East Midlands Ambulance Service NHS Trust

Draft

Quality Account2016/17

East Midlands Ambulance Service NHS Trust

Content (Please note page numbers will be included when the document is finalised)

East Midlands Ambulance Service NHS Trust

Introduction

Welcome to our Quality Account for 2016/17

[Opening to be added here statement from Richard Henderson, Acting Chief Executive Officer]

Declaration of accuracy

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

[Insert signature here when report completed]

Richard Henderson
Acting Chief Executive

About us

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

EMAS vision and values

It is our vision todeliver outstanding sustainable emergency and urgent care services across the communities of the East Midlands.

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

Our values support everything we do.

Respect: Respect for our patients and each other

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

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

Teamwork: Working together and supporting each other

Competence: Continually developing and improving our individual competence

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

People we serve

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

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

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

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

The area we cover

We provide emergency 999 and urgent care services for a population of approximately 4.8 million people within the East Midlands region.

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

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

There are several airports within our region with the largest being East Midlands Airport serving over 4 million passengers a year.

Two of the UK's mainline railways serve the region, providing regular high speed services.

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

Our Service

Our annual turnover is £152.5 million (2016/17) and we are commissioned (paid) to provide services by 22 Clinical Commissioning Groups (CCGs) based across the East Midlands. We deal directly with the A&E contract lead in NHS Hardwick CCG which represents the other CCG's in the region.

We employ over 2900 colleagues, the majority being front line Accident and Emergency ambulance personnel.

Patient Transport Services (PTS) are currently provided for people who have routine (non-urgent and scheduled) clinic appointments across Derbyshire.

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

Every day we receive approximately 2000 calls from people dialling 999 and other healthcare professionals making urgent transport requests.

During 2016/17 we received **xxxxx** emergency and 999 calls to our emergency operations centre, and dispatched ambulance clinicians to **xxxxx** incidents, using a fleet of 550 vehicles including responders.

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

- Specialist transfers: inter-hospital transfers that include adult critical care or for specialised surgery, paediatric and neo-natal care.

- Hazardous Area Response Team (HART): a dedicated team providing specialised cover for civil contingencies, major incidents and chemical, biological, radiological and nuclear (CBRN) incidents.

- Emergency Preparedness and Business Continuity (regional resilience): a service that ensures we are prepared to deal with a range of civil contingencies and major incidents. It works closely with the six Local Resilience Forums across the region, each of which includes local authorities, police and fire services. This also ensures business continuity in the event of a civil contingency or other adverse event that affects normal operations.

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

- Cycle Response Unit: these individuals carry the same essential life-saving equipment as a fast response car and can reach patients even faster in congested areas. Patients can often be treated on the scene by the Cycle Response Units meaning our ambulance vehicles can be deployed to other life threatening emergency calls.

- Community Public Access Defibrillators (CPAD): we have placed life-saving equipment in local communities across the East Midlands. Defibrillators are used when someone has gone into cardiac arrest (i.e. when the heart stops pumping blood around the body), to give the heart an electric shock to allow effective cardiac rhythm to be re-established.

- Events support: a commercially available team that provides professional emergency medical support to special events such as sporting, musical and athletic showcases

across the region.

- Admission avoidance schemes: provided through a number of schemes across the East Midlands including Falls Partnership Services and mental health nurse with a EMAS paramedic responding to related calls in a fast response car.

Review of Quality Improvements for 2016/17

This Quality Account demonstrates our achievements for the year 2016/17 and what we are aiming to achieve in the coming year.

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

Our 2016/17 priorities

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

- Clinical effectiveness
- Patient safety
- Patient experience

Priority 1: Cardiac arrest – return of spontaneous circulation (ROSC) and survival outcomes. EMAS has continued to focus its attention upon the improvement of successful ROSC rates in cardiac arrest.

Priority 2: Sepsis is a worldwide public health issue. In developing nations, sepsis accounts for nearly 80 percent of deaths. Sepsis kills far more citizens than AIDS, prostate cancer and breast cancer combined. It is the leading cause of death and has a high mortality in the developed world.

Priority 3: To identify the common themes of all maternity related incidents, and to reduce patient related incidents.

Priority 4: To explore the use of alternative pathways in each division by using the pathfinder leads to develop the pathways in the trust in each commissioning area.

Priority 5: Having signed up to the mental health Crisis Care Concordat, we will work collaboratively with local commissioners and relevant stakeholders to implement the agreed priorities within the mental health steering group.

Priority 6: To support the improvement of ROSC rates EMAS will continue to support the delivery of Red 1 national performance response targets. In 2016/17 we will increase Accident and Emergency workforce, to strengthen and improve operational resource levels,

improve our registered paramedics to non- registered ratio, and then develop actions and processes that contribute to a reduction of Red call conversion rates.

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

Commissioning for Quality and Innovation (CQUIN)

CQUIN Schemes are an opportunity for EMAS to provide a key focus on quality improvement. The outcomes from these schemes can be so significant and impact directly on patient care.

We focused on delivering schemes that make significant changes to the lives of patients and their outcomes, hence the key focus on priorities.

Frail Elderly Liaison Officer (FELO): The FELO scheme is to provide support and care for patients in the community who are frail and elderly. The FELO roles have been to work and facilitate a multi-agency approach to prevent avoidable admissions to the hospital Emergency Department. Clinical care packages have been designed around an individual's needs. The initiative has been focused on care, residential and warden controlled facilities.

Mental health: Managing patients presenting with mental health conditions has been one of the areas which has been lacking in support and investment for many years. The Crisis Care Concordat has highlighted how all partners who work across the whole spectrum of the health economy should work together to ensure that those patients presenting with mental health conditions obtain the same recognition and patient centred care as those with physical health conditions.

Emergency services have been for years poorly equipped to deal with patients presenting with mental health conditions or a mental health crisis.

EMAS has embarked on a two year programme of embedding 'parity of esteem' in its workforce. In April 2015, a two year CQUIN for mental health was written with the sole aim of improving outcomes for patients who present with a mental health crisis.

It is our vision that patients who present with a mental health crisis obtain help at the point of call, receive an appropriate response and are conveyed to the most appropriate place of care. This should not normally be an Emergency Department (unless requiring treatment for a physical health issue).

Sepsis: Sepsis is a worldwide public health issue. In developing nations, Sepsis is the leading cause of mortality, accounting for nearly 80% of deaths. Sepsis kills far more citizens than AIDS, prostate cancer and breast cancer combined.

During 2016/17 particular focus was to:

- Identify and treat Sepsis within our patients.
- Ensure the formalisation of an EMAS Sepsis Lead, including documented objectives and performance measures.
- Appoint divisional Sepsis champions (one per division) on a volunteer basis.
- Develop a robust action plan to ensure the availability of waveform capnography on a minimum of 95% of frontline operational resources (double crewed ambulance and fast response vehicle).
- Work with a partner acute trust to explore the increased pre-hospital use of IV antibiotics in the treatment of Sepsis.

Pathfinder Programme in Derbyshire and Lincolnshire:

During 2016/17 particular focus was:

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

New services and innovation

Sepsis

Sepsis is a time-critical condition that can lead to organ damage, multi-organ failure, septic shock and eventually death. It is caused by the body's immune response to a bacterial, fungal or viral infection. It commonly originates from the lungs, bowel, skin and soft tissues and urinary tract.

Rarer sources include the lining of the brain (meningitis), liver, or indwelling devices such as catheters. Sepsis causes, changes in the circulation reducing the blood supply to major organs such as the kidneys, liver, lungs and brain.

Although most dangerous in those with impaired immune systems, it can be a cause of death in young and otherwise healthy people (UK Sepsis Trust, 2015).

As previously mentioned, EMAS has introduced a pilot study for the administration of antibiotics in the pre hospital setting for patients presenting with Sepsis. The national guidance for administration of antibiotics for Sepsis patients is one hour from diagnosis. This has usually been an impossible task due to the time taken from recognition in the pre hospital setting and then travelling time to hospital and the administration of an antibiotic.

