East Midlands Ambulance Service NHS Trust

Emergency Care | Urgent Care | We Care

Draft

Quality Account
2015/16

Our Quality Account 2015/16

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Introduction

Production note: this section will be completed at the end of the current performing and financial year (1 April 2015 to 31 March 2016).

add signature here

Sue Noyes
Chief Executive

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

East Midlands Ambulance Service NHS Trust

Emergency Care | Urgent Care | We Care

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 that can support them in their homes and the community, 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: a growing and aging population with ethnicity and health diversities.

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

Historically the region's population has been growing fast and this looks set to continue over the next decade, putting pressure on our new and existing 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.

This region covers approximately 6,425 square miles and includes the counties of Derbyshire, Leicestershire, Lincolnshire, Nottinghamshire, 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 in 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.

Two of the UK's mainline railways serve the region, providing regular high-speed services, and there are 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 service

Our annual turnover is £158 million (2015/16) and we are commissioned (paid) to provide services by 22 Clinical Commissioning Groups (CCGs) based across the East Midlands. We deal directly with the A&E contract lead in NHS Hardwick CCG which represents the other CCG's in the region.

We employ over [update at end of year] 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 (see the new services and innovation section of this Account for more information on PTS developments).

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

Every day we receive approximately 2,000 calls from people dialling 999 and from other healthcare professionals making urgent transport requests.

During 2015/16, our clinicians responded to [update at end of year] calls in our Emergency Operations Centre, and dispatched ambulance clinicians to the patient using our fleet of [update at end of year] vehicles.

We also use [update at end of year] Patient Transport Service vehicles and [update at end of year] 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.

- Hazardous Area Response Team (HART): a dedicated team providing specialised cover for civil contingencies, major incidents and Chemical, Biological, Radiological and Nuclear (CBRN) incidents.

- 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.

- Bariatric transfers: specialist services and equipment to transport bariatric patients (our bariatric ambulances can transport patients with a weight of to 50 stone).

- Cycle Response Unit: these individuals carry the same essential life-saving equipment as a fast response car and can reach patients even faster in congested areas. Patients can often 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.

- Events Support: a commercially available team that provides support to special events such as sporting, musical and athletic showcases across the region.

- Admission Avoidance Schemes: provided through a number of schemes across the East Midlands including Falls Partnership Services and Mental Health Nurse and EMAS Paramedic in a car.

Review of quality improvements for 2015/16

This quality account demonstrates our achievements for the year 2015/16 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 2015/16 priorities

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

- Clinical effectiveness
- Patient safety
- Patient experience

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

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.

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

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.

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 a particular focus on delayed responses.

Priority 6: Develop a robust patient forum group and strategy that will ensure that we are working with all of our local communities.

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.

In this quality account we evidence how these priorities have been met and are progressing.

Commissioning for Quality and Innovation (CQUIN)

Further funding for EMAS's income in 2015/16 was dependent upon achieving quality improvement and goals through innovation. These have been agreed through EMAS and NHS Hardwick 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 five schemes and have provided evidence of how these schemes will have impacted on the quality of care that we provide as well as how the work will continue to be supported.

- **Paramedic Pathfinder:** This scheme was introduced in 2014 and rolled out across our service to allow clinicians on scene to access the most appropriate health service available for the patient. Whilst the introduction of Paramedic Pathfinder has been instrumental in reducing the number of patients transported to hospital Emergency Departments (ED), it is incumbent upon EMAS to support efforts to manage patients within the community where it is deemed clinically appropriate and will improve patients outcome and experience. The development of the scheme aims to build upon the success in 2014/15 with a review of alternate pathways across the whole East Midlands. We will be providing commissioners with a broader understanding of the options available to frontline ambulance clinicians, identifying the gaps in provision and capturing which schemes are perceived to be the most successful and clinically effective. In addition, EMAS is keen to develop and pilot a broader range of Pathfinder algorithms to support ambulance clinicians in dealing with patients whom have a greater clinical risk. Following audit and review and on the assurance of their safety and clinical effectiveness, these can then be adopted into future clinical practice in the subsequent year.

- **Mental Health:** Frontline ambulance crews are currently poorly equipped to deal with patients who present with mental health conditions. We will support the educational development of frontline staff with the aim of managing patients presenting with a mental health crisis more effectively and avoiding conveyance by utilising local mental health services. It is proposed that as part of this process an educational package is developed and delivered with key identifiable milestones for achievement, supporting and underpinning frontline staff's knowledge and experience. By utilising this extra skill set our crews will develop more confidence in their own abilities to sign post patients and their families to appropriate receiving facilities rather than transport to ED.

- **Quality Everyday:** Quality Everyday is a method of ensuring that we are focussed on quality at every opportunity. It helps ensure that everyone understands their responsibility to deliver a high quality service. The purpose of Quality Everyday is to provide crews, stations and departments with a coordinated, comprehensive and up to date range of standards which can be measured, providing accurate and timely feedback.

- **Frail Elderly Liaison Officer (FELO):** The FELO scheme is to provide support and care for patients in the community who are frail and elderly. The FELO roles have been to work and facilitate a multi-agency approach to prevent avoidable admissions to the Emergency

Department. Clinical care packages have been designed around an individual's needs. The initiative has been focussed on care, residential and warden controlled facilities.

- **Community Access Defibrillators:** There is a great deal of strong clinical evidence to illustrate that the provision of early basic life support and timely defibrillation can significantly improve the likelihood of a positive outcome. Having access to this vital equipment could have significant improvements in survival rates for patients in the community. By active partnership working, we can strengthen our working relationships in the communities we serve.

New services and innovation

Patient Transport Service

During 2015 the Patient Transport Service for Derbyshire was put out to tender by commissioners. After a lengthy, competitive process, we were announced as preferred bidder in November 2015. Since then EMAS and commissioners have discussed the final contract arrangements. Subject to signing of the contract, the proposed go live date for the new service is currently 1 August 2016.

Blue light services join forces

A new pilot scheme saw EMAS and fire services based in the region work together to save more lives, by launching the UK's first regional Emergency First Responder scheme.

Demand on the Ambulance Service is increasing by approximately 6% year on year. Thanks to successful electrical product safety, public education and safety campaigns, the traditional demand on the fire service is reducing which is why they are able to support this pilot.

EMAS receives a new 999 call every 43 seconds, and in an emergency seconds count. An Emergency First Responder (EFR) is dispatched at the same time as an ambulance and does not replace the usual emergency medical response from EMAS. However, the location of the EFR within local communities could mean they are nearer to the scene in those first critical minutes of the emergency, to deliver life-saving care until an ambulance clinician arrives.

EMAS has trained each EFR to enhance their existing medical care knowledge. They have been trained in basic life support, cardiopulmonary resuscitation (CPR) and oxygen therapy. The EFRs are equipped with a kit which includes oxygen and an automated external defibrillator (AED) to help patients in a medical emergency such as a heart attack, collapse or breathing difficulties. They respond to medical emergencies in a liveried fire and rescue EFR car.

The scheme with all six East Midlands based fire services officially launched in June 2015. There are 23 fire stations involved (Derbyshire: Buxton, Dronfield, Matlock and Staveley; Humberside: Crowle, Kirston Lindsey, Epworth and Winterton; Leicestershire: Ashby, Billesdon, Market Harborough and Uppingham; Lincolnshire: Donington, Mablethorpe, Saxilby, Skegness and Sleaford; Northamptonshire: Daventry, Kettering, Rushden and Wellingborough; and Nottinghamshire: Newark and Harworth).

The clear ambition of this pilot is to improve the survival rate for people who suffer from a cardiac arrest in the community. Data from the pilot is being reviewed on a monthly basis and we are currently in discussions with the fire service about extending the area covered by this scheme.

Mental health

Following the recruitment of 2 mental health specialists at EMAS, we are developing training sessions and our services to better support staff and our patients.

Some of the projects we are involved in include: the development of a collaborative street triage approach in line with the crisis care concordat principles, better and wider promotion of mental health awareness, provision of a training package on a compassion focused approach to mental health for colleagues in our Emergency Operations Centres, partnership working with the Samaritans on suitable proportionate signposting as clinically indicated, interpreting and learning lessons from risk patterns related to mental health incidents.

In addition we have developed a mental health workbook and disseminated it to all frontline operational staff, to further support our communications campaign to raise awareness.

We have developed a Safe Holding (restraint) Policy which has been presented to the Clinical Governance team for sign off. This links to our work to develop an accredited training package through a national provider on low level physical intervention techniques.

A mental health Directory of Services is being produced in partnership with local commissioners to establish suitable signposting options. We are also developing a dedicated mental health conveyance policy and evidence need with commissioners based on partnership feedback.

EMAS managers are being supported through training and advice to help them recognise and provide support to staff who are experiencing mental health problems. This is supported by close collaboration work with our 2 mental health specialists, equality and diversity mananger and chaplain and health and wellbeing lead.

New processes and technologies

The NHS is facing huge challenges and changes in the forthcoming years and EMAS needs to adapt and reflect this in the way it operates.

Moulding our services around patients is one way to achieve this, as is the development of current models of service and new service offerings.

As well as responding to formal tender opportunities, such as the Derbyshire Patient Transport Service contract mentioned earlier, we continue to engage with CCG's and Transformation Groups across the East Midlands to propose organic service changes.

These changes can be staff related or for example through the introduction of new processes or technologies, such as:

- Remote patient monitoring through telehealth equipment, targeting patients who may have certain conditions such as Chronic Obstructive Pulmonary Disease, diabetes etc, where on-going monitoring is seen as beneficial but can be achieved using technologies and via a web based monitoring platform prior to any physical care interventions.
- Introduction of the Enhanced Clinical Assessment Team in our Emergency Operations Centre to deliver patient care better in non-emergency department settings and reduce demand across the health community. The first service for this initiative went live for Northamptonshire on 29 February 2016.
- A holistic falls assessment protocol. Additional training for frontline clinicians is delivered in cooperation with Northampton University to better assess patients who have suffered a fall but may not require transporting to an Emergency Department. This initiative links across all service providers to deliver the right care as well as identifying prevention opportunities to avoid further falls for the patient.
- Collaborative working with other healthcare providers both in the NHS and private sector to capitalise on key strengths and build the EMAS activity portfolio, staff capabilities and operational resilience.

