

Quality Account 2010/11



East of England Ambulance Service **NHS**
NHS Trust

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Summary

Welcome to the East of England Ambulance Service NHS Trust Quality Accounts for 2010/11. This document has been approved by the Trust Board and reflects an accurate account of the level of quality of service provided to patients using the service during 2010/11. In developing this set of Quality Accounts the Chief Executive has set out a summary of the Trust's values and achievements for 2010/11, and goals for 2011/12. The Trust has drawn on information from a range of data sources and in setting the priorities for 2011/12 it has engaged with staff and service users to identify the key clinical areas which require its focus to further improve the quality of services to meet patient and public expectation.

Improving quality is an overarching priority of the Trust and this report lays out plans for developing future services to improve patient care and patient outcomes by delivering the right resource at the right time so that the Trust is publicly accountable for driving clinical quality higher.

NHS Bedfordshire, the service's lead commissioner (up until March 31, 2011), the Ambulance User Group, Local Involvement Networks (LINks) and Health Overview and Scrutiny Committees (HOSCs) have been asked to contribute to this document.

There is a glossary for reference from page 78 - 84.

This Quality Accounts will be made publically available on the NHS Choices website <http://www.nhs.uk/servicedirectoriest/pages/trust.aspx?id=ryc> by June 30, 2011 and hard copies are available on demand by contacting:

East of England Ambulance Headquarters
Cambourne Building 1020
Cambourne Business Park
Cambourne
Cambs
CB23 6DN
0845 6013733.

A copy of the Account will be sent to the Secretary of State.

Background

Trust Profile

The East of England Ambulance Service Trust (EEAST), formed in June 2006, operates over one of the largest administrative regions in the UK, covering an area of 19,000 km² including Bedfordshire, Cambridgeshire, Essex, Hertfordshire, Norfolk and Suffolk. The operational service is co-ordinated from three health emergency operations centres (HEOCs) in Bedford, Chelmsford and Norwich, and the service operates from more than 130 sites. The Trust Headquarters is in Cambourne.

EEAST is the only NHS ambulance service operating in the region and the only organisation which provides a wide range of emergency and urgent health services 24/7 across the whole eastern region. The Trust currently employs more than 4,000 staff and has more than 2,500 volunteers either supporting the community first responder (CFR) scheme, or working as volunteer ambulance car drivers.

Demography

The mid-2010 population projection for the East of England is around 5.83 million (ONS 2006), which equates to 11.15% of the total English population. The current gender split broadly reflects the overall England pattern of 50.7% female and 49.3% male (50.8 female, 49.2 male). By 2031 the population within the East of England is predicted to increase by 20% (compared to England average of 15.55%), to a total of around 7m, the second highest regional level of growth in England. The most marked increase is predicted to be within the elderly population, with those 65 years old and over increasing by 59.9% and those 85 years old and over by 118.8%. In the shorter term, over the five year period to 2016, the total population in the region is expected to grow by 5.9%, with the ages 65 and above expected to increase by 18.4%. The services that the Trust is responsible for are sensitive to population growth and services for the older population are a significant element of the patient profile. It is estimated (ONS experimental data 2007) that 13.1% of the population has an ethnic background other than White-British. However, the variation at county and unitary authority level is significant, with figures ranging from 7.6% in Norfolk to 41.2% in Luton.

Although those living in this region are more than 10% more likely to be injured or killed in a road accident than the England average, their health is generally significantly better in terms of the majority of the standard measures (DH 2009).

The population, on the whole, also enjoys below average deprivation rates, along with the lowest recorded crime rate in England and Wales. However, in two unitary authorities (Luton and Peterborough), scores against the majority of social and health indicators are consistently poor. Currently around 1.6m people in the region are living with a recognised long term condition, such as diabetes or coronary heart disease.

The increasing population, particularly amongst the elderly, is likely to have a significant impact on demand for health services, not least because the incidence of long term conditions is known to increase with age (NHS East of England 2009), as does the likelihood of injuries from falls, which already constitute 17% of all emergency calls. During 2009/2010 approximately 47% of all of EEAST's emergency responses were to the 65 years old and over age group. The increase in future demand likely to arise from the greater number of older people has driven the Trust to explore new and innovative ways of service delivery, which can improve the quality of care and deliver public, SHA and commissioner expectations.

The services we provide

The Trust provides a wide range of services to a variety of people, and can be categorised into four main areas:

- ▼ Emergency 999 ambulance and rapid response provision
- ▼ A scheduled Patient Transport Service (PTS)
- ▼ Primary and call handling urgent care (clinical)
- ▼ Other commercial services

The National Health Service (Quality Accounts) Amendment Regulations 2011

These Regulations require the Trust by law to publish a set of Quality Accounts by June 30, 2011. This will be the second set of Quality Accounts published by the Trust. The Quality Accounts is presented in three parts and includes a quality statement from the Board, the priorities for quality improvement for the following the year 2011/12 and a review of the quality improvements made in year 2010/11 with regards to the three domains of quality:

- ▼ Patient safety
- ▼ Clinical effectiveness and
- ▼ Patient experience

The Quality Accounts 2010/11 consists of three parts:

- (a) **Part 1**, containing a statement summarising the provider's view of the quality of NHS services provided or sub-contracted by the Trust during the reporting period and a written statement, at the end of Part 1, signed by the Chief Executive that to the best of his knowledge the information in the document is accurate (refer to Regulation 6)
- (b) **Part 2**, containing a description of the areas for improvement in the quality of NHS services provided or subcontracted by the Trust during the reporting period which is prescribed for the purposes of section 8(1) or (3) of the 2009 Act by paragraph (2) and the information required by Regulation 7;
- (c) **Part 3**, containing information about the review of the Trust's quality performance of NHS services provided or sub-contracted by it during the reporting period



This section outlines a statement from the Trust's Chief Executive and Executive Trust Board members on the quality of services delivered and provides a commitment to the list of priorities identified for improving the quality of services during the coming year.

Statement on Quality from the Chief Executive

The Trust's Vision is "to be the recognised leader in emergency, urgent and out-of-hospital care in the East of England". That vision statement acknowledges the strategically significant position that the Trust offers, as the only provider of services across the whole six counties of the eastern region and as the only 24/7 provider of emergency and urgent care.

The Trust places patient safety and clinical quality at the heart of all its work. It is committed to delivering high standards of clinical quality and patient care to improve patient satisfaction and the patient experience. The values of the Trust were formally adopted in November 2008 and support the NHS Constitution, which became law in January 2009. They are reflected in decision-making at all levels within the Trust, and are summarised as follows:

- ▼ Respect and dignity
- ▼ Commitment to quality of care
- ▼ Compassion
- ▼ Improving lives
- ▼ Working together for patients
- ▼ Everyone counts

It is committed to continuing to work closely with its patients, staff, commissioners and other key stakeholders to ensure it has the capacity and capability to respond positively to the growing expectations and rising needs of its patient population.

Overall, the main strategic challenge to the Trust is to re-design services to improve service quality and cope with the expected increase in demand, in a climate where funding is constrained.

PART 1

The Trust is operating from a strong base of on-going service innovation, from which it can develop further. The Trust has the following four strategic objectives in place to achieve its vision and strategy over the next five years

1. To be the market leader in providing patients the gateway to urgent and emergency healthcare services.
2. To have a workforce that has the skills to lead and deliver change, create flexibility and create a learning environment.
3. To become the best provider of unplanned healthcare needs in the country.
4. To have the best in class business intelligence tools to be the most responsive and innovative provider of unplanned healthcare.

Last year the Trust identified five quality priorities for improvement and Part 3 of this Quality Accounts will report on progress and performance in each of the priorities listed

1. Reducing preventable falls
2. Increasing the number of patients accessing the stroke care pathway
3. Improving the quality of patient handovers
4. Increasing the percentage of patients accessing their preferred end of life care
5. Improving the risk of infection.

These priorities have been instrumental in driving the Trust's service re-design and in developing areas which will ultimately support the implementation of the Trust's strategy and the introduction of a new Integrated Service Model.

PART 1

Statement of Accountability

The Trust Board has implemented structures and processes which are required to underpin its accountability for quality. The introduction of a set of Quality Accounts needs renewed focus on the development and delivery of the Trust's clinical strategy to ensure it works for the benefit of patients. As Accountable Officer and Chief Executive of this Board, I have responsibility for maintaining the performance and standards achieved within the Trust's services and in supporting an environment of continuous quality improvement.

This document is the second set of Quality Accounts by the East of England Ambulance Service NHS Trust, in line with the requirements of the Health Act 2009. The Quality Accounts contains details mandated by the Regulations and also the measures that the Trust, in association with NHS and public partners, has decided best demonstrate the work done to improve the standards and the quality of clinical care. The results of these measures in this set of accounts show there has been a lot of work undertaken this year which has improved the quality of care provided to patients; however there is still scope for further improvement to ensure all patients have a positive experience in using the ambulance service.

As Accountable Officer it is also my responsibility to ensure the quality and accuracy of the data within the Quality Accounts is both accurate and fair. I can provide this assurance based on the Trust's internal processes for ensuring the quality of data and the opinion of our internal auditors, who completed and delivered the annual audit programme including an audit on the Quality Accounts and the processes used to develop it. This is in keeping with, and in support of, the Government's White paper "Equity and Excellence: Liberating the NHS". Therefore to the best of my knowledge the information contained within this set of Quality Accounts for the East of England Ambulance Service NHS Trust is a true and accurate record of performance.



Signed:

A handwritten signature in black ink, appearing to read 'HN', written over a horizontal line.

Hayden Newton
Chief Executive,
East of England Ambulance Service

Statement on Quality from the Director of Clinical Quality

I am delighted to commend the Trust's second Quality Accounts to you. As I said last year patients and the care they receive matter to the Trust every moment of every day and it is striving to further improve the quality of care delivered to patients. Last year saw a number of improvements not only to the quality account priorities and quality challenges we set ourselves but to the structure and skills within the Trust to help deliver improvements to service quality. A Consultant Paramedic is now in post to lead a team of clinical general managers to support staff to deliver improvements in clinical practice and ensure patient care is safe, effective and provides patients with a positive experience.

During this reporting period, the Trust worked with staff who play a crucial role in frontline services and used their first-hand experience and knowledge to review, redesign and innovate services to make a difference to patients. Two of the new services implemented were so successful that the Trust received both a regional and a national award for the innovations made to patient care - it came top in the national Health and Social Care Awards Support for Independence category for a project run with Hertfordshire County Council which involves emergency care practitioners and social workers helping older people who have fallen at home, and also won a prestigious innovations award with the West Suffolk Hospital for a new scheme aimed at preventing unnecessary hospital admissions for respiratory patients across Suffolk.

It is hoped that where infrastructure exists the Trust will further develop these areas of good practice across the region to benefit more patients.

Clearly many challenges remain, hence a continuing focus on some of last year's quality account priorities and, in consultation with staff and key stakeholders, the Trust's assessment of new areas for improvement in 2011/12. However, the Trust is steadfast in its resolve to continue to improve care to patients.



Signed:

A handwritten signature in black ink that reads "Sheilagh Reavey".

Sheilagh Reavey
Director of Clinical Quality



PART 2 – Priorities for improvement and Statements of Assurance

During the reporting year and more recently during the Quality Accounts consultation the Trust has received valuable comments and contributions from its workforce and key stakeholders including the Ambulance User Group, Local Involvement Networks (LINKs), Health Overview and Scrutiny Committees (HOSCs), the commissioning PCT consortium and NHS East of England (the strategic health authority) to determine improvement priorities for next year's 2011/12 Quality Accounts.

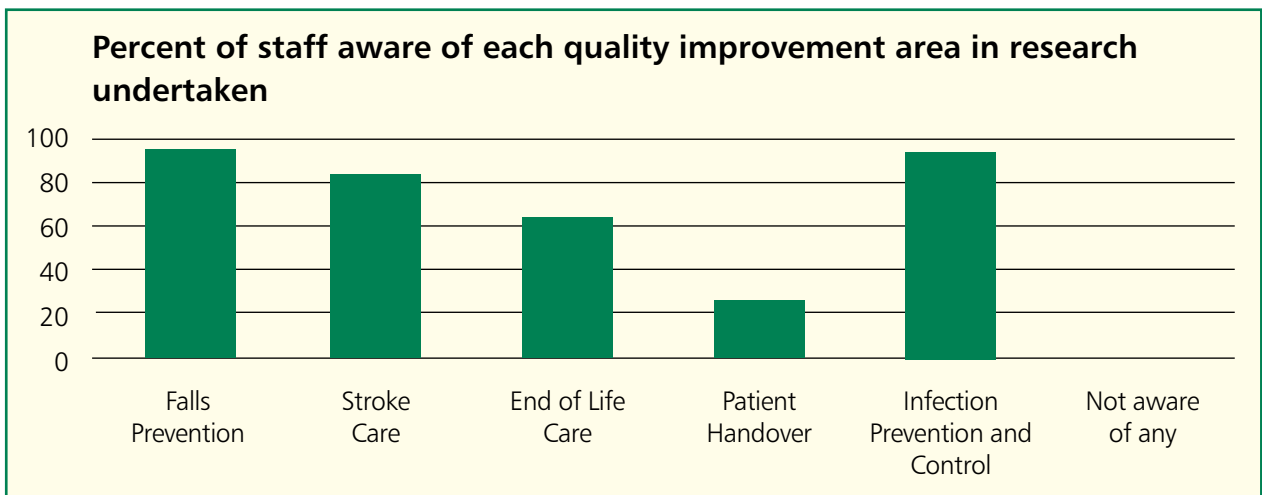
Stakeholder liaison

Significant work is being done to work with key stakeholder groups including LINKs, HOSCs, the User Group, community first responders and all staff groups. Methods of engagement have included

- ▼ discovery interviews with users and patient representatives
- ▼ setting up a dedicated email address for staff to provide feedback on the proposed priorities and to propose ideas
- ▼ articles in staff bulletins and in the monthly staff newsletter
- ▼ reviewing complaints and patient feedback
- ▼ reviewing patient survey information
- ▼ reviewing feedback from stakeholder groups.

During the year, 120 staff took part in a research project into understanding Quality Accounts and priorities set. Staff knew about the majority of quality improvement areas (see chart on the following page). However only 20.2% knew what 'Quality Accounts' were, and so this is an area for further development in 2011/12.

PART 2



During this year the Trust set up a working group to consider the Quality Accounts throughout the year. This included evaluating feedback from the groups outlined on the previous page. Progress on Quality Accounts priorities has been reported to various groups within the Trust, including the Board and the commissioners, on a regular basis.

Ideas were requested from clinical staff on the priority areas for consideration in the coming year and these were evaluated alongside information from investigations, compliments and complaints, audit results and stakeholder feedback. Shortlisted ideas were considered by a number of groups within the Trust to arrive at the five proposed priority areas for 2011/12.

The Trust has recently introduced a performance framework across all operational areas. The team responsible for leadership and management in each area will regularly meet with the executive team to discuss performance, including the progress and plans against the Quality Accounts priorities.

Feedback was sought from primary care trusts, health and overview scrutiny committees, the Ambulance User Group, and LINKs. Comments and statements were sent back, and the account has been amended to reflect these suggestions. All of the stakeholder engagement is recorded and all areas will be kept on record for future development.

PART 2

Setting priorities 2011/12

Based on the Trust's engagement throughout the year, the following five priority areas for 2011/12 have been set:

1. Improve the management of pain
2. Ensure the quality of patient handovers
3. Best possible outcome from cardiac arrest
4. Improve the management of acute brain events
5. Continuous improvement in prevention of infection

Priority 1 – Improve the management of pain

The Trust is committed to providing the highest level of patient experience. This quality priority will ensure the Trust focuses on the delivery of effective pain management to all patients. To do this it will concentrate on good patient assessment and appropriate interventions to manage pain.

Rationale for inclusion

Pain is a common symptom presented to the ambulance service in both emergency and primary care. In the year the Trust received more than 106,000 emergency calls relating to patients experiencing abdominal, chest, and back pain, and headaches.

In recent discovery interviews and patient experience surveys carried out by the Trust, pain management was identified as a key area where further development is required.

Clinical staff have also indicated there is a limited number of interventions for some groups of patients including paediatrics.

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PART 2

What we will measure

The Trust will monitor this priority through a number of areas:

- ▼ Recording of at least two pain scores recorded on patient care records (PCRs)
- ▼ Recording of pharmacological interventions used for patients in pain (emergency and primary care) – measures to be used
- ▼ Recording of non-pharmacological interventions used for patients in pain (emergency and primary care)
- ▼ Recording of changes in patient outcome in relation to pain, shown by improved pain score
- ▼ Discovery interviews
- ▼ A specific question in patient experience surveys relating to pain

Planned activities

The Trust will focus on developing further a holistic approach to pain management, including pain guidance and exploring appropriate developments in interventions (both pharmacological and non-pharmacological). This may include reassurance, driving technique, and medicine availability.

We will introduce pain management champions within operational areas to promote best practice.

