hospital complaints handling.

As a result, in October 2013, a review by MP Ann Clywd and Professor Tricia Hart was published, titled *A review of the NHS Hospitals Complaints System. Putting Patients Back in the Picture*.

EMAS reviewed both reports and identified actions to help us bring about change to improve quality of care; the way complaints are handled; ensure independence in complaints procedures and whistleblowing. The actions have been monitored via the EMAS Quality and Governance Committee as part of the Patient Experience Quarterly Reports.

[version 2 of this Quality Account to include year-end update on EMAS actions taken and completed]

Patient Feedback

During 2014/15 we replaced the previous postal patient surveys for accident and emergency patients, with a programme of patient focus groups and other engagement activities delivered jointly by the EMAS Community Engagement and Patient Experience teams. A series of public engagement events took place during the first two quarters of the year with 767 patients taking part in the EMAS Reputation Audit for 2014.

87% of patients who took part in the audit stated they had been either satisfied or extremely satisfied with the care received by EMAS.



EMAS Reputation Audit 2014



Six monthly postal patient surveys continue to be undertaken for the North Lincolnshire and Goole Patient Transport Service (PTS) patients. Of the 400 surveys sent out during quarters 1 and 2 of 2014/15, we received 75 responses; a 19% response rate. 90% of respondent stated they were either likely or extremely likely to recommend our services to friends or family.

From October 2014 all PTS and see and treat patients were issued with a Friends and Family comment card (a national NHS survey), to rate their care via the Net Promoter Score (NPS). The NPS is obtained by asking patients the question, 'on a scale of 0 to 10 (10 is extremely likely and 0 is not at all likely) how likely would you be to recommend East Midlands Ambulance Service to family and friends? Based on their reply, patients are categorised into one of three groups: promoters (who gave a 9-10 rating), passives (who gave a 7-8 rating) and detractors (who gave a 0-6 rating).

The percentage of detractors is subtracted from the percentage of promoters to obtain the Net Promoter Score – it can be as low as -100 (all those surveyed gave a 0-6 rating) to +100 (all those surveyed gave a 9-10 rating). An NPS that is positive (i.e. higher than zero) is felt to be good, and an NPS of +50 is excellent.

The Net Promoter Score for EMAS came in at [enter final result at year end].

Patient stories

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 two examples below of where we have done well or where we have identified areas for improvement.

Mrs B story, reported at the November 2014 EMAS Trust Board meeting:

Mrs B's 90 year old mother, whilst staying with the family, suffered a fall from her bed onto a wooden floor late at night and was not discovered until early the next morning. By this time she had been on the floor for over six hours and was cold and uncomfortable. The family did not know how to help her off the floor or if it was a good idea to try and so Mrs B called 999 at 6.30am.

Mrs B was told by the EMAS Emergency Medical Dispatcher (call taker) that her call was not an emergency and asked if a neighbour could perhaps assist in trying to lift her mother from the floor. Mrs B replied that manpower was not the problem; the family simply didn't know how to lift her mother safely.

An EMAS Clinical Assistant Team (CAT) clinician made the triage (assessment) call shortly afterwards and confirmed that there did not appear to be any serious injuries and that the patient was medically well. The CAT clinician asked if Mrs B and her son would be able to lift the patient from the floor. Mrs again advised that although her son was strong they did not have the knowledge or skill to safely lift her mother.

The clinician advised that we do not send blue light ambulances for calls of this nature and ambulances were for life threatening emergencies. The clinician suggested that the EMAS falls team could help although it would be a couple of hours before they arrived.

Mrs B replied that for her personally the fact that her mother had been on the floor for such a long time was an emergency and insisted that her call be put on the list for assistance. As the request of the CAT clinical, the family tried to lift the patient but was unsuccessful as the patient kept crying out in pain. The CAT clinician advised the patient would be added to the urgent falls list and the call was ended.

Mrs B found both the call taker and CAT clinician to be completely lacking in compassion and empathy. On terminating the call she felt no reassurance that her mother's condition had been taken seriously. She was left with the opinion that any help would take hours to arrive which left her feeling extremely anxious for her mother.

However, to her surprise an ambulance subsequently arrived approximately 30 minutes later and provided assistance and reassurance to both her mother and her family.

"I was told we did not qualify for an emergency 999 visit and that there was another option but that would probably be a couple of hours. At no time were we advised that this call had been escalated. It was a complete surprise when after having ended the telephone conversation with the assessment team; an ambulance very quickly arrived on the drive of my home."

This story illustrates how important it is for Emergency Medical Dispatchers (EMDs) and CAT clinicians to deliver a compassionate service to callers.

Mrs B said: *"I just wanted someone to say we'll be there as soon as we can, I just wanted some reassurance."* When asked what message she would like us to convey to all our staff as a result of her experience Mrs B stated that: *"staff have to display compassion 100% of the time, they have chosen to do this role, and I acknowledge the pressure they must be under but they have to be professional."*

Following the experience, Mrs B was adamant that she did not want her concern handled as a complaint but rather as an opportunity to highlight the important areas of compassionate care, empathy and reassurance. Actions that have been completed in relation to Mrs B's experience are

- Attendance at the EMAS Trust Board where Mrs B shared her experience responded to questions from the Board and received a personal apology from the Chair and Chief Executive for the experience.
- The importance of compassion, empathy and reassurance fed into EMAS education and communication campaigns.
- Feedback provided to the EMAS Emergency Medical Dispatcher and CAT clinician regarding their customer service and call handling skills.

Mrs D's story, reported at the June 2014 EMAS Trust Board meeting:

Mrs. D had previously been fit and well, but during the two and a half years prior to this attendance had suffered 'little incidents' where she had felt unwell and had lost consciousness on a number of occasions.

On the day in question Mrs. D was suffering from a Urinary Tract Infection (UTI) and felt unwell, she had walked her dogs as usual in the morning and on arriving home struggled to breathe in. Mrs. D was alone in the house and called 999 at 13.13. As soon as she had given her name, address and postcode Mrs. D lost consciousness. Soon after, Mrs. D's son arrived home and continued the call with the Emergency Medical Dispatcher (EMD).