Enhancing quality improvements and assurance

During 2015/16 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 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, key lines of enquiry, and other pertinent legislation or clinical initiatives.

Quality Everyday was introduced in 2015 as a 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. It has now evolved into a robust programme of engagement with senior managers and staff who embark on a quality assurance process which identifies issues locally and through active challenges aims to ensure all key lines of enquiry are acted upon. Quality Everyday provides ambulance crews with a comprehensive, up-to-date range of standards which can be measured, allowing for timely and accurate feedback.

Four strands are included in *Quality Everyday*.

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

The *Quality Everyday* noticeboards and updates help improve communication 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 people involved), as well as local clinical updates and performance standards data.

What we want to do better in 2016/17

At EMAS we are working hard to bring about significant improvements to the services we provide. We actively listen to all our colleagues, patients and stakeholders to act on things that did not go well, and also those that had a good outcome, to learn from and reflect on the services we provide.

As in 2015/16, we have identified three domains of quality

- **Clinical effectiveness**
- **Patient Safety**
- **Patient Experience**

Against those we have set five quality improvement priorities for 2016/17.

Clinical effectiveness	**Priority 1:** Cardiac arrest – return of spontaneous circulation (ROSC) and survival outcomes. EMAS has continued to focus its attention upon the improvement of successful ROSC rates in cardiac arrest. During 2016/17 we will: • Continue to develop and improve our cardiac arrest outcomes. • Continue to see our Ambulance Quality Indicators and outcomes around stroke, COPD and asthma improve. • Also see an increase in the presence of frontline clinical supervision to all active resuscitation attempts. **Lead: Medical Director**
Patient safety	**Priority 2:** Sepsis is a worldwide public health issue. In developing nations, Sepsis is the leading cause of mortality, accounting for nearly 80% of deaths. Sepsis kills far more citizens than AIDS, prostate cancer and breast cancer combined. During 2016/17 particular focus will be to: • Identify and treat Sepsis within our patients. • Ensure the formalisation of the EMAS Sepsis Lead, including

	documented objectives and performance measures. • Appoint divisional Sepsis champions (one per division) on a volunteer basis. • Develop a robust action plan to ensure the availability of waveform capnography on a minimum of 95% of frontline operational resources (double crewed ambulance & fast response vehicle). • Work with a partner acute trust to explore the increased pre-hospital use of IV antibiotics in the treatment of Sepsis. **Lead: Director of Quality and Nursing**
	Priority 3: To identify the common themes of all maternity related incidents, and to reduce patient related incidents: • We will aim to see a reduction in severity of all maternity related incidents within our care. • Receive an improvement on aspects of clinical care from maternity units. • Educate all operational workforces in maternity related training. This will be measured by current level of harm, complaints, Serious Incidents, feedback from patients and service users. **Lead: Medical Director**
	Priority 4: To explore the use of alternative pathways in each division by using the pathfinder leads to develop the pathways in each EMAS commissioning area. **Lead: Director of Quality and Nursing**
Patient experience	**Priority 5:** Having signed up to the Mental Health Crisis Care Concordat, we will work collaboratively with local commissioners and relevant stakeholders to implement the agreed priorities within the mental health steering group. We will:

	• Continue to build mental health pathways in all divisions • Embed parity of esteem in EMAS for all patients presenting with mental health issues. • Ensure that these patient groups receive an appropriate response and are signposted to the appropriate receiving facility. • Improve the awareness of mental health conditions with our staff. **Lead: Director of Quality and Nursing**

Evidence of quality improvements for 2015/16

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

Aim	What we did	What we have achieved	Quality Indicators
• 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	EMAS undertook a full review of the alternative care providers to understand the available options for patients to be referred into. A mapping exercise to identify where gaps in provision exist aligned to the calls that EMAS attends. Developed proactive relationships with alternative care providers to initiate discussions and streamline the process of patient referral into these services. Creation of a number	We now have a complete understanding of the options available to all frontline crews for patients who can be managed closer to home. Full mapping of these pathways by CCG area, against the presenting condition of the patient. Production of v3 of the Paramedic Pathfinder Pocket book to be on hand for clinicians when they need to seek options for referral in their area.	Progress of each of these actions and their outcomes is reported through the quarterly CQUIN reports. These reports are shared with Commissioner Colleagues through local Collaborative Commissioning and Quality Assurance Group meetings.

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.	of condition specific Paramedic Pathfinder algorithms to support clinicians in managing patients within community settings. Continued the programme of clinical training for staff in the Paramedic Pathfinder Tool.	Implemented four pilot schemes to test out the new condition specific Paramedic Pathfinder algorithms. Training of all relevant clinicians in the Paramedic Pathfinder Triage Tool.	

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.

Aim	What we did	What we have achieved	Quality Indicators
To develop a frail elderly steering group which will work with partnership with commissioners and acute providers within the East Midlands region. To work collaboratively with residential and nursing homes to ensure that residents can access care and	We have developed the frail elderly steering group which incorporates end of life care with representation from key stakeholders including Age UK and care homes. In Northamptonshire we have developed a Frail Elderly Liaison	By reviewing our current falls service we have identified the optimum model of care for our patients. We have also reviewed our end of life care pathways and are working with our commissioners regionally to	Appropriate pathways to ensure patient s can access local services and reduce admissions. Reduced admissions and development of education and training.

support.	officer who works with local care homes and universities to ensure residents can access appropriate health care in their local community and prevent inappropriate admission to hospital.	ensure that best practice is adopted, by ensuring that the key principles of growing old together are adopted. (Improving Urgent Care for Older People, NHS England)	

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.

Aim	What we did	What we have achieved	Quality Indicators
To concentrate on implementing the mental health triage car in Lincolnshire and to expand the role across the East Midlands. To ensure that our staff in EOC have mental health training in our clinical assessment teams To produce and agree local mental health awareness for all our staff.	Recruited two mental health specialists who have assessed the educational needs of our staff and designed and developed bespoke educational packages for the Trust. These include the mental health workbook, safer holding technique and suitable pathways for patients. They have enhanced the communication skills of staff to enable them to assess and signpost those patients accessing our services who have mental health needs.	A mental health strategy that has been agreed and monitored by commissioners through our mental health steering group. Delivered bespoke training to our EOC and CAT teams, agreeing on an educational strategy that incorporates safer holding techniques and a mental health workbook. Active partnership engagement with our stakeholders through partnership working and Crisis Care Concordats.	Reduced admissions and conveyance to inappropriate care providers. Parity of esteem in the Trust through our strategy, monitored through the mental health steering groups. We have representation and involvement within each locality.

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

Aim	What we did	What we have achieved	Quality Indicators
Completion of pit crew training for cardiac arrest management. Increase the presence of fronline clinical supervision to all active resuscitation attempts. Conclude the evaluation of mechanical CPR devices and determine use	Continued expansion of the pit crew strategy for cardiac arrest management. Adopted new pieces of equipment into practice to reduce the inefficiencies during cardiac arrest scenarios. Developed pre and post ROSC pathways for Heart Centres to increase the number of eligible suitable patients. Concluded the evaluation of mechanical CPR devices and reviewed this against the 2015 Resuscitation Council Guidelines.	Provided a consistent and sustained improved ROSC performance throughout the year. Introduced the pre and post ROSC pathways into two of the region's Heart Centres.	Monthly reporting of the ROSC and Survival to Discharge (STD) rates through the Ambulance Care Quality Indicators

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 a particular focus on delayed responses.

Aim	What we did	What we have achieved	Quality Indicators

Having signed up to safety campaign our trust will work to reduce avoidable harm for patients presenting with mental health conditions, maternity related incidents, and reduce adverse incidents in EOC with a particular focus on prolonged delays.	Identified our work streams and agreed priorities. Set agreed action plans to reduce harm over the three year period.	Base line data on each aspect of harm, and identified individual clinical leads to drive the relevant actions that have been determined to reduce harm	Monitored through QGC

Priority 6: Develop a robust patient forum group and strategy that will ensure we are working with all of our local communities.

Aim	What we did	What we have achieved	Quality Indicators
Develop a robust patient strategy and forum group that will ensure we work together to develop patient engagement events and have patient representation in key EMAS meetings, to ensure that the patient voice is representative.	Patient and Public strategy in place. Patient Voice forum has been formed and an agreed work plan has been ratified that incorporates a review of our patient complaints process with an agreed schedule of quality visits to ensure a strong patient voice within EMAS. At the AGM we launched the group and encouraged patients to join in order to enhance our patient representation. There are patient representatives on the relevant meetings i.e. Frail Elderly and mental health steering groups.	Strengthened our Patient Voice group by increasing the representation and strengthened the terms of reference to ensure a strong voice within EMAS. Agreed work plan. Patient Representation on key groups Undertaken Quality visits. Provided a patient perspective on key policies and procedures. Reviewed our complaints process and reviewed actual patient complaints	

		to ensure that we are responding appropriately to patient concerns and experiences.	

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.

Aim	What we did	What we have achieved	Quality Indicators
To continue the roll out of the 'Hello my name is' campaign and to relaunch the Dignity campaign sharing the importance of the dignity pledges and beliefs.	Developed a compassion in practice steering group which has developed a work plan that incorporates the Peer to Peer support with the 'Hello my name is' and dignity pledges to ensure triangulation of actions that enable staff to be treated compassionately, ensuring that patients are treated with dignity and respect. This also is congruent with our Trust values.	We have continued with the roll out and promotion with 'Hello my name is'. During the induction process for staff we have a session on the programme that promotes dignity, respect and the trust values. We have continued to highlight to staff the dignity pledges that we have signed up to ensuring that they remain at the centre of patient care and staff welfare We have appointed an Equality and Diversity manager who is working across the Trust to embed our Trust values and introduce the	Compliments and complaints Quality Everyday Audit visits. Staff surveys Equality and Wellbeing group.

		Equality Delivery System into the Trust.	

What have we done to improve patient safety?