EMAS colleagues have been able to administer antibiotics to patients who were positively recognised as septic, within a time frame of 45 minutes.

The outcomes of this study are being released and we will continue to develop relationships with hospitals to ensure that the patients in the East Midlands region receive the highest standard of clinical care.

Mental health

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

Some of the projects we are involved in include:

- The development of a collaborative street triage approach in line with the Crisis Care Concordat principles, better and wider promotion of mental health awareness.
- Provision of a training package on a compassion focused approach to mental health for colleagues in our Emergency Operations Centres.
- Partnership working with the Samaritans on suitable proportionate signposting as clinically indicated, interpreting and learning lessons from risk patterns related to mental health incidents.

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

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

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

EMAS managers are being supported through training and advice to help them recognise and provide support to staff who are experiencing mental health problems. This is supported by close collaboration work with our two mental health specialists, Equality, Diversity and Involvement Manager, Chaplain and health and wellbeing colleagues.

New processes and technologies

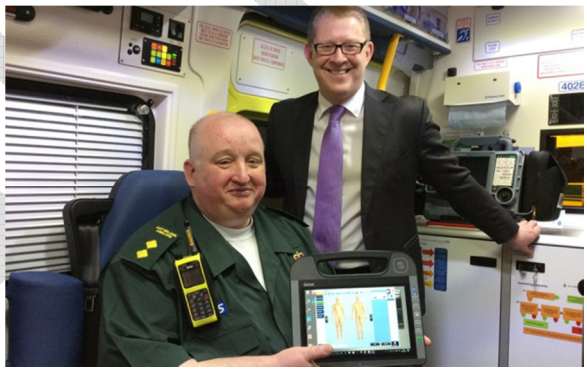
The NHS is facing huge challenges and changes in the forthcoming years and EMAS needs to adapt and reflect this in the way it operates.

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

Electronic Patient Record Form (ePRF) system

During 2016/17 we have committed to invest more than £3 million to enhance our ePRF system during the next two years, which will improve the care and treatment received by patients across the East Midlands.

The system will be used by EMAS ambulance crews across the region, bringing many benefits, including:



- Supporting clinical decision making: ambulance crews can access online information about medical and traumatic conditions and treatment.
- Providing prompt transfer of patient care to other health organisations: before leaving the scene of an incident or whilst en-route to hospital, ambulance crews can electronically send details about the patient to the emergency department including appropriate photographs from the scene of the incident, for example road traffic collision or electrocardiogram readings, to help doctors determine the extent of injury that may have been sustained. This allows staff in the hospital to prepare and be ready to act when the patient arrives.
- Increasing the integration of care systems across the healthcare environment: via the system ambulance crews can access details about alternative healthcare providers, allowing them to signpost patients and carers to the most appropriate local treatment or care facility, or to access any pre-existing care plans for the patient to ensure we treat them in accordance to their wishes.
- Improving the legibility of patient specific information: ambulance crews often complete paper report forms in difficult environments for example in the back of a fast moving ambulance vehicle, at the scene of an incident in various weather conditions, making it a challenge to keep written records clear and succinct.
- Readily available data for our research and audit teams: waiting for paper report forms to be received can delay our ability to identify trends and areas where improvements have or can be made, or to access important information for Coroners purposes. Equally the automated introduction of electrocardiograms (relating to cardiac care) into the patient record will support improvements in sharing of

important information with receiving hospitals, and to aid our research, development and education work.
- Enhancing the security of patient records: electronic storage of records is a more robust, secure way to store patient records compared to paper copies.

The new system will begin to be rolled out across of all of EMAS from April 2017, with the project completing in September.

Enhancing quality improvements and assurance

During 2016/17 we have continued to improve our quality and assurance processes through a variety of ways. We have talked with and listened to our colleagues and patients to identify areas for improvement to help share best practice.

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

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

Four strands are included in Quality Everyday.

- Central inspections (audits).
- Monthly quality visits.
- Articles in the weekly electronic staff newsletter *ENews.*
- Quality station / base noticeboards.

The Quality Everyday noticeboards and updates help improve communication with colleagues via the sharing of key messages, patient feedback, lessons learned from incidents and discussions at our Lessons Learned Group (protecting the identity of people involved), as well as local clinical updates and performance standards data.

[add a picture of a Quality Everyday inspection here]

What we want to do better in 2017/18

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

As in 2016/17, we have identified three domains of quality:

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

Against those we have set five quality improvement priorities for 2017/18:

Clinical effectiveness	**Priority 1:** Staff health and wellbeing The quality priority area for staff health and wellbeing focuses on improving staff member's health and wellbeing at work. EMAS will continue to develop staff support mechanisms that ensure the health and wellbeing of our staff. **Lead: Director of Quality and Nursing**
	Priority 2: Improving Sepsis care Red Flag Sepsis is the Sepsis Trust's definition of a patient who is presenting with clinical signs that suggest the patient is either suffering or approaching septic shock. EMAS will continue the work from last year that will focus on delivering antibiotics to Red Flag Sepsis patients **Lead: Medical Director**

Patient experience	**Priority 3:** Cardiac arrest – return of spontaneous circulation (ROSC) and survival outcomes. Aligned with Red 1 performance. During 2017/18 we will: • Continue to develop and improve our cardiac arrest outcomes. • Continue to see our Ambulance Quality Indicators and outcomes around stroke, chronic obstructive pulmonary disease (COPD) and asthma improve. • Also see an increase in the presence of frontline clinical supervision to all active resuscitation attempts. **Lead: Chief Operating Officer**
Patient safety	**Priority 4:** Continue to reduce conveyance by the utilisation of alternative care facilities**.** During 2017/18 we will: • Maintain and improve 'see and treat'. • Reduce conveyance by accessing alternative pathways that are available. • Have robust patient safety plans in place that support non-conveyance. **Lead: Medical Director**

Evidence of quality improvements for 2016/17

Priority 1: Cardiac arrest – return of spontaneous circulation (ROSC) and survival outcomes. EMAS has continued to focus its attention upon the improvement of successful Return of Spontaneous Circulation (ROSC) rates in cardiac arrest.

Aim	What we did	What we have achieved	Quality Indicators
During 2016/17 we will: Continue to develop and improve our cardiac arrest outcomes. •Continue to see our Ambulance Quality Indicators and outcomes around stroke COPD, asthma improve. •Also see an increase in the presence of frontline clinical supervision to all active resuscitation attempts.	EMAS has ensured that annual refresher training is now part of our annual statutory and mandatory education programme to ensure our staff are highly skilled in cardiac arrest. Introduce a structure that supports clinical delivery and outcomes and strengthens our resilience.	EMAS ROSC rates have seen a sustained and marked improvement over the past 12 months. We have seen an improvement in our Ambulance Quality Indicators across the year.	Monthly reporting of the ROSC and Survival to Discharge (STD) rates through the Ambulance Care Quality Indicators.

Priority 2: Sepsis is a worldwide public health issue. In developing nations, sepsis accounts for nearly 80 percent of deaths. Sepsis kills far more citizens than AIDS, prostate cancer and breast cancer combined. It is the leading cause of death and has a high mortality in the developed world.