Pain is a symptom for patients of all ages and this priority will reflect appropriate pain management for all age groups.

This priority focuses on clinically effective care through appropriate pain management, and improved patient experience where interventions alleviate pain.

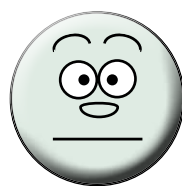
Board sponsor: Dr Pamela Chrispin



0
No hurt



1
Hurts a little bit



2
Hurts a little bit more



3
Hurts even more



4
Hurts a whole lot



5
Hurts worst

PART 2



Priority 2 – Ensure the quality of patient handovers

This priority focuses on ensuring that all appropriate information relating to a patient encounter is passed between healthcare professionals in the continuing care of patients, known as a handover. It includes both written and verbal exchanges about patient care.

Rationale for inclusion

Appropriately and properly providing information to other health professionals is an important patient safety issue (for example, the recording of allergies). The successful passing of information between healthcare professionals caring for a patient ensures clinical effectiveness and patient experience.

This was a priority the Trust set in 2009/10 but compliance with the completion of records is still not at the high level of care the Trust strives for.

It is known from patient experience engagement that being repeatedly asked for the same information frustrates patients. By improving the quality of patient handover, it is hoped that the times when this happens is less often.

PART 2

What the Trust will measure

- ▼ Submission of PCRs (emergency services, primary care, Patient Transport Service)
- ▼ Use of the electronic PCR – measure to be used
- ▼ Use of a person's NHS number
- ▼ Quality of completed records against a set criteria
- ▼ Compliance with elements of verbal handover
- ▼ Patient experience in relation to handover
- ▼ Turnaround times at hospital.

Planned activities

- ▼ Continued implementation of the ePCR region wide
- ▼ Information to staff on the importance of record-keeping
- ▼ Introduction of electronic care record in Primary Care
- ▼ The development of a verbal handover procedure
- ▼ Improved reporting mechanisms to individuals on personal completion of records.

Board sponsor: Sheilagh Reavey



PART 2

Priority 3 – Best possible outcome from cardiac arrest

This priority focuses on increasing the number of positive outcomes from cardiac arrest. For some patients this will be high quality resuscitation, including full advanced life support interventions in line with the recent revised international guidance on resuscitation. For some patients, ensuring they have a dignified death in their preferred place will be of significant meaning. This priority focuses on ensuring patients in both categories receive the care they deserve.

Rationale for inclusion

Last year the Trust received more than 7,000 emergency calls for patients in cardiac or respiratory arrest. Saving lives is a core function of the ambulance service, including rapid response to scene, and high quality resuscitation where appropriate.

The Trust is often called on for patients towards the end of life in both emergency and primary care settings, it also routinely transports a number of patients for palliative care purposes. There is a national steer towards dying with dignity.

Compliance with the national care bundle for cardiac arrest in EEAST for 2010/11 was 20.4%, 18.7% and 28.2% compared with national average of 26.6%, 23.7% and 21.6%. Whilst there has been improvement throughout the year continued focus is required to ensure consistent improvement in cardiac arrest treatment.

What the Trust will measure

- ▼ Return of Spontaneous Circulation (ROSC) rate – aiming to achieve at least 8% (all cardiac arrests)
- ▼ Survival to discharge rate - measure to be used 5%
- ▼ Compliance with algorithm for resuscitation
- ▼ Audit of care provided by specialist paramedics trained in end of life care
- ▼ Patient and carer experience
- ▼ Complaints and compliments.

Chain of survival



PART 2

Planned activities

- ▼ Resuscitation training in line with new resuscitation guidelines
- ▼ Further development of community first responders
- ▼ Introduction of region wide 'Do Not Resuscitate Policy' and process
- ▼ Introduction of resuscitation aids such as metronomes
- ▼ Further information for clinicians on end of life care and dignity in dying.

Board sponsor: Dr Pamela Chrispin



PART 2

Priority 4 – Improve the management of acute brain events

Last year the Trust set the priority to increase the number of patients accessing a suitable stroke patient care pathway. Throughout the year this priority has meant a greater number of patients have accessed appropriate care when suffering an acute – otherwise known as sudden - brain event.

The priority on strokes will remain in place, with the remit broadened to include all acute brain events. This will increase the care provided across the spectrum of conditions presented to the ambulance service. The focus of this priority will be to ensure the Trust has appropriate pathways in place for managing acute brain events and that staff are educated to recognise and use the pathways.

Rationale for inclusion

In the year the Trust received more than 17,000 emergency calls related to stroke-type symptoms along with primary care calls with similar symptoms. In 2007 the Department of Health published its national stroke strategy with a key number of quality markers including access to care. The priority is included and broadened for the coming year to ensure that all patients have access to appropriate treatment and services. Within 2010/11 the compliance with the national care bundle for stroke showed results of 79.2%, 79.1% and 82.3%, these were below the national average and are an area for continuous improvement in 2011/12.

What the Trust will measure

- ▼ National Care Bundle for Stroke – aiming to achieve at least 85% compliance
- ▼ Number of patients accessing an appropriate hospital within 60 minutes for acute stroke
- ▼ Number of patients referred directly to transient ischaemic attack (TIA) service.

Planned activities

- ▼ Further development of TIA referral pathway in both emergency and primary care
- ▼ 24/7 access to acute stroke hospital pathway region wide
- ▼ Development of a multi-disciplinary acute stroke life support course

PART 2

- ▼ Focus on improvement in national care bundle for stroke (recording of blood pressure, blood glucose, time of onset and neurological assessment)
- ▼ Introduction of stroke champions in each operational area.

Board sponsor: Alan Murray



PART 2

Priority 5 – Continuous improvement in the prevention of infection

This priority is set to focus on building on the foundations laid this year in relation to prevention of infection.

Rationale for inclusion

To maintain and monitor compliance against CQC outcome 8 (regulation 12) Cleanliness and Infection Control, and associated Code of Practice on the Prevention and Control of Infections (Health and Social Care Act 2008).

What the Trust will measure

- ▼ Hand Hygiene compliance at point of care, against World Health Organisation's (WHO) Five moments for Hand Hygiene principles
- ▼ Vehicle cleanliness
- ▼ Station cleanliness - including clinical waste management, linen and sharps.

Planned activities

- ▼ Compliance of Hand Hygiene will be audited by practical observations at A&E departments and other receiving centres for 12 hours per month at each centre
- ▼ 90% of vehicles to be audited per month
- ▼ 90% of stations where two-person crew ambulances operate from to be audited per month.

Board sponsor: Sheilagh Reavey

N.B the National standard for cleanliness issued by the NPSA is 85% so the Trust is setting itself a challenging target.

Monitoring Quality Priorities 2011/12

Learning from the 2010/11 quality review process the Trust will introduce further monitoring of the five priority areas set for 2011/12. The Trust will take four approaches to ensuring that quality care is being delivered in each of the priority areas. The results from these will be fed back to stakeholders throughout as part of our ongoing engagement in partnership working. The full results will be published in next year's Quality Accounts.



Indicators

A number of indicators will be used on a monthly basis including measuring both process and outcome. The figures will be reported at sector level and areas benchmarked. The Trust Clinical Quality and Safety Group (CQ&SG) will review the indicator values throughout the year looking for continuous improvement and establishing what good care looks like.

Process indicators include the monitoring of elements in the care pathway, for example recording pain scores, or compliance with drug administration.

Outcome indicators monitor specific criteria achieved, for example survival to discharge from cardiac arrest, or reduction in pain scores following an intervention.

The following objectives and indicators will be measured throughout the year in line with the quality priorities and shared stakeholders during our engagement in the year. The measures will be reported on in the next quality account published in June 2012.

PART 2

Objective	Indicator	
	Numerator	Denominator
Increase the number of patient care records completed with two pain scores	PCRs with two pain scores recorded	Number of patients in pain
Increase the number of appropriate pain management interventions where a pain score is recorded	Usage of pharmacological intervention. Use of non pharmacological interventions	Number of patients in pain
Increase the number of patients in whom the pain stays the same or improves whilst in ambulance care	Decrease or stabilised pain score	Number of patients with two pain scores
Increase the submission rate to medical records of patient care records	Number of submitted PCR	Number of patients
Increase the adequate completion of fields within the patient care record	Number of successfully completed PCR against set criteria	Number of PCR reviewed
Increase the use of electronic patient care records	Number of ePCR completed	Number of patients in ePCR active area
Increase the compliance with all elements of a verbal handover	Number of successful verbal handovers against criteria	Number of observed handovers
Increase the compliance of resuscitation interventions against national algorithm	Number of cases reviewed compliant with algorithm (CPR ratio, time off chest, shock and drug intervention)	Number of cardiac arrest cases reviewed
Increase the return of spontaneous circulation rate on handover of care at hospital	Number of patients with return of spontaneous circulation	Number of patients in cardiac arrest
Increase the survival to discharge rate for patients presenting in cardiac arrest	Number of patients still alive at 30 days post event	Number of patients in cardiac arrest
Increase the number of patients who are cared for in their preferred place of death	Number of patients kept in preferred place of death	Number of patients visited by EoL trained specialist paramedic

PART 2

Objective	Indicator	
	Numerator	Denominator
Increase the usage of the low risk TIA referral pathway	Number of patients entered into low risk TIA pathway	Number of patients with TIA that meet criteria
Increase compliance with the national stroke care bundle	Stroke care bundle compliance	Stroke care patients treated
Increase the number of patients transported to hyperacute stroke care centres within 60 minutes of call.	Number of patients conveyed to hyper acute stroke centre within 60 minutes	Number of eligible stroke patients
Increase the number of vehicles audited each month for infection prevention and control	Number of vehicles audited	Number of vehicles
Increase the number of vehicles compliant with IPC audit criteria	Number of vehicles compliant with Infection Prevention Control criteria	Number of vehicles audited

Staff reported outcomes

Increasingly the views of clinical staff in the patient outcome is important in assessing quality. The quality account priorities will be an agenda item at each locality clinical focus group for discussion on patient care outcomes. During the year online surveys will be undertaken of staff, these will be constructed to elicit their views on patient outcome in relation to the priority areas.

Patient experience

The Trust has an established method via the Clinical Audit and Patient Experience Group (CAPE) to receive patient experience from multiple sources including complaints, Serious Incidents, audits, patient surveys and discovery interviews. As this information is analysed on a regular basis it will be reviewed against the quality account priorities.

The Trust aims to ensure inclusion across the range of patients from all backgrounds. Surveys are sent to a proportion of those calling the service and made available in alternative formats as required so all groups can participate. The Trust User Group is also a pivotal part of patient and public feedback.

Specific questions will be included in the Trust patient experience programme related to the quality account priorities.

PART 2

Full case review

To ensure that clinical effectiveness, patient safety and patient experience is considered as a whole the Trust will introduce full case review in 2011/12. A proportion of cases will be selected for review and followed throughout the patient journey. This will seek to evaluate both the process and outcome and will include feedback from the staff involved, the patient, external opinion and will also consider longer term outcome measures.

Discontinued priorities

All the previous years priorities have been carried forward apart from End of Life Care (which is now encompassed within priority 3) and falls. It was felt that falls is an area of Trust work that has seen considerable growth over the last year including the establishing of a falls register, setting up alternative falls response models (including winning a national award) and starting a region wide multi agency falls forum. Within the quality account research that was undertaken, falls prevention was the area that most staff were aware of quality improvement in (93%).

Other priorities

The dialogue and consultation on quality led to a number of quality account priority suggestions, which ranged from equipment issues to broad areas such as mental health, Chronic Obstructive Pulmonary Disease (COPD), and bariatric patients. Each of these were considered carefully and acknowledging the importance of these subjects it is felt further scoping needs to be done to identify key areas for improvement; therefore it is felt that these should not be Quality Accounts Priorities for 2011/12 but will be considered further by the clinical development group during the year. Discussion, feedback and consultation will continue throughout the year with stakeholders on quality issues.

Statements of Assurance

Review of services

During 2010/11 the East of England Ambulance Service NHS Trust provided a wide range of NHS services to a variety of people. The services can be categorised into four main areas:

- ▼ Emergency 999 ambulance and rapid response provision
- ▼ A scheduled Patient Transport Service (PTS)
- ▼ Primary and call handling urgent care (clinical)
- ▼ Other commercial services.

The Trust has reviewed data on the quality of care in these four areas and performance is monitored by the Trust Board through the corporate dashboard and other Trust Board business papers.

The income generated by the NHS services reviewed in 2010/11 represents 99% of the total income from the provision of NHS services by the East of England Ambulance Service for 2010/1.

The emergency 999 ambulance and rapid response provision represents the largest service line by value, equivalent to 80% of the total Trust income. The Trust's Scheduled Transport Service consists of two elements: Patient Transport Service (PTS) and the Courier Transport Service (CTS) which is 13% of the total income and the primary and urgent care service accounts for 6% of total Trust income.

The performance of the Trust's emergency service is measured against the three national targets in respect of calls received, called category A8, category A19 and category B19. These relate to the response times of the service against the three categories of call.

The criteria for each of these three categories are:

- ▼ Category A8 – 75% of potentially life threatening calls must be responded to within 8 minutes;
- ▼ Category A19 – 95% of potentially life threatening calls must be responded to within 19 minutes;
- ▼ Category B19 – 95% of non-life threatening calls must be responded to within 19 minutes.

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In addition, there is also a locally agreed target for Category C calls. These are 999 calls that are triaged and determined as not being life threatening, but require a response within 60 minutes of the call on 75% of occasions.

There will be a continued review of performance and the model worked against.

National targets and response statistics

2010/11 was another challenging year for the Trust as it saw a 4.2% increase in the number of emergency and urgent calls received from the public. At the same time the Trust's response performance was hindered by the appalling weather conditions seen across the region in late November and into December. As a result the Trust's category A performance for the eight minute target fell just below the national standard, despite a strong recovery coming out of the winter period. However, like a number of ambulance services, the Trust made a successful application* to its commissioners for dispensation in the target for the dates affected by the adverse weather which made road conditions very difficult and obviously meant that it took longer to reach patients than usual. This will be submitted to the Care Quality Commission for consideration in relation to the published national performance and quality standards. Category A performance for the 19 minute target exceeded the national standard and the Trust fell short of the category B target.

	2010/11	2009/10
Total number of 999 responses	693,382	668,451
Category A responses	223,856	207,616
Category B responses	264,199	263,095
Category C responses	205,327	197,740
Category A performance – 8 minutes	74.6%	75.7%
Category A performance – 19 minutes	95.6%	96%
Category B performance – 19 minutes	93.1%	94%

(as per KA34 return to Department of health)

*(with dispensation, Category A8 compliance rises to 75.2%)

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- ▼ Category A: Potentially life threatening calls. National target was to respond to 75% of these calls within 8 minutes and 95% within 19 minutes
- ▼ Category B: Non-life threatening calls. The target was to respond to 95% of these calls within 19 minutes
- ▼ Category C: Minor problems. Some of these can be dealt with by giving advice over the phone or by sending an ambulance under normal driving conditions. Targets for these calls are agreed locally with Primary Care Trusts, but typically specify that the Trust should arrive within 60 minutes if an ambulance is required.

In 2011/12, new performance indicators are being introduced for ambulance services, more details of which are set out in the section entitled 'Future plans'. This will see a shift from measuring ambulance performance solely on response times to a greater emphasis on the quality of care the patient receives.

The Trust will continue to focus on improving its response times to life threatening emergency calls, and this is monitored regularly across the year.

Generally, within scheduled Patient Transport Services commissioners monitor activity by measuring the number of patient journeys undertaken. During 2009/10 we provided around 1 million patient journeys and it is anticipated that activity for 2010/11 will remain around this figure.

Due to the diversity and range of services delivered under Primary and Urgent Care, the most meaningful measure of activity for comparison purposes is currently based on the number of patient contacts.

Participation in clinical audits

During 2010/11 one national clinical audit and one national confidential enquiry covered NHS services that EEAST provides.

During that period EEAST participated in all (100%) national clinical audits and all (100%) national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that EEAST was eligible to participate in during 2010/11 are as follows:

- ▼ National clinical audit: Myocardial Ischemia National Audit Project (MINAP)
- ▼ National confidential enquiry: Centre for Maternal and Child Enquires (CMACE) Confidential Enquiry into Head Injury in Children.

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The national clinical audits and national confidential enquiries that EEAST participated in, and for which data collection was completed during 2010/11, are listed below alongside the number of cases submitted to each audit or enquiry:

National clinical audit: Myocardial Ischemia National Audit Project (MINAP):

EEAST submits information on specific patients conveyed to hospital at the request by acute hospitals who then submit the data to the project; there is no system for ambulance services to submit directly.

The Trust did not participate in any other national clinical audit as ambulance information was not included as part of the audit.

National confidential enquiry: Centre for Maternal and Child Enquires (CMACE) Confidential Enquiry into Head Injury in Children: All pertinent cases were submitted: 83 (100%).