First on-scene was a Community First Responder (CFR) at 13.17 closely followed by a Fast Response Vehicle (FRV) Paramedic at 13.19.

Resuscitation commenced with a Double Crewed Ambulance (DCA) arriving on-scene at 13.25 and leaving at 13.51 to transfer Mrs. D to Nottingham University Hospitals. Arrival time at hospital was 14.02.

Mrs. D stayed in hospital for 3 weeks during which time she had a pacemaker fitted. At the time of the June 2014 EMAS Trust Board Mrs. D was back at home and convalescing.

Mrs D and her children gave particular praise for:

- The speed that the 999 call taker identified an emergency situation
- The speed of the arrival of the CFR, FRV and DCA
- The timely and effective actions of the ambulance staff
- The care and teamwork displayed by the staff

Mrs. D stated: *'I am so grateful to EMAS and particularly to the staff who came to help, they saved my life.'*

Extracts from messages of thanks during 2014/15

'Around 6.30am I was at home when I suffered a sudden attack of being unable to breathe. My husband immediately called 999 for an ambulance. Within I think about 5 minutes a paramedic arrived who was absolutely first class. Subsequently he summoned an ambulance and a male and female arrived. Again they were first class and conveyed me to hospital where I was immediately treated in A&E and diagnosed as having had a heart attack. Could you please thank the paramedic and ambulance crew on my behalf. I certainly owe my life to them. My treatment and the manner in

which I was dealt with was first class. In an age in which it seems fashionable to attack our emergency services, I know I can't speak too highly of the ambulance people who helped me.'

Letter from MT of Nottingham

'We are writing to draw your attention to exemplary care, service and understanding that your colleague showed when she responded to our 12-year-old son. Her calmness, compassion and professionalism helped tremendously and, after talking through his symptoms with our son patiently and at exactly the appropriate level for him, she was able to leave him calm and reassured. Please pass on our gratitude and best wishes to her, and forward to her senior managers so that they are aware of the tremendous asset the service has in her.'

Letter from Mr & Mrs C from Northamptonshire

'I had an Asthma attack in Morrison's in Swadlincote. I took myself to the local walk in centre. The practitioner called 999 even though I didn't want to bother you. However two of your crew came out and took me to hospital. They asked why I hadn't called them. I said I didn't want to bother them or waste their time. I was quite upset for having to use them and they made me feel at ease and said I did need them and wasn't wasting their time. I wondered if you could pass on my thanks to them. You are not given enough praise.'

Letter from Ms CW from Leicestershire

Extracts from 'could do better' messages

'Disappointed to see @EMASNHSTrust Logistics Team Van (FY55 JYC) driver using his mobile phone on A46 when we know the dangers of #fatal4!

Tweeted by DO via the social media network Twitter.

'@EMASNHSTrust any major incidents this morning? My great aunt has a suspected broken hip – been waiting for 1 hour for ambulance/paramedic!'

Tweeted by SK via the social media network Twitter.

Community Engagement

The Communications and Engagement Strategy for 2014-2016 was approved by the EMAS Trust Board in November 2014. It includes a 2014/15 work plan for Stakeholder Engagement which has seen us deliver a range of engagement activities to improve patient experiences.

We do this by listening to patient and relatives stories and experiences, capturing their feedback and sharing it with the organisation. This allows us to respond to concerns raised, share praise with colleagues, and identify potential for improvement.

We have increased the public's knowledge and understanding of EMAS by producing materials and distributing them at events, and using social media to help explain:

- how emergency and urgent calls are graded (categorised) and responded to
- alternative pathways to emergency care
- where professional medical advice can be gained for non-urgent problems
- methods of self-care and good health and wellbeing

In addition to attending community events and other health service awareness days, we identified a number of groups which would benefit from direct engagement with EMAS. These included:

- the top three postcodes in the East Midlands for use of our service for serious and non-serious problems (this included deprived areas)
- Carers, including young carers
- Young parents – we worked jointly with SureStart groups

We continued to hold EMAS Membership engagement events across the region, giving us another good opportunity to hear from local people, share our updates with them and get their views on our future plans.

Everyone has a role to play in an emergency and giving first aid within the first few minutes of an incident can make the difference between life and death. The team has trained hundreds of people in emergency life-saving skills through free courses during 2014/15, offered in each county. People attending learn CPR (cardio pulmonary resuscitation used when someone goes into cardiac arrest), the recovery position and how to help someone suffering from a heart attack, choking or a serious bleed.

During July to September 2014, we conducted EMAS' first Reputation Audit. Over 3,000 people responded to the audit, with 87% saying they were very satisfied or satisfied with the care received from EMAS. 78% of respondents said they would recommend EMAS to friends and family; 73% said EMAS had improved in some way over the past 12 months; and 80% felt that EMAS has a positive reputation.

Stakeholder relationships have improved over the last 12 months with EMAS attending meetings and events, and inviting individuals or groups to visit us at our premises to build an understanding of our vision and future direction. We have been encouraged by the number of people who have expressed a desire to work with EMAS to ensure improvements continue, and we thank those who have taken the time to recognise the steps taken to date to bring about better care and services for our patients.

Communications and Social Media

Everyone in our service plays their part in saving lives, from our Ambulance Support Teams to our frontline clinicians, each person works hard to ensure our patients across the East Midlands receive the best possible patient care.

We are eternally grateful to the patients and their family who share their story and positive experience with local, regional and in some cases national media.

Here are a few examples of the stories that have been promoted this year:

You are my angels: On 25 April, paramedic Georgina Pickering and her student paramedic Megan Owen were first on scene to help Peter Jellett who was in cardiac arrest. Due to the shape of Peter's house, support was needed from other colleagues to assist Georgina and Megan with keeping Peter alive whilst trying to maneuver him from his house. Paramedics shocked Peter three times with a defibrillator to get his heart to beat again. Once he was in a stable position they worked hard to get him into the ambulance and took him to hospital. Peter, who now has a mini defibrillator fitted, said: "The ambulance crews who helped me are angels. I am so grateful that they have given me my life back. I feel very lucky that I can watch my grandchildren grow up and enjoy life thanks to their actions. Thank you will never be enough but I hope Georgina, Megan and the team understand what a huge impact they have had on my life."