Learning from incidents, experiences and feedback

At EMAS we have an open and honest approach that we proactively communicate to our staff, encouraging them to report good and poor practice. EMAS has a robust reporting system in place where staff can report issues and be confident that they will be taken seriously. This method of reporting helps us to identify learning opportunities ensuring that we learn from mistakes to reduce the risk of it occurring again or replicate best practice into other areas.

Learning is also identified through investigating untoward incidents, serious incidents and complaints. Other sources are patient surveys, compliments, community events, patient focus group and 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 to learning and promote the learning outcomes across the service.

Duty of Candour

EMAS' priority is to deliver safe, prompt care to our patients. We are committed to openness and will always tell patients if something has gone wrong during their care. We encourage a culture which involves acknowledging, apologising and explaining when things go wrong, conducting thorough investigations and ensuring that lessons learned assist in future incident prevention and providing support for those involved. All front line staff will be receiving Duty of Candour training to embed our commitment to openness.

Quality Visits

Quality visits are how the Trust Board members have the opportunity to see what goes on in the Trust by observing patient safety experience and effectiveness.

All the 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.; Falls team, fleet and logistics, HART HQ

The purpose of the 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

In 2015/16 a total of XXX visits have been undertaken. These visits have been proven successful in engaging frontline staff and providing a board to floor approach where the senior leaders at EMAS engage with operational staff and listen to their concerns.

A template is completed by the Board member to record feedback which is collated into a report and the actions are addressed. The information collated during 2015/16 tells us the following:

What's good?

- Patients were well cared for with their dignity respected by being covered and spoken to kindly.
- Crews were observed to be caring and compassionate to patients and family members.
- One of the visits undertaken by an Executive observed care being delivered to two children and their parent which they felt was positive; the children and their parent given explanations of care.
- 'Rapid turnover' pilot observed as working well in one of the local Emergency Departments.
- Ambulances were observed as being clean and within their deep clean cycle.
- Medicine boxes were secure.
- Equipment was seen to be replaced diligently.
- Consent was observed to be gained by crews before undertaking interventions.
- Patients seen to be treated as individuals and their individual needs taken into account; observed special attention being given to a patient with dementia.

What could be improved?

- Continued education of public on appropriate use of ambulance and 999 calls.
- Ensuring numbers and skill mix meet the demand of the service.
- Joint quality visits by an Executive and a Non-Executive Board member.
- The Executive Board member to be assigned to an area that they are less familiar with.

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 to

identify and put in place actions to reduce the risk of recurrence. XX of all patient safety incidents (including SIs) reported during 2015/16 resulted in low or no harm which indicates a healthy reporting culture. During the year, EMAS identified XX serious incidents requiring investigation. The general themes are:

1. [enter detail at year end]
2. [enter detail at year end]
3. [enter detail 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. 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 the Board to frontline staff. It 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.

Improvements in Safeguarding

Safeguarding remains a priority within EMAS from Board to frontline with the view that safeguarding is everybody's business. EMAS continue to remain committed to the agenda evidenced by increasing referral levels; 2014-2015 saw a higher referral rate with 11414 referrals and 2015-2016 already appears to have even higher numbers. The Safeguarding Triage team enable EMAS to maintain a 24/7 service for all staff who need to raise referrals, they have doubled in size from 5 staff members to 10, enabling more effective and efficient information sharing with health and social care colleagues. The safeguarding coordinators continue to play a vital role coordinating and collating information for EMAS multiagency partners as well as supporting the triage desk.

The Care Act 2014 provided adult safeguarding with a statutory framework for the first time. EMAS have embraced this and updated the policy and procedures accordingly. Staff are given updates on the Care Act through bulletins and will be receiving additional training in the coming months. To further support the changes through the care act EMAS have set up new partnership pathways with the three of the fire services within the region. This enables home assessment by the fire service for those most vulnerable in our society who has two or more fire risks. There is on-going work to look at how this service can be provided across all five regions of EMAS.

The Safeguarding Children's and Young Person Policy was updated to reflect the changes within Working Together 2015. Rapid Response to Child Death is now embedded within the service with referral being made for all children who die or have a poor prognosis, and staff being provided support on scene and as part of the Trauma Risk Management (TRiM) process. EMAS are working on expanding frontline staff working knowledge of female Genital Mutilation (FGM), honour based violence and forced marriage. EMAS have reviewed the themes and lessons learnt from the NHS investigations into matters relating to Jimmy Saville. Following a benchmarking process EMAS are assured that they have taken on board the recommendations that are applicable to provider organisations to ensure we are aware of potential risks from personalities such as Saville and can manage these appropriately. EMAS have received communication regarding the Goddard Enquiry and have ensured that records are protected so that the organisation is able to fully support the inquiry should it be required.

The Safeguarding team continue to play a vital role in educating all new staff joining EMAS and supporting the work force plan with safeguarding induction training. This is being provided by the safeguarding team as well as organisational learning. The education delivered was written and developed by the safeguarding team and has been quality assured by four Local Safeguarding Boards (LSB). The education provided to our staff is unique to EMAS, and provides ambulance centred approach, which supports our call takers and our frontline staff. The Safeguarding Leads and Head of Service for EMAS have contributed towards 53 Serious Case Reviews, SILPs and Domestic Homicide Reviews during 2014-2015 promoting EMAS culture of openness and honestly and supporting multiagency working and learning.

East Midlands Ambulance Service NHS
NHS Trust

Emergency Care | Urgent Care | We Care

East Midlands Ambulance Service NHS
NHS Trust

Emergency Care | Urgent Care | We Care

Evidence for improvements in clinical effectiveness

Part of ensuring good Clinical Governance, is through Clinical Audit. This provides the means by which the Trust ensures 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

Clinical Audit and Research is led by our Clinical Audit and Research department which reports to the Clinical Governance Group. The department is responsible for developing EMAS' clinical audit programme and ensures that all necessary support for the undertaking of clinical audit is readily available to staff and that progress is monitored.

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
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

Through clinical performance indicators both national and local our clinical care is assessed and monitored as improvement plans are put into place. The Clinical Audit department works closely with clinicians in order to ensure quality clinical care is embedded into the care we give to our patients.

The department has a pivotal role in ensuring that 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.

Clinical Audit and Service monitoring plan 2015/16

Audit/monitoring activity	Type	Timescale	Notes	Progress
National Clinical Performance Indicators (nCPIs)	Mandatory - national audit requirement	As per nCPI programme (see appendix X)	National report completed by EMAS Clinical Audit & Research Co-ordinator Topics: • Asthma • Falls in elderly patients • Febrile convulsions • Lower limb trauma. Data collection, analysis of local and national data, report / template preparation and dissemination.	These audits are completed according to the cycle times and presented in the quarterly Clinical Effectiveness report. The most recent report is quarter 2 which overall shows satisfactory progress to improved quality of clinical care. Where improvements

				are necessary there is an improvement Plan which shows improvement activity. Data collection has also commenced for a pilot Mental Health/Self Harm nCPI.
Local Clinical Performance and Quality Indicators (LCPIs) – SPC run charts and data tables	Discretionary – local clinical audit project	Monthly	Audits completed by Clinical Audit Department. Topics: • Asthma • Cardiac arrest return of spontaneous circulation (ROSC) • Cardiac arrest survival to discharge • End-tidal CO2 (ETCO2) monitoring • Exacerbation COPD • Falls in elderly patients • Febrile convulsion • Lower limb fracture • Suspected fractured neck of femur • STEMI • STEMI PPCI within 150 minutes • Stroke/TIA	These are local audits which agreed as part of the clinical audit programme at the beginning of the year. The results are presented at the Clinical Governance Group. The audits are broken down to show the position of the different counties,

			• Stroke (FAST positive) arrival at hyperacute stroke centre (HASU) within 60 minutes. Data collection, analysis, breakdown by county, report preparation and dissemination.	so that local improvement can be monitored. All stated audits have been completed to time and target and are on-going.
Local Clinical Performance and Quality Indicators (LCPIs) – SPC funnel plot locality comparisons	Discretionary – local clinical audit project	Quarterly	Audits completed by Clinical Audit Department. Topics: • Asthma • Exacerbation COPD • Falls in elderly patients • Febrile convulsion • Lower limb fracture • Suspected fractured neck of femur • STEMI • Stroke/TIA Data collection, analysis, breakdown by locality, report preparation and dissemination	The results of these audits are as above but shown in a different way. The report layout has been updated to show findings in a table rather than showing the funnel plots used to analyse the data.

Audit/monitoring activity	Type	Timescale		Progress as at December 2015
Ambulance Clinical Quality Indicators (ACQIs)	Mandatory – national performance monitoring	Monthly as per NHS England timetable (see appendix 2)	Audits completed by Clinical Audit Department Topics: • Cardiac arrest (ROSC and survival to discharge). • Stroke (care bundle and arrival at hyperacute stroke centre (HASU) in 60 minutes). • STEMI (care bundle, PPCI within 150 minutes). • Data collection, analysis, report preparation and submission to NHS England/Unify.	These audits are reported in the quarterly Clinical Effectiveness Report, quarter 2 having just been completed and presented at Clinical Governance Group. For Cardiac Arrest (ROSC) there has been a significant step change, which shows improvement over several months.
Clinical Effectiveness Report	Mandatory local service monitoring	Quarterly	Report completed by Clinical Audit Manager • Report that collates all CPI and AQI metrics for the quarter, along with information relating to audit methodologies and criteria, and a clinical effectiveness improvement plan.	The Clinical Effectiveness Report Quarter 2 has been completed and presented to

				Clinical Governance Group. The report has been updated to reflect the new EMAS report template.
Cardiac arrest annual report	Discretionary local audit / evaluation New Audit report	Annual	Completed by Clinical Audit and Research Co-ordinator • Annual report covering treatment of and outcomes for cardiac arrest patients.	Report for 2014/15 completed and published. Data collection for 2015/16 underway.
Controlled drugs storage and management audit	Local service monitoring	Bi-annual	Audit completed by Accountable Officer for Controlled Drugs for the Trust • Monitoring of correct storage and management of controlled drugs in line with misuse of controlled drug regulations	This audit has been completed and presented to Clinical Governance Group. There are no significant findings.
Controlled drugs usage audit	Local service monitoring	Annual	Report completed by Accountable Officer for Controlled Drugs • Monitoring the use of controlled drugs in line with the duties of accountable officers.	This audit has been completed and presented with the above report to Clinical Governance Group. There are

				no significant findings.
Trigger Tool Audit	Local Clinical Audit project	Quarterly	Audit completed by Clinical Team Mentors. • Monitoring of agreed criteria essential for quality patient care.	Trigger Tool Report for Quarter 2 presented to Clinical Governance Group. The results show that over 90% of records audited have no triggers.