Two other national confidential enquiries, namely:

- ▼ the National Confidential Enquiry into Patient Outcome and Death (NCEPD) and;
- ▼ the National Confidential Inquiry into Suicide and Homicide by people with Mental Illness (NCISH)

were not participated in as no ambulance service information was included.

The report of one national clinical audit (Myocardial Infarction National Ischemia Project) was reviewed by the provider in 2010/11 and EEAST intends to take the following actions to improve the quality of healthcare provided:

- ▼ Although performance is good, the Trust will continue to seek improvements in the number of patients taken directly to specialist heart attack centres (HACs) by continually monitoring and discussing cases with the HACs and by the Trust's Cardiac Specialist continuing to monitor clinical practice and feeding back directly to paramedics
- ▼ More general improvements in care to cardiac patients are planned with the implementation of the National Ambulance Services Cardiovascular Quality Initiative, which will see a senior paramedic work directly with clinical teams to find new ways of overcoming barriers to best possible care.

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The reports of eight clinical audits were reviewed by the provider in 2010/11 and the following actions were recommended to improve the quality of healthcare provided:

Cardiac time performance:

- ▼ Instruct ambulance crews to formally report any excessive time issues using the Trust's on-line reporting system, particularly when a single response is not quickly backed up by an ambulance able to transport
- ▼ A review by the Trust's Cardiac Specialist of all cases which exceed the target set and feedback directly to clinicians individually and to clinical monitoring groups.

Coronary heart disease (CHD):

- ▼ Review cardiac time performance in detail to better understand the issues of insufficient performance
- ▼ Arrange appropriate system of supply of the drug Clopidogrel for a specific geographical area with poor performance, and then re-audit

Cardiac arrest:

- ▼ Implementation of specific action plan: 'Back to Basics' which concentrates on the latest best practice and the most effective cardio-pulmonary resuscitation (CPR)

Children under three years old:

- ▼ Complete more extensive audit of children, taking into account any recent National Institute for Clinical Excellence (NICE) guidance

Emergency Care Assistants (ECAs):

- ▼ Clinical General Managers are to review the cases which ECA staff attend
- ▼ Re-audit during 2011/12 to ensure the policy is being adhered to and risks are controlled

Patient Care Record retrieval:

- ▼ Implement new system of PCR submission to provide improved security and improved ability to monitor process

Patient Care Record completion:

- ▼ Inform clinicians of audit outcome and areas for improvement

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Participation in clinical research

The number of patients receiving NHS services provided or sub-contracted by the Trust in 2010/11 that were asked during that period to participate in research approved by a research ethics committee was 313 at the time of preparing this statement. This represents a big increase from the previous baseline year when 37 accruals were achieved.

Accruals during 2010/11 arose from Trust participation in two large-scale projects on the National Institute for Health Research Portfolio. Both studies were successfully completed during the reporting period; the Trust also supported small-scale student level projects being undertaken by Trust staff.

Participation in clinical research activity demonstrates the Trust's commitment to improving the quality of care given and to making the Trust's contribution to wider health improvement.

Looking ahead to 2011/12, the Trust research strategy will focus on hosting further portfolio activity, meeting accrual targets, and getting subjects involved in studies more evenly across the Trust's geographical area. External funding has been used to appoint a research paramedic in support of the Research Manager to ensure these duties are discharged. Other key areas will be to implement a Trust research training package, and further preparation of bids for sponsorship of research work.

Goals agreed with commissioners

Commissioning for Quality and Innovation (CQUIN) enables commissioners, which are the NHS bodies charged with provision and funding of services, to reward innovation and excellence. A proportion of the Trust's income during 2010/11 was conditional on achieving quality improvement and innovation goals for the provision of emergency and urgent ambulance NHS services, as agreed by NHS Bedfordshire the lead commissioning PCT until April 2011.

Further details of the agreed goals for 2010/11 and for the following 12-month period are available electronically at:

www.institute.nhs.uk/world_class_commissioning/pct_portal/cquin.html

Statement from the Care Quality Commission

The East of England Ambulance Service NHS Trust is required to register with the CQC and its current registration status is registered without any conditions or restrictions to carry on with three regulated activities:

- ▼ Treatment of disease, disorder or injury
- ▼ Transport services, triage and medical advice provided remotely
- ▼ Diagnostic and screening procedures.

The Trust also registered against the following service types under which the registered activities fall: The service types registered include the following CQC codes:

- AMB – Ambulance service
- MBS – Mobile doctors service
- CHC – Community healthcare services
- DCS – Doctors consultation services
- DTS – Doctors treatment services.

In completing the registration application process the Trust initially declared non compliance to four regulations namely:

- ▼ Regulation 14 Outcome 5 Meeting nutritional needs – Not Applicable
- ▼ Regulation 13 Outcome 9 Management of Medicines
- ▼ Regulation 12 Outcome 8 Cleanliness and infection control
- ▼ Regulation 11 Outcome 7 Safeguarding.

The Trust developed an action plan for regulation 11, 12 and 13 and these were submitted to the CQC along with the completed application form.

The CQC has not taken enforcement action against the Trust during 2010/11 and as of March 31, 2011 the Trust has not participated in any special reviews or investigations by the CQC during the reporting period 2010/11.

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On June 24, 2010 the CQC carried out an unannounced review visit to monitor the progress made against the Trust's actions plans submitted at the time of registration. The CQC also took the opportunity to review evidence against Regulation 9 Outcome 4 – "The Care and Welfare of People who use services" to provide assurance that the recommendations made by the Secretary of State for Health, after a high-profile case relating to a medications error by a locum out of hours doctor had been acted upon. During the visit, CQC representatives interviewed operational staff at two ambulance stations and an A&E department so information could be triangulated. The CQC assessed the Trust as compliant for each of the four regulations reviewed and a report was published on the CQC website which is in the public domain.

Data Quality

The East of England Ambulance Trust has undertaken the following actions to improve data quality:

- ▼ employed a project manager to lead on the data quality agenda
- ▼ assigned the Information Governance Group (IGG) responsibility for monitoring data quality issues
- ▼ attends the East of England Data Quality Network Forum to share information on data quality initiatives.

The Trust scored level 2 compliance for Information Quality and Records Management in 2010/11, which is assessed using the Connecting for Health Information Governance Toolkit. The Trust is not subject to the Audit Commission payment by results clinical coding audit during 2010/11.

NHS Number and General Medical Practice code validity

The East of England Ambulance Service NHS Trust did not submit records during 2010/11 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are in the latest published data.

Information Governance Toolkit attainment levels

The East of England Ambulance Service NHS Trust Information Governance Assessment Report's overall score for the reporting period 2010/11 was 67% and was graded Green using the IGT grading scheme, which means satisfactory on all requirements.

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To improve the level of risk associated with the use of information, the Trust is required to work within the parameters of an information governance framework. Information Governance (IG) is an umbrella term used within the NHS to indicate to stakeholders there is a set of standards, processes and procedures for the use of information which the Trust is required to comply with.

Satisfactory compliance will provide assurance to the Executive Management Team and the Trust Board that all information created and used by the Trust is kept confidential and secure, and that all Trust records meet the NHS Code of Practice. The Code encompasses legal requirements, central guidance and recognised best practice in information handling and includes:

- ▼ The common law duty of confidentiality
- ▼ Data Protection Act 1998
- ▼ Information security
- ▼ Information quality
- ▼ Records management
- ▼ Freedom of Information Act 2000.

The Trust is required to complete an annual self-assessment using the Information Governance Toolkit, which is an on-line assessment tool managed by NHS Connecting for Health. The Toolkit is reviewed by Connecting for Health following the final submission of Trust's scores annually at the end of March. The results are shared with the National Information Governance Board, the Care Quality Commission (CQC) and Monitor. The Toolkit is the principal method of assessing the Trust's information governance framework and its performance during the year, and is a key element of the wider NHS Information Governance Assurance Framework.

In the 2010/11 Ambulance Trust Toolkit there were 35 specific information governance standards contained within five work areas:

- ▼ Information Governance Management
- ▼ Confidentiality and Data Protection Assurance
- ▼ Information Security Assurance
- ▼ Clinical Information Assurance
- ▼ Corporate Information Assurance.

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Each Toolkit standard consists of three attainment levels, scored from level 0 (no compliance) to level 3 (full compliance). Connecting for Health has discontinued the previous red/amber/green assessment rating scheme and specified that Trusts will only be considered compliant if they have achieved a minimum of level 2 against all standards.

The Trust's final Toolkit self assessment was submitted electronically on March 31, 2011. Thirty-four Toolkit standards were considered to have sufficient evidence to justify a level 2 compliance score. One standard (relating to non-EEA information flows) was not relevant to the Trust.

The Trust's internal auditors carried out an independent review of the Toolkit evidence in January 2010. Some recommendations for further improvement were made, and these were implemented before the final score submission.

The Information Governance Toolkit is available on the Connecting for Health website www.igt.connectingforhealth.nhs.uk

Clinical coding error rate

The East of England Ambulance Service NHS Trust was not subject to the Payment by Results clinical coding audit during 2010/11 by the Audit Commission.



Introduction

This section outlines a review of the quality over the period 2010/11. In this year the Trust set five priority areas each of which contributes to the domains of patient experience, clinical effectiveness, and patient safety.

Priority 1 – Reducing preventable falls

Emergency calls to patients who have fallen make up the largest category of calls at around 17%. Last year the Trust set the aim of working with other healthcare providers to reduce the number of falls and avoidable admissions and to increase the identification and referral of patients at risk of future falls.

There is clear evidence that a number of falls are preventable, and that the ambulance service could be a key partner in ensuring this happens.

During the year the Trust's Strategic Transformation Program (STP) accepted a strategic direction for falls. This strategy was based on developing falls work in three key areas across the Trust:

- ▼ Register and referral
- ▼ Prevention
- ▼ Response

These areas fit with the initiatives outlined in last year's Quality Accounts to establish what triggers for intervention could be used as a 'trigger tool', setting up a register, and reviewing the pilot schemes.

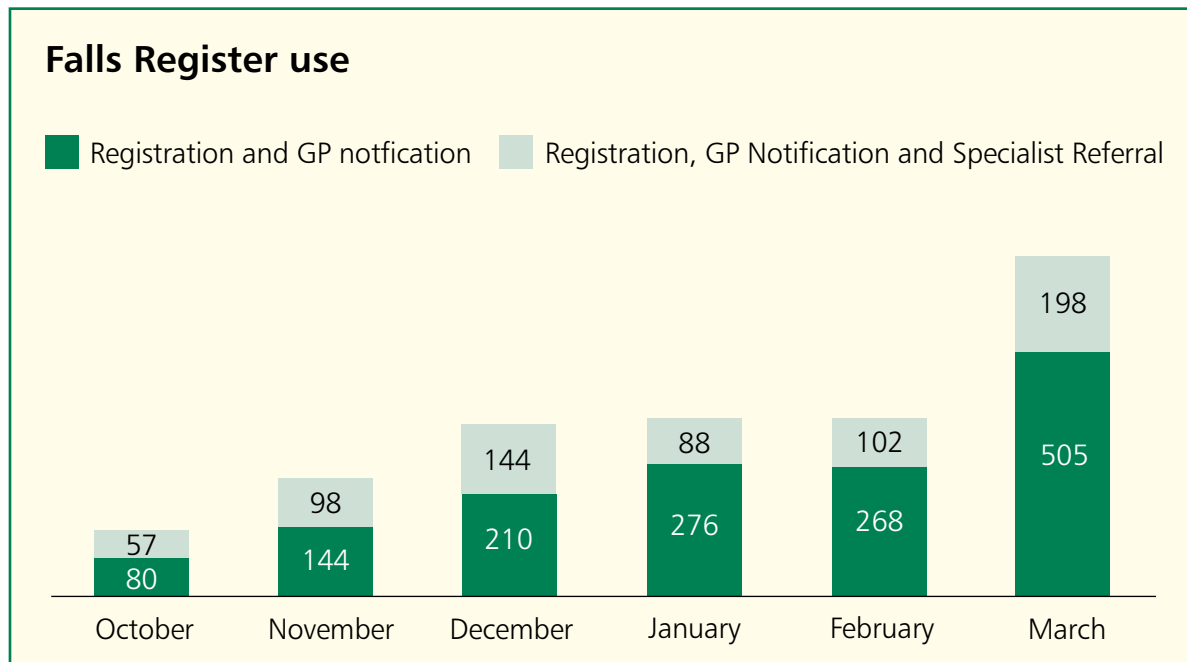
Each of these areas have been developed throughout the year in various ways to improve the quality of care developed for patients calling the service who have fallen.

Register and referral

A register and referral system was developed in the first part of the year based on a trigger tool introduced to all accident and emergency staff through the professional update programme. Clinicians use the trigger tool to identify key areas which contribute to falls prevention, and can access an electronic system 24/7 with the patient's consent to record the details so they can be passed on to other appropriate healthcare professionals. After the development stage the system went live in October.

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The Trust has developed a directory of specialist falls services so in some areas as well as a notification of a fall to the General Practitioner, a specialist team in the community is informed. This is an area that needs further work and liaison, and the Trust will continue to build its directory in 2011/12.



Prevention

The Trust established a regional falls forum which has met throughout the year. At this stage the work has been focused on the development of the register but plans are in place to extend the forum over the coming year to analyse trends in the register and other data sets held by the ambulance service. Using this data and working with members of falls forum, the Trust aims to reduce preventable falls using jointly-held action plans.

The Trust has been present at a number of forums across the year, highlighting the significant number of falls calls attended and how the health community as a whole needs to work on the prevention agenda.

All falls that occur whilst in ambulance care, including scheduled transport are reported as incidents so they can be fully investigated and lessons learnt to improve future practice.

Response

The Trust has continued to explore different options for responding to patients who have fallen. It has pilot schemes operating in east and north Hertfordshire, south-east Essex, west Hertfordshire and Luton.

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The Trust received the National Health and Social Care Award for the falls response project running in west Hertfordshire and received regional innovation funding for its project in east and north Hertfordshire, as well as being advocated as a best practice example of innovation funding. This scheme focused on providing both clinical and social care to the patient at the point of call. The results have shown increased admission avoidance rate, and early access to social care provision.

The Trust received a number of positive comments in relation to falls:

'Husband fell and I was unable to get him up. I have no complaints I can only praise the paramedics'

'Service has been called 3 times when my husband has fallen. Each time staff are extremely efficient and very reassuring to myself. Twice they made calls to GP practice'

'The ambulance paramedic must have seen me fall and stopped immediately. He was with me within seconds and called for ambulance'

'I have had reason to call several times when husband has fallen and been unable to lift him. Each time we have received exemplary kindness and help. Thank you'

In reviewing the quality the Trust has found the majority of experiences in relation to falls to be positive, however, there are areas which also require development:

'I consider my answers fair and have no intention of getting crew into trouble with their services. Felt at time attitude towards my injuries very trivial as I had tripped and fallen and was bleeding heavily and had severe pain in shoulder and arm. Staff said it was not much and they would send a mini bus to pick me up to take me to hospital. Which took about 3/4hr to arrive'

In reviewing this case it is clear that pain was not managed appropriately and forms one of our priority areas for 2011/12.



Priority 2 – Increase the number of patients accessing an appropriate stroke patient care pathway

Stroke is a major cause of mortality and morbidity. Since the national stroke strategy was published in 2008 the Trust has made significant progress on the quality markers outlined. There is however still more that can be done to ensure the Trust is consistently getting the patient to the right place for stroke and transient ischaemic attack (TIA) services.

In 2010/11 stroke was identified as a priority with an overall aim to increase the number of patients who presented with a stroke to access the correct treatment pathway by introducing:

- ▼ TIA patient care pathway to identify high and low risk patients by employing the ABCD2 system
- ▼ A low-risk TIA referral system
- ▼ Region-wide access to acute thrombolysis service 24/7 for all stroke patients.