I help to save lives: We produced a short film about the people in our service who help save lives. The film (available on the EMASNHSTrust social media YouTube channel) features patient John Gilmartin from Chaddeston in Derbyshire. John praised the 'team work' and 'dedication' of our colleagues who saved his life when his heart stopped 17 times. By working together, the team were able to give John's family their husband and father back.

You saved me: Not many people can re-live their accident by watching it on national television, but eight year old Danny Pitchford was able to do just that when his story featured on BBC Three's Junior Paramedics after he was involved in a collision. Danny was hit by a car and needed to be taken to hospital after paramedics feared he had sustained a severe head injury. Paramedic mentor Johnny Holmes was being filmed with student Nick Bailey whilst responding to calls in the area. After seeing how 'amazing' the paramedics were who helped him Danny asked his mum if he could meet Johnny and student Nick to say thank you. Danny said: "It was great to meet Johnny and Nick they are my heroes, when I saw them on the television I was very proud of what they did for me. When I grow up I want to be a paramedic too!"

Thank you: Patient David Marks was seriously injured in a motorbike collision in 2011. He met the ambulance crews that saved his life in 2014. He said: "I need to say thank you to the EMAS crews who responded to me, their quick thinking and skilful response saved me and means my family are eating dinner with me this weekend, not visiting my grave. I was in hospital for six months, suffered two cardiac arrests, had eighteen broken bones and a severe brain injury which has taken a lot of recovery time but I am here alive and breathing which is the most important thing."

Equality & Diversity

Equality and diversity must be embedded in our business portfolio due to legal and regulatory requirements as well as contract and commissioning requirements and specifications.

By implementing the 'NHS Equality Delivery System Two' we will look at objectives that generate workforce capability and confidence around equalities through better awareness, ownership and involvement. This will not only increase the diversity of our workforce, but also deliver services that effectively respond to and meet the needs of the diverse communities that we serve.

Through our Equality and Wellbeing Committee, we aim to embed equalities within all our staff engagement initiatives, especially in areas that support the development of special interest groups.

We also pledge to identify and engage with national and regional equalities initiatives that nurture talent and support career development particularly from under-represented staff. We will also identify innovative and creative ways to improve collection and use of equalities data to improve our equality performance.

Improving the care environment

We have made numerous improvements as a result of learning from a wide-range of sources including serious incidents, complaints and patient experience surveys. Some examples are shown below, with more to feature in the EMAS Strategic Learning Review Group Annual Report.

- ✓ Development of education/workshop programme for dispatch staff within our Emergency Operations Centres (EOC) to facilitate accurate and consistent applications of the updated Dispatch Protocols.
- ✓ Introduction of Red1/Red2 call assessments (life-threatening 999 calls) where the Clinical Assessment Team clinician provide additional support to both call-takers and callers until arrival of ambulance personnel on scene where potential delays in response is anticipated.
- ✓ Recruitment of additional Clinical Assessment Team clinicians to provide additional clinical support within our Emergency Operations Centre
- ✓ Provision of welfare calls to Green priority calls (serious but not life-threatening 999 calls) by the Clinical Assessment Team clinicians where delays are being experienced.
- ✓ Recruitment of General Practitioners to act as additional clinical support for the Clinical Assessment Team during the weekend.
- ✓ Human factors in healthcare education provided to operational staff as part of the EMAS Essential Education programme for 2014/15. This training is aimed at addressing the recurring themes in care management Serious Incidents e.g. 'framing' of incidents and the effect of personal factors such as stress and fatigue on effective decision making.
- ✓ The implementation EMAS wide of the Paramedic Pathfinder tool, a clinical triage tool that enables paramedics and technicians to safely identify those patients for whom an appropriate alternative to a hospital Emergency Department is available.
- ✓ 'Be an EMAS Ambassador' education implemented to operational staff via Essential Education programme for 2014/15.
- ✓ Development of calling card for colleagues to leave at patients addresses to inform carers and relatives when patients have been taken to hospital.
- ✓ Introduction of peer review of formal complaints and serious incidents with neighbouring ambulance trust to facilitate benchmarking and learning.
- ✓ Being part of *Breaking the Cycle* with the Queen's Medical Centre Emergency Department (Major Trauma Centre) which is a whole system approach aimed at improving care by improving capacity and processes to tackle winter pressures.
- ✓ Launch of the JACP – Joint Ambulance Conveyance Project – with Lincolnshire Fire Service (as highlighted previously in the Quality Account)
- ✓ 'Change Free Fridays' were implemented during quarter two. There will be no major changes to policies or procedures on Fridays; also the Chief Executive's Bulletin is now released on a Tuesday, giving colleagues the remainder of a 'normal working week' to ask a question about any of the news items rather than having to wait until after the weekend.
- ✓ On-going deep dive analysis of the formal complaints and serious incident reporting and investigation processes has led to improvements including quality assurance of investigation reports and identification of learning points and actions.
- ✓ Analysis of all slip, trip and fall incidents and development of a risk mitigation strategy.
- ✓ EMAS-wide Better Patient Care programme action plan to improve operational performance.
- ✓ Overarching review of medicines management completed and the recommendations arising from the review being monitored by the Better Patient Care programme.
- ✓ Familiarization training for all third party providers (private ambulance services) to ensure that all clinicians are aware of the geographical locations of relevant hospitals when working in division.
- ✓ Undertaking both a maternity and a paediatric review to ensure that our policies, protocols' practice and equipment reflect current practice.

Appendix 1 – Workforce

We have developed a new People Strategy with a vision “to develop and support our people to be highly skilled, motivated, caring and compassionate professionals proud to be part of the EMAS family.”