So how are the Clinical Audits done?

Clinical Audits are carried out by the Clinical Audit team, using the methodology laid down in the Clinical Audit Policy. Wherever it is possible clinical staff are encouraged to be involved.

The Clinical Audit team collects, scans, and validates all patient report forms (PRFs) for the topic areas listed to ensure that the extracted data is correct, and that free-text areas have been captured. Both electronic and paper patient report forms are included. The validated data are analysed, checked for anomalies, presented in various formats, and disseminated to stakeholders.

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, and lower limb fracture and a new assessment of falls in the elderly - 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 clinical effectiveness report, which compares performance by locality, and brings together all EMAS' clinical metrics in one summary document.

The projects described on the Clinical Audit & Service Monitoring Plan 2015/16 are complete (or are a continuous requirement and are up-to-date). The team also provide clinical information and reports for a number of unplanned and ad-hoc requests, such as freedom of information requests and coroners requests.

To show how the assessment is done the table below gives the definitions for the ACQIs.

Ambulance Quality Indicator	Definition
Cardiac Arrest – ROSC	Of patients who had Advanced or Basic Life Support (ALS/BLS) commenced/continued by ambulance staff following an out of hospital cardiac arrest, the percentage that had a return of spontaneous circulation (ROSC) on arrival at hospital.
Cardiac Arrest – survival to discharge	Of patients who had Advanced or Basic Life Support (ALS/BLS) commenced/continued by ambulance staff following an out of hospital cardiac arrest, the percentage that survived to discharge from hospital.
STEMI – time to PPCI within 150 minutes	The percentage of patients with initial diagnosis of 'definite myocardial infarction' for whom primary angioplasty balloon inflation occurs within 150 minutes of call connected to ambulance service, where first diagnostic ECG performed is by ambulance personnel and the patient was directly transferred to a dedicated PPCI centre as locally agreed.
STEMI _ care bundle	The percentage of STEMI patients who received all appropriate interventions from the attending ambulance clinicians.
Stroke – time to hyperacute stroke unit within 60 minutes	The percentage of FAST positive stroke patients (assessed face to face) potentially eligible for stroke thrombolysis within agreed local guidelines, who arrive at a hyperacute stroke centre within 60 minutes of call connecting to the ambulance service.
Stroke – care bundle	The percentage of stroke patients who received all appropriate interventions from the attending ambulance clinicians.

National Clinical Performance Indicators (nCPI)

The National CPIs have seen changes during the year as a new National CPIs are developed and piloted. They are falls in elderly people and mental illness. The reports give 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, examples of which are described below:

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

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 anticonvulsant if appropriate
V4 Temperature management recorded
V5 Appropriate discharge pathway recorded

The local CPIs for Chronic Obstructive Airways Disease and fractured neck of femur use a similar methodology as the national CPIs. The table below describes the criteria.

CPI	Inclusion Criteria	Exclusion Criteria	Criterion & Inclusion Criteria
Chronic Obstructive Airways Disease (COPD).	Emergency patients suffering from acute exacerbation of COPD.	Transfers Patients whose symptoms resolve prior to ambulance arrival ECP follow up visits after patient has already been treated for the acute episode by a crew.	**C1 Respiratory rate assessed** Where respiratory rate is recorded on the patient record. Can be taken at any time during patient assessment. **C2 Oxygen saturation (SpO2) recorded before treatment** □□Must be recorded before treatment □□Benefit of doubt is given to incidents where observations are carried out within a few seconds of administration of drugs. □□If no treatment is recorded but an SpO2 reading is, this scores a 1. □□If patient (or someone else on scene) has administered treatment before crew's arrival but an SpO2 is recorded this scores a 1. **C3 ECG performed** □□May be a 3 or 12 lead ECG **C4 Beta-2 agonist administered** □□Includes administration of by health professional or patient unless stated that this was NOT EFFECTIVE N.B. Beta-2 agonist in use at EMAS is Salbutamol **C5 Oxygen administered appropriately** □□Where oxygen was administered appropriately for COPD patients – includes cases where O2 was **not** administered because the patient's oxygen saturation was satisfactory i.e. >= 88% □□Includes cases where salbutamol is given by the crew as this is via oxygen driven nebuliser. □□Includes cases where patient is on home oxygen or has been given oxygen prior to crew's arrival. □□Where the patient has not received oxygen via a nebuliser, it must be given only if

			SpO2 is <88%. □□For SpO2 85-87%, 2-6l/min should be administered via nasal cannulae or 5-10l/min via a simple face mask. □□For SpO2 <85% 15l/min should be administered via a reservoir mask.
N Suspected fractured neck of femur (#NOF)	Emergency patients suffering from suspected fractured neck of femur	Transfers	**N1 Heart rate assessed** **N2 Blood pressure assessed** Full blood pressure required - Systolic and Diastolic **N3 Two pain scores** Incidents where two pain scores have been recorded at any time prior to arrival at hospital. The initial pain score must be a number between 0 and 10. The second pain score can be expressed in any of the following ways: □□A number between 0 and 10 □□A visual pain score (this applies to ePRFs and appears as 'the worst pain' or 'a little pain' under the pain part of the vital signs). □□A statement in the free text like 'pain reduced after treatment' or 'pain relieved after treatment' (or 'pain increased after treatment') □□An entry in the Treatment/Reassess section on the ePRF (near the drugs) that says something about pain having been reassessed. **N4 Morphine Given** **N5 Analgesia** N.B. Although paracetamol may also be given as an analgesic, it does not count for the purposes of this indicator. If morphine (or oramorph) is not appropriate, then entonox should be given.

Results and dissemination

These audit results are illustrated using Statistical Process Control methodology, where improvement can be measured over a period of time, with the aim of continuous improvement being seen. This method means the knee-jerk reactions are kept to a minimum, and special situations can be investigated.

The audit reports are presented to the Clinical Governance Group for discussion and approval. The Clinical Effectiveness Group will then form the actions for improvement which will be disseminated in their area. These will be gathered into an overall Improvement Plan which is monitored by the CGG, Quality Governance Committee and the Quality Assurance Group.

EMAS Research and Development

EMAS' 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 leads a prestigious £2 million National Institute for Health Research (NIHR) Programme for Applied Research: Pre-hospital Outcomes for Evidence Based Evaluation (PhOEBE) in partnership with the Universities of Sheffield, Lincoln and Swansea.

One of the drivers for increased Ambulance Service research in England has been the National Ambulance Research Steering Group (NARSG), set up in 2007. The role of NARSG is to set a strategy and develop the pre-hospital research agenda for Ambulance Services in England. 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, a further four funding applications have been successful and received funding from the NIHR programmes during 2015/16.

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

During the year EMAS has been involved in 17 research studies, some on-going and some which have been completed.

EMAS is collaborating in two major studies:

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). AIRWAYS-2 is an NIHR funded study designed to determine the best approach to the management of a patient's airway during an out of hospital cardiac arrest.

Rapid Intervention with Glyceryl trinitrate in Hypertensive stroke Trial (RIGHT2): Assessment of safety and efficacy of transdermal glyceryl trinitrate, a nitric oxide donor, and of the feasibility of a multicentre ambulance based stroke trial.

With these 2 studies and other smaller trials nearly a quarter of EMAS clinicians are now involved in research.

The EMAS research status table to date for year 2015/16 can be found at appendix 3.

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 above studies show the variety and scope of research in EMAS. However, 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. Over the year EMAS clinicians have presented papers or posters at 7 conferences both national and international, and there have been 3 journal publications.

What we have done to improve patient experience

Compliments

During 2015/16, we received more than XXXX expressions of appreciation from patients or members of the public. This is an increase 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 meetings 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.

Continuing improvements to the EMAS complaints system

Following the 2013 Francis Report into Mid Staffordshire NHS Foundation Trust and the Clwyd/Hart Report, EMAS carried out a review of the complaints process to identify actions to improve the way complaints were handled. This improvement has continued throughout 2015/16 as we benchmarked our processes and outcomes across other NHS Ambulance Services nationally, and with additional published advice from the Parliamentary and Health Service Ombudsman.

Changes implemented throughout both the PALS and Complaints and Investigation Teams, including the centralisation of processes and recruitment of additional team members, have helped the service to become more robust and to deliver a higher quality outcome for complainants. Improvement work will continue through 2016/17 to ensure that learning is identified and actions are implemented comprehensively across the Trust further improving the quality of patient care and the complaints service delivered.

Formal Complaints (FC)

During 2015/16, EMAS identified XXX formal complaints requiring investigation; XXX related to our Accident and Emergency Services (X.XXX% in relation to journeys provided or XX.XX complaints from per 100,000 journeys), and X to our Patient Transport Services (X.XXX% in relation to journeys provided or X.XX complaints from 100,000 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: [the themes may have changed at the end of this performing year]

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

Compliments and complaints received per county during 2015/16:

County	Compliments	Complaints
Derbyshire	XXX	XX
Leicestershire & Rutland	XXX	XX
Lincolnshire	XXX	XX
Northamptonshire	XXX	XX
Nottinghamshire	XXX	XX
Emergency Operations Centre	XXX	XX
Not specific	XXX	XX

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 2015/16, we received XX requests for information from the Ombudsmen. Of these, the Ombudsmen confirmed XX were not upheld, and XX remain open.

Patient Feedback

During 2015/16 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 XXX patients taking part in the EMAS Reputation Audit for 2015.

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

Six monthly postal patient surveys continue to be undertaken for the North and North East Lincolnshire Patient Transport Service (PTS) patients. Of the XXX surveys sent out during quarters 1 and 2 of 2015/16, we received XX responses (a XX% response rate). XX% of respondents 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 Net Promoter Score for EMAS came in at +XX for our 999 A&E services, and +XX for Patient Transport Service.