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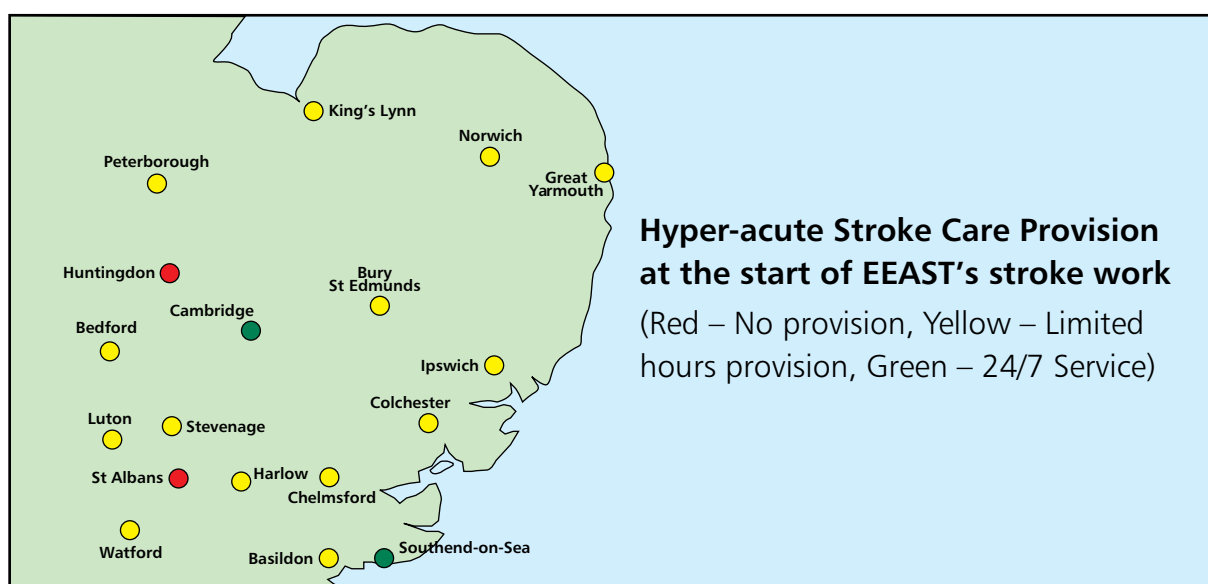
Over the course of 2010/11 the Trust has made significant improvements in the quality of care delivered by front line emergency crews to suspected stroke patients. The Trust has achieved this by introducing new pathways, facilitating access to stroke thrombolysis 24/7 across the EoE as well as implementing a variety of projects and public engagement activities. These have been achieved by developing close partnerships across many different NHS bodies including NHS East of England, Essex, Anglia, and Bedfordshire and Hertfordshire cardiac and stroke networks, 18 primary care trusts and 14 acute hospital trusts.

Access to 24/7 stroke thrombolysis and EOE stroke pathway

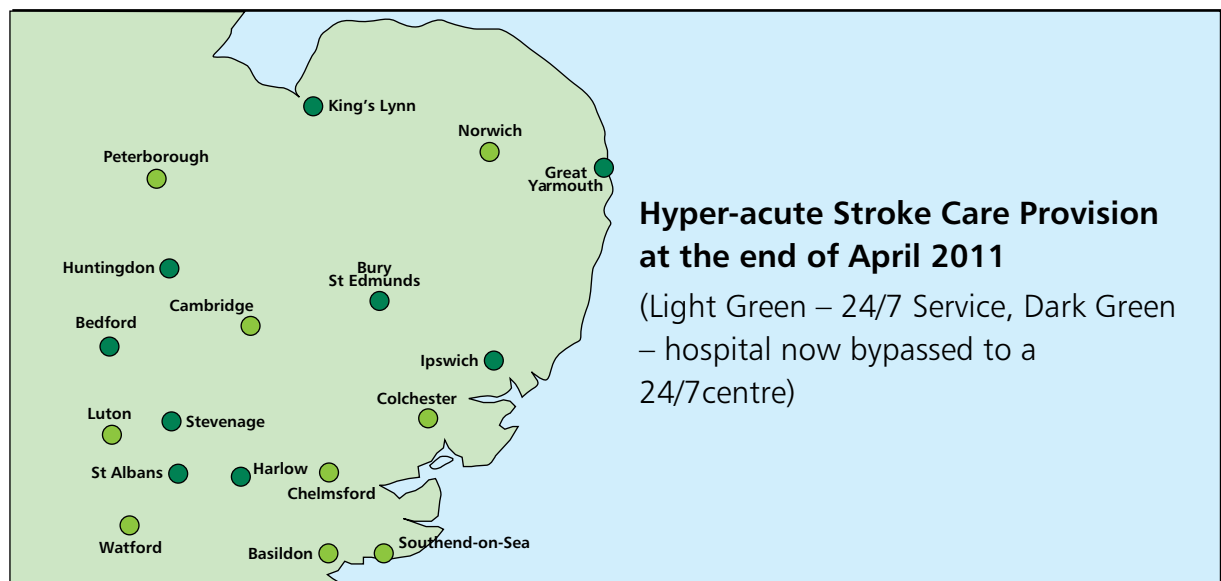
In April 2010 there was limited access to 24/7 stroke thrombolysis across the region. Over the course of the year in partnership with colleagues, access to 24/7 stroke thrombolysis has improved considerably. This is in part due to the implementation of the stroke telemedicine network which EEAST has been involved with at both SHA and network level, but also in the implementation of several out of hours stroke thrombolysis diverts in which EEAST has taken a significant lead.

These diverts allow clinicians to take stroke patients potentially eligible for stroke thrombolysis directly to a centre which provides thrombolysis, meaning that the patient's local hospital which does not provide thrombolysis is bypassed. This has meant a significant increase in equality of access to 24/7 stroke thrombolysis regionally.

It involved working in partnership to develop a regional stroke divert and repatriation policy which was supported by the SHA and was implemented following agreement at the EoE directors of commissioning steering group.



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In conjunction with the implementation of stroke diverts, the Trust has developed a single stroke pathway for all clinicians. This new pathway details the assessment process for all clinicians when attending suspected strokes as well as clearly outlining the inclusion criteria for thrombolysis detailing when and in what circumstances divert to a centre providing thrombolysis. It promotes best practice and highlights the need for rapid emergency access to hyper acute stroke units (HASU) for all stroke patients, in line with the national stroke strategy. The pathway developed also reflects the importance of national clinical performance indicators (NCPI) and details the requirements for complying with these. In 2010/11 the NCPI care bundle for stroke showed 79.2%, 79.1% and 82.3% compliance with care. Continued improvement in these scores is required and will be met with the continuation of this priority into 2011/12.

Primary Care clinicians have been updated on stroke guidelines to ensure that appropriate pathways are followed also.

Positive patient comments have included 'Crew exemplary arrived within 2 minutes. Diagnosis and treatment text book perfect (stroke) however this was wasted due to wait in A&E (far from busy) and then ACU shambles'

We are seeking to increase knowledge that stroke is an emergency, another patient comment highlighted this message needs to continue to be cascaded throughout 2011/12:

'Due to the fact that I was suffering symptoms of a stroke there did not seem any urgency to get me to hospital for treatment. Was told by crew it was muscular when in fact it was a stroke'

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TIA pathway and low referral system

EEAST has worked in conjunction with the Essex Cardiac and Stroke Network to develop a single transient ischemic attack (TIA) referral pathway. This pathway allows clinicians attending patients who have experienced a TIA to carry out a thorough assessment using the ABCD2 assessment tool to identify low and high risk TIAs. Where a high risk TIA is identified, taking the patient to the nearest accident and emergency department is advocated for urgent specialist follow up. When a low risk TIA is identified this pathway enables a direct referral of the patient to specialist TIA outpatient clinics via a single point of contact call centre. All appropriate details are recorded electronically and then sent to the patient's local hospital so that follow up within seven days can be arranged.

This system is currently operated as a pilot scheme across Essex following which it is envisaged that the pathway and referral scheme will be expanded to cover the region.

Patient comments relating to TIA knowledge and provision have been positive:

'After a slight TIA I declined hospital, but was told if I changed my mind they would be right back. They could not have been more caring, thoughtful and thorough. They were very nice people.'

'The event turned out to be a mini stroke but in view of age and in the middle of the night the crew felt that hospital was the correct option. And I am most grateful.'

Pre-alert all suspected stroke to stroke teams

Basildon and Thurrock NHS Foundation Trust, Peterborough City Hospital NHS Foundation Trust, Norfolk and Norwich University Hospital NHS Foundation Trust, and the James Paget University Hospital NHS Foundation Trust have, with EEAST, agreed to ambulance clinicians alerting specialist stroke teams prior to the arrival of ANY suspected stroke. This has enabled more rapid specialist assessment of the stroke patient's arrival in A&E. At Norfolk and Norwich a 'direct to the CT scanner' pathway has been established; crews en route to hospital alert the stroke nurse specialist directly to provide a detailed handover and pre-alert message. The nurse specialist then activates the appropriate radiology and stroke specialist teams to allow for a rapid assessment on arrival, resulting in the majority of cases being taken directly to the CT scanner by EEAST clinicians with a specialist nurse escort. This example of joint working has seen both

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significant improvements in the number of stroke patients being scanned within the national target time frame and reductions in the time between arrival at A&E and the intervention of stroke specialists.

It has been found that the earlier specialist teams are aware of the potential arrival of a stroke patient, the more time can be spent on arranging direct admission and rapid access to a specialist stroke unit. This minimises the time stroke patients spend in assessment areas such as A&E and maximises the amount of specialist involvement at the earliest opportunity.

Public engagement

Over the course of 2010/11 the Trust ran a series of public engagement events across the region, the majority of which were in conjunction with other healthcare organisations. The main aims of these events was to highly publicise the importance of using the FAST assessment and calling 999 immediately when a stroke is suspected. The events also invited people to have their blood pressure taken and members of the public were able to speak to clinicians, who distributed information about stroke/TIA and the associated risk factors.

Those who had a BP screen received advice regarding their BP and modifiable life style factors. Members of the public who were identified to have high a BP where advised to follow up with their GP for further healthcare advice. The Trust set up 10 events during which 1,706 blood pressures were taken (of which 215 members of the public were referred for further assessment).



Priority 3 – Improve the quality of patient handovers

An important component of continuing care is that the patient is effectively handed over from one healthcare professional to another, using both verbal and written instructions. Generally this happens in A&E, but may also occur with GPs, nursing teams and Social Services. Last year the Trust set a priority for ensuring that all paper and electronic patient care records were accurately completed and submitted. In discussion with clinicians and staff this year, the Trust focused on improving the completion and submission of the paper patient care record.

Aim

To improve the Trust's compliance to Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which states that the Trust must ensure all service users are protected against the risks of unsafe or inappropriate care and treatment which may arise from a lack of proper information held about them. The patient care record which may be in paper or electronic form must be:

- ▼ kept securely and located promptly when required
- ▼ retained for an appropriate period of time (See DH guidance)
- ▼ securely destroyed when it is appropriate to do so.

Identified areas of improvement

The Trust needed to significantly improve the quality of the completed of the PCR and to improve the rate of submission of its paper PCRs.

New initiatives to be implemented in 2010/11

- ▼ Improve the completion of patient care records to 90%
- ▼ Improve submission of PCRs to 90%

Progress to date

Improve rate of submission of PCRs to 90%:

The Trust began the year with a 69.4% submission rate for its patient care records. Since setting this improvement target, the rate of submission has improved but this has been variable month on month.

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In the year to date, 17,262 calls have been audited against the number of available PCRs submitted with the following results:

Patient Care Records Submitted 2010/11					
Objective: PCR submitted - all cases	Target	Trust-wide total		2010/11 year to date	
April	90%	1,315/1,651	79.6%	1,315/1,651	79.6%
May	90%	1,400/1,707	82.0%	2,715/3,358	80.9%
June	90%	1,181/1,779	66.4%	3,896/5,137	75.8%
July	90%	1,403/1,877	74.7%	5,299/7,014	75.5%
August	90%	1,337/1,635	81.7%	6,636/8,649	76.7%
September	90%	1,288/1,661	77.5%	7,924/10,310	76.9%
October	90%	1,272/1,611	79%	9,196/11,921	77.1%
November	90%	1,404/1,729	81.2%	10,600/13,650	77.7%
December	90%	1,402/1,806	80.2%	12,002/15,456	77.9%
January	90%	1,489/1,806	82.4%	13,491/17,262	78.9%
February	90%	1,328/1,578	84.2%	14,819/18,782	78.9%
March	90%	1,221/1,503	81.2%	16,040/20,285	79.1%

In an effort to understand the reasons behind this monthly inconsistency and to continue to improve its position, the Trust reviewed its approved care record policy and Patient Care Record Shift Log Guidance document to establish whether these approved documents had been fully implemented across the whole Trust.

The review identified there was still some variation in the management of PCRs across the Trust which required further action. The Clinical Audit department developed a PCR submission audit tool and posted it on the intranet to assist managers in collecting and submitting PCRs. The PCR policy was re-issued and additional security wallets were bought and re-introduced across the Trust to improve the safety and speed of PCR returns. A single archiving company was also contracted to streamline PCR storage as well as the safe destruction of PCRs.

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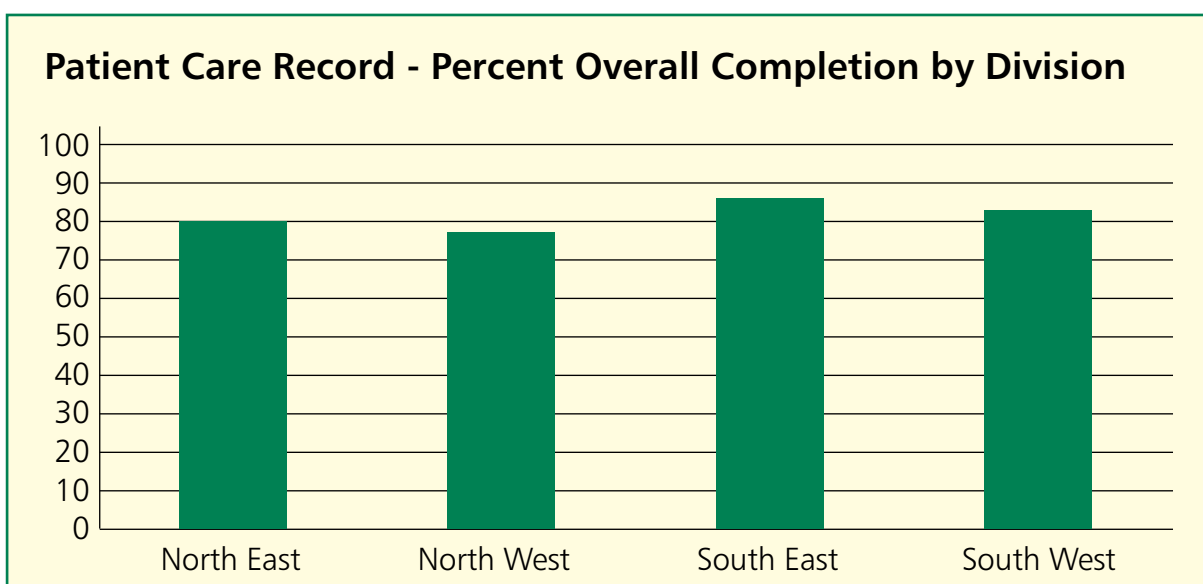
More work needs to be done to mitigate the clinical risk which could potentially arise from attending patients without having a written PCR in place for each patient episode. The clinical general managers and clinical operational managers have implemented a clinical quality improvement action plan to improve this position and have published posters at stations to encourage staff to complete a PCR for every patient contact. In addition the Trust is rolling out ePCR and is considering a scanning system which would be introduced as an interim measure whilst the ePCR project is worked on, which is estimated to take another 12-18 months.

Improve rate of completion of PCRs to 90%

All records must be correctly and accurately completed so adequate information is held about each patient responded to and treated. PCRs are often requested by the police and coroners, by the patient, or by third parties acting for the patient. All patient identifiable data is only released by the Trust once it is satisfied that there is proof of identity and there is written patient consent. PCRs also provide valuable information used to support clinical audits so the Trust can evaluate and improve patient care and service provision. Each year on top of the annual clinical audit programme it audits and monitors the quality and standard of PCR completion. The Trust began the year with a completion rate of 50.5% and set an improvement target of 90%.

Audit of the quality and standard of PCR completion

PCR completion compliance for 2010 was 82.2% which is much improved since the last comparable clinical audit in 2009 when the overall completion of PCRs was just 50.5%.



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Within primary care an electronic system is used to record all patient episodes and using this system the patient's own GP is faxed details of encounters in the out of hours period by 8am the following morning.



Priority 4 – Increase the percentage of patients accessing preferred type of end of life care

In discussion with patients and in line with national guidance the Trust has adopted and implement the principles of the Liverpool Care Pathway to ensure palliative care patients avoid inappropriate admission to hospital and are able to die in a place of their choice. The majority of people would like a dignified death and would like to remain at home. As such the Trust has worked with end of life care (EOLC) networks to decrease the number of palliative care transfers to hospital and increase the number of Computer Aided Dispatch (CAD) system flags indicating the preferred place of death for palliative care patients.

Aim

To ensure that Trust clinicians play a part in ensuring that patients die in a dignified fashion in a place of their choosing.

Identified areas of improvement

- ▼ Improve the collection and dissemination of management plans relating to end of life (EoL) care
- ▼ Improve the education in EoL care of the Emergency Care Practitioner cadre so that they can intervene appropriately when despatched to a call
- ▼ Contribute to future planning of EoL services by attending local and regional meetings.

Progress to date

The Trust has three call centres (HEOCs) and each centre has a different computer system and so this has necessitated a separate system for entering end of life management plans in each centre. 2010 was used to establish the system and to publicise to primary care teams and hospices the route by which these can be sent.

