QUALITY ACCOUNT 2013-14

Summary Review of 2012-13

Trust us to care.

Contents

INTRODUCTION

Welcome to our Quality Account Summary, which aims to take the key highlights from the full Annual Report -Quality Account 2012/13 which can be found at:
http://www.

The Trust would like to share with you what West Midlands Ambulance Service NHS Foundation Trust is doing well with and where improvements in quality can be made and the way in which these have been prioritised.

The Vision for West Midlands Ambulance Service NHS Foundation Trust is:

"Delivering the right patient care, in the right place, at the right time, through a skilled and committed workforce, in partnership with local health economies"
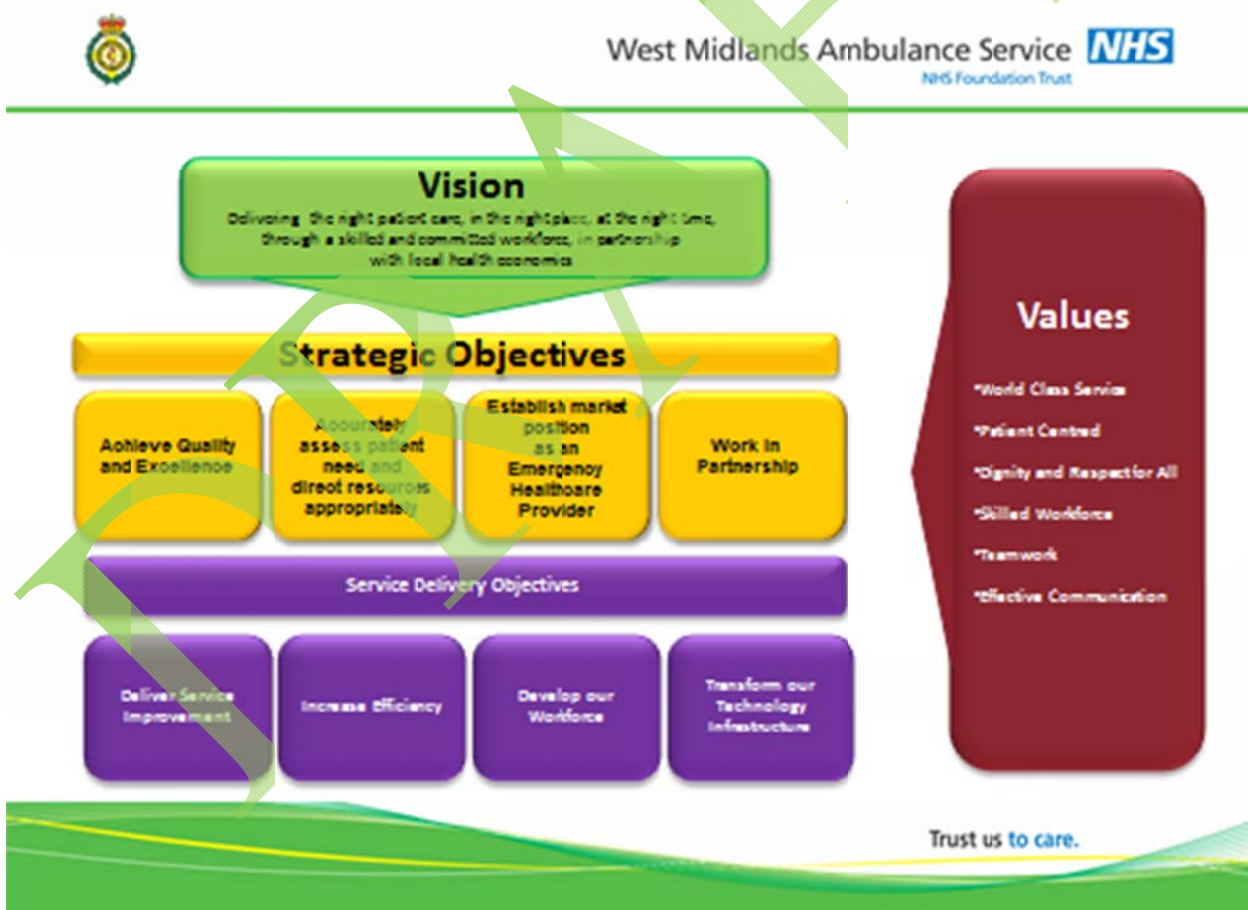
Part 1

1.1   Statement on quality from the Chief Executive of West Midlands Ambulance Service Foundation Trust

Mr Anthony Marsh **SBStJ, MBA, MSc, FASI**

Part 2

2.1   Priorities for Improvements and Statements of assurance from the board from Projects from 2012-13.

The quality improvements priorities are reviewed and performance is demonstrated in the table below for 2012-13 Year to Date.