Our aim is to develop EMAS as an Employer of Choice. We will achieve this by ensuring a safe and healthy workplace, where colleagues feel valued, their views are heard, have a sense of purpose and direction, are able to reach their full potential, and contribute to achieving our strategic vision and objectives.

The People Strategy Framework reflects our approach to developing positive employment relationships with our staff and is modelled on recognised motivational theory – Maslow's Hierarchy of Needs, ensuring a person centred approach in its development, and acknowledgement of the range of mutually reinforcing factors that impact on motivation and satisfaction.

Desired Outcomes of the Strategy include:

- Planning and Attraction: Comprehensive and integrated workforce planning that supports the delivery of the right care, with the right resource, in the right place and at the right time.
- Retaining and Valuing: Positive employment relationships where individuals value the contribution of each other, wish to remain working with at EMAS and recommend EMAS as a place to work.
- Development and Career Progression: An engaged, committed, motivated and skilled workforce that has the capability to deliver effective patient care and drive organisational development, improvement and transformation.
- Exiting: To manage those who exit the EMAS sensitively and effectively, ensuring feedback contributes to organisational learning and development.

We have strengthened our workforce plans to ensure our focus on capacity and capability to support transformation to the new service model and achievement of the quality-improvement programme. This will provide assurance that we have the right number of resources with the right skill mix required to meet operational demand, ensure business continuity and meet the regional and national standards.

More frontline staff

We have a wide variety of frontline personnel at EMAS, who as part of a team provide professional healthcare services to the people of the East Midlands all day, every day. Examples of the different role types can be found under the careers section of our website www.emas.nhs.uk

In line with our Workforce Plan, during 2014/15 we recruited and trained xxx emergency care assistants, xx paramedics, xx staff for our Emergency Operations Centre (control) across both Emergency Medical Dispatch and Clinical Assessment Team roles, and xx other staff in support functions. This included an increase in overall frontline staff by xx new roles, as well as keeping up with natural turnover.

We have also reintroduced the Ambulance Technician role and are actively recruiting qualified Technicians.

Career progression opportunities have been increased for our existing workforce, and a major recruitment and education campaign has been launched. This includes a range of options including:

- New Emergency Care Assistant roles
- Trainee Technicians
- Emergency Care Assistant to Technician
- Emergency Care Assistant to Paramedic

During the year we experienced a xx% turnover rate of frontline staff and our recruitment plan reflects the rate needed to maintain establishment and skill mix.

Supporting young people at the start of their career

We continued to support the national apprenticeship programme by recruiting apprentices into a range of support and operational support positions. Since 1 April 2014, xxx apprentices began work in various departments across the service. Of the xx apprentices that completed their schemes in 2014/15, xx went on to successfully secure roles within EMAS.

Values based recruitment improves quality of care

Through our recruitment campaigns we have ensured a values-based approach focussed on attitudes, behaviours and ability. While assessment of ability has remained an integral component of the recruitment process, it is now widely recognised that employees' values, attitudes and behaviours have a significant impact on the quality of care and patient experience. This has been highlighted in a number of high-profile publications, not least, the recommendations made by Robert Francis QC in the Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry and the Government response.

To better support values-based recruitment, we have employed a number of strategies during the year including education and training for recruiting managers, values-based interview techniques, questions to explore attitude and behavioural factors, use of psychometric instruments, assessment centres and patient and stakeholder involvement.

Education and development

In December 2013, we developed our People Capability Framework to define the competencies, attitudes and behaviours for staff and managers at every level. The framework supports leadership and management development; cultural development and underpins workforce planning, values-based recruitment, education and training, appraisals and succession planning.

Development of our Learning and Development Strategy will enable our colleagues to feel fully supported in their education and career progression.

Last year, we set out our education and training plan. At the end of March 2015, xxx% of staff had successfully completed the programme; we aimed to achieve our target of xxx% by the end of March 2016.

During 2014/2015, our Education Team implemented the annual Essential Education programme supporting essential standards of quality and safety, statutory and mandatory requirements and clinical updates.

Continued delivery of the rolling programmes for clinical staff resulted in an additional xxx staff completing the Pre-Hospital Assessment and Disposition Education programme and xxx staff becoming accredited mentors to support newly-qualified paramedics in practice.

Staff support and well being

In 2014 we developed our Health and Wellbeing Strategy. Key objectives include:

- Deliver improvement in employee health, wellbeing and attendance at work through health promotion and prevention approaches within a comprehensive health and wellbeing service.
- Improve levels of attendance and productivity in line with sickness absence targets and reduce the annual cost of sickness absence.
- Reduce incidence of musculoskeletal injury and absence through prevention and early intervention strategies.
- Reduce incidence of work-related stress and mental ill-health through prevention and early intervention strategies including the development of individual care pathways to support staff following traumatic incidents.

Whilst continuing to ensure appropriate management of sickness in accordance with the Attendance Policy, we have implemented a number of supportive measures to support staff wellbeing:

- 2014 Flu campaign – which has seen xxx staff vaccinated against flu – a xx% rise compared to last year
- A Peer to Peer (P2P) support programme has been implemented. This group of volunteers support their colleagues by providing a listening ear and signposting to other support mechanisms. Within the P2P group, we have over 30 volunteers who will also work as Pastoral Care Workers to support our EMAS Chaplain in his work. The scheme launched in February 2015, with training for P2P and PCW taking place during February and March 2015.
- We have developed and communicated a staff support handbook written by a paramedic for his colleagues who experienced trauma.
- We are developing resilience training for all colleagues and team leaders. Team leader training is being developed through Sheffield Hallam University.
- A group of 16 staff (mainly team leaders) will attend Trauma Risk Management (TRiM) training in April 2015, enabling us to provide more specialist debriefing support for our colleagues.

Staff engagement

Through the 2014 staff engagement programme Listening into Action (LiA) we aimed to mobilise and empower colleagues to lead and drive change both locally and at an organisational level, and embed LiA as ‘the way we do things around here’.