Aim	What we did	What we have achieved	Quality Indicators
During 2016/17 particular focus will be: •To identify Sepsis within our patients. •Ensure the formalisation of the EMAS Sepsis Lead, including documented objectives and performance measures. •Appoint divisional Sepsis champions (1 per division) on a volunteer basis. •Develop a robust action plan to ensure the availability of waveform capnography on a minimum of 95% of front line operational resources (double crewed ambulances and fast response cars). •Work with a partner acute trust to explore the increased pre-hospital use of IV antibiotics in the treatment of sepsis.	Our Sepsis Lead was appointed and a pilot scheme introduced into North Lincolnshire and Goole for the treatment and management of Sepsis. We identified a number of staff and gave them specific awareness and training in the administration of antibiotics. Working collaboratively with the acute trusts and microbiologists, we have completed our pilot study.	The results have been significant in patient outcomes, in that we have achieved the National Institute of Clinical Excellence (NICE) guidance recommendations that in positive septic patients, we have delivered antibiotics within the nationally recognised one hour window. Currently no other ambulance trust in the UK is administering antibiotics to patients in the pre hospital environment. Our results have significantly changed the lives of so many patients that we will work with other hospital trusts to ensure patient care is at the centre of all that we do.	The results of the trail have been monitored through Quality Governance Committee

Priority 3 :To identify the common themes of all maternity related incidents, and to reduce patient related incidents

Aim	What we did	What we have achieved	Quality Indicators
During 2016/17 we will aim to see a reduction in severity of all maternity related incidents within our care. We will work to: •Receive an improvement on aspects of clinical care from maternity units. •Educate all operational workforces in maternity related training. This will be measured by current level of harm, complaints, serious incident feedback from patients and service users.	As a part of the Sign up to Safety campaign we identified an executive and non-executive director lead, alongside a clinical lead for maternity care. We are now an active member of the Regional Maternity Strategic Clinical Network and have introduced a set of regionally agreed obstetrics emergency management procedures. A deep dive into the themes of maternal incidents identified themes related to decision making and communication between the community and receiving units. The procedures set out clear decision making processes and communication links for all receiving units.	We have seen a reduction in serious incidents and high level reports, resulting in a reduction in investigations into maternity related incidents. This has been a significant achievement based upon our awareness campaigns, increased education and guidance booklets sent out to all staff. There has been 24-hour midwifery advice support in our Emergency Operations Centre and access to specialist care and support for our operational staff.	Progress of actions and their outcomes reported as part of the Sign up to Safety report submitted to at Clinical Governance Committee for assurance.

Priority 4: To explore the use of alternative pathways in each division by using the pathfinder leads to develop the pathways in the trust in each commissioning area.

Aim	What we did	What we have achieved	Quality Indicators
Improve non-conveyance and utilisation of pathways at EMAS	Reinforced the utilisation of the Paramedic Pathfinder assessment tool, revised our algorithms to ensure that the utilisation of pathways are now embedded across the trust. Issued clear guidance and changes to our on scene conveyance and referral policy that assist staff in safety netting and ensuring appropriate signposting.	Despite the increase in demand from 999 calls over the year, EMAS has seen a sustained increase in see and treat and hear and treat activity over the past 12 months.	Progress of the actions for Derbyshire and Lincolnshire and their outcomes is reported through the quarterly CQUIN reports.

Priority 5: Having signed up to the mental health Crisis Care Concordat, we will work collaboratively with local commissioners and relevant stakeholders to implement the agreed priorities within the mental health steering group.

Aim	What we did	What we have achieved	Quality Indicators
During 2016/17 we will continue to build mental health pathways in all divisions, to: •Embed parity of esteem in the trust for all patients presenting with mental health issues. •Ensure that these patient groups receive an appropriate response and are signposted to the appropriate receiving facility. •Improve the awareness of mental health conditions with our staff. •Continue to work with divisional multi-agency suicide prevention steering groups.	Progress against all key points of pathway design in each division are being built to ensure patient safety. We have introduced a bespoke training programme for our staff which has received national interest for safer holding techniques. Rolled out our Mental Health Workbook to give guidance into mental health conditions. It is complemented by other aide memoirs to support our staff with decision making. We have significant staff support mechanisms in place from Peer 2 Peer and Trauma Risk Management (TRiM) that have raised the awareness of our own wellbeing. We have introduced a memorandum of understanding with the Samaritans that allows us to signpost callers to support if they call our trust in crisis.	Our operational staff have received bespoke education in assessing mental capacity and given them a deeper understanding in mental health in the law, mental health awareness and conditions. We have seen a marked improvement in reducing conveyance to the Emergency Department for patients presenting with mental health issues. We have introduced pocket guides as an aide memoir that will support our staff in decision making.	Reduced admissions and conveyance to inappropriate care providers. Ensure Parity of Esteem is embedded in the Trust through our strategy, monitored through the mental health steering groups.

Priority 6: to support the improvement of ROSC rates, EMAS will continue to support the delivery of RED1 response targets. In 2016/17 we will increase Accident and Emergency establishments, to strengthen and improve operational resource levels, improve our registered (Paramedics) to none registered ratio within our accident and emergency workforce, and then develop actions and processes that contribute to a reduction of Red call conversion rates.

Aim	What we did	What we have achieved	Quality Indicators
To improve our Red 1 performance and in support of our frontline establishment a new operational restructure would be required .The key drivers behind this were: • Ensuring operational leadership is fit for purpose and prepared for the future. • Greater devolution of accountability to local teams through key enabling strategies. • Ensuring operations balances external partnership working and relationships, with a sharp focus on people, quality, efficiency and clinical outcomes.	In October 2016 a consultation process was commenced on a new operational leadership structure. We have increased the requirement for supporting and developing staff to manage a range of workforce priorities – appraisals, coaching, and attendance. We have introduced a structure that supports clinical delivery and outcomes and strengthens our resilience and preparedness for terrorist events. We improved role clarity and reduce reliance on a plethora of seconded roles. In response to a tightening financial climate, we are driving efficiency and effective use of all resources.	Utilising all our frontline available resources in the most clinically appropriate way, we have seen a sustained stabilisation an improvement in our Red 1 performance. By improving our Red 1 trajectory, this has meant that we have seen a sustained improvement in ROSC rate for the trust.	Monthly reporting of the ROSC and Survival to Discharge (STD) rates through the Ambulance Care Quality Indicators

What have we done to improve patient safety?

Learning from incidents, experiences and feedback

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

Learning is also identified through investigating untoward incidents, serious incidents and complaints. Other sources are patient surveys, compliments, community events, patient focus group and community events.

We share learning across the organisation through our established Lessons Learned Groups which include senior representatives from all divisions and teams within EMAS, review the feedback to learning and promote the learning outcomes across the service.

Duty of Candour

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

Quality visits

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

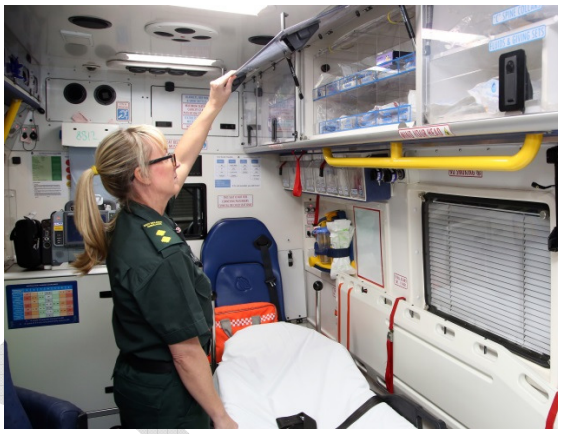
All the executive directors and non-executive directors should undertake at least two quality visits each year and these should take place in the county for which they are the lead.

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

- Hospital Emergency Departments.
- Emergency Operations Centres - Clinical Assessment team/call takers/ emergency medical dispatchers.
- Patient Transport Service.
- Ambulance stations and ambulance support teams.
- Other services eg Falls team.
- Operational shifts with frontline staff.
- Air Ambulance providers.

The purpose of the quality visits is to:

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



In 2016/17 a total of **XXX** visits have been undertaken. These visits have proven successful in engaging frontline staff and providing a board to floor approach where the senior leaders at EMAS engage with operational staff and listen to their concerns.

A template is completed by the Board member to record feedback which is collated into a report and the actions are addressed. The information collated during 2016/17 tells us the following:

What's good?

Comments included:

- Extemporary patient care is shown.
- Patients were respected by the crews and they had their dignity protected at all times.
- Patients on the phone were given professional and courteous advice.
- Crews were observed to be caring and compassionate to patients and family members.
- Appraisal and statutory and mandatory education up to date.
- Deep clean up to date.
- Team leader protected time is working well.
- Noticeboards up to date, in particular Quality Everyday noticeboards.
- Ambulances were observed as being clean and vehicle checklists had been completed.
- Some staff reported having access via email to the clinical bulletins and finding them useful. Enews was seen as a positive step forward and communications had improved.
- Equipment was seen to be replaced diligently and staff were aware of policies and procedures.
- Patients had their individual needs taken into account, observed special attention being given to patient with dementia.
- Good communication skills and interactions between the fast response vehicle paramedic and the crew in a double crewed ambulance with full involvement of the patients and their families.