Patient Safety Priorities 2012-13

	Priority	Target	Status	Commentary on Achievement to Date
Patient Safety	**Falls Pathway** To focus on prevention and education in this area, to make sure that people get referred to the right place at the right time for a better outcome.	Qtr. 1: Planning Stages	✓	
		Qtr. 2: Develop an Educational Package	✓	Education package developed
		Qtr. 3: Distribute the Educational Package on to the Virtual Learning Site	✓	Education package launched
		Qtr. 4: Identify the baseline	✓	Baseline was realised
	Infection Prevention and Control. "• Premises Audit: to ensure premises are clean and safe for staff and patients • Vehicle Cleanliness Audit to ensure vehicles are clean and safe for staff and patients • Hand Hygiene Audit: to ensure compliance with hand hygiene standards at point of care	Premises Cleanliness Audit: Minimum 90%	⇔	last audit at 86% awaiting recent audit results
		Vehicle Cleanliness Audit: Minimum 90%	✓	
		Hand Hygiene Audits: baseline & 85% compliance.	✓	last audit at 85% awaiting recent audit results
	Near Miss Reporting – Patient Safety Incidents	An increase in reports of incidents occurring that did not result in harm but could have a 25% increase	✓	Increased by 27%

Patient Experience Priorities 2012-13

	Priority	Target	Status	Commentary on Achievement to Date
Patient Experience	**Patient Survey** offered to service users proactively	0.5 % of Emergency and Non – Emergency Patient Activity in 2012/13 will be targeted	✔	At 3802 against revised target of 5000
	Patient involvement when things go wrong (Being Open Policy)	100% of Patient Safety incidents will comply with the Trusts 'Being Open Policy'	✔	Being open is separated into 2 categories. Harm incidents reported through incident reports and Serious Incidents: Patient Safety Incidents through incident reports 100% compliance Serious incidents currently at 98.39% compliance/.

Clinical Effectiveness Priorities 2012-13

	Priority	Target	Status	Commentary on Achievement to Date
Clinical Effectiveness	**Medicine Management** Appropriateness of Drug Administration	85 % of patients will be treated. This target set considers that on occasion the patient within close vicinity to a hospital would benefit by timely transportation rather than delay on scene.	✔	Achieving at 85%
	Management of Onset of Stroke	90% of hyper-acute stroke patients have an onset of symptom time recorded where known	⇔	Achieving at 87% to date possible non achievement of 90% therefore to continue this priority in 2013-14

From the priorities and the performance described the Trust will build on them during 2013-14 as agreed by the board and as described in detail in Part 3 of this report. These priorities for improvement will have monthly data collection and be reported to the board at least quarterly. The rational for the selection is a combination of priorities unachieved in 2012-13, for example, the documentation of onset of symptoms, also CPI`s which are struggling to be achieved such as documentation of pain scoring. From listening to our patients such as the renal priority where WMAS has received complaints and PALs, and from this have engaged with patients to find out what really matters to them.

2.2 Performance Summary for year to date 2012-13

April 2012-December 2012	75% - 8 min	75% - 8 min	75% - 8 min	95% - 19 min	90% - 30 min	90% - Triage in 60 min
Financial Month	Red 1- 08 Min Performance	Red 2 - 08 Min Performance	Red - 08 Min Performance	Red - 19 Min Performance	Green 2 Performance	Green 4 Performance
April	83.1%	76.7%	76.8%	97.7%	97.0%	99.6%
May	83.4%	74.8%	75.0%	97.7%	95.9%	99.8%
June	79.9%	77.2%	77.2%	97.5%	95.2%	99.6%
July	81.2%	76.2%	76.3%	97.4%	94.4%	99.5%
August	75.6%	75.8%	75.8%	96.9%	92.9%	99.6%
September	77.0%	75.6%	75.6%	97.0%	92.9%	99.6%
October	80.3%	78.3%	78.4%	97.8%	95.3%	99.7%
November	79.6%	78.3%	78.3%	97.9%	96.5%	99.8%
December	77.5%	74.0%	74.0%	96.9%	93.5%	99.6%
Grand Total	**79.7%**	**76.3%**	**76.4%**	**97.4%**	**94.8%**	**99.7%**