A number of listening events were held across the region together with station and ‘pass it on’ events providing opportunities to listen, engage, involve and communicate change and celebrate success.

A wide-range of ‘quick wins’ were achieved, including (but not limited to):

- Improved access to charitable funds to improve facilities for colleagues at stations
- Re-establishment of the Ambulance Technician role
- ‘No Change’ Fridays
- Appreciation letters being placed on colleague personal files

In addition, LiA has brought about success in organisational projects, including:

- Emergency Care Assistant (ECA) support programme which has led to developments in the education programme and improvement in their transition into frontline operations. This will

be subject to a post implementation review as the current ECA cohort experience these improvements.

- We have significantly improved staff support available through the introduction of the new Peer to Peer Network, Pastoral Care Workers and the TRiM programme.
- Staff engagement in the new vehicles programmes which sees delivery of the new vehicles during quarter 4 of this year.

LiA has enabled matters of concern to colleagues to be raised and addressed, has enabled staff engagement and involvement, and facilitated staff leadership to drive change and improvement.

Planning for LiA year two is in progress.

Positive impact

A number of initiatives came to fruition during 2014/15, including:

- Continued provision of our Occupational Health (OH) and Employee Assistance programme focussed on taking proactive and preventative measures to support staff wellbeing.
- A range of education and training programmes to support management capability were available for staff and managers.
- Introduction of Listening into Action and a range of staff support mechanisms

A 'wellbeing' fortnight is scheduled for May 2015 to allow more proactive promotion of the numerous support networks and services available to our colleagues.

NHS Staff Opinion Survey

The annual Staff Opinion Survey was conducted by the Picker Institute on behalf of EMAS. Picker also administered the survey for five other ambulance services enabling us to have some comparative data ahead of the Department of Health report which details results from other parts of the NHS.

Our response rate for 2014 was 28.8%. The average response rate for the five other ambulance Trusts was 36.7%.

How do we compare to other services?

In this year's survey, a comparison could be drawn between EMAS and the average for all 'Picker' ambulance trusts on a total of 92 questions. The survey showed that EMAS is:

- Significantly better than average on 36 questions
- Significantly worse than average on 6 questions
- The scores were average on 50 questions

Have we improved since the 2013 survey?

A total of 86 questions were used in both the 2013 and 2014 surveys. Compared to the 2013 survey, EMAS is:

- Significantly better on 15 questions
- Significantly worse on 4 questions
- The scores show no significant difference on 67 questions

[Draft version 2 of this quality account will include more detailed analysis of the NHS Staff Opinion Survey results]

Appendix 2 – IG Toolkit

Our Information Governance Toolkit assessment overall score for 2014/15 was [figure to be entered at year end%] and was graded **satisfactory**.

The EMAS Information Governance Manager is responsible for maintaining evidence to support the Information Governance Toolkit for our service. Assurance on the process to collect the evidence is overseen by the EMAS Information Governance Group, chaired by the Senior Information Risk Owner (SIRO), which is accountable to the Finance and Performance Group.

Requirements within the Information Governance Toolkit were assessed by Internal Audit in February 2015, who were able to provide significant assurance that there is a sound system in place to support Information Governance.

Data incident 2014

We proactively reported a data loss incident in August 2014, informing the Information Commissioner, Clinical Commissioning Groups and other key stakeholders, including the media. A telephone helpline was set up to allow patients to contact us directly should they be concerned with the news (update reports have also featured in EMAS Trust Board papers available on our website).

In January 2015, we received a letter from the Information Commissioner's Office (ICO) confirming its decision having investigated the incident.

The Information Commissioner considered the information we provided about a potential breach of the Data Protection Act and decided that no further action is necessary at this stage. This includes their decision not to impose a fine on EMAS.

In summary, the Commissioner felt the likelihood of substantial damage or distress to data subjects appeared to be low, particularly given the obsolete nature of the system used to access the data cartridge and read the content.

It acknowledged that our investigation into the circumstances revealed several flaws in the technical and organisational measures to keep this personal data secure, however that we have taken extensive remedial measures to improve our compliance with the Data Protection Act.

In conclusion, it confirmed that the case did not appear to meet the criteria set out in the ICO's Data Protection Regulatory Action Policy necessitating further action by the Information Commissioners Office.

Appendix 3 – Research and Development

EMAS research status to date for year 2014/2015

Project	Type	Chief Investigator	Funding Organisation	Overarching study aim	Status	Recruitment
Epidemiology and outcome from out of hospital cardiac arrest	NIHR Portfolio	Professor Gavin Perkins University of Warwick	British Heart Foundation Resuscitation Council UK	To develop a standardised approach to collecting information about out of hospital cardiac arrest and how outcomes are followed up to confirm if a resuscitation attempt was successful.	<p>This is a national study involving all ambulance services in England and Wales. The OHCAO project team are supporting the services to assist with improvements in data capture, quality and quantity. Discussions with all services have been taking place to agree the OHCAO definitions. This will ensure there is minimal variation across services and improve overall data quality and consistency.</p> <p>Sample data from EMAS has been submitted to OHCAO for data verification and quality. After completion of this process EMAS will submit data from April 2012 to March 2013, as well as data captured between April 2014 and November 2014.</p> <p>Project data for October 2014 has also been submitted to OHCAO as part of a wider project for the European Registry of Cardiac arrest (EuReCA One).</p>	None. This study does not involve taking consent from patients and therefore is considered a non-recruiting study.
Preventing repeat hypoglycaemic episodes in people with type 2 diabetes: The hypo ambulance study	NIHR Portfolio	Professor Kamlesh Khunti University of Leicester	NIHR CLAHRC (Collaborations for Leadership in Applied Health Research and Care)	To implement and evaluate the effectiveness of a diabetes specialist nurse (DSN) led intervention following a call out of an ambulance to treat a hypoglycaemic episode	This study is currently in development. The EMAS Research Team are working alongside the University of Leicester to develop the protocol.	Expected recruitment: 100