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 O's story, reported at the July 2015 EMAS Trust Board meeting:

Whilst being a legitimate PTS patient, Mrs O agreed to also be part of the mystery patient PTS survey. Mrs O recalls that she received appropriate training and guidance and was more than happy to participate. On 2 occasions during May 2015 Mrs O was transported from her home to hospital. Mrs O recalls travelling in four different vehicles, one of which was a private car driven by EMAS volunteer and three were EMAS PTS ambulances. Mrs O stated that all staff were friendly and courteous, introducing themselves to her on arrival. Mrs O reported that all vehicles were clean and comfortable. Mrs O also stated that she did not wait long for either of her 2 return journeys home. Mrs O recalls all staff ensured that her seatbelt was fastened and worn correctly, and that on arrival at home the staff saw her inside the front door of the main building.

Mrs O stated that the PTS booking service was good and helpful and also found the training and guidance offered to undertake the mystery patient survey to be good.

Mrs O has also had cause to call 111 several times recently and an EMAS ambulance has responded. MrsO states that: *the staff who attended were always quick and I was happy with the service*, adding that the crews were '*most fantastic'*.

Mrs O voiced her satisfaction with the service she received from EMAS PTS:

- On all occasions the service from EMAS was timely and pleasant.
- During all journeys the staff were polite, helpful and courteous.

Mrs O said: *'I have had good experiences with EMAS and would encourage others to take part in the mystery patient survey as they can help EMAS to improve. What I think is good, others might not.'*

Work is underway to recruit additional participants for the mystery patient survey to help to identify good practice and potential areas for improvement. Mrs O has agreed to take further part in the survey should she utilise the PTS again in future.

Mr O's story, reported at the December 2015 EMAS Trust Board meeting:

Mr O is 52 years old and lives with his wife. He is a retired retained fire fighter and a former member of the Air Force.

In January 2015, Mr O was outside his home cutting wood with an electric saw using the correct personal protective equipment. Whilst cutting the wood the saw hit a knot and the guard covering the blade was pushed aside. Mr O saw the fingers on his left hand go through the saw. He turned off the saw, went inside and grabbed a towel to wrap his hand, raising his hand above his head. Mr O felt shocked and shouted his wife for help.

Mrs O called 999 at 14.48 but struggled to convey the situation to the call taker due to her panic, so Mr O completed the call. Originally the call was correctly coded as Green 2 (30 minute response time) but was incorrectly downgraded to Green 4 (Clinical Assessment Team (CAT) call within 60 minutes). Mr O was informed that an ambulance would not be provided and to expect a CAT call within 60 minutes. At this time EMAS was in Capacity Management Plan level 3. A double crewed ambulance (DCA) was mobilised at 14.49 and allowed to continue travelling to the scene, arriving at 15.07, a response time of 21 minutes.

During the time between Mr O ending his 999 call and the DCA arriving, Mr O called 111 and was informed that they did not have the authority to override the 999 call decision. Mr O was still on the call to 111 when the DCA arrived. He said *'I felt totally isolated; there was no help or guidance. It was a massive relief when the ambulance arrived. The two ambulance men were professional to a tee, I couldn't fault them.'*

On arrival, when examining Mr O, the ambulance crew realised that he had completely severed the top half of his thumb and it was missing. They went back outside and located the missing digit transferring it to hospital with the patient. The DCA left the scene at 15.23. Mr O received Entonox and Morphine and chose to travel to the Royal Derby Hospital arriving at 15.39. Mr O experienced a good handover and no wait. Since his accident Mr O has undergone 3 surgeries and is currently receiving physiotherapy. Mr O has regained some movement, but unfortunately the reattachment of his thumb was unsuccessful. Mr O still wears a small protective cast in bed and outside of the house and is unable to use cutlery properly.

Mr O states: *'I felt totally let down by the initial 999 call. I felt like no-one wanted to know or help, I was close to despair.'*

PALS received the concern from Mr O following the incident voicing his disappointment with the service he had received from EMAS. Mr O was particularly unhappy with:

- The fact that such a serious injury could be coded as requiring such a non-emergency response.
- Poor communication – Mr O was informed that an ambulance would not be sent, however one had already been mobilised.
- The feelings of helplessness and despair experienced by Mr O when he was told that EMAS would not be sending help.

Mr O said *'I just don't want anyone else to experience what I went through that day.'*

When asked what message he would like to convey to EMAS as a result of his experience Mr O stated: *'I hope something can change as a result of my story to make things better for other patients.'*

When asked about his experience of PALS, Mr O stated: *'I was happy with PALS and the response I received. I had thought I might be fobbed off but I was proved wrong.'*

Two areas were identified as actions for the Training team during the PALS case investigation:

1. The 999 call should have remained as Green 2 and should not have been downgraded. A member of the Training team has addressed this issue with the staff member.
2. The dispatcher should have stood down the DCA mobilised to the call instead of allowing it to travel. Had the call been appropriately downgraded the DCA might have been required for another, more urgent call. A member of the Training team has addressed this issue with the staff member.

In addition to the actions above, following a suggestion made by Mr O at the meeting held with the EMAS Patient Safety and Experience Manager and the Head of Patient Experience and Engagement, the action below has been agreed with the aim of ensuring that if a patient or family is using the first telephone number provided when the CAT call to make a further assessment, there is another number to try. In Mr O's case, had the CAT tried to call back straight away Mr O would have been speaking to NHS111 and would not have been contactable on that telephone number.

Action	Lead	Deadline
Implement the recording of a second contact telephone number during 999 calls.	Head of Patient Experience and Engagement.	November 2015,

This story illustrates the importance of adhering comprehensively to AMPDS (the system used within the EMAS call centres to process and prioritise 999 calls), and the importance of effective, clear communication.

Extracts from messages of thanks during 2015/16

Letter from Ms B, Lincolnshire: **'***Thank you so much for the care and kindness you showed me last Thursday when I fell at the railway station. You were all wonderful and showed me nothing but kindness and compassion. I could not have been treated any better and I really did appreciate it. Thank you all for doing such a terrific job.'*

Mr AM from Northamptonshire said: *"The first responders who came out in the paramedics car were absolutely fantastic. Both were extremely good with my daughter, putting her at ease while they did what they had to do in assessing her. I wanted to message to tell you how great the paramedics you have on your staff were. She luckily hasn't fractured anything in her spine and is home safe and sound."*

Mrs JD thanked the three paramedics who attended her stepfather in Nottinghamshire in January. She wrote: *"I just want to thank you for the care, reassurance, patients and professionalism that you showed to and gave my stepdad, who I had found on the floor in his flat and was very ill. Thank you also for the way you all dealt with me - in a very compassionate and empathetic way. It helped to bring much needed calmness to the situation. Thank you once again for the service that we received and for your caring attitudes towards the patient, family and friend."*

We've received an email from Nottingham University Hospitals NHS Trust praising the care we give to children. The Children's Major Trauma Dashboard for July to December 2015 show that despite only having one major trauma centre in quite a large geographical region we get a good proportion of children there when compared to other areas. The hospital colleague said: *"EMAS are doing a very good job, and should be told so!"*

Mr VC, from Derbyshire, wrote: *"I wish to send our thanks for the wonderful help the ambulance crew gave to my wife; taking her to the hospital, giving her oxygen to help her breath and taking down details on her health for the hospital doctors. She was treated for pneumonia and is now recovered. I can't thank you both enough."*

Mr AL has praised colleagues in Leicestershire for the care they provided when his twin sons were born early and one needed an urgent transfer to Great Ormond Street Hospital in London. He said: *"The ambulance staff were great, especially those who took him down to London. The speed in which they sorted out an ambulance and the crew definitely had a role in saving his life."*

Extracts from 'could do better' messages

[examples – protecting patient's identity - to be included here]

Community Engagement

The Communications and Engagement Strategy for 2014-2016 was approved by the EMAS Trust Board in November 2014. Our 2015/16 stakeholder engagement plan saw us have a renewed focus on engagement with our Members of Parliament, following the election in May 2015. Through the year we continue to 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

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 2015/16, 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 2015, we conducted EMAS' second Reputation Audit. Just under 5,000 people responded to the audit, with 89% saying they were very satisfied or satisfied with the care received from EMAS. 89% of respondents said they would recommend EMAS to

friends and family, 90% said EMAS had improved in some way over the past 12 months, and 90% 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 stories and positive experiences with local, regional and, in some cases, national media.

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

Off duty paramedic hailed hero

Thanks to a Facebook appeal to 'find his hero' Nick Andrews from Matlock was reunited with the off duty paramedic who saved his life after a serious road traffic collision that closed the M6 for five hours.

Nick said: "Everything happened so quickly. Before I had time to lift my head Kelly was there. I was trapped in the vehicle and in a lot of pain but I didn't lose consciousness because she was there keeping me going. A doctor at the hospital said if I had gone to sleep or passed out I wouldn't have woken up. She truly saved my life and I will forever thank her."

Nick had broken 8 ribs, which had punctured his liver and lung and crushed his heart. His elbow and arm had also been crushed and had to be rebuilt.

Paramedic Kelly Topliss was on her way to West Midlands Safari Park with her family. "I didn't see the crash happen but I knew something was wrong because the traffic suddenly stopped. I got my florescent jacket out of the boot and went over to help."

Nick's wife Tracey said: "You take everything for granted knowing that we have an Ambulance Service. That day Kelly wasn't on duty, she didn't have to get out and do what she did. It shows what a dedicated selfless woman she is."

Derby resident thanks ambulance crew for restarting his heart five times

A Derbyshire resident met the ambulance crew that saved his life after restarting his heart 5 times during a sudden heart attack. EMAS paramedics were called by Kevin Payne, 36, after an onset of central chest pain during the evening in August.

“At first I thought it was heart burn or indigestion, as I’d been to the gym earlier in the day but the pain started radiating to both of my arms,” said Kevin. “It was getting worse and I was very clammy and sweaty- then it became more difficult to breathe.”

The ambulance crew arrived at Kevin’s home and immediately assessed that he needed urgent hospital treatment.

“On the way to the hospital, Kevin suffered a cardiac arrest in the back of the ambulance,” said EMAS paramedic Russell Nelson-Tempest.