January 2013-March 2013	75% - 8 min	75% - 8 min	75% - 8 min	95% - 19 min	90% - 30 min	90% - Triage in 60 min
Financial Month	Red 1- 08 Min Performance	Red 2 - 08 Min Performance	Red - 08 Min Performance	Red - 19 Min Performance	Green 2 Performance	Green 4 Performance
January	81.2%	77.1%	77.2%	97.5%	94.9%	99.7%
February	80.0%	73.9%	74.1%	97.3%	93.2%	99.7%
March *	77.4%	68.9%	69.1%	96.1%	89.9%	99.5%
Grand Total	**79.5%**	**73.4%**	**73.6%**	**96.9%**	**92.7%**	**99.6%**

* up to and including 28th March 2013

	Red 1 - 75% - 8 min	Red 2 - 75% - 8 min	Red - 75% - 8 min	Red 19 - 95% - 19 min	Green 2 - 90% - 30 mins	Green 4 - 90% - triage in 60 mins
National Target	**75%**	**75%**	**75%**	**95%**	**90%**	**90%**
WMAS Performance	**79.7%**	**75.9%**	**76.0%**	**97.4%**	**94.5%**	**99.7%**

* Up to and including 7th March 2013

2.3   West Midlands Ambulance Service Year End Key Performance Indicators (KPI) and Ambulance Quality Indicators (AQI)

To ensure patients of the West Midlands receive quality care from their ambulance service a set of key performance indicators has been set nationally. These help set our policies, guidelines and continue to develop an organisational culture that places quality at the top of the Trust's agenda.

From April 2011, the Department of Health introduced Ambulance Quality Indicators. These are focused more on patient outcomes.

The following reports the figures for each KPI/AQI and highlights the national mean percentage, the position of WMAS against other Trusts and whether the Trust was in the upper quartile of Ambulance Trusts

2.3.1   Outcome from Cardiac Arrest

The Ambulance Quality Indicator includes measurements for 2 elements:
(a)   Return of Spontaneous Circulation (ROSC) at hospital (i.e. the patient has a pulse on arrival at hospital)
(b)   Survival to hospital discharge (i.e. the patient has survived the cardiac arrest and been discharged from hospital)

There are 2 patient groups that the above measures these are:
(a)   The overall group refers to all patients in cardiac arrest where resuscitation has been commenced.
(b)   The comparator group is referring to those patients in cardiac arrest where resuscitation has been attempted, where the arrest was witnessed by a bystander, the rhythm that the patient was initially presenting with was VF/VF and the aetiology was presumed to be cardiac.

ROSC at Hospital	Overall Group	Comparator Group
2012-2013 (April to November 2012 data)		
Birmingham	26.01%	45.61%
Black Country	30.63%	46.34%
C&W	19.44%	26.67%
West Mercia	27.85%	42.50%
Staffs	28.62%	48.39%
WMAS	27.50%	44.02%
National Mean	25.39%	48.02%