Project	Type	Chief Investigator	Funding Organisation	Overarching study aim	Status	Recruitment
EDICES: ERC Dispatch Centre Survey on dispatch assisted CPR	Non-portfolio	Dr Michael Baubin The Medical University of Innsbruck	Medical University Innsbruck	The study aims to better understand the effects of different dispatch centre strategies and to improve the quality of dispatch strategies for life support measures. This will be done by gathering information on how emergency calls for out of hospital cardiac arrests are being processed within dispatch centres throughout Europe.	EMAS' involvement in this study was completed in December 2014 on completion and submission of an online survey. EMAS also undertook a national coordinator role recruiting the other ambulance services within the UK.	1
Pre-hospital Outcomes for Evidenced Based Evaluation (PhOEBE): Developing new ways of measuring the impact of ambulance service care Work Package 2 – Data Linkage	NIHR Portfolio	Professor Niroshan Siriwardena University of Lincoln & East Midlands Ambulance Service NHS Trust	NIHR Programme Grants for Applied Research	To develop new ways of measuring the impact of ambulance service care to support quality improvement through monitoring, auditing and service evaluation.	This is a five year programme and is currently in year four. The systematic review on pre-hospital care outcome measures, the consensus study to identify measures relevant to patients and NHS staff, and the qualitative review are complete and in the process of being written up. The data linkage element of the study, linking pre-hospital data with other data sources (e.g., Hospital Episode Statistics and national mortality data) to create a single data set, is in progress.	None. This study does not involve taking consent from patients and therefore is considered a non-recruiting study.
Understanding variation in rates of ambulance service 'non-conveyance of patients to an emergency department'	NIHR Portfolio	Professor Alicia O'Cathain University of Sheffield	NIHR Health Services and Delivery Research Programme (HS&DR)	This study aims to identify the determinants of variation between and within ambulance services for three different types of non-conveyance: 'hear and treat', 'see and treat' and 'see and convey elsewhere'. The study will explore the determinants of potentially inappropriate non conveyance	This study has recently gained organisational approval and is in the process of site initiation.	Expected recruitment: 22

Project	Type	Chief Investigator	Funding Organisation	Overarching study aim	Status	Recruitment
				for the three types. The study will also seek to understand organisational variation in the provision of 'hear and treat' within ambulance services and specifically explore the different types of non-conveyance rates for respiratory problems.		
Impact of closing Emergency Departments in England (closED)	NIHR Portfolio	Dr Emma Knowles University of Sheffield	NIHR HS&DR	The aim of the study is to establish the implications of closing, or downgrading Emergency Departments on the population and emergency care providers and in doing so provide the public, the NHS and policy makers with the necessary evidence to inform decision making about future ED closures.	This study is currently in the process of obtaining NHS permission. The planned study start date is March 2015.	None. This study does not involve taking consent from patients and therefore is considered a non-recruiting study
Improving pre-hospital pain management: development and validation of a patient and practitioner reported outcome measure for pain treatment (PROMPT)	Non-portfolio Doctoral Study	Dr Mohammad Iqbal	Internally funded (EMAS)	The study aims to test the reliability and validity of the PROMPT and then to evaluate its effectiveness in pre-hospital pain management. The study aims to find out how reliable and valid the new tool is for assessing pain in the pre-hospital setting.	Data collection for the study is currently in progress and recruited paramedics are using the pain assessment tool. The next phase will be to analyse the data collected.	Expected recruitment: 77 (21 paramedics & 56
Using National Early Warning Scores to support	Non-portfolio Doctoral	Nadya Essam	University of Lincoln Research	The overarching aim is to investigate the feasibility, usefulness and effectiveness of	The study has completed the first part of the qualitative phase – interviews, focus groups and	Expected recruitment:

Project	Type	Chief Investigator	Funding Organisation	Overarching study aim	Status	Recruitment
paramedic decision-making: Modelling and improving effectiveness of pre-hospital ambulance transport to hospital	evaluation study		Investment Fund Internally funded (EMAS)	NEWS to support paramedics' decision-making to transport or treat patients closer to home (i.e. 'see and treat', 'see and refer' or 'treat and refer').	observations. An application for the quantitative data has been made to the Health and Social Care Information Centre.	22
Improving Pre-hospital and Ambulance Care and Treatment following the Ambulance Services Cardiovascular Quality Initiative (IMPACT-ASCQI)	Quality Improvement	Niro Siriwardena	The Health Foundation	The aim of the project is to widen the impact of the Ambulance Services Cardiovascular Quality Initiative (ASCQI) by providing a sustainable and long term increase in quality improvement (QI) knowledge and skills to a wider proportion of ambulance staff and to extend this further to other healthcare professionals.	This is a project involving nine ambulance services. Services have been using quality improvement methods to increase the performance of an aspect of clinical care (chosen locally). This has involved the use of PDSA cycles, workshops, process mapping, root cause analysis, 1:1 feedback and visual prompts. In EMAS this has resulted in significant improvements in ETCO2 recording (from 29.41% to 77.78%). Other aspects of the project included developing an ASCQI website and e-learning toolkit to facilitate the ongoing education of QI, delivering QI webinars and holding a conference to showcase the ongoing QI work.	Not applicable -the project is not research.
Pre-hospital Care of Patients After a Suspected Seizure: Incidence, Patient Characteristics and Costs	Non-portfolio research	Dr Zahid Asghar	University of Lincoln	The study aims to determine the incidence, patient characteristics and costs of suspected seizure and which clinical factors predict transport to hospital in the pre-hospital (ambulance) setting	This study is using routinely collected data to quantify the number of emergency incidents dealt with by EMAS in 2011/12. Analysis is currently in progress. Further work will include linking ambulance data to HES data. It is hoped that further collaborative work will inform discussions into the development of	None. This study does not involve taking consent from patients and therefore is considered a non-recruiting study