“We performed CPR and actually had to use our defibrillator 5 times to shock and restart his heart during the journey. But thankfully, by the time we reached the hospital, Kevin had regained a pretty good level of consciousness.”

“I thank the ambulance crew that saved my life and helped keep me here,” said Kevin. “They do an incredible job and definitely deserve to be recognised for it.”

Special delivery for paramedic on New Year’s Eve

When Chrissy Lane went into labour on New Year’s Eve she didn’t expect to give birth to her daughter in her own home with the help of a paramedic.

Chrissy, 25, was 41 weeks pregnant (due on Christmas day) when she experienced a worrying bleed. Her husband Tom spoke to her midwife who advised him to call 999 and get Chrissy to hospital as soon as possible.

Northamptonshire paramedic Chloe Civil was nearing the end of her night shift when she got the call to respond. Expecting to be rushed into an ambulance and taken straight to hospital Chrissy was preparing herself to leave when Chloe examined her and saw the baby’s head.

“I remember Chloe telling me we wouldn’t make it to hospital” added Chrissy “I suddenly realised I would be having my baby at home. Chloe was so friendly, it felt so natural to have her there helping me.”

Around 10 minutes after Chloe arrived at the Lanes home, baby Hollie Christine Chloe Lane was born.

“We will always be grateful to Chloe for her involvement in our life. To say thank you we decided to give Hollie ‘Chloe’ as a middle name. We hadn’t considered the name before but wanted her to have a constant reminder of the lady who welcomed her into the world.”

Man had his heart shocked 17 times

When Yvonne Ainsworth found her partner collapsed at home last September she feared the worst. After calling 999 she realised he had gone into cardiac arrest and followed the call handler’s instructions to perform chest compressions to try and keep him alive.

Ambulance crews raced to the emergency. They worked on Patrick for over 50 minutes, using a defibrillator to shock his heart 17 times.

Paramedic Daniel Sneath was first on scene, he said: “Patrick was clearly a fighter. This was a real team effort and everyone on scene worked hard to keep him alive. As we were working on him he continued to show signs that his heart had started but then it would stop again. We kept going until we were able to stabilise him and he was then flown straight to Glenfield.

“By performing CPR as soon as she saw him collapse Yvonne gave Patrick the best chance. Her bravery should be commended for remaining calm in such a scary situation.”

Yvonne said: “Whilst I knew I needed to pump his chest I was terrified by what was happening. The 999 call handler (Joshua Selwood) was so calm and gave me clear instructions helping me stay in rhythm whilst reassuring me that I was doing the right thing. I couldn’t have done it without him.

“It is down to the call handler and paramedics that my Patrick is alive. Some of them had just finished a 12 hour shift but were still willing to stay with us, working on Patrick for over an hour during our moment of need.”

Equality and diversity

Equality, Diversity, Inclusion and Human Rights are at the forefront of our quality agenda. Valuing and promoting equality and diversity are central to the effectiveness of East Midlands Ambulance Service. Our ability to provide quality through equality depends on understanding the diverse communities we serve to plan and deliver services that take account of their needs. If we can fully engage with our communities they will have greater confidence in us and are more likely to accept our professional support and advice. An effective relationship with our communities is therefore vital to ensure both quality and equality.

We deliver a public service and have a duty to ensure equality of access, equality of impact and equality outcomes for all. In other words a service which equally meets the needs of all people we serve. For our staff the right to ensure equality of opportunity for all, to treat people with respect, dignity, fairness and to create a culture which benefits everyone. Underpinning this approach is legislation. The Equality Act 2010, the Public Sector Equality Duty and the Equality Framework (EDS2) help shape the quality agenda thus allowing for effective service delivery and community engagement.

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.

- ✓ Pre hospital sepsis screening tool revised.
- ✓ New medicine management procedure covering the recording, issuing and restocking of medicines to stations and vehicles.
- ✓ Cardiac arrest on scene checklist and addition of adrenaline PGD for haemodynamic support post return of spontaneous circulation.
- ✓ On-going work to further align acceptance criteria of ACP's to that of amber outcome on paramedic pathfinder to increase non conveyance with appropriate care. ACP's participating includes Skegness Urgent Car Centre (UCC), Ilkeston Community Hospital, Ripley UCC, Loughborough UCC and Nottingham UCC.
- ✓ Mental Health and suicide risk awareness training for our Clinical Assessment Team raising consciousness of appropriate priority to attend callers in crisis.
- ✓ Hospital handover delays Emergency Department Standard Operating Procedure
- ✓ Revised trigger tool used to audit 1:30 patient report forms with increased robustness of parameters around COPD management, capnography and pain management.
- ✓ Revised diagnosis of death procedure and resuscitation decisions policies to give greater emphasis and enablement for clinicians to respect the wishes of patients.
- ✓ Improved Mental Health triage and training packages for EMAS staff, designed to improve the triage and outcome of all mental health patients.
- ✓ Improved resilience for our Emergency Operations Centres in the event of the IT systems crashing. This includes better paper process, monthly system upgrades and testing of resilience and the introduction of tabards for specific roles.
- ✓ Early escalation for patients that have called 999 more than once within 30 minutes. These calls will be escalated early to a clinician for further triage.

- ✓ Introduction of 24 hours a day Regional Operations Manager within the Emergency Operations Centre to give support management of key issues relating to demand and response.
- ✓ Improved business continuity plans.
- ✓ New mental health referral pathway with the Samaritans charity.

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, that they 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

During the year we experienced an 11% turnover rate of frontline staff and our recruitment plan reflects the rate needed to maintain establishment and skill mix.

In line with our Workforce Plan, during 2015/16 we recruited and trained 30 emergency care assistants, 257 technicians, 57 paramedics, 42 staff for our Emergency Operations Centre (control) across both Emergency Medical Dispatch and Clinical Assessment Team roles, and 78 other staff in support functions. This included an increase in overall staffing by 155.

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

- Trainee technicians
- Emergency care assistant to technician
- Technician to paramedic

Supporting young people at the start of their career

We continued to support the national apprenticeship programme by recruiting apprentices into a range of enabling service and operational support positions. Since 1 April 2015, we have recruited 13 apprentices who have taken up roles in our enabling services. Of the apprentices that completed their schemes in 2015/16, 5 went on to successfully secure roles within EMAS. In addition, 53 members of our current establishment commenced an apprenticeship within their current role to enhance and progress career development.

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.

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.

We have continued to offer leadership programmes and master classes to existing and aspiring managers and have facilitated a level 4 business administration course for existing administrators within the service.

During 2015/16, our Education Team continued to support 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 65 staff completing the Pre-Hospital Assessment and Disposition Education programme and a further 51 staff becoming accredited mentors to support newly-qualified paramedics in practice.

The modernised national Emergency Response Driving Course in conjunction with our new awarding body FutureQuals has been implemented from January 2016. The clinical award to replace the IHCD Ambulance Aid award is in development nationally to be rolled out from April 2016. Work has continued through the year on a partnership arrangement with Coventry University for our internal Technician to Paramedic route for a Foundation Degree leading to registration as a Paramedic. We will see the first cohorts start early in the new financial year.

Staff Support and Wellbeing

During 2015/16 EMAS has progressed with initiatives to enhance staff support and wellbeing within the Trust. Key achievements are detailed below.

Staff Support:

- Peer to Peer – In February 2015 the Peer to Peer (P2P) and Pastoral Care Worker (PCW) support network was launched with 90 volunteer staff from across EMASt trained in supporting and signposting colleagues to further support where required. During 2015/16 the P2P/PCW support network has grown from strength to strength demonstrated through 1024 support contacts being made during quarter 1 to quarter 3 (Q1 241 contacts, Q2 386 contacts, Q3 397 contacts). With the demand for support increasing a recent recruitment drive for more P2P/PCW volunteers has created an additional 70 more volunteers awaiting training to expand the staff support provision at EMAS
- Trauma Risk Management (TRiM) – As part of the staff support initiatives within EMAS was the introduction of the TRiM. It was was launched in May 2015, initially with 16 TRiM practitioners (including 2 TRiM managers) expanding in September/October 2015 to 48 TRiM practitioners (including 10 TRiM Coordinators) operating across EMAS supporting staff who have been exposed to traumatic situations.
- Induction – Staff support information sessions are now integrated into all induction courses for new staff joining EMAS to ensure awareness of the different support mechanisms that are available.
- Internal Support Network Groups – LGBT support group launched in March 2015 and continues to represent and support employees from the lesbian, gay, bisexual and/or transgender community. The Disability and Carer's Group launched in December 2015 and the BME support group is currently in development launching March 2016. These support groups focus on issues poignant to individuals and provide a 'group voice' and support mechanism for staff within their community.
- Mediation Service – EMAS provides an internal mediation service to employees who are experiencing conflict, frustration or disagreement with another employee or manager. The mediation service provides an informal approach to resolving issues in an aim to avoid escalation or formal processes being initiated. In the first year of operation the service

received 13 contacts (May 2014 – March 2015). This service has continued to be offered during 2015/16.
- Lead Chaplain (established in February 2015) providing pastoral support to any employee when required.

Health and Wellbeing:
- Mental Health Awareness - In May 2015 EMAS' wellbeing fortnight focused on mental health support and information. During 2015/16 EMAS has been working with MIND on the Blue Light Programme to recognize the prevalence of mental health within emergency service personnel and promote mental health awareness within the emergency services. This has resulted in EMAS taking part in a mental health webinar and 'blue light champion' volunteers from across EMAS to support the promotion, acknowledgment and acceptance of mental health.
- Occupational health – EMAS has continued to work in collaboration with our contracted occupational health provider to ensure the provision of a high quality, prevention focussed, and comprehensive occupational health service. This includes line by line reviews with PAM and the HR team accessing each individual case. Sickness/Attendance action plans continue to be monitored through the Workforce Committee and Intensive Support Board.
- Sickness/Attendance – EMAS has continued to actively manage sickness absence in accordance with the Managing Attendance Policy. An alternative duties framework has been developed at EMAS, a day 1 referral service to the physiotherapy helpline (PhIL) is in operation to help reduce the incidence of musculoskeletal injury and absence, and each individual on long term sickness has a specific care pathway and rehabilitation plan which is managed through the long term sickness process. To support the reduction of incidences of work related stress and mental ill health EMAS continues to enhance the staff support provision across EMAS as mentioned previously.
- Declaration of Tobacco Control – This Pledge is aimed at encouraging organisations to commit to taking action on tobacco. EMAS' commitment to health promotion is evidenced by the signing of the tobacco pledge in March 2016 with smoking cessation promotion and support accessible to any member of staff who requires support to stop smoking.
- Seasonal influenza vaccination programme 2015 – This year EMAS vaccinated 51.2% of staff against the seasonal flu virus. This was a 2% increase in staff vaccinated compared to the 2014 programme with EMAS appearing in the top three best performing Ambulance Trusts throughout the campaign.