Survival to Hospital Discharge	Overall Group	Comparator Group
	2012-2013 (April to November 2012 data)	
Birmingham	7.16%	14.04%
Black Country	6.61%	14.63%
C&W	6.48%	20.00%
West Mercia	10.13%	12.50%
Staffs	5.92%	16.13%
WMAS	7.36%	14.67%
National Mean	7.85%	21.21%
Position	9th	12th
Upper Quartile	No	**No**
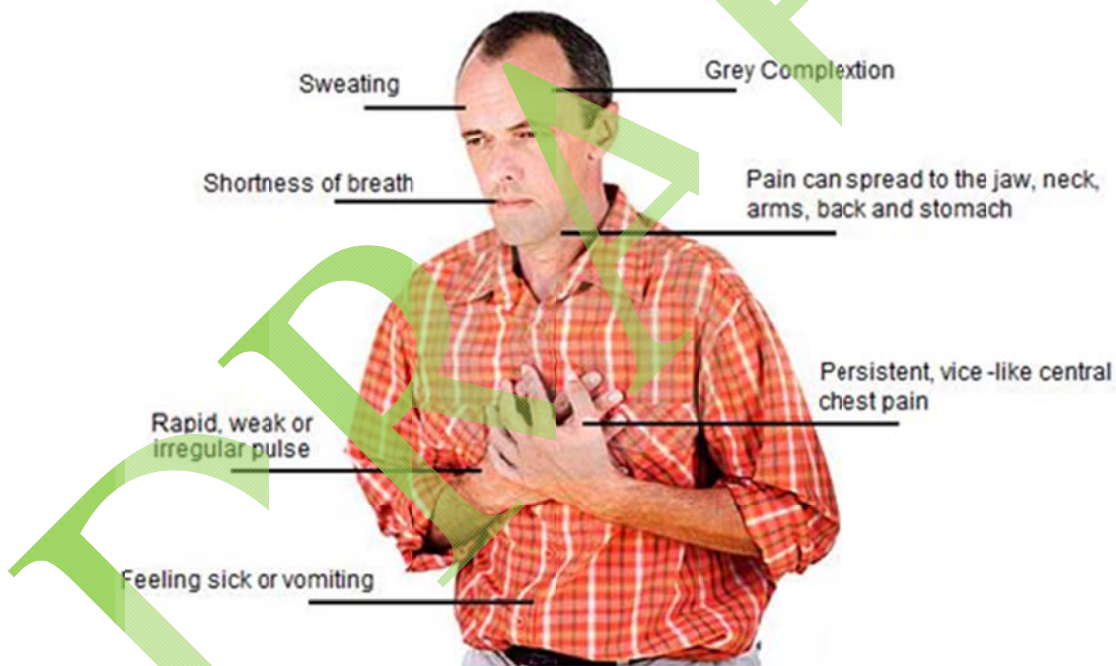
2.3.2 Acute ST-elevation myocardial infarction (STEMI)

STEMI (ST-elevation myocardial infarction): This is a type of heart attack. It is important that these patients receive the following:

- Aspirin - this is important as it can help reduce blood clot formation
- GTN – this is a drug that increases blood flow through the blood vessels within the heart (improving the oxygen supply to the heart muscle and also reducing pain)
- Pain scores – so that we can assess whether the pain killers given have reduced the pain.
- Morphine – a strong pain killer which would usually be the drug of choice for heart attack patients

- Analgesia – Sometimes if morphine cannot be given entonox, a type of gas, often given in childbirth, can be used.
- SPO2 documented – The routine administration of oxygen to patients suspected of suffering an acute myocardial infarction is not recommended, however oxygen saturation should be monitored using pulse oximetery to ensure oxygen is offered to patients with an SpO2 of 94% and below.
- Call to Needle - 68% of patients that receive thrombolysis should receive this treatment within 60 minutes of the initial call. The use of thrombolysis in the region has significantly reduced due to the availability of PPCI and patients only receive this treatment if they are more than 90 minutes from a specialist heart attack center.
- Call to Balloon - 75% of patients that have Primary Percutaneous Coronary Intervention (PPCI) should do so within 150 minutes of the initial call. This treatment is provided at a specialist heart attack center.

The Care Bundle requires each patient to receive each of the above.
The Ambulance Quality Indicators include measurements for the management of STEMI cases. The indicator has three components:

(a) The percentage of patients suffering a ST-elevation myocardial infarction (STEMI) receiving thrombolysis within 60 minutes of call.
(b) The percentage of patients suffering a STEMI who are directly transferred to a centre capable of delivering primary percutaneous coronary intervention (PPCI) and receive angioplasty within 150 minutes of call.
(c) The percentage of patients suffering a STEMI who receive an appropriate care bundle.
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(c) The percentage of patients suffering a STEMI who receive an appropriate care bundle.

West Midlands Ambulance Service NHS Foundation Trust

*Apr-Nov 12 data	Aspirin Administered			GTN administered			2 Pain Scores Documented		
	2010-2011	2011-2012	*2012-2013	2010-2011	2011-2012	*2012-2013	2010-2011	2011-2012	*2012-2013
Birmingham	97%	98.88%	96.50%	98%	98.88%	98.00%	77%	88.81%	87.50%
Black Country	98%	96.94%	97.12%	95%	99.49%	94.96%	74%	85.71%	89.21%
C&W	97%	98.44%	100.00%	93%	97.40%	97.73%	86%	87.50%	86.36%
West Mercia	96%	97.69%	97.41%	96%	95.83%	96.55%	82%	92.13%	93.10%
Staffs	92%	94.27%	91.81%	95%	96.35%	92.98%	67%	84.38%	83.04%
WMAS	97%	97.37%	96.08%	96%	97.65%	95.94%	78%	87.88%	87.54%
National Mean		96.00%			95.90%			92.50%	
Position		7th			4th			8th	
Upper Quartile		No			No			No	