Project	Type	Chief Investigator	Funding Organisation	Overarching study aim	Status	Recruitment
					ambulance clinical performance indicators for epilepsy.	
Cluster randomised trial of the clinical and cost effectiveness of the i-gel supraglottic airway device versus tracheal intubation in the initial airway management of out of hospital cardiac arrest (AIRWAYS-2)	NIHR Portfolio	Professor Jonathan Benger	NIHR Health Technology Assessment (HTA) Programme	AIRWAYS-2 aims to determine the best approach to the management of a patient's airway during an out of hospital cardiac arrest.	The study is currently in the set up phase within EMAS. The trial is scheduled to begin in March 2015 and will involve comprehensive training for participating paramedics before randomisation and use of the interventions can begin.	Expected recruitment 1550 (250 paramedics & 1350 patients)
Rapid Intervention with GTN in Hypertensive Stroke Trial 2(RIGHT 2)	NIHR Portfolio	Professor Philip Bath	British Heart Foundation	The purpose of this study is to determine whether early use of GTN within 4 hours of suspected ultra-acute stroke, and continuing administration once daily for a further three days, is associated with improved outcome.	The study is currently gaining approvals from the regulatory bodies. The study is scheduled to begin recruiting in May 2015.	Expected recruitment: 150
Understanding the implementation, organisation of centralised specialist services: the reconfiguration of major trauma service in the East Midlands	NIHR Portfolio	Professor Justin Waring	The Health Foundation	The study aims to understand the reconfiguration of major trauma services within the East Midlands region of the English NHS to identify lessons for similar service reconfigurations based on centralisation of specialist services into regional centres.	This project is currently in set up within EMAS. Recruitment to the study is expected to commence in May 2015.	Expected recruitment: 15

Successful research is measured by its effect on patient outcomes. This is achieved in a number of ways through dissemination at conferences, publications and clinical education and training.

The table below shows some of the publications and presentation the Trust has delivered. The names in bold are EMAS staff

Presentations and Publications					
Type	Title	Date	Location / Journal published in	Authors / Presenters	Study
Oral	Feasibility study of a novel pain assessment tool for improving pre-hospital pain management	04/02/2015	999 EMS Research Forum, Nottingham	Iqbal M	Improving pre-hospital pain management development and validation of a patient and practitioner reported outcome measure for pain treatment (PROMPT)
Poster	Feasibility study of a novel pain assessment tool for improving pre-hospital pain management	04/02/2015	999 EMS Research Forum, Nottingham	Iqbal M	Improving pre-hospital pain management development and validation of a patient and practitioner reported outcome measure for pain treatment (PROMPT)
Poster	The Impact of Quality Improvement Interventions on the Monitoring and Recording of End Tidal Carbon Dioxide in Intubated Patients	04/02/2015	999 EMS Research Forum, Nottingham	Knowles S, Spaight R, Siriwardena AN	ImPACT-ASCQI
Poster	Service user perspectives on patient safety in the ambulance service	06/10/2014	College of Paramedic Conference 2014	O'Hara R, Johnson M, Turner J, Shaw D , Newman C	Decision Making and Safety in Emergency Care Transitions
Journal Publication	Identifying barriers and facilitators to ambulance service assessment and treatment of acute asthma: a focus group study	03/08/2014	BMC Emergency Medicine 2014, 14:18 doi:10.1186/1471-227x-14-18	Shaw D, Siriwardena AN	Identifying barriers and facilitators to evidence based assessment of asthma in EMAS: exploring the perception and belief of ambulance paramedics to the

Presentations and Publications					
Type	Title	Date	Location / Journal published in	Authors / Presenters	Study
Oral	Modified Early Warning Scores (MEWS) to support paramedics' decisions to transport or treat at home: a time series study	11/07/2014	Society for Academic Primary Care 2014, Edinburgh	Essam N	assessment of asthma Modified Early Warning Scores (MEWS) to support ambulance clinicians' decisions to transport or treat at home: time series study
Journal Publication	A qualitative study of systemic influences on paramedic decision making: care transitions and patient safety	02/12/2014	Journal of Health Services Research & Policy 2015, 20: 45 doi:10.1177/1355819614558472	O'Hara R, Johnson M, Siriwardena AN , Weyman A, Turner J, Shaw D , Mortimer P, Newman C, Hirst E, Storey M, Mason S, Quinn T, Shewan J	Decision Making and Safety in Emergency Care Transitions
Journal Publication	Views of Paramedics on Their Role in an Out-of-Hospital Ambulance-Based Trial in Ultra-Acute Stroke: Qualitative Data From the Rapid Intervention With Glyceryl Trinitrate in Hypertensive Stroke Trial (RIGHT)	18/04/2014	Annals of Emergency Medicine 2014, 64:640 doi:http://dx.doi.org/10.1016/j.annemergmed.2014.03.016	Ankolekar S, Parry R, Sprigg N, Siriwardena AN and Bath P	RIGHT
Poster	Systematic review: the barriers and facilitators for minority ethnic groups in accessing urgent and pre-hospital care.	19/06/2014	The Health Services Research Network (HSRN) Symposium 2014, Nottingham	Phung VH, Windle K, Asghar Z, Ortega M, Essam N , Barot M, Kai J, Johnson M, Siriwardena AN	BME
Poster	Investigating the understanding, use and experiences of older people in Lincolnshire accessing emergency and urgent services via 999 and NHS 111: A scoping study	19/06/2014	The Health Services Research Network (HSRN) Symposium 2014, Nottingham	Togher F, Essam N , Windle K, Hardwick J, Siriwardena AN , Phung VH, Vowles V	999/111
Oral	Experiences and Understanding of 999 111 services of people 65 and over	25/06/2014	Lincolnshire Community Health Services Research Forum	Hardwick J, Essam N , Windle K, Togher F, Siriwardena AN , Phung VH, Vowles V	999/111

Appendix 4 – CQC registration

Draft version 2 to include this section [previous updates and reports included in EMAS Trust Board papers made available online ahead of each meeting]

Appendix 5 – Third Party Statements

This section will be completed when official responses are received from the Overview and Scrutiny Committees, Healthwatch groups and Lead Commissioner for EMAS.