The management plans can alert us to the fact a patient is near to the end of their life or more specifically that resuscitation is inappropriate or would be futile. It also receives plans which detail the setting in which a patient wishes to spend their final days. This information is put on the computer system so an appropriate response can be dispatched and that clinicians are forewarned and so can approach the patient with the appropriate attitude in both emergency and primary care settings.

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EoL CAD flags	Apr 10	May 10	Jun 10	July 10	Aug 10	Sep 10	Oct 10	Nov 10	Dec 10	Jan 11	Feb 11	Mar 11	Total
Chelmsford				24	57	14	15	18	48	18	36	0	230
Bedford			31	18 (-29)	34 (-26)	14 (-26)	16 (-22)	34 (-20)	24 (-31)	33 (-17)	30 (-24)	45 (-25)	280 (-220)
Norwich			23	34	56 (-1)	11 (-43)	60 (-19)	28 (-35)	23 (-0)	156 (-38)	2 (-0)	132 (-123)	525 (-259)
Total			54	76	147	39	91	80	95	207	68		1035
				(-29)	(-27)	(-69)	(-41)	(-55)	(-31)	(-55)	(-24)		(-479)

It is just as important to remove these note flags once a patient has died. It would be unkind and impractical to keep phoning patients and their families to check whether a patient had died.

Access to the Open Exeter System has been achieved, which allows the staff who enter the data to check on whether people have been reported as having died. This has worked well in Norwich and Bedford but has not proved possible in the Chelmsford HEOC. It is hoped once the three computer systems are combined then this can be achieved region wide.

Education is a key component to any system change. The Trust approached all hospices in the region to see if they would help in the further education of the emergency care practitioners (ECPs) and had an overwhelmingly positive response from them. They were asked to deliver a programme which gave an overview of end of life care, the practical application of the Liverpool Care Pathway and also the management of end of life emergencies.

	Apr	May	Jun	July	Aug	Sep	Oct	Nov	Dec	Jan
Day 2 CPD ECP attendance (last year 68)	17	23	14	23	2	28	3	5	0	0
Day 3 CPD ECP attendance (last year 19)	0	0	0	0	0	11	7	38	12	0

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The mandatory part of Trust education included a session on EoL care so that every clinician starts to grasp the part they can play in achieving a 'good death'; by a 'good death' we mean one which is free of pain, with family and friends nearby, with dignity and in the place of one's choosing. The education programme was largely suspended during the winter months due to operational demands.

There have been a number of cases where relationships fostered during these education courses have led to Trust staff being included in hospice education sessions.

Communication is vital in all areas of healthcare delivery but particularly in end of life care and it is gratifying to hear about this ongoing education.

The Trust also gave each ECP a copy of a self learning module produced by the National Council for Palliative Care called Care to Learn which has allowed ECPs to further their knowledge during their rest periods.

There is a continual demand at all levels of the healthcare economy for representation from the ambulance service and in planning and delivering EoL care. The Trust has provided representation at a number of levels from SHA and the regional cancer network arena, through to primary care trusts and Marie Curie Projects down to GP practices and hospices. It is gratifying to receive these invitations as the Trust is seen as a key player in helping improve the current situation. However, one of the difficulties with a regional ambulance service is being able to provide this representation, and for it to be someone knowledgeable in that area. Dr Nick Morton, Associate Director of Clinical Services, has led the representation but the development of a network of EoL Clinical Champions has allowed local representation and a system by which information can be relayed on local initiatives. These initiatives include all the services the Trust provides including emergency, primary care and scheduled transport. An example is patients in Cambridgeshire who are directly taken to hospice care promptly and responsively. Staff in Suffolk represent EEAST in the development of the "Maria Curie Delivering Choice Programme" for end of life care.

CASE STUDY 1

'999 call to a 50-year-old woman who was found to be receiving palliative care for lung cancer.'

An assessment showed that her shortness of breath was due to pain. All her observations were stable but her pain had raised her pulse and rapidity of breathing. The increase in pain had happened following a change in pain relief within the past 24 hours when a syringe driver had been commenced. It was clear that nurses had

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been with her overnight, and doses of diamorphine had been administered. In addition to the pain, the patient was complaining of extreme nausea. The severity of her pain resulted in her asking to be 'put to sleep.' The paramedic requested help from the district nurse who quickly phoned and said that she would attend to agree a care pathway within the next 30-45 minutes.

Action:

The patient had a emergency pack of anticipatory drugs and included in this was an effective anti emetic.

The Clinical Advice Line (CAL) was contacted and authorisation given to the paramedic to administer this drug together with morphine sulphate for the break through pain. Titrating morphine to 10 mg was required to achieve appropriate analgesia after which the patient's condition improved.

In liaison with the district nurse who attended and the patient's GP a direct referral to a palliative care bed in the local hospice was obtained and transport was duly arranged.

This case showed:

- ▼ a good assessment by the paramedic who found the cause of the problem
- ▼ awareness of end of life issues meant that an alternative to transporting to the local A&E was sought. This awareness had been provoked by the module on the education course for the year
- ▼ anticipatory drugs prescribed by the GP and left in the patient's house allowed a prompt response to the patient's changing clinical condition.

CASE STUDY 2 – Practitioner Account

'Call to an unconscious 80 year old lady mid Saturday morning'

On our arrival she was unresponsive, tachycardia of 150 with radial pulse barely palpable, respiration rate of 46 and noisy in all lung areas, blood pressure 60 systolic, oxygen saturation 70% on air, temperature 38.5c.

According to the family she was terminally ill but she had deteriorated quicker than anticipated. There was a DNA-CPR order dated two days previously and family didn't want any interventions other than to make her as comfortable as possible. It was obvious that she was dying, and her very noisy breathing was distressing her family.

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We agreed with the family that we would give her oxygen while waiting for the out of hours doctor to arrive, but that we wouldn't be able to leave her on the oxygen - ultimately we would have to withdraw or transport to the A&E department which we all agreed was inappropriate. The doctor agreed with our decision to leave the patient at home and asked us to continue with the oxygen.

He prescribed hyoscine but we found that the district nurses had already left some together with other palliative care medication and that they were going to return the next day to set up a syringe driver. Whilst I was contacting the district nurses to get them back sooner the patient died, peacefully and surrounded by her family who had been given time to gather. The patient was kept comfortable whilst her family arrived, and we avoided a pointless and totally inappropriate journey to an A&E department which is so often the only option open to us.

Points:

- ▼ Improved recognition of end of life phase
- ▼ Improved awareness of other agencies and their part in providing a "dignified death"
- ▼ Improved communication skills with families
- ▼ Improved ability to allow patients to die in the location of their choosing.

CASE STUDY 3

Female patient in residential home was having breathing difficulties so staff called 999.

The ambulance service dispatched an ECP but backed him up with a double paramedic crew. The patient was severely demented and had been on antibiotics for four days for a chest infection. She had not been eating and the staff were concerned that fluid intake was decreasing.

Examination by the ECP found blood pressure 138/70, pulse 76 and agonal respirations of 32. Oxygen saturation was 98% and the patient was apyrexial. The lungs sounded clear and there was nothing abnormal found in other systems. The patient was uncommunicative but resisted physical examination.

The ECP discussed end of life issues with the staff of the residential home and their ability to cope. He managed to discuss the options with the next of kin who made

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it clear that the patient hated hospitals, doctors and medicines. She would not have wished to be admitted.

The ECP spoke with the GP, who he knew from working with her in the Out of Hours Service, who agreed to attend and review the patient. A review took place and after discussion with the care staff a plan was formulated to manage the patient at home in her familiar surroundings.

The paramedics commented that they would have transported this patient, as they would not have considered these options open to them.

Points:

- ▼ The end of life training undertaken by the ECP allowed him more confidence in recognising the end of life phase
- ▼ He was aware of options other than admission to hospital
- ▼ Working alongside GPs in the OOH service gave him a greater awareness of help available from his GP colleague
- ▼ He was able to educate the paramedic crew in options other than hospital admission.



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Priority 5 – Improve the cleanliness of the pre hospital environment and reduce the risk of infection

Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2009 stipulates that providers of services comply with the Code of Practice for the prevention and control of infections in health and social care and related guidance (2010). This Code of Practice encompasses 10 criteria relating to the management of IPC against which the Trust will be judged on how it complies with Regulation 12.

Compliance criterion	What the Trust is required to demonstrate
1	Systems to manage and monitor the prevention and control of infection are in place. These systems use risk assessments and consider how susceptible service users are and any risks that their environment and other users may pose to them
2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infection
3	Provide suitable accurate information on infections to service users and their visitors.
4	Provide suitable accurate information on infections to any person concerned with providing further support on nursing / medical care in a timely fashion
5	Ensure that people who have or develop an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of passing on the infection to other people
6	Ensure that all staff and those employed to provide care in all settings are fully involved in the process of preventing and controlling infection
7	Provide or secure adequate isolation facilities
8	Secure adequate access to laboratory support as appropriate
9	Have and adhere to policies designed for the individual's care and provider organisations, that will help to prevent and control infections
10	Ensure, so far as is reasonably practicable, that care workers are free of and are protected from exposure to occupational infections and that all staff are suitably educated in the prevention and control of infection associated with the provision of health and social care

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In June 2010, the Trust received an unannounced inspection by the Care Quality Commission (CQC); this visit looked at compliance to three regulations, one of which was Regulation 12. Following the inspection, the Trust was deemed to be fully compliant against this regulation.

The Trust's IPC Annual Work Programme has been developed around the 10 criteria of the Hygiene Code of Practice to ensure that it meets its statutory responsibilities and provides care in a clean and safe environment. However, it should be noted that criteria 7 and 8 are not applicable to EEAST.

A clean environment provides the right setting for good patient care and good infection prevention and control. This is very challenging in the pre hospital arena where paramedics are required to treat and stabilise patients in a variety of settings and environments which are often not clean. All staff play an important role in improving the quality of service provision and in improving public confidence in the service by reducing and mitigating infection related risks.

The areas that are to be cleaned in the pre hospital environment are divided into functional areas. Maintaining the required standard of cleanliness is more important in some functional areas than in others. In line with the revised National Specifications for Cleanliness in the NHS: a Framework for Setting and Measuring Performance Outcomes (2007) the functional areas are grouped into three levels of cleaning intensity, based on the risks associated with inadequate cleaning in that particular area, for example:

- ▼ High risk areas - includes ambulance vehicles, sterile storage areas in stations, dirty utilities and toilets
- ▼ Significant risk areas - includes the staff kitchens, rest rooms, locker rooms and response post rooms
- ▼ Low risk areas - includes administrative areas, non-sterile supply areas, record storage and archives.

In addition the Trust has taken into account the Revised Healthcare Cleaning Manual (2009). Both documents provide comprehensive guidance on all aspects of cleaning performance and frequency together with audit.

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Aim

As part of the annual programme and to minimise the risk of infection to patients, staff and visitors and in response to the inspections undertaken by the CQC, the Trust has developed additional systems and key performance indicators to monitor and improve the cleanliness of all its risk areas listed on page 57.

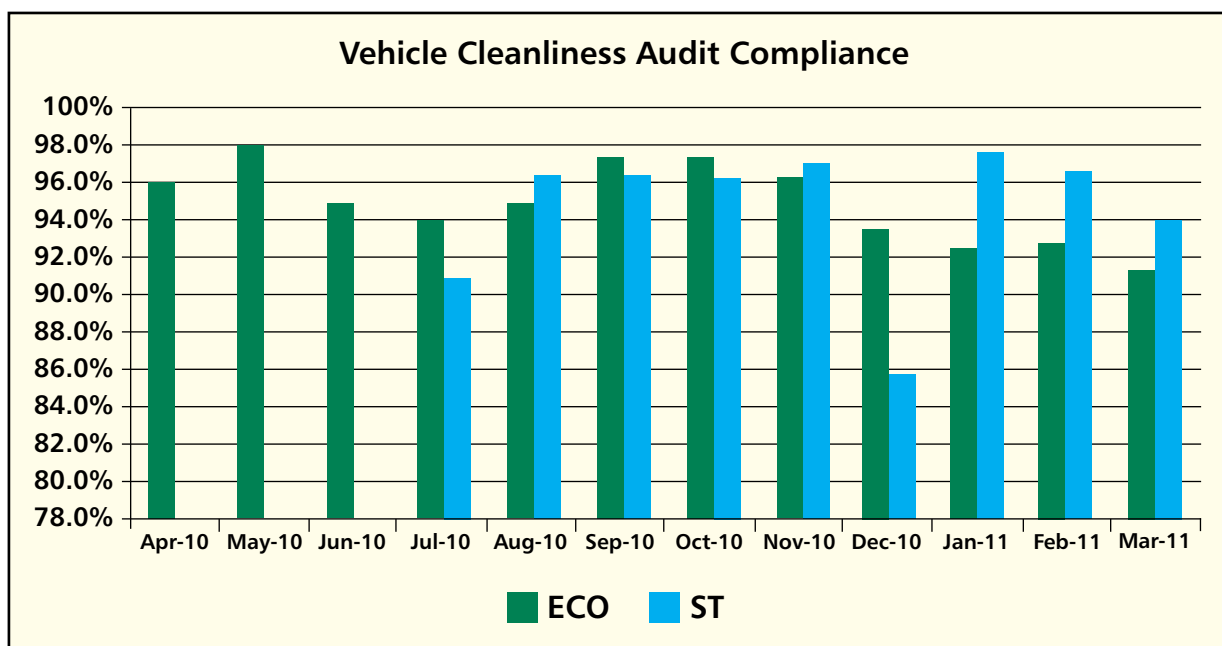
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Progress to date

As previously stated, the Trust has a comprehensive IPC annual work plan which encompasses all relevant criteria defined within the Hygiene Code of Practice. The Trust also has a detailed IPC audit schedule and continues to complete actions contained within this. Both the annual work programme and audit schedule are monitored by the IPC Group. Any areas of concern are highlighted to the Clinical Quality and Safety Group which in turn escalates any issues to the Integrated Governance Committee.

Cleanliness audits in relation to emergency care operation (ECO) vehicles have been in place since April 1, 2010 and the auditing of Scheduled Transport (non-emergency) (ST) vehicles began on July 1, 2010. Although the National Patient Safety Agency (NPSA) has specified compliance against standards of 85%, the Trust has made a decision to set a level of 95% as the aspirational target for vehicle and station cleanliness.

The chart below demonstrates the audit compliance for both ECO and ST vehicles.



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To better understand the compliance in relation to vehicle cleanliness, results are grouped into two areas; non-patient (vehicle exterior, interior cab) and patient (saloon interior, equipment). Monthly results are fed back to local staff as well as to the IPC Group and to the Trust Board in the format of the Corporate Dashboard.

In December 2010, the Trust saw a substantial drop in compliance for the cleanliness of the exterior of vehicles; this can be attributed to the extreme adverse weather conditions as the severe cold weather caused many locality pressure washers to remain frozen for the majority of the month, and the Trust experienced an unprecedented high call volume.

The Trust implemented ambulance station 'Spot Check – Housekeeping' audits across all operational areas from September 1, 2010 and also introduced 'Technical Audits' of station cleanliness mid-year, which were carried out by an expert. This invaluable feedback and findings from an in-depth Trust-wide estates audit have been used to develop a comprehensive Estates Strategy.

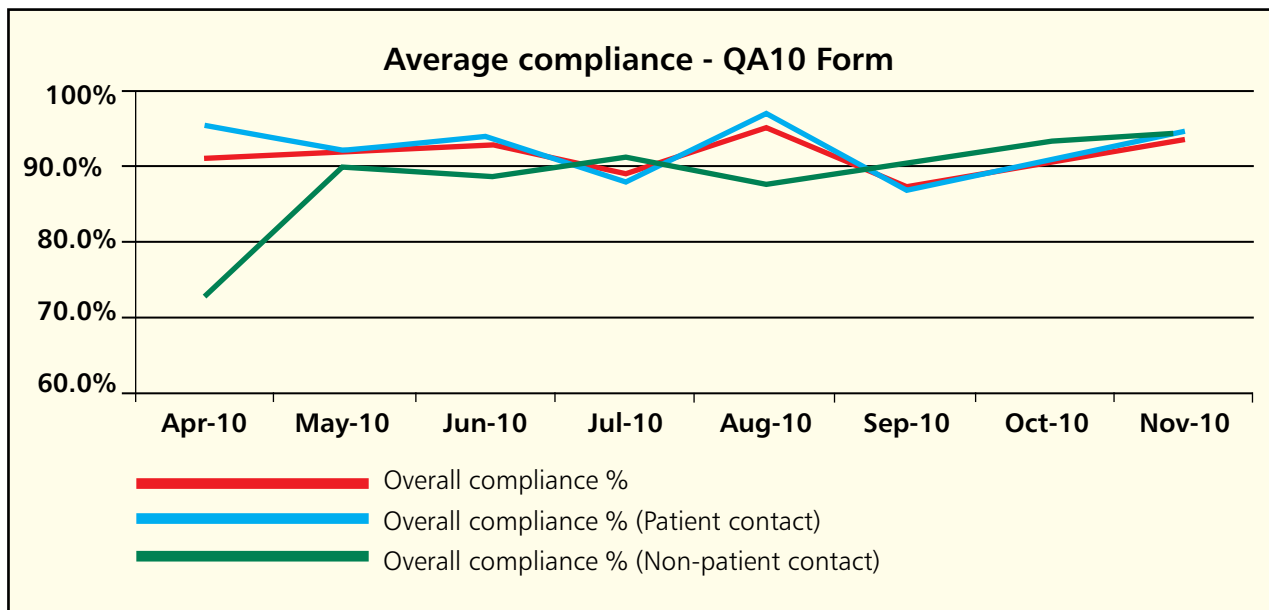
As part of the monitoring process, members of the Trust User Group and representatives from PCTs have also been carrying out spot checks of both vehicle and station cleanliness; their findings are taken back to the Trust and monitored for any actions. Following a comment from one PCT, changes were made to the audit form and additional questions were included about mattresses/trolleys (whether there were any splits or tears), and sharps bins (whether they are labelled and attached to vehicle correctly). A comment from a Trust User Group member was '...now completely reorganised and excellent.'