*Apr-Nov 12 data	Morphine administered			Analgesia administered		
	2010-2011	2011-2012	*2012-2013	2010-2011	2011-2012	*2012-2013
Birmingham	63%	82.09%	79.00%	59%	82.84%	80.00%
Black Country	71%	90.31%	88.49%	69%	89.80%	88.49%
C&W	80%	88.54%	89.77%	76%	87.50%	92.05%
West Mercia	84%	87.50%	95.69%	82%	87.04%	93.97%
Staffs	64%	77.60%	78.36%	64%	79.69%	78.36%
WMAS	73%	85.06%	84.73%	70%	85.24%	85.01%
National Mean		87.50%			89.90%	
Position		5th			5th	
Upper Quartile		No			No	

The following elements are new measures therefore there are no previous year figures to compare to.

*Apr-Nov data **Apr-Aug data	SPO2 documented		Care Bundle		Call to Needle		Call to Balloon	
	2011-2012	*2012-2013	2011-2012	*2012-2013	2011-2012	**2012-2013	2011-2012	**2012-2013
Birmingham	100.00%	100.00%	74.63%	70.00%				
Black Country	99.49%	100.00%	77.04%	79.86%				
C&W	100.00%	100.00%	77.60%	79.55%				
West Mercia	100.00%	100.00%	79.63%	85.34%				
Staffs	100.00%	100.00%	68.75%	64.33%				
WMAS	99.91%	100.00%	75.56%	74.23%	48.57%	20.00%	87.23%	84.92%
National Mean	96.90%		73.18%	77.57%	53.56%	41.82%	89.64%	89.38%
Position	Joint 1st		5th	10th	7th	Joint 5th	10th	12th
Upper Quartile	Yes		No	No	No	No	No	No

2.3.3 Stroke / Mini Stroke

- Blood pressure – as raised blood pressure may be a contributing factor for stroke

- Blood glucose level - as patients with an altered level may present with the same symptoms as a stroke

- FAST test – this is an assessment of the following:
    - **F**acial weakness - can the person smile? Has their mouth or eye drooped?
    - **A**rm weakness - can the person raise both arms?
    - **S**peech problems - can the person speak clearly and understand what you say?
    - **T**ime to call **999**

The Care Bundle requires each of the above elements to be undertaken and documented during the patient assessment.

This test can be used by anyone (not just ambulance or hospital staff). If you suspect a stroke think FAST and provide valuable information when you call for an ambulance.

The Ambulance Quality Indicators include measurements for the management of stroke cases. The Ambulance Quality Indicator requires the Trust to review all cases of Stroke, not a sample as the Clinical Performance Indicator requires. Therefore there are 2 figures reported for the care bundle.

The indicator has two components:

(a) The percentage of Face Arm Speech Test (FAST) positive stroke patients (assessed face to face) potentially eligible for stroke thrombolysis, who arrive at a hyperacute stroke centre within 60 minutes of call.

(b) The percentage of suspected stroke patients (assessed face to face) who receive an appropriate care bundle.

*Apr to Nov 12 data	FAST Documented			Blood Glucose documented			Blood Pressure documented		
	2010-2011	2011-2012	*2012-2013	2010-2011	2011-2012	*2012-2013	2010-2011	2011-2012	*2012-2013
Birmingham	98%	99.18%	100.00%	95%	98.48%	98.56%	100%	100.00%	100.00%
Black Country	96%	98.99%	100.00%	98%	99.28%	98.81%	100%	100.00%	100.00%
C&W	96%	97.17%	98.60%	94%	96.97%	96.65%	100%	99.60%	100.00%
West Mercia	97%	99.16%	99.54%	94%	98.32%	97.92%	100%	100.00%	100.00%
Staffs	100%	97.73%	96.88%	96%	95.61%	96.46%	100%	99.70%	100.00%
WMAS	98%	98.55%	99.08%	95%	97.82%	97.79%	100%	99.88%	100.00%
National Mean		98.50%			97.10%			99.90%	
Position		6th			Joint 3rd			Joint 1st	
Upper Quartile		No			Yes			Yes	

The following elements are new measures therefore there are no previous year figures to compare to.