The first draft version will be sent to OSC early March to comply with purdah which begins on 30 March.

The EMAS Trust Board will also receive a copy of the first draft to review in March.

The second draft version will be shared with Healthwatch groups in April 2014.

Appendix 6 – EMAS Trust Board

Critical to the continued improvements of our services is the appointment to key, substantive leadership roles in the Executive Director team. Our current board were recruited substantively during 2014/15 with the full support of the NHS Trust Development Authority.

The main role of the EMAS Trust Board is to guide the overall strategic direction of our ambulance service, to ensure we can meet our current challenges, establish and achieve our objectives and plan effectively for the future.

Our Trust Board has overall corporate responsibility for how EMAS runs.

Our Trust Board is led by our Chairman and comprises of Executive and Non-Executive Directors.

Executive Directors are responsible for managing our affairs on a day-to-day basis, while Non-Executive Directors provide essential balance with their skills and expertise in the public and private business sectors to complement those of our Executive Directors.

Chairman

Pauline Tagg

Non-Executive Directors

Stuart Dawkins, Dermot Toberty, Rachel Morrison, Karen Tomlinson and Vijay Sharma

Chief Executive

Sue Noyes

Director of Operations

Richard Henderson

Medical Director

Bob Winter

Director of Nursing & Quality

Judith Douglas

Acting Director of People

Kerry Gulliver

Director of Finance

Richard Wheeler

Director of Information and Performance

Will Legge

Director of Business Development and Strategy

Tim Loveridge

Director's responsibilities in respect of the Quality Account

The EMAS Trust Board has been involved in identifying the quality indicators, agreeing the content and endorsing the content of this Quality Account [to be confirmed once Board has reviewed draft QA in April 2015]. We have developed our quality priorities and indicators 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.

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 these requirements in preparing this Quality Account. This has been confirmed through a resolution of the Trust Board. [to be confirmed once Board has reviewed final QA in May 2015]

The Core Quality Account Indicators

Performance standards

During 2014/15, we received [insert number at year end] emergency 999 calls from members of the public. Our accident and emergency crews responded to [insert number at year end] of these calls, which equates to [insert number at year end] responses every day. Of these, [insert number at year end] were Red (serious, life threatening calls).

There are two national performance standards for Red, life-threatening calls. The first requires us to respond to at least 75% of incidents in eight minutes or less, the second requires us to provide a support vehicle within 19 minutes or less for 95% of calls.

During 2014/2015, we achieved a response rate of [insert number at year end]% Red1 and [insert number at year end]% Red2 (response within eight minutes) and [insert number at year end]% (support vehicle within 19 minutes) across the East Midlands – see the at-a-glance guide to our response to 999 calls on page X of this report [include guide infographic in final version].

The performance standards hit for each division of EMAS during 2014/15 is as follows:

	Red 1	Red 2	A19
Derbyshire	tbc%	tbc%	tbc%
Nottinghamshire	tbc%	tbc%	tbc%
Lincolnshire	tbc%	tbc%	tbc%
Leicestershire & Rutland	tbc%	tbc%	tbc%
Northamptonshire	tbc%	tbc%	tbc%

We accept that more work needs to be done in 2015/16 to achieve both the 75% and 95% standards. However we are pleased that our performance has continued to improve since the introduction of our *Better Patient Care* quality improvement programme.

To help explain the different types of call categories, we have produced a guide 'responding to your 999 calls'. It can be found on our website at www.emas.nhs.uk under the 'about us' section.

Clinical Quality Indicators

On 1 April 2011, the Department of Health introduced new national targets for ambulance services. 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 any treatment rather than just timeliness. By monitoring performance in this way, we are able to identify good practice and any areas which need improvement. Examples of the quality measures are:

- outcome following a heart attack or stroke
- proportion of calls dealt with by telephone advice or managed without transport to A&E (where clinically appropriate)

You can read more about Clinical Quality Indicators in the Clinical Audit section of this Account.

Glossary

A&E

Accident and Emergency, also referred to as 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 or 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.

Clinical Commissioning Group (CCG)

Clinical commissioning groups (CCGs) are NHS organisations set up by the Health and Social Care Act 2012 to organise the delivery of NHS services in England.

Commissioners

NHS organisations who effectively purchase services from EMAS, based on the identified health needs of their local population. NHS Erewash Clinical Commissioning Group is the 'lead commissioner' for EMAS. That is, they (on behalf of all the Clinical Commissioning Groups 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.

CPI

Clinical Performance Indicator is a way to measure quality.

CQC

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, a set of 11 indicators introduced to the ambulance service by the Government from 1 April 2011 as measures of clinical quality.

CQUIN

Commissioning for Quality and Innovation, known as CQUIN, is a payment framework that 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.

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)

ECA

Emergency Care Assistant responds 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

The role of Emergency Care Practitioners, or known as 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.

ED

Emergency Department 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 Accident and Emergency or A&E.

EMAS

East Midlands Ambulance Service, also referred to as EMAS, is part of the NHS and provides emergency and urgent for the six counties of Derbyshire, Leicestershire, Rutland, Lincolnshire (including North and North East Lincolnshire), Northamptonshire and Nottinghamshire. Patient Transport Services are provided in North and North East Lincolnshire and parts of Nottinghamshire.

EMICS

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

EOC

Emergency Operations Centre (control) at East Midlands Ambulance Service. One based in Nottingham and one based in Lincoln. These centres receive the emergency and urgent 999 calls and dispatch ambulance crews to them or give 'hear and treat' advice via the Clinical Assessment Team (paramedics and nurses who work in the control centre).

HCPC

Health and Care 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 is 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.

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.

SI

Serious Incident

STEMI

ST Elevation Myocardial Infarction is a heart attack.

Our Quality Account

2014/2015

We welcome your comments about our Quality Account.

Please contact us using the details below:

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Nottingham Business Park
Nottingham, NG8 6PY

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To receive this information in large print, audio or in another language, please call us on 0845 299 4112.