Questions about vehicle cleanliness are included in patient surveys and were also included in Discovery interviews and community feedback sessions with patients.

The Trust continued to audit individual staff performance through its Quality Assurance programme. Each clinical member of staff takes part in an observational audit as part of their continual professional development (CPD) and is assessed, amongst other areas, for adherence to criterion such as: aseptic technique, cleaning of equipment, cleaning of vehicle between patients, management of sterile consumables.

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The overall compliance for April-November 2010 can be found in the chart below.



Other initiatives and plans implemented in 2010/11 include:

- ▼ the appointment of full-time Infection Control Nurse Specialist
- ▼ the appointment of Decontamination Operatives at main depots
- ▼ IPC manuals for all stations containing information such as IPC Management Policy, IPC Audit Policy, Safe Practice Guidelines, cleaning schedules, audit templates, etc.
- ▼ dedicated IPC notice boards at all stations
- ▼ involvement with
 - ▼ air ambulance charities
 - ▼ independent ambulance provider – validation and terms and conditions
 - ▼ in-house cleaning schedules – non-contracted areas
- ▼ a vehicle cleaning operative plan
- ▼ a review and standardisation of cleaning products across the Trust
- ▼ specialised in-depth training delivered to clinical managers
- ▼ a review of all training for 2011/12.

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We have specifically asked about vehicle cleanliness within the discovery interviews this year. One comment received was that "The vehicle was full of rubbish." (Interview 7, Hertfordshire). This priority has been carried forward to 2011/12 and we aim to ensure ongoing improvements.

However, the majority were positive comments:

'Spotless.' (Interview 53, Norfolk)

'Excellent and clean.' (Interview 65, Essex)

'Very clean and comfortable.' (Interviews 10 & 11, Hertfordshire)

'I didn't notice if the vehicle was clean but would have noticed if dirty so assume it was clean.' (Interview 85, Cambridgeshire)

National Clinical Performance Indicators

Ambulance trusts throughout England have been working together to produce a set of National Ambulance Services Clinical Performance Indicators (NCPIs). The system has been well tested; five topics were set in 2008, and are reviewed twice a year, using a month's patients for each sample. The results are benchmarked against other ambulance services.

The process measures factors which are particularly known to have an effect on the patient's outcome, such as aspirin or thrombolysis in acute myocardial infarction'. Such measures are grouped within a single care indicator known as a 'care bundle'; the NCPIs use this principle in their design.

Clinical performance monitoring may often show that the giving of individual aspects of care often perform well; however when we look to see that the patient has received every element of care, we find that too often a single element of care has not been implemented.

EEAST uses the care bundle principle when possible as a simple measure of the overall quality of care for the patient. By focusing on improving the performance of the care bundle not only should performance for individual aspects of care improve, but importantly the overall care of the patient should improve.

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To help facilitate improvements in the overall care of the patient the following steps have been taken during 2010/11 and will continue throughout 2011/12:

- ▼ NCPI reporting has been added to the Trust monthly reports. The report is sent to senior Trust managers and is available on the Trust's intranet for all staff to access
- ▼ Local stations/teams are monitoring local performance each month which is being collated centrally, with immediate action to be taken locally when performance needs improving
- ▼ The Trust is taking part in a national Cardiovascular Quality Initiative project which is designed to improve the care of patients suffering a stroke or heart attack.

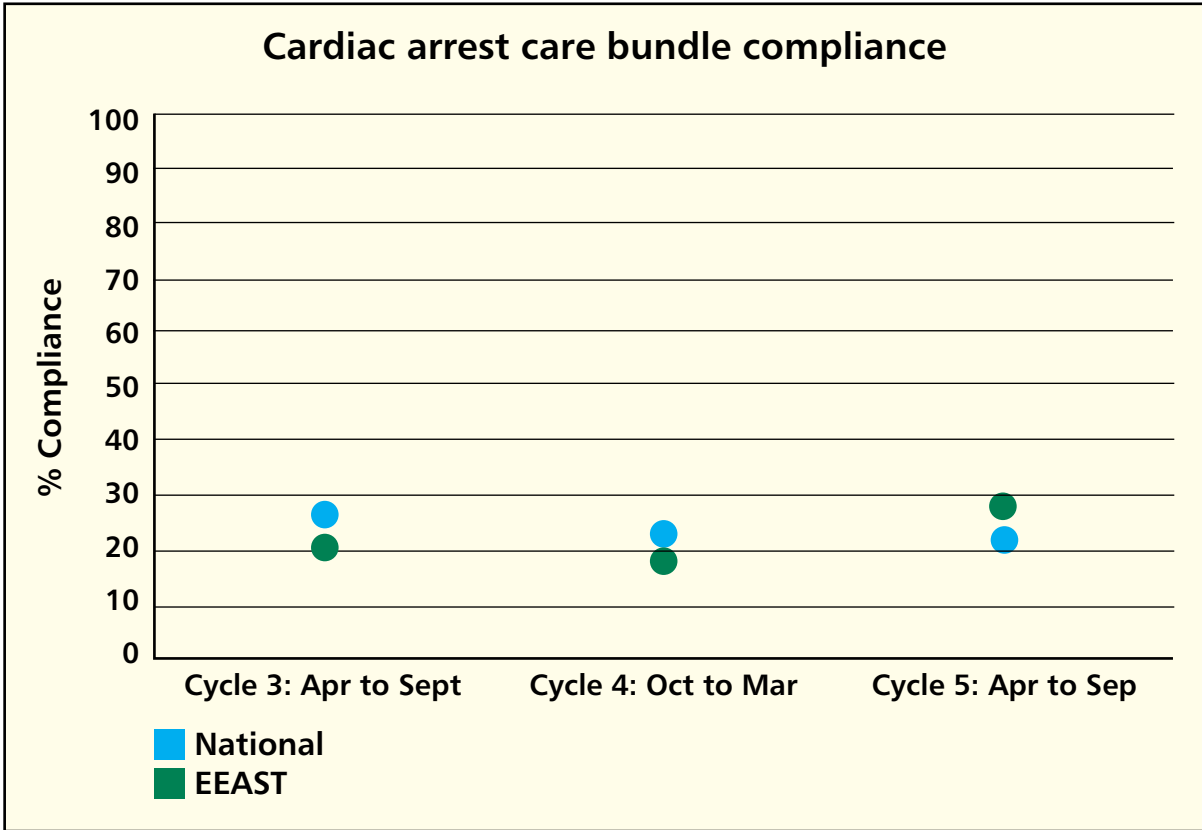
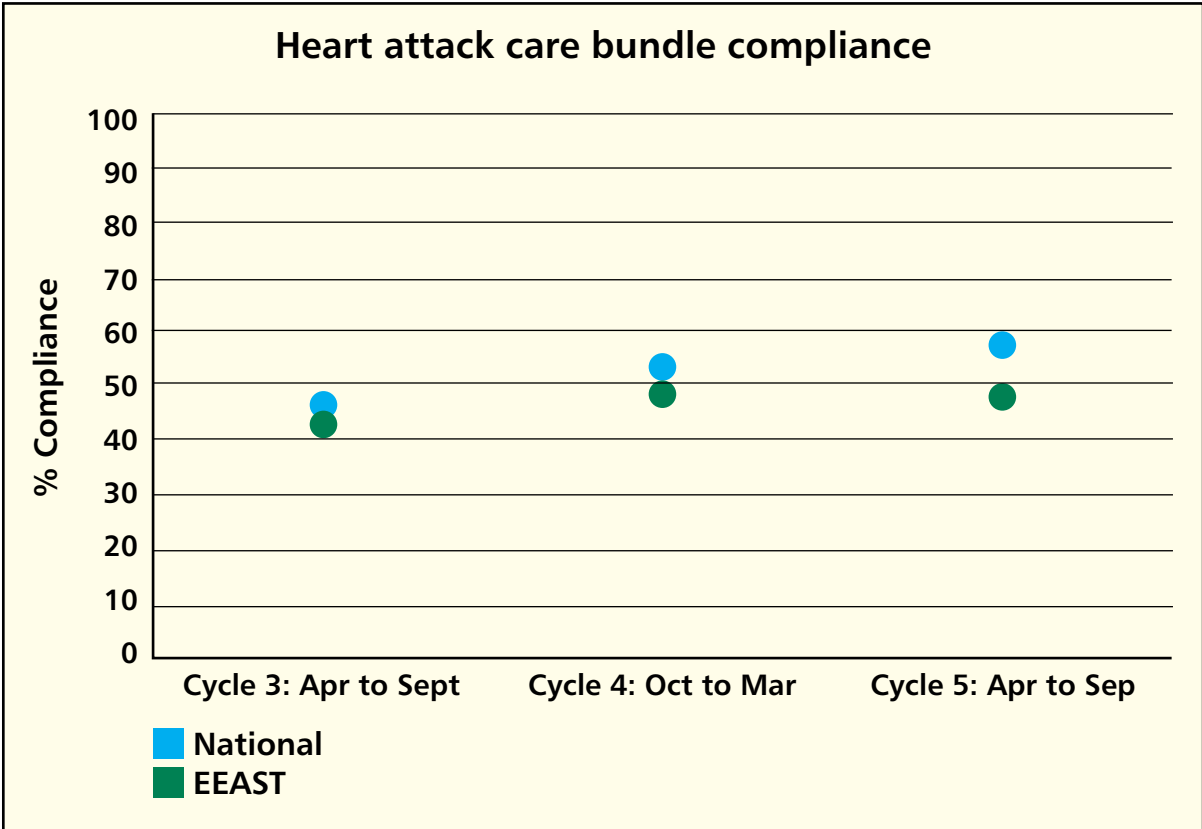
The aim is to help ensure that every appropriate treatment should be given to every patient, on every occasion, by every clinician and the Care Quality Commission (CQC) monitors the results of the Trust's NCPIs.

The table below shows the last three cycle results for each care bundle; it compares the results for the EEAST with the national average result.

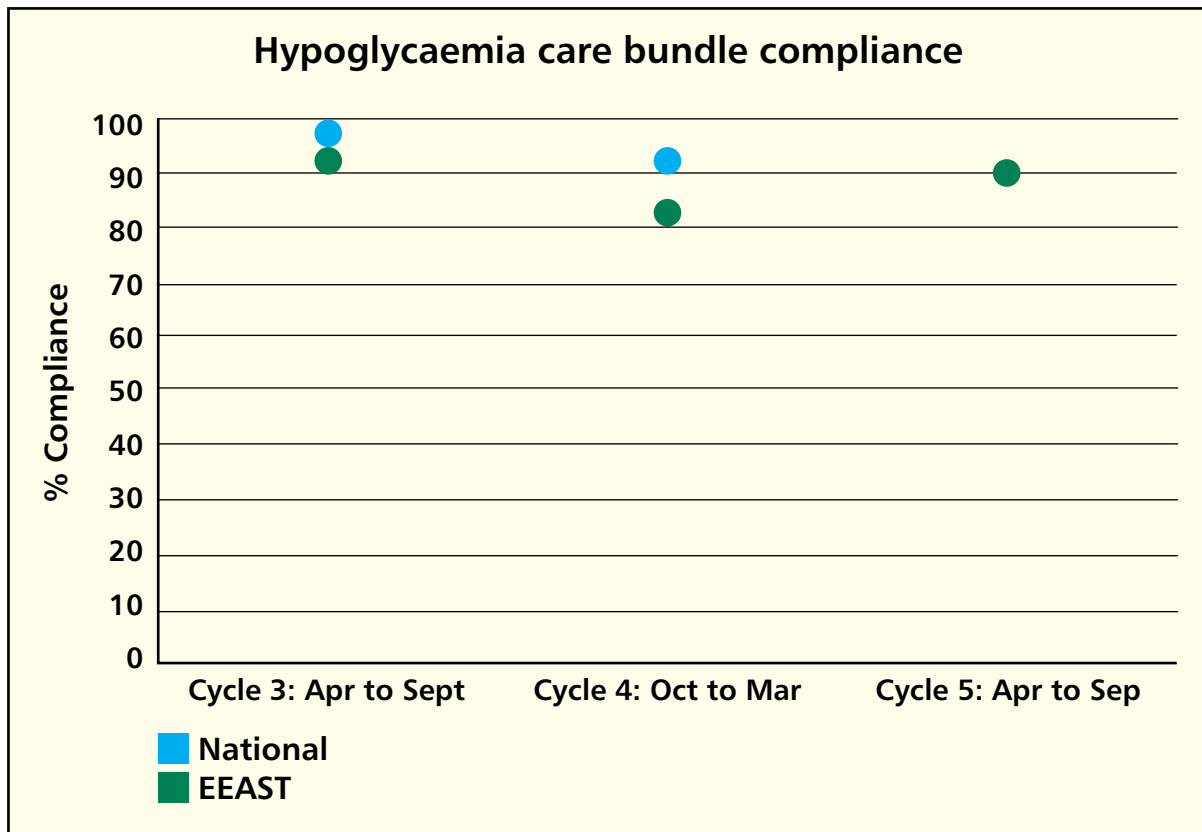
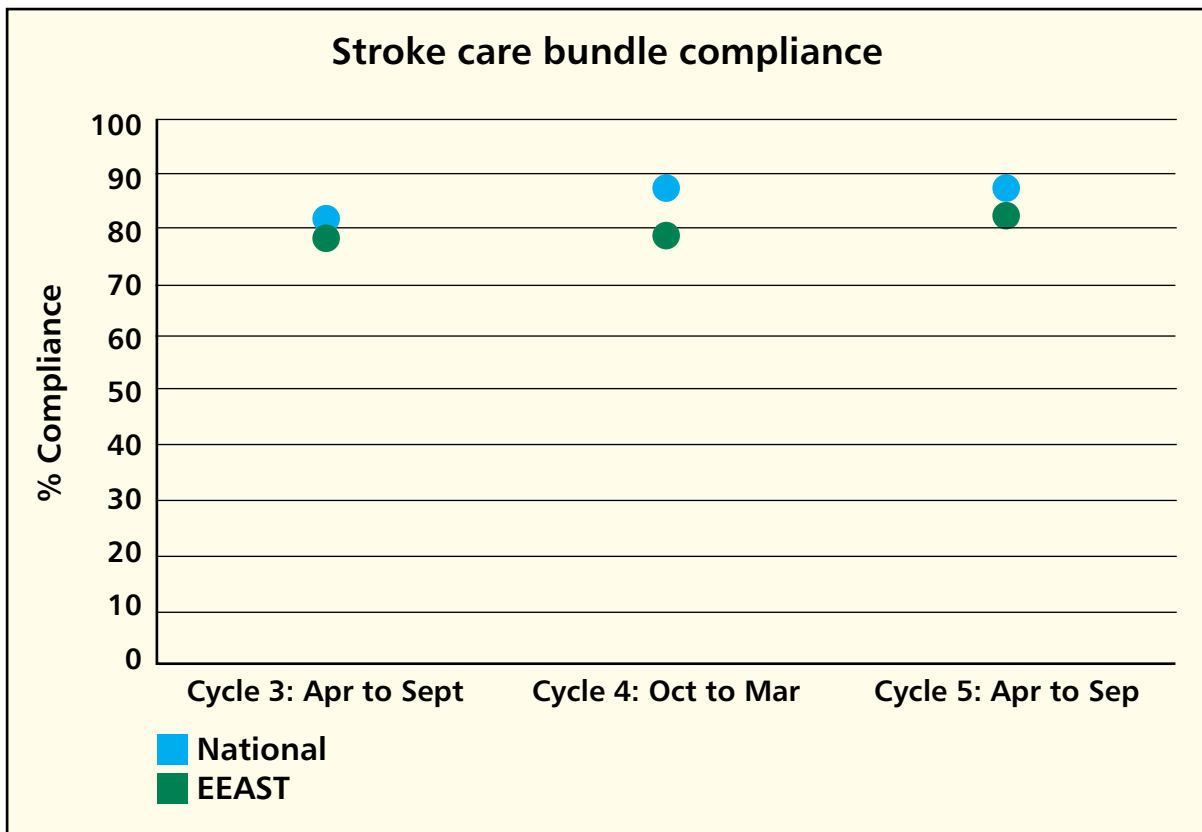
NCPI: Care bundle results for EEAST