- Dignity and compassion shown and full explanation of the course of treatment and the rationale for transfer to hospital.
- Good documentation and understanding of individual patient needs with extra care and consideration taken to ensure a patient is transferred whilst very breathless and anxious to ensure that they felt safe and treatment continued throughout the transfer process.

What could be improved?

Comments from the quality visits included:

- Meal breaks being taken away from stations eg in a different location, caused concerns.
- Discussions identified board to floor communication needs to improve.
- Staff were feeling pressurised with the current workloads and the intensity during their shifts.
- Discussions with staff through the shift identified challenges regarding work life balance and flexibility in rotas, particularly staff on relief.
- Staff don't seem to be able to access time off in lieu when they need to.
- Clinical risk in the community due to hospital handover delays.
- Concerns raised around the new divisional structure and roles.
- Discussions had around supplies of available equipment on vehicles.

Assurance rather than improvement

Serious incidents (SI)

Our transparent approach sees us proactively encourage colleagues to report patient safety incidents in line with a mature safety culture. Reporting allows us to analyse what happened to identify and put in place actions to reduce the risk of recurrence. 95% of all patient safety incidents (including SIs) reported during 2016/17 resulted in **XXXXX** which indicates a healthy reporting culture. During the year, EMAS identified **XX** serious incidents requiring investigation. The general themes are:

1. Care management
2. Delayed response
3. Service delivery

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

As part of the Serious Incident Investigation process a Root Cause Analysis (RCA) meeting takes place at which the root cause, contributory factors and learning for both individuals and the organisation are established; recommendations and Action Plans are also put in

place to prevent reoccurrence. The Medical Director and Director of Quality and Nursing chair our Peer Review Group which looks at all incidents that happen in the trust and reviews each incident to ensure learning is embedded into the trust. A review of learning and implemented actions is completed every six months by the lessons learned to provide assurance that the learning and actions are embedded practice and have resulted in service improvement.

Evidence for improvements in clinical effectiveness

Part of ensuring good clinical governance, is through clinical audit. This provides the means by which the trust ensures quality clinical care, by making individuals accountable for setting, maintaining and monitoring standards. It is focused around the three domains of quality – clinical effectiveness, patient safety and patient experience.

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

For Clinical Audit, topics are divided into 4 main types:

- Mandatory
- Discretionary
- Performance driven
- Staff initiation

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

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

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

The department has a pivotal role in ensuring that recommendations from clinical audit are a) distributed to frontline staff to ensure improvement in clinical practice and b) used to drive EMAS' continuous quality improvement aims.

Clinical Audit and Service monitoring plan 2016/17

Audit/monitoring activity	Type	Timescale	Notes	Progress
National Clinical Performance Indicators (nCPIs)	Mandatory - national audit requirement	As per nCPI programme (see appendix X)	National report completed by EMAS Clinical Audit & Research Co-ordinator Topics: • Asthma • Falls in elderly patients • Febrile convulsions • Lower limb trauma. Data collection, analysis of local and national data, report / template preparation and dissemination.	

Local Clinical Performance and Quality Indicators (LCPIs) – SPC run charts and data tables	Discretionary – local clinical audit project	Monthly	Audits completed by Clinical Audit Department. Topics: • Asthma • Cardiac arrest return of spontaneous circulation (ROSC) • Cardiac arrest survival to discharge • End-tidal CO2 (ETCO2) monitoring • Exacerbation COPD • Falls in elderly patients • Febrile convulsion • Lower limb fracture • Suspected fractured neck of femur • STEMI • STEMI PPCI within 150 minutes • Stroke/TIA • Stroke (FAST positive) arrival at hyperacute stroke centre (HASU) within 60 minutes. Data collection, analysis, breakdown by county, report preparation and dissemination.	
Local Clinical Performance and Quality Indicators (LCPIs) – SPC funnel plot locality comparisons	Discretionary – local clinical audit project	Quarterly	Audits completed by Clinical Audit Department. Topics: • Asthma • Exacerbation COPD • Falls in elderly patients • Febrile convulsion • Lower limb fracture	

			• Suspected fractured neck of femur • STEMI • Stroke/TIA Data collection, analysis, breakdown by locality, report preparation and dissemination	
Audit/monitoring activity	**Type**	**Timescale**		**Progress as at December 2016**
Ambulance Clinical Quality Indicators (ACQIs)	Mandatory – national performance monitoring	Monthly as per NHS England timetable (see appendix 2)	Audits completed by Clinical Audit Department Topics: • Cardiac arrest (ROSC and survival to discharge). • Stroke (care bundle and arrival at hyperacute stroke centre (HASU) in 60 minutes). • STEMI (care bundle, PPCI within 150 minutes). • Data collection, analysis, report preparation and submission to NHS England/Unify.	
Clinical Effectiveness Report	Mandatory local service monitoring	Quarterly	Report completed by Clinical Audit Manager • Report that collates all CPI and AQI metrics for the quarter, along with information relating to audit methodologies and criteria, and a clinical effectiveness improvement plan.	
Cardiac arrest annual report	Discretionary local audit / evaluation	Annual	Completed by Clinical Audit and Research Coordinator • Annual report covering treatment of and outcomes for cardiac arrest patients.	

Controlled drugs storage and management audit	Local service monitoring	Bi-annual	Audit completed by Accountable Officer for controlled drugs for the Trust • Monitoring of correct storage and management of controlled drugs in line with misuse of controlled drug regulations	
Controlled drugs usage audit	Local service monitoring	Annual	Report completed by Accountable Officer for controlled drugs • Monitoring the use of controlled drugs in line with the duties of accountable officers.	
Trigger Tool Audit	Local Clinical Audit project	Quarterly	Audit completed by Clinical Team Mentors. • Monitoring of agreed criteria essential for quality patient care.	

So how are the clinical audits done?

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

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

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

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

The projects described on the Clinical Audit & Service Monitoring Plan 2016/17 are complete (or are a continuous requirement and are up-to-date). The team also provide clinical information and reports for a number of unplanned and ad-hoc requests, such as freedom of information requests and coroners requests.

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

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

National Clinical Performance Indicators (nCPI)

The nCPIs have seen changes during the year as a new nCPI are developed and piloted. They are falls in elderly people and mental illness. The reports give more prominence to the data and in particular, the care bundles for each nCPI.

Data Collection and reports

The eleven Ambulance Trusts in England submit data to the nCPI coordinator who produces a cycle report using various analytical techniques. The reports that are produced are distributed to the National Ambulance Service Medical Directors (NASMed), as well as to each individual Ambulance Service. Each nCPI has a number of indicators based on best practice, examples of which are described below:

Asthma

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

The CPI has five elements:

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

Single limb fracture

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

The CPI has the following four elements:

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

Febrile Convulsions

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

This CPI has five elements:

V1 Blood glucose
V2 SpO2 recorded (prior to O2 administration)
V3 Administration of anticonvulsant if appropriate
V4 Temperature management recorded
V5 Appropriate discharge pathway recorded

The local CPIs for chronic obstructive airways disease and fractured neck of femur use a similar methodology as the nCPIs. The table below describes the criteria.