Staff engagement

Through the 2015 staff engagement programme, Listening into Action (LiA), we continued 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'.
EMAS LiA year 2 utilised a core divisional approach to cascading the LiA ethos throughout the service. The Divisional General Managers adopted the LiA process into their engagement plans and with the help of their local management teams and Human Resources business partners to develop ideas that came from our colleagues.

In addition, LiA has been instrumental in gaining success in organisational projects, including:

- Expansion of the P2P/PCW network.

- Development of the TRiM training.
- Aide Memoire for new starters.
- Buddy scheme for new emergency care assistants in Leicestershire/Northamptonshire.
- GRS at home (a software package that allows colleagues to access their shift details).
- Team Leaders starting and finishing shifts at a designated station in Nottinghamshire.
- Development of a new solo response bag (due for completion early 2016).
- Laverick Award, in memory of a colleague who tragically passed away, to recognise children for acts of bravery.

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

In addition to these innovations the LiA leads have travelled the length and breadth of EMAS holding numerous 'breakfast/cake/tea with the Chief' events hosted by our Chief Executive Sue Noyes. These events represent a real commitment to engage our colleagues on frontline, in our control centres, at divisional headquarters and in enabling services too.

Planning for LiA year 3 is in progress.

Positive impact

A number of initiatives came to fruition during 2015/16, 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.
- Targeted local leadership development for team leaders and managers (ongoing)
- Embedding of Listening into Action and a range of staff support mechanisms.

There is a planned Health and Wellbeing Topic of the Month with the 12 month schedule being prepared for launch in April 2016.

NHS Staff Opinion Survey

The annual NHS Staff Opinion Survey was conducted by the Picker Institute on behalf of EMAS. Picker also administered the survey for 5 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 2015 was 25.4%. The average response rate for the 5 other Ambulance Trusts was 34.6%. The response rate was disappointing given the efforts by the Organisation Development and Communications teams to publicise the survey in a positive way.

Over 77% of the 745 EMAS responses in this year's survey were from frontline staff (including Emergency Operations Centre and Patient Transport Service).

How do we compare to other services?

A comparison could be drawn between EMAS and the average for all 'Picker' Ambulance Trusts on a total of 60 questions. The survey showed that EMAS is:

- Significantly better than average on 19 questions.
- Significantly worse than average on 7 questions.
- The scores were average on 40 questions.

Have we improved since the 2014 survey?

A total of 60 questions were used in both the 2014 and 2015 surveys. Compared to the 2014 survey, EMAS is:

- Significantly better on 18 questions.
- Significantly worse on 2 questions.
- The scores show no significant difference on 40 questions.

Overall the results are positive and the majority of staff look forward to going to work (figure 1), are enthusiastic about their job and are of the view that time passes quickly when they are working (figure 2). Immediate managers are demonstrating more supportive behaviours (figure) and far more staff feel recognised and supported and work (figure 6).

Figure 1

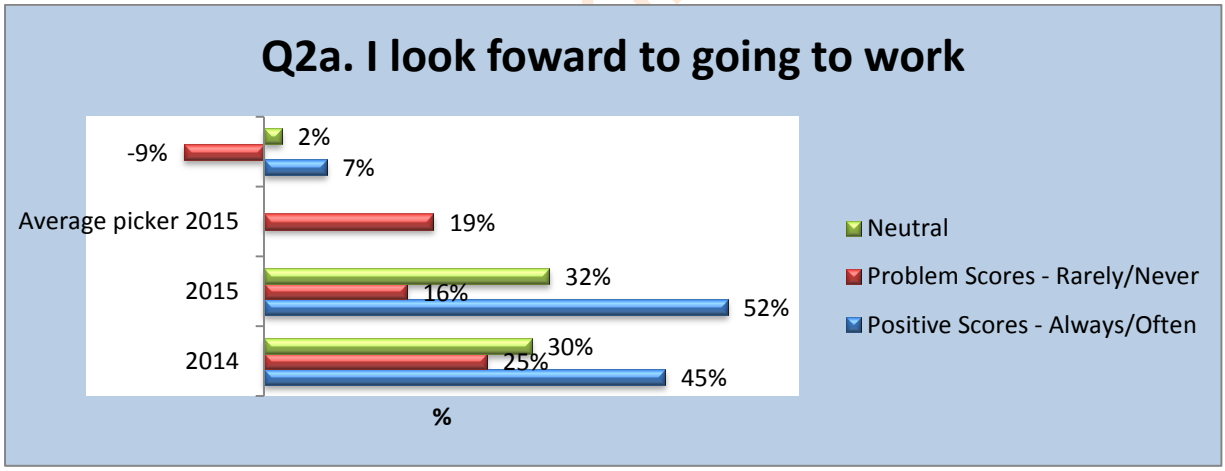


Figure 2

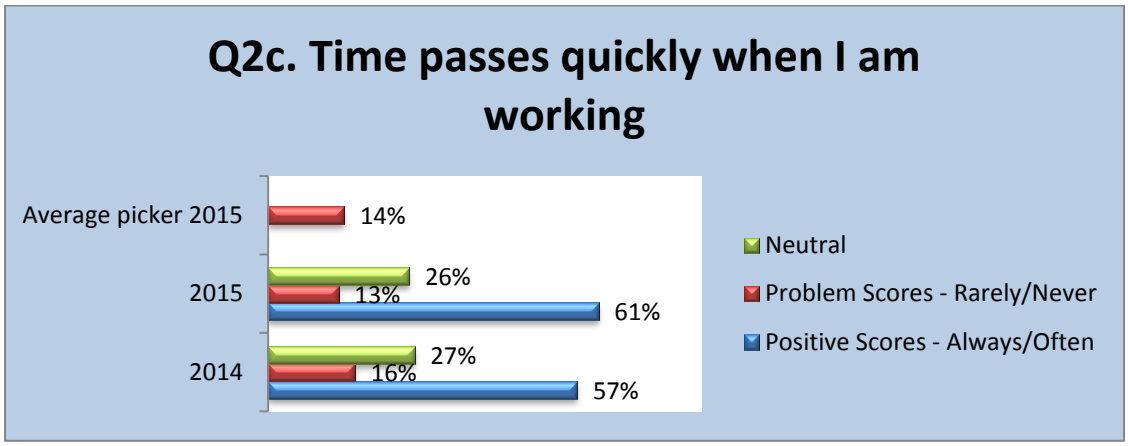


Figure 3

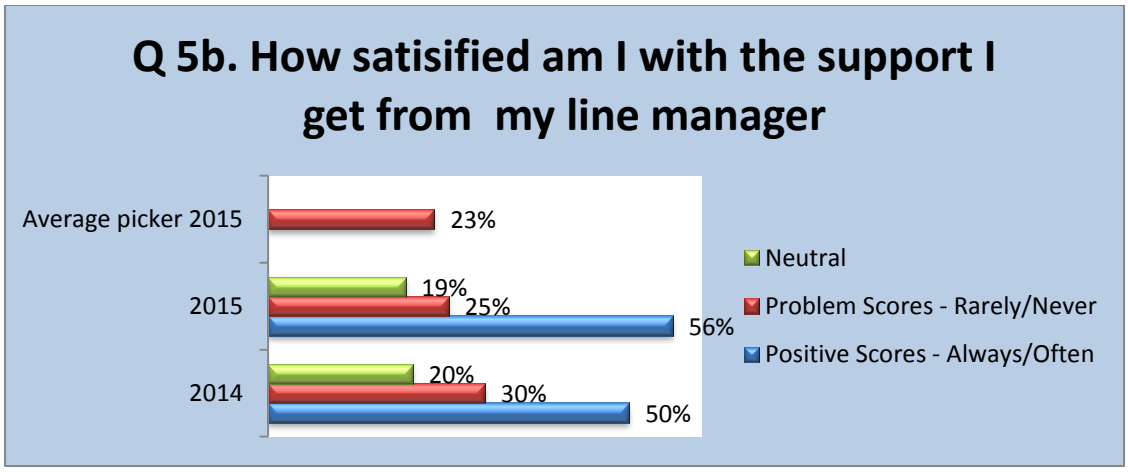
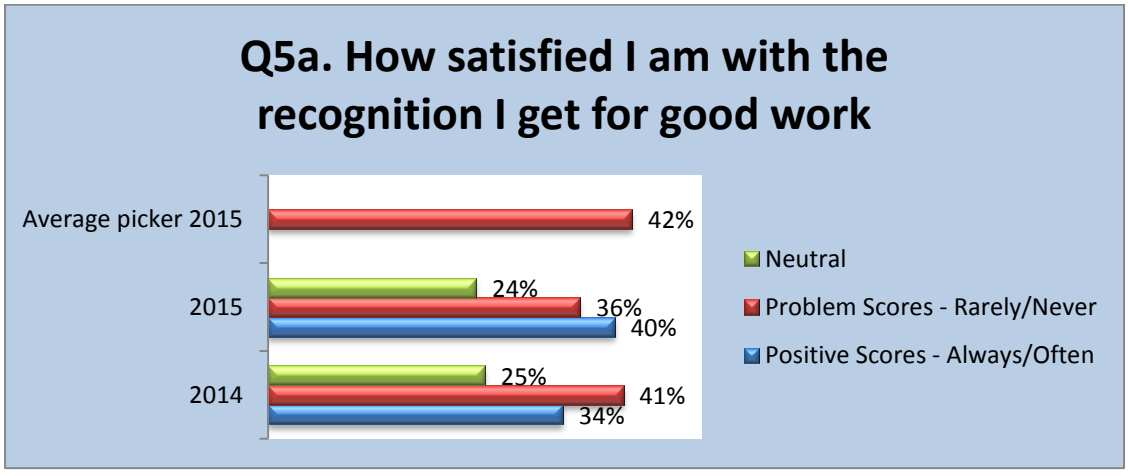


Figure 4



The results provide an indication of the areas for improvement. Amongst those are the 2 that have slipped back since the previous year:

- Staff feeling satisfied with the quality of care they give.
- Appraisal/performance review not adequately addressing development needs.