	Cycle 3: Apr to Sep		Cycle 4: Oct to Mar		Cycle 5: Apr to Sep	
	EEAST	National	EEAST	National	EEAST	National
Heart Attack	42.3%	45.5%	48.6%	53.0%	49.6%	56.7%
Cardiac Attack	20.4%	26.6%	18.7%	23.7%	28.2%	21.6%
Stroke	79.2%	83.1%	79.1%	86.2%	82.3%	87.2%
Hypoglycaemia	98.0%	92.3%	83.4%	91.5%	89.3%	89.8%
Asthma	22.0%	27.8%	52.5%	39.6%	46.6%	45.3%

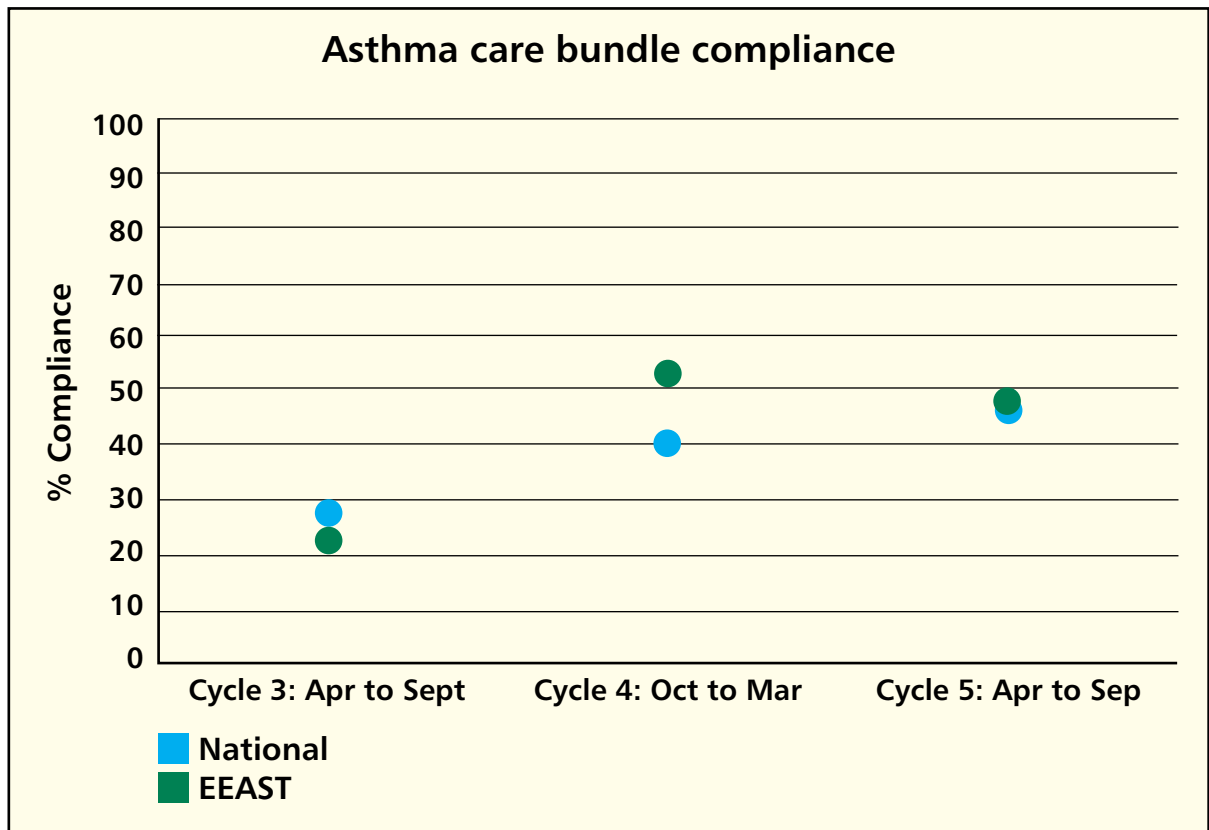
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The Trust has recognised that there is significant work to do in some of these areas. These are now monitored at both a local and regional level and the plan is to ensure local ownership of these indicators, with clinicians being able to review individual care given over the coming year.

The NCPIs are reported to the Board and commissioners, and during the year 2011/12, stroke and heart attack will also become clinical indicators reported to the Department of Health with associated technical guidance so that benchmarking can be achieved between Trusts.



Statements from LINKs

Hertfordshire LINK's response to East of England Ambulance Service NHS Trust Quality Accounts

The Trust's Quality Accounts is well written with clearly defined priorities for 2011/12. It is easy to understand how the priorities have been chosen and what action will be undertaken to achieve the aims and how the outcomes will be measured. Views from a wide range of patients, staff and groups have been used to evaluate the priorities. Some members would have liked to have seen chronic obstructive pulmonary disease (COPD) as a priority; however LINK recognises the need for prioritisation.

Hertfordshire LINK would like to see more evidence of how the views of the vulnerable are gained and used to identify the priorities.

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Working with staff to ensure that Quality Accounts priorities are embedded at every level is to be applauded particularly as this joint working is needed to bring about the new and innovative ways of service delivery required to meet the ever changing needs of the population and to improve patient experience.

Hertfordshire LINK is pleased to see that the excellent work on falls prevention has been successful and nationally recognised for the falls response project in West Hertfordshire as well as receiving regional innovation funding for its project in East and North Hertfordshire.

Good joint working on End of Life Care with hospices has also resulted in some new ways of working that has benefited patients where hospital admission would not have been in their best interest.

Overall the report gives a broad vision of a Trust that recognises the need to continually adapt and improve.

Hertfordshire LINK looks forward to continued engagement with the East of England Ambulance NHS Trust to support quality improvement.

Luton LINK's response to East of England Ambulance Service NHS Trust Quality Accounts

The key service delivery opportunity for the Trust in the town is their response to emergency calls via the 999 or 111 systems. The monitoring of the minimal complaints received during the year indicates that the population was well served by the Trust who was able, within the very tight geographical boundary of Luton, to attend the majority of calls well within the required targets. In addition the Trust delivers the call handling element of the town's Out of Hours service and no issues concerning this have been brought to the LINK's attention.

The rationalisation of staff terms and conditions affected those based in the town, but there is no evidence that this compromised service delivery to residents. Indeed, against this backdrop, the initiatives to improve the patient experience proposed for the year were implemented by dedicated staff, focused training and effective management. In particular, the local Emergency Care Practitioners have been trained in End of Life Care and are working with Macmillan Nurses, to provide an improved service for palliative care patients who have chosen to die at home.

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Suffolk LINK's response to East of England Ambulance Service NHS Trust Quality Accounts

Suffolk LINK thanks the East of England Ambulance NHS Trust Board for the opportunity to comment on the Quality Accounts for 2010/2011 at this time.

This report is well presented, and is written in language that should be accessible to the general public, who are the intended readership. The Suffolk LINK is pleased to note that there has been considerable stakeholder involvement in determining the quality agenda for the Trust.

The priorities for 2011-2012 are clearly set out and we support them.

The Suffolk LINK is also pleased to note that the number of patients participating in research has increased substantially. Research of this type is important in improving the clinical care of patients, both by this ambulance Trust but also across the nation.

We are pleased to note that the East of England Ambulance Service Trust achieved improvements against all of the goals agreed with commissioners in the year 2010 – 2011.

The Ambulance Trust has set out five priorities for the coming year and these build on the achievements of the previous year. The Suffolk LINK welcomes these priorities.

The Trust has increased the involvement in clinical research trials and last year saw a considerable increase in patients enrolled on trials from 37 to 313. Such research is important as it has the potential to improve services both locally and nationally. The Trust has also taken several steps to improve its data quality record and has performed well.

The Trust is continuing its development of a directory of specialised falls services. Suffolk LINK is pleased to note that the trust received a national award for its falls response project in West Hertfordshire and we encourage them to develop this across the whole region.

The Trust has made many improvements in its service during the last year and these are detailed in the Quality Accounts. It is also good to note that the Trust have been very frank regarding the areas where further improvement is required.

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The Suffolk LINK congratulates the Ambulance service on its achievements thus far and looks forward to hearing of the results of the continuing improvements planned for the coming year. We wish them well in their efforts.

The Suffolk LINK looks forward to hearing of the progress of the East of England Ambulance Service NHS Trust and looks forward to working with them in the year ahead.

Bedfordshire LINK's response to East of England Ambulance Service NHS Trust Quality Accounts

Thank you for giving Bedfordshire LINK the opportunity to review the Quality Accounts for the East of England Ambulance Trust. Overall the contents of the document is welcomed by the LINK as it indicates a real commitment to improving in the three specified domains of :- Patient Safety, Clinical Effectiveness and Patient Experience. In line with all the comments we have made to other Trust's Quality Accounts, it is difficult to comment on the full document, as we are only knowledgeable in aspects of the patients' experience and take the information as written at face value.

The document is clearly set out particularly with regard to spacing, formatting of the document, the presentation of statistical data and inclusion of case studies, which will assist those non-clinical readers to understand the Quality Accounts.

The issues to do with the Trust which have come to the LINK from the public over the year has been very encouraging; we have received comments from four individual members who have said that their experience of the EoE Ambulance service has been very good; particularly in terms of the speed at which ambulance crews have arrived at emergencies, the care, consideration and general cheerful demeanour of the paramedics and first responders. One member said "Paramedics who attended my wife after a fall were most helpful, understanding her confusion following a severe fall, and reassuring to myself."

We have also been encouraged by the Trust's move to keep stakeholders informed and involved with the production of the regular bulletins.

The only areas that the LINK has been confused about are the Patient Transport Service (PTS) and the provision of bariatric ambulances and trolleys. In the case of the PTS, it is an area that is not well understood in respect of knowing that such provision is in

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place and about the eligibility for such transport. Also, we are unclear about the role volunteers can play in transporting patients to and from hospital. With regard to bariatric ambulances and trolleys, there has been some uncertainty about the availability and booking of such vehicles and provision.

In conclusion, we would like to congratulate the Trust for the commitment, hard work and professionalism shown by all its front-line staff.

N.B The Trust provides Patient Transport Services to the Counties of Essex, Cambridgeshire, Norfolk and Suffolk only.

Comments from East of England LINKs' Ambulance Services Group

The Local Involvement Networks (LINKs) in East of England have formed a joint group to address generic issues to do with ambulance, patient transport and out of hours services. During 2010/11, this group has developed a good working relationship with East of England Ambulance Service NHS Trust (the Trust) as a 'critical friend'. The Trust has invited a regional LINKs' representative to attend and contribute to its Clinical Quality & Safety Group, its Clinical Audit & Patient Experience Group and its Ethics Group.

These formalised arrangements are continuing in 2011/12 and are welcomed by the LINKs, which gain information and understanding and the opportunity to press the case for patients and public. The attitude of staff and clinical practice remain the matters of most concern to patients and public. These issues are under constant monitoring by the Trust. It is good to see that patients regularly place their gratitude on record for the care they receive from ambulance staff, often in extremis.

The progress made by the Trust in 2010/11 is acknowledged:

- ▼ Innovative steps have been taken to reduce preventable falls; it is in everyone's interests that this momentum continues;
- ▼ More patients are accessing appropriate stroke care pathways quicker;
- ▼ Whilst the quality of patient handovers has improved, patients still complain they have to tell their story time after time in their initial assessment by 'the NHS';

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- ▼ The Trust has developed an end of life care strategy which it shared with us at a special meeting in July 2010; the Trust is reliant upon end of life pathway care information being given to it by GPs and hospitals and others and needs to continue to work closely with the entire health and social services network to ensure patients, and their families, do receive the end of life experience which they chose; and
- ▼ The Trust has taken a number of steps to improve cleanliness and reduce the risk of infection when working in the most challenging environments of any health service provider; this remains work in progress.

The five quality priorities for 2011/12 will focus the Trust upon patient safety, patient experience and clinical effectiveness:

- ▼ Early and effective relief of pain is a key priority for patient care;
- ▼ It is good that the Trust recognises that the work to improve the quality of patient handovers needs to continue and build on the start with this made last year;
- ▼ The most serious possible event needing best care and attention from the Trust is a cardiac arrest; patients and public expect the quickest possible arrival of skilled intervention to give the patient the best chance of survival; paramedics must be dispatched immediately and when they cannot arrive within the first few crucial minutes other measures must be taken; bystander and community response needs to increase with more partnership working, including education and training in schools and colleges, Heartstart courses and establishing more community first responder schemes; the Trust also needs to contribute to the education of the public and patients that inappropriate 999 calls divert paramedics from the patients who really need them, such as those suffering a cardiac arrest;
- ▼ Strokes are another extremely serious event for patients and their families and the same considerations apply as to cardiac arrests and so continuation with this priority, building on the start made last year, is welcome and necessary; and,
- ▼ Patients do not expect to acquire infections during their NHS care; arguably the greatest challenge to this lies with the ambulance service and so continuing with this priority is essential.

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This Trust has the challenge of reaching a population of around 5.8m spread around six counties. This provides a significant challenge and the Trust needs to increase and improve its community relations, public relations, partnership working and external relations to engage effectively and consistently with its patients and public.

Developing itself as it prepares to apply for Foundation Trust status will focus the Trust on engaging with the communities it serves, increase accountability and continue its journey to become the recognised leader in emergency, urgent and out of hospital care in East of England; the public in this region want it to go on to become the leader for all of that in the land.

Bedford LINK's response to East of England Ambulance Service NHS Trust Quality Accounts

Bedford LINK is very supportive of the contents of this draft report.

The only reference we would wish to make is that "Setting Priorities" section for the previous year are not dropped, but added to the list for 2011/12

Bedford LINK is particularly pleased to see the inclusion of a priority for 2011/12 - "Improve the management of falls". This is often overlooked as the beginning of a downward spiral in health, of people who have a fall and then never properly recover. Thank you for allowing Bedford LINK to comment on your Quality Accounts, it is appreciated.

Trust User Group's response to East of England Ambulance Service NHS Trust Quality Accounts

Introduction:

During 2010 the Trust User Group (TUG) responded to an investigation carried out on the perception of the Quality Accounts programme. Overall we were aware of the concept and welcomed it as a means of focusing all members of staff on certain priorities which affected the patient pathway. Indeed the TUG actively got involved in some of the monitoring process.

The 2009/2010 Priorities:

During the past year, as part of our activities, the TUG has been involved in carrying out Discovery Interviews with patients and their cares on their experiences at the hands of the Trust. This has had particular relevance on the impact of appropriate care.

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We support the emphasis on good end of life care and the evolving and improving care offered to stroke patients.

We were active in monitoring the Trust's cleanliness and infection risk reduction programmes. This is a continuing programme and supports the Trust's own regular inspections.

The TUG also worked on a survey identifying the shape and timing of hospital handovers for frontline crews; our view always being that this is an under reported area requiring resolution.

The 2010/11 Priorities:

The Trust has enlisted the support of TUG in monitoring the priorities identified for the current year. In particular TUG will continue to carry out Discovery Interviews to monitor the priorities on pain management and the outcome for patients experiencing strokes.

If appropriate TUG will work with the Trust end of life Group in a manner yet to be finalised.

In addition TUG will continue to survey hospital handovers hopefully seeing greater availability and less dead time at A&E departments of frontline resources.

As an extra almost all members of TUG network locally at all opportunities the "message in a bottle" scheme. This simple process has proved to be a helpful aid to patient care and is very cost effective.

We noted that some of the priorities for 2009/2010 are now incorporated in the new target areas.

As already mentioned TUG will continue to monitor vehicles and stations as part and parcel of the infection prevention effort.

General comment:

TUG notes the continuing effort to maintain and develop good communications throughout the Trust. Even after five years there is still much to do to ensure that the constituent parts weld into an operation whose outcome is greater than the sum of the parts. This is essential at a time of pressure on resources and funds and rising public expectation.

Given the widespread location of our members we are also conscious of the challenges in meeting targets and good patient outcomes over a region with a very varied demographic pattern.

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Cambridgeshire LINk response to East of England Ambulance Services NHS Trust, Quality Accounts 2010/11.

As part of Cambridgeshire LINk, the Ambulance work group thanks the trust for their draft quality accounts and the opportunity to comment on them. We continue to work with the trust on local issues affecting the local population with regards to ambulance and patient transport services.

We are encouraged to see that the Trust has introduced performance frameworks across all operational areas, it is also positive that the majority of staff know about most of the priorities that have been set; but only 20.2% knew what Quality Accounts were. This is an area to develop, to ensure that staff understands that priorities are part of the Trusts Quality Accounts. It also needs to be acknowledged that the Trust has set priorities for 2011/12 after engagement with staff.