CPI	Inclusion Criteria	Exclusion Criteria	Criterion & Inclusion Criteria
Chronic obstructive airways disease (COPD).	Emergency patients suffering from acute exacerbation of COPD.	Transfers patients whose symptoms resolve prior to ambulance arrival ECP follow up visits after patient has already been treated for the acute episode by a crew.	**C1 Respiratory rate assessed** Where respiratory rate is recorded on the patient record. Can be taken at any time during patient assessment. **C2 Oxygen saturation (SpO2) recorded before treatment** • Must be recorded before treatment • Benefit of doubt is given to incidents where observations are carried out within a few seconds of administration of drugs. • If no treatment is recorded but an SpO2 reading is, this scores a 1. • If patient (or someone else on scene) has administered treatment before crew's arrival but an SpO2 is recorded this scores a 1. • **C3 ECG performed** • May be a 3 or 12 lead ECG **C4 Beta-2 agonist administered** • Includes administration of by health professional or patient unless stated that this was not effective. N.B. Beta-2 agonist in use at EMAS is Salbutamol **C5 Oxygen administered appropriately** • Where oxygen was administered

			appropriately for COPD patients – includes cases where O2 was not administered because the patient's oxygen saturation was satisfactory i.e. >= 88% • Includes cases where salbutamol is given by the crew as this is via oxygen driven nebuliser. • Includes cases where patient is on home oxygen or has been given oxygen prior to crew's arrival. • Where the patient has not received oxygen via a nebuliser, it must be given only if SpO2 is <88%. • For SpO2 85-87%, 2-6l/min should be administered via nasal cannulae or 5-10l/min via a simple face mask. • For SpO2 <85% 15l/min should be administered via a reservoir mask.
Suspected fractured neck of femur (NOF)	Emergency patients suffering from suspected fractured neck of femur	Transfers	**N1 Heart rate assessed** **N2 Blood pressure assessed** Full blood pressure required – Systolic and Diastolic **N3 Two pain scores** Incidents where two pain scores have been recorded at any time prior to arrival at hospital. The initial pain score must be a number between 0 and 10. The second pain score can be expressed in any of the following ways: • A number between 0 and 10 • A visual pain score (this applies to ePRFs and appears as 'the worst pain' or 'a little pain' under the pain part of the vital signs). • A statement in the free text like 'pain reduced after treatment' or 'pain relieved after treatment' (or 'pain

			increased after treatment') • An entry in the Treatment/Reassess section on the ePRF (near the drugs) that says something about pain having been reassessed. **N4 Morphine Given** **N5 Analgesia** N.B. Although paracetamol may also be given as an analgesic, it does not count for the purposes of this indicator. If morphine (or oramorph) is not appropriate, then entonox should be given.

Results and dissemination

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

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

East Midlands Ambulance Service NHS Trust

EMAS Research and Development

[detail to be added here when received from the EMAS Research and Development team]

What we have done to improve patient experience

Compliments

During 2016/17, we received more than **XXXX** expressions of appreciation from patients or members of the public. When the colleague can be identified by the information provided, the individual(s) are thanked personally by the Chief Executive in the form of a letter which accompanies a copy of the patient feedback. We are grateful to the patients and their relatives who have been happy to share their experiences at our public Trust Board meetings, via our social media channels, and with local and national media. We are tremendously proud to be able to promote the achievements of our colleagues in this way and it always gives a real boost to morale.

Continuing improvements to the EMAS complaints system

Following the 2013 Francis Report into Mid Staffordshire NHS Foundation Trust and the Clwyd/Hart Report, EMAS carried out a review of the complaints process to identify actions to improve the way complaints were handled. This improvement has continued throughout 2016/17 as we benchmarked our processes and outcomes across other NHS Ambulance Services nationally, and with additional published advice from the Parliamentary and Health Service Ombudsman.

Changes implemented throughout both the Patient Advice and Liaison Service (PALS) and Complaints and Investigation teams, including the centralisation of processes and recruitment of additional team members, have helped the service to become more robust and to deliver a higher quality outcome for complainants. Improvement work will continue through 2017/18 to ensure that learning is identified and actions are implemented comprehensively across the trust further improving the quality of patient care and the complaints service delivered.

Formal Complaints (FC)

During 2016/17, EMAS identified **XX** formal complaints requiring investigation. These were all related to our Accident and Emergency Services.

Following investigation, **XX** complaints were found to be justified and **XX**, partially justified. The remainder were not justified or not applicable, or still being investigated (eg the complaint related to a different service).

The general themes related to:

- Delayed response
- Care management
- Attitude

Compliments and complaints received per county during 2016/17:
[figures to be added at year end, 31 March 2017]

County	Compliments	Complaints
Derbyshire		
Leicestershire and Rutland		
Lincolnshire		
Northamptonshire		
Nottinghamshire		

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

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

- Communication of key learning points through education, training, communication and awareness.
- Clinical case reviews and reflection of the practice by individuals.
- Amendment to policies, procedures and practices.
- Themes being reviewed by our Lesson Learnt Group which consists of multi-disciplinary membership.

Ombudsmen Requests

During 2016/17, we received **XX** requests for information from the Ombudsmen. Of these, the Ombudsmen confirmed **XX** was not upheld, and **XX** partially upheld, the rest are still being investigated and remain open.

Patient stories

EMAS captures patients' experience in a variety of ways. One way is by inviting patients and carers into our Trust Board meetings to tell their story. We have included two examples below of where we have done well or where we have identified areas for improvement.

Mrs V's story, reported at the May 2016 EMAS Trust Board meeting

Mrs V had previously had a left hip replacement 2006 and in October 2014 began to suffer left hip dislocations. In March 2015 Mrs V went outside early evening to move her car and whilst getting into the car Mrs V's left hip dislocated leaving her standing half in and half out of the vehicle and had immediate on-set of intense pain. Mrs V found she was unable to move and because of this factor it was some time before Mrs V was able to raise the alarm by alerting a passer-by who informed Mrs V's niece, who was staying with Mr and Mrs V. Mrs V's niece called NHS111 and was told an ambulance was required. NHS 111 transferred his call to 999 at 19.24.

Despite a classification of a Green 2 call that required a response within 30 minutes and four subsequent calls to 999 Mrs V remained standing half in and half out of the car for around an hour becoming increasingly cold and weak. At the time EMAS was in Capacity Management Plan Level 3 and had requested assistance from a neighbouring trust, who was unable to help. A welfare call was made at 21.36 when the call was upgraded. EMAS sent a fast response vehicle with a solo responder at 21.41. A double crewed ambulance arrived at Mrs V's house at 22.32 to transfer her to hospital.

Mrs V observations

PALS received a complaint from Mrs V following the incident voicing her disappointment with the service she had received from EMAS.

Mrs V stated "Since October 2014 I have dislocated my hip five times and on each occasion had to call 999. Other than the incident concerning my complaint, the ambulances arrived within a reasonable time and all staff have been wonderful." Mrs V added "the wait seemed endless and I felt colder and colder and I wondered when the ambulance would come, I started to feel weak."

Mrs V did comment "All of the staff who came were wonderful, cheerful and efficient."

Conclusion

Following the complaint areas were identified as actions for EMAS:

1. The EMAS duty manager feedback to dispatch officers regarding checking the resource allocation function when Green 2 call timescales are exceeded and all procedures were followed.
2. Patient welfare calls have been increased, wherever possible, to provide support to the patients when they are experiencing prolonged waits. All welfare calls and clinical assessment calls are escalated in relation to their presenting clinical conditions and support is provided whilst awaiting a response.
3. The Clinical Assessment team underwent a refresher process on soft tissue viability and risk to elderly patients.

Mr G's story, reported at the July 2016 EMAS Trust Board meeting

A formal complaint had been raised by Mr G's son as a result of a prolonged wait following a fall at a care home; Mrs G suffered a fractured neck of femur as a result of the fall. In 2012 Mrs G had experienced a prolonged wait after suffered a different fall then and Mr G had raised a similar complaint at that time.

An initial 999 call was made to EMAS at 23.35 coded as a Green 3 call meaning the care home should have expected a telephone call from our Clinical Assessment team within 20 minutes. However, four subsequent 999 calls were made with the fourth call resulting in the call being upgrade to a Red 2 code due to the deterioration of Mrs G's condition. A welfare call was made between the third and fourth 999 calls and pain relief advice was provided.

A double crewed ambulance (DCA) arrived on-scene at 02.17, two hours and 52 minutes after the original 999 call. On arrival observations and assessment were completed and Mrs G was taken to the ambulance and transported to hospital. Mr G advised that he was relieved that help had arrived and commented that he thought, from his observations, that the crew were experiencing a difficult shift. Mr G and his family were happy with the care provided and the timely nature of the transfer to hospital: "The crew were professional even though it was obvious they were tired and having a difficult shift. I was happy with their care."