Additional areas of challenge are also identified in the ratings given for:

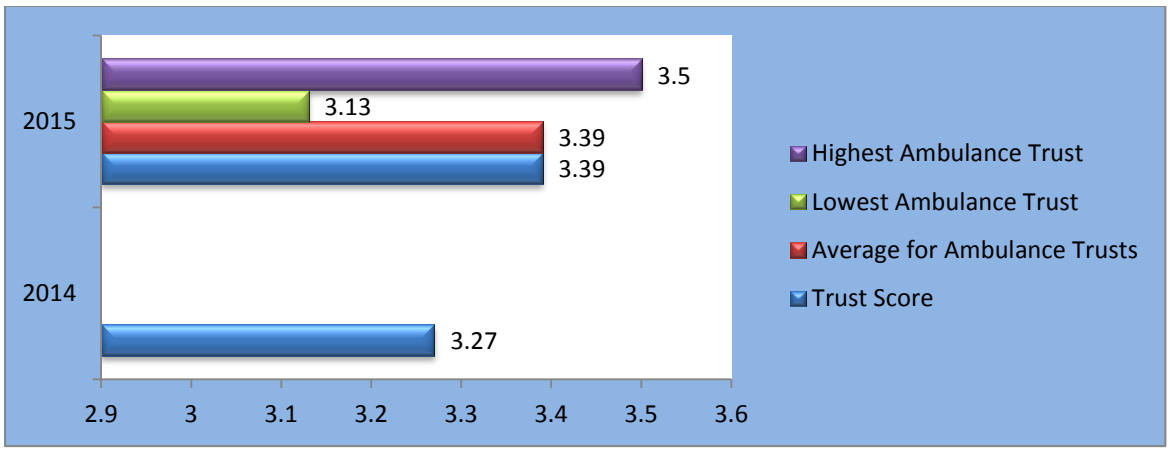
- Have you put yourself under pressure to come to work despite not feeling well enough, 94% of respondents saying yes.
- Do you work additional unpaid hours' with 10% of respondents in EMAS reporting on more than 11 hours vs 5% for other Ambulance Trusts. This figure needs further diagnosis with outputs being fed into the trust organisational development plan.

In relation to Equality and Diversity the responses were generally more positive than the previous year, however there is a challenging increase in staff feeling discriminated against on the grounds of age and disability along with a slight increase against sexual orientation. The survey findings have been shared with the Equality and Diversity Manager for further consideration.

The National Survey results are a direct extrapolation of the Picker results discussed above and the areas of strength and challenge are similar and continue the encouraging trends already discussed.

Of particular note is that the national staff engagement score has again increased, despite the well-publicised extreme operational pressures and is likely to have been influenced by the continuing LiA, tea with chief, awards and commendation initiatives as well as the support networks provided by P2P and TRiM. The 2015 engagement score is shown in Graph 5.

Graph 5



The National Survey also identifies 5 areas where EMAS is stronger than all other Ambulance Trusts amongst which are Percentage of staff reporting errors, near misses or incidents witnessed in the last month and Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month. These indicate that we are witnessing less errors, near misses or incidents and are reporting them more often than the other Trusts. These figures along with the data in Percentage of staff experiencing harassment, bullying or abuse from

patients, relatives or the public in last 12 months and Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months, indicate that our reporting, investigation and prosecution strategy is effective when compared to other Ambulance Trusts. It is noted that there is a worrying trend of violence and harassment towards staff from these groups increasing both locally and nationally.

Summary

There are some key challenges and these will be addressed using targeted plans to address areas of concern. Actions in response to this report will also be incorporated into the EMAS Engagement action plan.

Next Steps

- The survey findings will inform the development of our Organisational Development and Workforce Transformation Plan.
- The Organisational Development and Workforce Transformation Plan will be submitted to the Better Patient Care Transformation Board and Workforce Committee for approval in March 2016.

The Equality and Diversity Manager will review the NHS Staff Opinion Survey findings in line with the Workforce Race Equality Standard to ensure findings inform the Equality and Diversity Action Plan for 2016/2017.

Appendix 2 – IG Toolkit

Our Information Governance Toolkit assessment overall score for 2015/16 was [to be updated on 31 March when the final submission is made].

The EMAS Head of Information Governance is responsible for collating, checking and uploading 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 2016 who were able to provide significant assurance that there is a sound system in place to support Information Governance.

Appendix 3 – Research and Development

EMAS research status to date for year 2015/2016

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.	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. EMAS has continued to provide data for this data-base.	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.	The EMAS Research team are working alongside the University of Leicester and is about to train paramedics in the study protocol. Patients will be recruited after the end of March.	Expected recruitment: 100
Pre-hospital	NIHR	Professor	NIHR	To develop new ways of	This is a five year programme	None. This

Project	Type	Chief Investigator	Funding Organisation	Overarching study aim	Status	Recruitment
Outcomes for Evidenced Based Evaluation (PhOEBE): Developing new ways of measuring the impact of Ambulance Service care **Work Package 2 – Data Linkage**	Portfolio	Niroshan Siriwardena University of Lincoln & East Midlands Ambulance Service NHS Trust	Programme Grants for Applied Research.	measuring the impact of Ambulance Service care to support quality improvement through monitoring, auditing and service evaluation.	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.	study does not involve taking consent from patients and therefore is considered a non-recruiting study.
Understand 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	This study is now completed.	Expected recruitment: 22

Project	Type	Chief Investigator	Funding Organisation	Overarching study aim	Status	Recruitment
				non conveyance for the 3 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	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 Emergency Department closures.	This study is currently in progress	None. This study does not involve taking consent from patients and therefore is considered a non-recruiting study
Improving pre-hospital pain management:	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	The study is in the process of being written up following the analysis the data collected.	Expected recruitment: 77

Project	Type	Chief Investigator	Funding Organisation	Overarching study aim	Status	Recruitment
development and validation of a patient and practitioner reported outcome measure for pain treatment (PROMPT)				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.		
Using National Early Warning Scores to support paramedic decision-making: Modelling and improving effectiveness of pre-hospital ambulance	Non-portfolio Doctoral evaluation study	Nadya Essam	University of Lincoln Research Investment Fund Internally funded (EMAS)	The overarching aim is to investigate the feasibility, usefulness and effectiveness of 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).	The study has completed the first part of the qualitative phase – interviews, focus groups and observations. An application for the quantitative data has been made to the Health and Social Care Information Centre.	Expected recruitment: 22

Project	Type	Chief Investigator	Funding Organisation	Overarching study aim	Status	Recruitment
transport to hospital						
Pre-hospital Care of Patients After a Suspected Seizure: Incidence, Patient Characteristics 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 ambulance clinical performance indicators for epilepsy.	None. This study does not involve taking consent from patients and therefore is considered a non-recruiting study.
Cluster randomised trial of the clinical and cost effectiveness of the i-gel supraglottic airway device versus tracheal	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 began in 2015 and has recruited 767 patients during the year with 317 paramedics involved.	Expected recruitment 1550 (250 paramedics & 1350 patients)

Project	Type	Chief Investigator	Funding Organisation	Overarching study aim	Status	Recruitment
intubation in the initial airway management of out of hospital cardiac arrest (AIRWAYS-2)						
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 commenced in 2015 and has recruited 27 patients.	Expected recruitment: 150
Understand the implementation, organisation of centralised specialist services: the reconfiguration of major	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	This project is currently in set up within EMAS. Recruitment to the study is expected to commence in May 2015.	Expected recruitment: 15

Project	Type	Chief Investigator	Funding Organisation	Overarching study aim	Status	Recruitment
trauma service in the East Midlands				centres.		

Appendix 4 – CQC registration

During 2014/15 the Care Quality Commission consulted on new inspection arrangements for Ambulance Services.

EMAS was inspected under these new arrangements in October 2015.

We are currently awaiting the CQC's report following the inspection, and confirmation of the date for the CQC Quality Summit.

Appendix 5 – Third Party Statements

Statements to be posted here once received from Health Overview Scrutiny Committees, Healthwatch groups and EMAS members.

Appendix 6 – EMAS Trust Board

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, Rachel Morrison, Karen Tomlinson, Vijay Sharma and William Pope

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'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. 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.
- 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.

The Core Quality Account Indicators

Performance standards

During 2015/16, we received XXXX,XXX emergency 999 and urgent calls. Our accident and emergency crews responded to XXX,XXX of these calls, which equates to ,XXXX face to face responses every day. Of these, XXX,XXX were Red (serious, life threatening) calls.

There are two national performance standards for Red 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 XX.XX% Red 1 and XX.XX% Red 2 (response within eight minutes) and XX.XX% (support vehicle within 19 minutes) across the East Midlands – see the at-a-glance guide to our response to 999 calls on the back cover of this account.

The performance standards hit for each division of EMAS during 2015/16 is as follows:

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

We accept that more work needs to be done in 2016/17 to achieve both the 75% and 95% standards.

Clinical Quality Indicators

On 1 April 2011, the Department of Health introduced new national targets for Ambulance Services, including 11 new Clinical Quality Indicators 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.

BPC
Better Patient Care – EMAS Quality Improvement Programme

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 that 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.

DIVISON/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 Assistants respond to emergency calls as part of an accident and emergency crew or at times as a first responder, using skills and procedures that they have been trained and directed to do.

ECP
The role of Emergency Care Practitioners 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 Services.

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

LiA
Listening into Action staff engagement programme

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.

East Midlands Ambulance Service NHS Trust

Emergency Care | Urgent Care | We Care

Our Quality Account

2015/16

We welcome your comments about our Quality Account.

Please contact us using the details below:

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