1. Improve the management of pain

Developing a holistic approach and effective care in pain management as well as developing champions is a good way to ensure best practice is consistent throughout the Trust.

2. Ensure the quality of patient handovers

Whilst the Trust recognises that this priority hasn't met its targets in terms of completing records, we would expect to see this developed effectively and efficiently over the 2011/12 period.

3. Best possible outcome from cardiac arrest

Currently the Trust is not reaching the national average in terms of cardiac arrest care pathways, there needs to be a continuous improvement building on what has been achieved so far.

4. Improve the management of acute brain events

Whilst the Trust may not be reaching all the national targets set, there has been a positive response to ensure that all patients have access to the most appropriate treatment and services; the introduction of stroke champions should help to promote best practice.

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5. Continuous improvement in prevention of infection

Auditing of vehicles and World Health Organisation compliance, contribute to the ongoing compliance of this priority.

On the whole this year's Quality Accounts are clearly laid out and easy to understand, we would also like to comment on the positive impact and pro-active approach taken by the Trust with regards to falls, which has been a previous priority. Cambridgeshire LINK recognises the valuable contribution made in terms of establishing a falls register, response model and multi-agency falls forum.

Essex and Southend LINK response to East of England Ambulance Services NHS Trust, Quality Accounts 2010/11.

Quality Accounts purport to be "an accurate reflection of the quality of the care provided." That assumes they are reliable. For the purposes of this Consultation exercise, we are being asked to accept that Quality Accounts will guide us to produce reliable evidence as to the quality of the Ambulance Trust's services. A recent study was conducted, as part of her Degree Course by a Staff member to evaluate whether "Quality Accounts are embedded in the Trust."

Jenny Bayliss set about this task with great gusto and followed a conscientious path to conduct a high quality research project. She spoke at length to many members of Staff – over 30 in all; from the Managing Director and other Board Members downwards. After all this she came to the conclusion, at the end of 2010 that the trust displayed "little evidence of a link between quality service improvements and Quality Accounts, which suggests that the concept of Quality Accounts is still under developed within the organization."

Changed Priorities.

She was able to demonstrate that various strata of Staff were not giving sufficient effort to these theoretical priorities. Thus, how much reliance can we place on them?

Looking at the priorities from last year, the number one priority was "reducing preventable falls." That this priority is now not even in the top five list, must throw some doubt on the selection of these priorities. Whilst I am aware that a great deal of effort was expended on delivering on this priority, can we be sure that it was adequately carried out to justify its non inclusion this year?

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The raising of Hospital "Handovers" to a higher priority is, however to be welcomed. It has always seemed odd that an Ambulance Service, which has to meet time standards in getting Category A Patients to hospital in minimum time, is then forced to endure the frustration of being kept waiting at A. & E. Units to deliver the patient before getting back on the road for more patients.

There is some dispute, however, whether these delays are entirely the fault of the Hospital Staff. The procedures followed by Ambulance crews may also be a contributory factor. There is, therefore, a need for "Auditing." As a member of the Trust's "User Group" I have taken part in these audits and have 'basked' in the praise heaped on us by the Trust Board for helping them in these efforts. Unfortunately, this praise is not always reflected in the attitude of some crews, who appear to regard our efforts with suspicion and there are dark hints that we are "spying" on our crews, rather than trying to help.

I fully support the 3rd. and 4th. Priorities to give emphasis to "Cardiac Arrest" and to "Acute Brain events." Here the Trust are sensibly following past policies to ensure that our patients get the benefit of major advances in the treatment of Cardiac and Stroke patients.

The fifth priority to "Improve the cleanliness of the pre-hospital environment and reduce the risk of infection," also points up the need to carry out an Audit of Ambulances and Station cleanliness. The User Group has again played an active part in this procedure and has, again, been praised by the Board. This has not been fully appreciated by all Ambulance Crews, who have again, hinted at "spying on them!"

The Future.

There is much that the Trust can be proud of. They are meeting most of the standards required of them and making excellent provision to cope with the strains of preventing Terrorism in this Region and catering for the extra burden of hosting next year's Olympic Games. It is greatly to be hoped that the Trust are successful in gaining Foundation Trust Status and the Essex & Southend LINK wish them every success.



PART 3

Statements from HOSCs

Cambridgeshire County Council's Health Overview and Scrutiny Committee response to East of England Ambulance Service NHS Trust Quality Accounts

Cambs County Council Adults Wellbeing and Health Scrutiny Committee welcomes the progress made by EEAST in 2010/11 towards achieving its quality priorities, and is pleased to report that liaison between the Trust in Cambridgeshire and the Scrutiny Committee has strengthened over the past year.

We have the following specific comments:

- ▼ We welcome the continued focus in 2011/12 on prevention of infection, the management of acute brain events, and ensuring the quality of patient handovers. In relation to the latter, we suggest that this explicitly include improving hospital turnaround times.
- ▼ We welcome the work that has been done to reduce preventable falls. We consider that the Trust should continue to focus on this, particularly in ensuring that best practice is extended throughout the County.
- ▼ We welcome the work that is being undertaken to increase the percentage of patients accessing their preferred end of life care, and encourage the Trust to build on this, particularly in relation to inter-agency working.
- ▼ We support the Trusts intention to prioritise improving the management of pain and achieving the best possible outcome from cardiac arrest.
- ▼ We remain concerned that the Trust is still not achieving its Cat A response time targets in Southern and Western Cambridgeshire

We suggest the Trust include in its quality improvement plans for the coming year:

- ▼ In relation to patient safety, patient experience and clinical effectiveness: ensuring that the Trust has the vehicles, equipment and trained staffing to move very obese patients.
- ▼ In relation to patient experience and clinical effectiveness: working in partnership with other organisations in ensuring people from black and minority ethnic and migrant communities in the region access the appropriate healthcare services.

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Norfolk County Council's Health Overview and Scrutiny Committee response to East of England Ambulance Service NHS Trust Quality Accounts

The Norfolk Health Overview and Scrutiny Committee has decided not to comment on the 2010/11 Quality Accounts of any of the NHS trusts operating in Norfolk and would like to stress that this should in no way be taken as a negative statement.

Statements from PCTs

NHS Bedfordshire response to East of England Ambulance Service NHS Trust Quality Accounts

NHS Bedfordshire was the Lead Commissioning PCT up until 31st March 2011 for East of England Ambulance Service NHS Trust. NHS Bedfordshire therefore has a duty under the National Health Service Act 2006, to confirm that this Quality Accounts contains accurate and relevant information in relation to the NHS services provided in 2010-2011. NHS Norfolk has taken the role of Lead Commissioning PCT from April 2011 and will therefore comment on the future account.

NHS Bedfordshire is pleased that the East of England Ambulance Service NHS Trust continues to be registered with the Care Quality Commission.

The trust is to be congratulated for their achievement of receiving regional and national awards for the innovations made to patient care.

Reasonable steps have been taken to ensure the data has been checked for accuracy against data supplied by the trust throughout the year, regular reviews and monitoring of data is part of the contractual quality monitoring systems.

The Trust has worked hard to improve the quality of services, and the various initiatives that have been introduced to improve the quality of services are encouraging.

The Trust has had regular clinical quality review meetings with the commissioners where progress against an agreed quality schedule is monitored.

The Trust's management of serious incidents has markedly improved with good reporting and improved quality of root cause analysis of Serious Incidents (SIs).

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The Trust has worked with partner organisations across the region to improve safeguarding for children and adults.

The overall management of infection control at the Trust is good and there is an improving picture of vehicle cleanliness which is evidence of the work undertaken this year. NHS Bedfordshire can confirm that the Quality Accounts provided for 2011/12 contains accurate information and reflects the quality of current service provision. The account contains the challenges for continued improvement and monitoring of effective patient outcomes which NHS Norfolk will continue to review with input from.

NHS Norfolk response to East of England Ambulance Service NHS Trust Quality Accounts

As you know NHS Norfolk assumed the role of lead commissioner for EEAST from April 2011. We are looking forward to working with your Trust.

As lead commissioner we have been asked, by NHS Bedfordshire, to respond to the 5 priority areas for improving the quality of services set by the Trust for 2011/12.

The five priorities are:

- ▼ Improve the management of pain
- ▼ Ensure the quality of handovers
- ▼ Best possible outcome from cardiac arrest
- ▼ Improve the management of acute brain events
- ▼ Continuous improvement in prevention of infection.

In addition, a recent quality initiative has been agreed with the Trust through the QIPP process:

- ▼ To reduce the number of people conveyed to A&E following an ambulance call.

I can confirm that we endorse all of these topics.



Glossary

Term	Acronym	Describe
ABCD2 Algorithm	ABCD2	A simple score (ABCD2) to identify individuals at high early risk of stroke after a transient ischemic attack
Advanced Directive	AD	Also known as living wills, advance directives, or advance decisions, are instructions given by individuals specifying what actions should be taken for their health in the event that they are no longer able to make decisions due to illness or incapacity
Advanced Medical Priority Dispatch System	AMPDS	Licensed software to clinically triage the category of emergency calls.
Care Quality Commission	CQC	The independent watchdog for healthcare in England. It assesses and reports on the quality and safety of services provided by the NHS and the independent healthcare sector, and works to improve services for patients and the public
Clinical, biological, radiological, nuclear	CBRN	Term in common use worldwide, to refer to incidents in which any of these four hazards have presented themselves radiological, nuclear
Clinical performance	CPI	A performance indicator designed to monitor important aspects of clinical which require either monitoring or improvement indicator
Clinical support desk	CSD	Clinically trained individuals providing telephonic support following an emergency call. Generally utilised for lower acuity calls not necessarily requiring attendance at scene or a transportable response
Commissioning		The processes which local authorities and PCTs undertake to make sure that services funded by them meet the needs of the patient with the financial envelope
Commissioning for Quality and Innovation	CQUIN	Specific money from commissioners to incentivise initiatives which raise quality through innovation
Community first responders	CFR	Teams of volunteers who are trained by the ambulance service to a nationally recognised level and provide life saving treatment to people in their local communities

Glossary continued

Term	Acronym	Describe
Computer aided dispatch system	CAD	Computer hardware used to record all patient calls and patient activity
Continuous professional development	CPD	An updating of professional knowledge and the improvement of professional competence throughout a person's working life. It is a commitment to being professional, keeping up to date and continuously seeking to improve
Chronic Obstructive Pulmonary Disease	COPD	
Clinical Quality & Safety Group	CQ&SG	
Courier transport service	CTS	Transports medical freight, mail and supplies
Directory of service	DoS	A live list of available health and social care provision
Do not attempt Resuscitation	DNAR	A patient with capacity has the right to refuse CPR and agrees to an advance decision refusing CPR, this should be respected. A Do Not Attempt Resuscitation (DNAR) decision does not override clinical judgement in the unlikely event of a reversible cause of the patient's respiratory or cardiac arrest that does not match the circumstances envisaged. DNAR decisions apply only to CPR and not to any other aspects of treatment
East of England Ambulance Service Trust	EEAST	
Emergency Care Assistant	ECA	A new assistant and support worker introduced to work on urgent tier vehicles and or teamed up with a Paramedic to enable them to concentrate on delivering clinical care and treatment to patients
Emergency Care Practitioner	ECP	
Emergency service	ES	999 ambulance service providing patient care, treatment and transport to acute hospitals

Glossary continued

Term	Acronym	Describe
End of life care	EoLC	A DH programme, to improve the quality of care at the end of life for all patients and enable more patients to live and die in the place of their choice
Foundation Trust	FT	A type of trust created to devolve decision-making from central government control to local organisations and communities so they are more responsive to the needs and wishes of their local people
Hyper Acute Stroke Units	HASU	
Hazardous area response teams	HART	Specially trained personnel who provide the ambulance response to major incidents
Health Emergency Operations Centre	HEOC	Control centre for managing call receipt, triage and dispatch functions
Health Overview and Scrutiny Committee	HOSC	The Committee provides external assessment of any NHS consultation process giving local assurance that the business case for any future NHS developments are robust
Information governance (defined on pg 35)	IG	
Information Governance Group	IGG	
Infection Prevention and Control	IPC	
Inpatient quality indicators	IQI	IQIs are a set of measures that provide a perspective on the quality of care given to patients
Joint Royal Colleges Ambulance Liaison	JRCALC	A committee that provides robust clinical speciality advice to ambulance services and is well known for the development and the production the UK Ambulance Service Clinical Practice Guidelines. JRCALC Works closely alongside the Directors of Clinical Care of all UK ambulance services, local Ambulance Paramedic Steering Committees, the British Paramedic Association and other interested groups it effectively fulfils the liaison role of its title

Glossary continued

Term	Acronym	Describe
Knowledge and Skills Framework	KSF	The NHS KSF process involves managers working with individual members of staff to plan their training and development
Local involvement networks	LINKs	Run by local individuals and groups and independently supported. The role of LINKs is to find out what people want, monitor local services and to use their powers to hold them to account
Metrics		Set of ways of quantitatively and periodically measuring performance
Myocardial Infarction National Audit Project	MINAP	The Myocardial Infarction National Audit Project (MINAP) was established in 1999, in response to the national service framework (NSF) for coronary heart disease, to examine the quality of management of heart attacks in England and Wales. The project uses a highly secure electronic system of data entry, transmission and analysis developed by the Central Cardiac Audit Database (CCAD). This system uses encryption of patient identifiers to allow secure transfer of data between hospitals and central servers and allows linkage with the Office of National Statistics for tracking of mortality
NHS East of England	NHS EoE	Strategic health authority (SHA) in the East of England
National Clinical Performance Indicator	NCPI	
National Institute for Clinical Excellence	NICE	
National Patient Safety Agency Care Bundle (term expanded on pg 62)	NPSA	
Quality Innovation Prevention Productivity	QIPP	Lord Darzi argued in High Quality Care for All that quality, innovation and prevention are inseparable. QIPP is a concept for delivering quality services through a period of tighter financial challenge

Glossary continued

Term	Acronym	Describe
Patient and public involvement	PPI	Involving the public in shaping a care system's development, and keeping patients well informed of clinical processes and decisions
Patient public involvement & engagement	PPI&E	The NHS fully supports engaging people in the design and delivery of services. They are routinely asked for their views, about their experience of services, to contribute to staff training and to be members of NHS foundation trusts.
Patient care record	PCR	All NHS providers are required to record the care given to a patient on a patient care record
Patient Transport Service	PTS	Provides transport to and from premises providing NHS healthcare and between NHS healthcare providers
Primary and urgent care	P&UC	The term for out-of-hospital health services that play a central role in the local community
Primary care operations		Comprises the patient transport service (PTS) and courier transport services (CTS)
Primary care trust	PCT	NHS bodies with responsibility for delivering health care services and health improvements to their local areas
Primary percutaneous coronary intervention	PPCI	Commonly known as coronary angioplasty or simply angioplasty, is a therapeutic procedure to treat the narrowed coronary arteries of the heart found in coronary heart disease
Return of spontaneous	ROSC	A palpable pulse is present after clinically documented asystole/circulation
Service user		Anyone who uses, requests, applies for or benefits from health or local authority services
Single point of contact	SPOC	A single telephone number which will facilitate patient navigation to a range of health and social care services around the clock and prevent unnecessary admission
Stroke		A stroke happens when the blood supply to the brain is disturbed. Transient ischaemic attack (TIA) or 'mini-stroke' has similar symptoms to

Glossary continued

Term	Acronym	Describe
		stroke but these symptoms are resolved faster and the person usually will get better within 24 hours. The TIA may be a warning sign of a more serious stroke and always requires further immediate medical attention
Stakeholders		Anyone with an interest in the way services are delivered including service users, carers, patients, service providers, staff, health professionals and partner organisations, councils and other community or voluntary groups
Strategic health authority	SHA	Regional NHS headquarters, responsible for ensuring national priorities are integrated into local plans and PCTs are performing well
Telehealth		The delivery of health-related services and information via telecommunications technologies
Transient Ischaemic Attack	TIA	This is an acute brain attack where a bleed or clot to the brain happens. It is similar to a stroke, but there are no signs of symptoms between a few minutes and 24 hours later
Voluntary and community sector		Groups set up for public or community benefit such as registered charities, and non-charitable non-profit organisations and associations

Providing feedback

The East of England Ambulance Service NHS Trust Quality Accounts 2010/11 describes the quality of services that the Trust has provided patients during 2010/11, our priorities for improvement during 2011/12 and the actions we intend to take to secure these improvements. This will help people to make better informed choices about their healthcare and will also support our clinicians to benchmark, compare and improve their own clinical performance and practice.

To continue to drive improvement and as part of this process, it is important to be openly accountable for the quality of services delivered and to listen to our patients, staff, members of the public and other healthcare partners about the quality of services that the Trust provides. Therefore we would be grateful if you could take a few minutes to read the Quality Accounts which can be accessed at www.eastamb.nhs.uk or alternatively hard copies of this years and last years Quality Accounts are available on request by writing to:

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East of England Ambulance Service **NHS**
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