Mrs G arrived at hospital at 03.25 where a fractured neck of femur was confirmed, although Mr G informed EMAS that his mother had waited a further four and a half hours to see a doctor in the hospital.

During the lifetime of this call EMAS was responding to high demand and was at Capacity Management Plan Level 3.

Mr G's observations

Mr G raised a complaint with EMAS as his mother had experienced the same problem before. Mr G explained: "to suffer the exact same experience three years later was unacceptable".

Mr G stated: "It became very emotional seeing my mum on the floor in pain and not being able to help her. The situation was very frustrating."

The family were happy with the care provided by the crew.

Mr G was particularly unhappy with the fact that:

- following his almost identical complaint three years previously and a subsequent meeting with the Chief Executive Officer, the situation did not appear to have improved.
- the Advanced Medical Priority Dispatch System (AMPDS) does not allow all of the facts to be given and considered in the assessment of the patient.
- the ambulance service is failing the public by not having the capacity to attend calls within the national performance targets.

Conclusion

Following the conclusion of this complaint, the Head of Safety is reviewing 'elderly fall' investigations with a view to identifying what can be done differently to improve our response to patients. The findings will be presented to the Quality Governance Committee with recommendations for the trust to consider early in financial year 2017/2018.

Within the Emergency Operations Centre when three calls to the same patient occurs this is now a trigger for escalation of response to that patient.

Extracts from messages of thanks during 2016/17

Ms GT wrote in to thank paramedic Tracey Wardle from Eckington station: *"I would just like to thank the paramedic who came out to my daughter this morning. She was wonderful and did an amazing job of reassuring us all and really needs to be commended on her attitude and professional, friendly approach. Please pass on our thanks and gratitude for her kindness and help."*

Mrs SH has thanked Tim Scott, Daniel Forbes and Natalie Butler who attended her son in Retford in November 2016. She said: *"A big thank you to the professionals involved in my son's recent seizure. The first responder was great at his job, and very helpful. He spoke clearly to my eight year old son without frightening him, while making the required assessment. The two ambulance crew were also very reassuring and quickly transported us to A&E."*

A doctor from a practice in Melton Mowbray has written to praise colleagues who attended one of her terminally ill patients. She wrote: *"I just wanted to write to express my gratitude for the wonderful help of our paramedic crew on 7 December 2016, with a gentleman who was facing a very serious illness and who was refusing hospital admission. It was six o'clock at night and we had to rush to get end of life drugs in place since he was clearly in pain. I wanted to thank the wonderful ambulance crew for offering to collect the end of life drugs from the pharmacy whilst I prepared the authorisations. I know that this was above and beyond the crew's contract but it really did make a huge difference for the patient."*

Mr AH has praised colleagues who attended him in July in Claypole when he was experiencing chest pains and shortness of breath. He said: *"Andy and Martin were dispatched from Newark station and arrived around 09.15. They quickly assessed my status, hooked me up to the ECG monitor and gave pain relief. By 09.30 they had determined I was a blues and twos and we were quickly on our way to Lincoln County Hospital. We arrived approximately 26 minutes later and I felt more comfortable thanks to their prompt actions. I have been allowed to return home today after an angioplasty with another planned for six-eight weeks. I have nothing but praise and admiration for their professionalism. Cool, calm, and first class all the way."*

Mr H from Northamptonshire wrote: *"I would like to say a big thank you to the crew who attended my husband. They arrived quickly and were professional and caring. I understand that one of the crew was due to finish their shift but heard the call and responded, showing their care and commitment to their job."*

Mr PF, who was unable to speak when he called 999 recently, wanted to praise EOC Bracebridge staff Karen Hutchinson and Gillian Holmes: "*The amazing staff in the EOC did an exceptional job when they logged the 999 call. The training must be fantastic because they put into practice methods of communicating with me when I was unable to speak such as tapping the phone etc."*

Mrs B from Derbyshire wrote to thank the Patient Transport Service crew who transported her to hospital. She had an excellent journey the staff were lovely and the service was great.

Community Engagement

The Communications and Engagement Strategy for 2014-2016 was approved by the EMAS Trust Board in November 2014. Our 2016/17 stakeholder engagement plan gave us a renewed focus on engagement with our tier two councillors in District and Borough Councils. Through the year we continue to deliver a range of engagement activities to improve patient experiences. We do this by listening to patient and relatives stories and experiences, capturing their feedback and sharing it with the organisation. This allows us to respond to concerns raised, share praise with colleagues, and identify potential for improvement. We have increased the public's knowledge and understanding of EMAS by producing materials and distributing them at events, and using social media to help explain:

- How emergency and urgent calls are graded (categorised) and responded to.
- Alternative pathways to emergency care.
- Where professional medical advice can be gained for non-urgent problems.
- Methods of self-care and good health and wellbeing.

Here are a few examples of our community engagement this year:

Sikh Temple

Colleagues from across Leicestershire volunteered their time to showcase EMAS' work at the Rangharia Board Sikh Temple, Leicester. It was a special day for the Sikh community marking the birthday of Guru Nanak (founder of Sikhism). The EMAS team were able to talk (in Punjabi, Hindi and English) about different roles within the service, show people around an ambulance vehicle and talk about how the service works. By working with local doctors they also carried out 150 mini health checks.

Paul Fitzgerald, Equality, Diversity and Involvement Manager said after the event: "Engaging with our diverse communities remains an important aspect of the work that EMAS does. The event at the temple provided us with a platform to both showcase what EMAS does and also provide an opportunity to engage individuals to consider a career in the service"

Several hundred people attended on the day and there was great interest and enthusiasm from attendees regarding the event, as well as acknowledgement for the amazing work that the ambulance service provides to the community. Similar events are planned for 2017/18.

School Visits

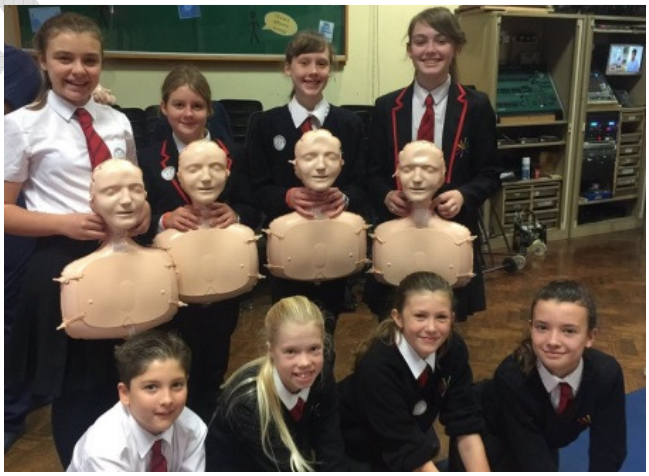
Community engagement officers have visited nursery and school children showing an ambulance, talking to them about the service we provide and teaching them lifesaving skills.

Everyone has a role to play in an emergency and giving first aid within the first few minutes of an incident can make the difference between life and death. The team has trained hundreds of people in emergency life-saving skills through free courses during 2016/17, offered in each county.

People attending learn CPR (cardio pulmonary resuscitation used when someone goes into cardiac arrest), the recovery position and how to help someone suffering from a heart attack, choking or a serious bleed.

Restart a Heart Day

Educating young people in lifesaving skills was a highlight of the year as EMAS joined in the international initiative Restart a Heart Day 2016 where students across the East Midlands where taught CPR.



EMAS and partners trained on the day 4,061 students contributing to the national figure of 150,581 students taught in one day.

Communications and social media

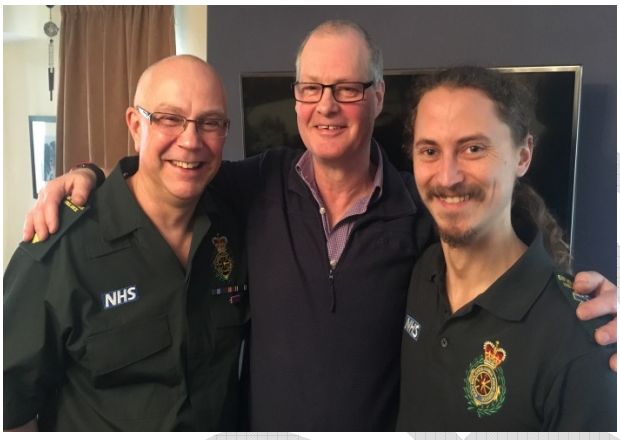
Everyone in our service plays their part in saving lives, from our Ambulance Support teams to our frontline clinicians, each person works hard to ensure our patients across the East Midlands receive the best possible patient care.

We are eternally grateful to the patients and their family who share their stories and positive experiences through social media, and with local, regional and, in some cases, national media.

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

Paramedics reunited with man who suffered 15 cardiac arrests in one hour

Two colleagues who saved the life of a mountain rescuer 15 times in less than an hour have been reunited with him at his home. Chris Haywood from Sparrowpit near Buxton, went into cardiac arrest just hours after rescuing a hiker with a broken ankle near Chapel-en-le-Frith.



Chris began experiencing chest pains while driving home from the rescue mission and mistakenly thought his pains were indigestion. But 10 minutes after his wife had taken their dog for a walk, Chris realised he was having a heart attack and rang 999. Paramedic team leader Steve Harrison arrived in a fast response vehicle within minutes to begin advanced life support.

Ambulance crew Jack Sutherland and Ellie Parsons backed Steve up in an ambulance and took Chris to Wythenshawe General Hospital in Manchester. In the next hour, Chris went into cardiac arrest a total of 15 times, including six times in the back of the ambulance and once in the lift at hospital.

Paramedic Jack said: “Chris even had one in the lift and we managed to get his heart going again before the lift stopped and opened the doors.

“I have been a paramedic for seven years and this is only the second case where we have shocked a patient and they have walked out of the hospital.”

Chris was in hospital for one-and-a-half weeks, but is now on the road to recovery and is walking three miles several times a week to build his strength up again. He was delighted that he was able to thank the paramedics who gave him a second chance at life.

He said: “I now have two birthdays, the second one is the day when they gave me my life back. I will never be 100% ever again due to the damage done to my heart, but I have a second chance at life.”

Cyclist meets colleagues who saved his life

A cyclist who sustained multiple life threatening injuries after being involved in a collision with a car has been reunited with colleagues who helped save his life.

Graham Huck, from Doncaster was celebrating 50 years of cycling at the North Midlands Veterans Cycling Club 25 mile bike ride he was hit by a car on the A1 travelling at 70 miles per hour.

Nichola Haywood, paramedic was first on scene and found Graham in a layby, half on a kerb unconscious. Andy Watson was on scene a few minutes later and they both provided care at the scene and transported Graham to Queen's Medical Centre for surgery and further treatment.

After being reunited with the crew Graham said: "I would like to thank Nichola and Andy for all they did, they saved my life, they are amazing."

Cardiac arrest patient to meet paramedic lifesaver

A Nottinghamshire family got the chance to say thank you to the paramedic who saved their mum's life, even though he wasn't officially on duty.

Jayne Stevens, collapsed at home in Nottingham suffering multiple cardiac arrests. Her daughter Hayley, saw her mum through the letterbox during a chance visit and managed to get in through an open window to help her. Hayley dialled 999 and began to perform CPR.

The person who responded to the call was Mark Bushell who works for EMAS as a paramedic but wasn't on duty in his usual role at the time. As part of the EMAS Emergency First Responder scheme, Mark was volunteering his spare time to respond to any emergency calls in his local area.

Mark said: “I had only been on call for about half an hour when the alert came in. I try to do an Emergency First Responder shift a few times a month as normal shifts and life allows. I tend to use the time to get household jobs done but then I’m available if needed. I live in Nuthall and Jayne was literally a minute and a half away so I was able to get to her quickly.

“When I got there, Jayne was on the floor and her daughter was doing CPR. I set up the defibrillator and found out what rhythm her heart was in and shocked her and a pulse came back straight away.”

Jayne was rushed to Queen’s Medical Centre in Nottingham and later transferred to the City Hospital, where she spent a week in a coma. She was seriously ill having suffered seven cardiac arrests in total but thankfully has now made a full recovery.

Jayne’s daughter Hayley who found her mum added: “My mum still gets very tired but on the whole is valuing her life. We just feel so grateful that it was Mark who turned up. We want him to get the recognition he deserves and that is why we’ve invited him around to mum’s house so that she can say thank you face to face.

[Insert photo of reunion here]

A prestigious award has been presented to a teenager for his lifesaving actions and bravery.

17-year-old Ben Coles from Northampton was in his Grandad’s car on the way to college when his Grandad suddenly went into cardiac arrest. Ben realised his Grandad had lost consciousness and grabbed the steering wheel to swerve the vehicle away from crowds of pedestrians. The car came off the road between several trees and over a bank ending in a wall.

The incident happened around 08:30 when lots of commuters and children were on the roads. Thanks to Ben’s actions his Grandad David Watters survived the ordeal and no other road users or pedestrians were injured.

Anya Donald, EMAS paramedic, was first on scene to the incident, she said: “Ben was incredibly brave that morning. To have the ability to steer the vehicle away from others in both an upsetting and stressful situation undoubtedly not only saved both his and his grandad’s life but others as well.”

To commend his actions Ben has received a very special Laverick Award presented by his Grandfather and Anya. The award was set up in memory of a Northamptonshire paramedic Nick Laverick who sadly lost his battle with cancer in 2013. It is presented to children and young adults who have committed a selfless and brave act for the benefit of others.

“We hope Ben will cherish this award for a long time” added Anya. “He should be so proud of himself for his actions that day."

David Watters : “We are very proud of Ben, it’s thanks to him and everyone involved on that fateful morning that I made a full recovery. We are delighted that he has been recognised for what was quite an ordeal.”

PICTURE TO COME

BBC Ambulance Day

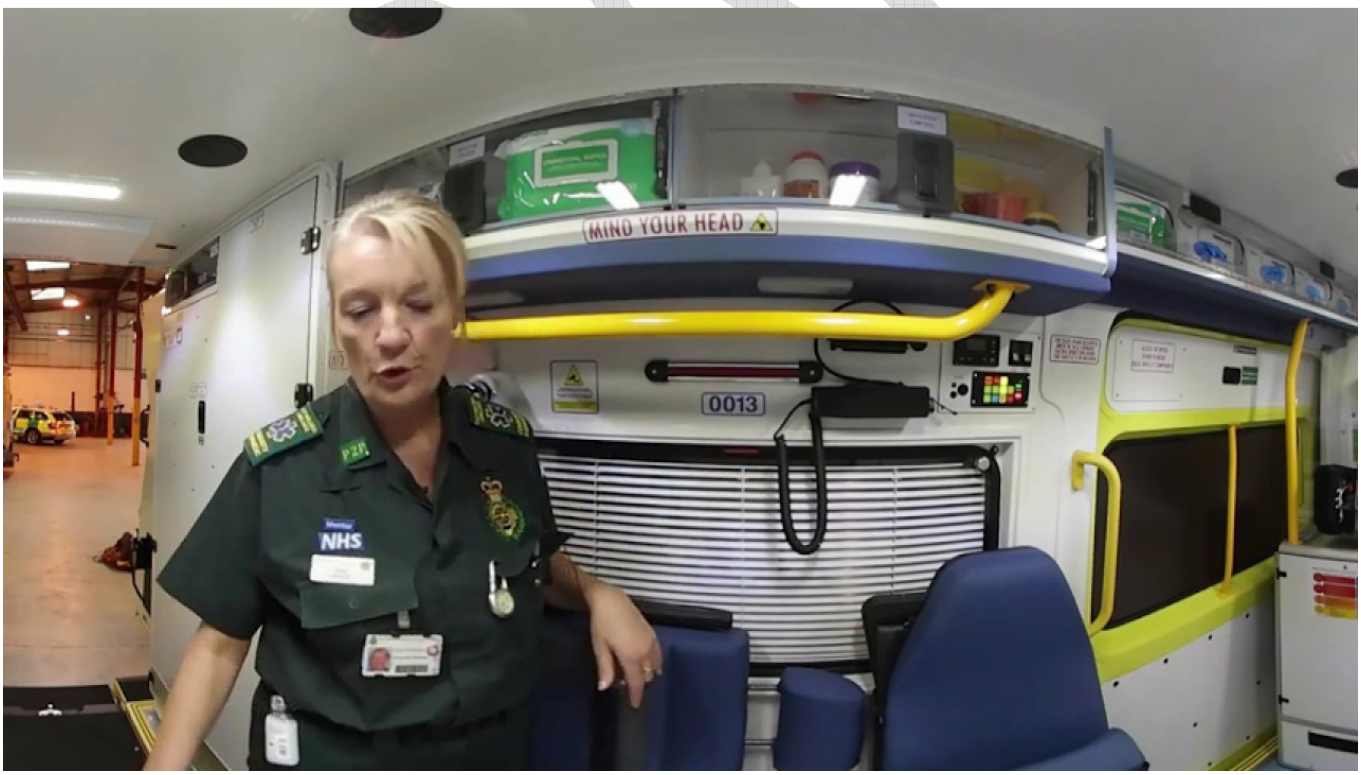
On Wednesday 30 November national and regional BBC teams plan to focus their attention on the UK Ambulance Services through news bulletins, radio broadcasts and online content.

Their aim is to inform and educate BBC audiences, to generate grown up debate about the issues facing the services in England, Scotland, Wales and Ireland and showcase some of the innovations introduced by services and partner organisations to help cope with demand.

We took part in pre-record filming including a double crewed ambulance observation shift in Leicester, a fast response paramedic observation shift in Lincolnshire, interviews with a Derbyshire paramedic who has given a 360 degree tour in one of our ambulances, pictured below, and interviews with our Clinical Assessment Team Manager and Chief Executive. There were also live broadcasts from our Horizon Place Emergency Operational Centre.

Our open and proactive approach helped to demonstrate the current pressures we face and improve understanding, manage expectations and encourage the public to use 999 and the NHS wisely.

The Association of Ambulance Service Chief Executives reported that up to 19 million people saw the national television coverage and the NHS England media team declared the day ‘a triumph’.



Equality and diversity

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

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

Improving the care environment

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

[Examples to be added here]

Appendix 1 - Workforce

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

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

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

Desired Outcomes of the Strategy include:

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

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

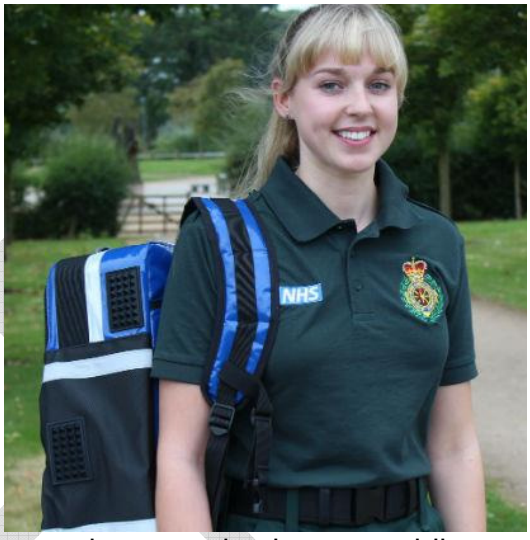
More frontline staff

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

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

In line with our Workforce Plan, during 2016/17 we recruited and trained **XX** emergency care assistants, **XX** technicians, **XX** paramedics, **XX** staff for our Emergency Operations Centre (control) across both Emergency Medical Dispatch and Clinical Assessment team roles and **XX** other staff in support functions. This included an increase in overall staffing by **XX**.

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



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

Supporting young people at the start of their career

We continued to support the national apprenticeship programme by recruiting apprentices into a range of enabling service and operational support positions. Since 1 April 2016, we have recruited **xx** apprentices who have taken up roles in our enabling services. Of the apprentices that completed their schemes in 2016/17 went on to successfully secure roles within EMAS. In addition, **XX** members of our current establishment commenced an apprenticeship within their current role to enhance and progress career development.

Values based recruitment improves quality of care

Through our recruitment campaigns we have ensured a values-based approach focussed on attitudes, behaviours and ability. While assessment of ability has remained an integral component of the recruitment process, it is now widely recognised that employees' values, attitudes and behaviours have a significant impact on the quality of care and patient experience.

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

Education and development

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

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

During 2016/17, our Education team continued to support the annual statutory and mandatory education programme supporting essential standards of quality and safety, statutory and mandatory requirements, and clinical updates.

Staff support and wellbeing

During 2016/17 EMAS has progressed initiatives to enhance staff support and wellbeing. Key achievements are detailed below.

Health and wellbeing:

[detail to be added here at year end]

Staff engagement

[detail to be added here at year end]

Positive impact

[detail to be added here at year end]

NHS Staff Opinion Survey

[detail to be added here when full results received from the Picker Institute]

Have we improved since the 2016 survey?

[detail to be added here at year end]

Appendix 2 – IG Toolkit

Our Information Governance Toolkit assessment overall score for 2016/17 was **XX**%

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

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

East Midlands Ambulance Service NHS Trust

Appendix 3 – Research and Development

[to be added at year end]

Appendix 4 – CQC registration

EMAS was inspected by the Care Quality Commission (CQC) in November 2015, and again in February 2017 under the domains of Well Led, Effective and Safe.

[More detail to be added here when EMAS has received the CQC's report and findings following the February inspection].

Appendix 5 – Third Party Statements

[add detail here when received from lead commissioner, OSC, Healthwatch]

Appendix 6 – EMAS Trust Board

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

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

Our Trust Board is led by our Chairman and comprises of executive and non-executive directors.

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

Chairman
Pauline Tagg

Non-Executive Directors
Stuart Dawkins, Rachel Morrison, Karen Tomlinson, Vijay Sharma and William Pope

Chief Executive
Richard Henderson

Chief Operating Officer
Dave Whiting

Medical Director
Bob Winter

Director of Nursing and Quality
Judith Douglas

Director of People and Engagement
Kerry Gulliver

Director of Finance
Mike Naylor

Director of Strategy and Information
Will Legge

Director's responsibilities in respect of the Quality Account

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

Statement of Directors' responsibilities in respect of the quality account

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

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

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

Glossary

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

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

Audit
A continuous process of assessment, evaluation and adjustment.

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

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

Commissioners
NHS organisations that effectively purchase services from EMAS, based on the identified health needs of their local population. NHS Hardwick Clinical Commissioning Group is the 'lead commissioner' for EMAS. That is, they (on behalf of all the CCGs in our area) negotiate what level of income EMAS will receive – and, alongside this, what quality measures we are expected to achieve as set out in our service level agreement.

CPI
Clinical Performance Indicator is a way to measure quality.

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

CQI
Clinical Quality Indicators, a set of 11 indicators introduced to the Ambulance Service by the Government from 1 April 2011 as measures of clinical quality.

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

DCA
Double crewed ambulance – the vehicle which responses to patients and in the majority of cases will transport patients to hospitals.

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

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

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

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

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

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

FRV
Fast response vehicle – a car normally manned by a solo clinician.

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

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

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

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

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

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

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

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

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

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

SI
Serious incident

STEMI
ST Elevation Myocardial Infarction is a heart attack.

Our Quality Account
2016/17

We welcome your comments about our Quality Account.

Please contact us using the details below:

East Midlands Ambulance Service NHS Trust
Trust Headquarters
1 Horizon Place
Mellors Way
Nottingham Business Park
Nottingham, NG8 6PY

Call	0115 884 5000
Email	communications@emas.nhs.uk
Visit	www.emas.nhs.uk
Twitter	@EMASNHSTrust
Facebook:	EMASNHSTrust

To receive this information in large print, audio or in another language, please call us on 0115 884 5807