*Apr-Nov 12 data	SPO2 documented		Care Bundle for the CPI		Care Bundle for the AQI		FAST+ patients transported to a hyperacute	
	2011-2012	*2012-2013	2011-2012	*2012-2013	2011-2012	*2012-2013	2011-2012	*2012-2013
Birmingham	88.23%		97.79%	98.56%				
Black Country	88.02%		98.41%	98.81%				
C&W	81.82%		94.34%	95.25%				
West Mercia	89.06%		97.47%	97.45%				
Staffs	86.21%		93.64%	93.96%				
WMAS	86.97%		96.52%	97.00%	93.87%	94.74%	65.34%	64.48%
National Mean	**85.80%**		**95.90%**		93.27%	95.46%	66.11%	65.38%
Position	**5th**		**4th**		8th	9th	5th	6th
Upper Quartile	**No**		**No**		No	No	No	No

2.3.4 Asthma

A common respiratory condition where the tubes going into the lungs are inflamed and thus narrowed, making it difficult for the patient to breath. Measurements of quality include the following being undertaken and documented during the patient assessment;

- **Respiratory rate** – how frequently the patient takes a breath, usually measured as number of times per minute.
- **PEFR** prior to treatment – **PEFR** is a device used to determine and measures the flow on breathing out and indicates the amount of narrowing of the tubes. Measuring this before treatment allows doctors in the hospital to assess how bad the asthma attack was, and thus what further treatment is required.
- **PERF** after to treatment – this shows how effective the treatment given has been.
- **SpO2** before treatment - this shows the amount of oxygen present in the blood
- **Oxygen** – whether we gave oxygen as a treatment
- **Salbutamol** – The most commonly used treatment for patients with asthma is Salbutamol. Salbutamol is a beta 2 agonist which is administered nebulised with oxygen and has a relaxant effect in the medium and smaller airways which are in spasm in acute asthma attacks.

*Apr-Nov 12 data	Respiratory Rate documented			Peak Flow documented			SPO2 documented		
	2010-2011	2011-2012	*2012-2013	2010-2011	2011-2012	*2012-2013	2010-2011	2011-2012	*2012-2013
Birmingham	100%	99.88%	100.00%	51%	87.65%	86.59%	100%	99.07%	99.84%
Black Country	100%	100.00%	99.79%	40%	85.28%	85.39%	100%	99.71%	99.79%
C&W	99%	100.00%	100.00%	50%	90.30%	89.24%	99%	98.59%	100.00%
West Mercia	99%	99.66%	100.00%	66%	93.60%	90.59%	100%	99.83%	100.00%
Staffs	100%	100.00%	99.79%	66%	88.94%	85.42%	99%	98.33%	99.17%
WMAS	99%	99.91%	99.92%	55%	88.88%	87.22%	100%	99.12%	99.75%
National Mean		**99.10%**	**99.00%**		**78.30%**	**80.60%**		**92.30%**	**94.70%**
Position		**Joint 1st**	**Joint 1st**		**2nd**	**2nd**		**5th**	**Joint 1st**
Upper Quartile		**Yes**	**Yes**		**Yes**	**Yes**		**No**	**Yes**

*Apr-Nov 12 data	Salbutamol administered			Oxygen administered			Care Bundle	
	2010-2011	2011-2012	*2012-2013	2010-2011	2011-2012	*2012-2013		*2012-2013
Birmingham	93%	97.90%	96.61%	96.00%	98.14%	97.25%	85.20%	83.68%
Black Country	95%	96.10%	95.20%	97.00%	96.25%	96.03%	83.12%	82.25%
C&W	96%	96.97%	96.03%	97.00%	97.37%	95.18%	87.68%	86.40%
West Mercia	96%	97.98%	96.47%	98.00%	97.47%	96.00%	91.25%	88.47%
Staffs	94%	94.39%	94.58%	96.00%	94.55%	95.63%	84.39%	81.88%
WMAS	95%	96.70%	95.80%	97.00%	96.79%	96.14%	86.06%	84.30%
National Mean		96.60%	97.30%		96.20%	96.50%	71.80%	76.70%
Position		4th	5th			2nd	Joint 5th	2nd	2nd
Upper Quartile		No	No		Yes	No	Yes	Yes

2.3.5 Hypoglycaemia

This is when the amount of glucose (sugar) in the blood is lower than the normal range.

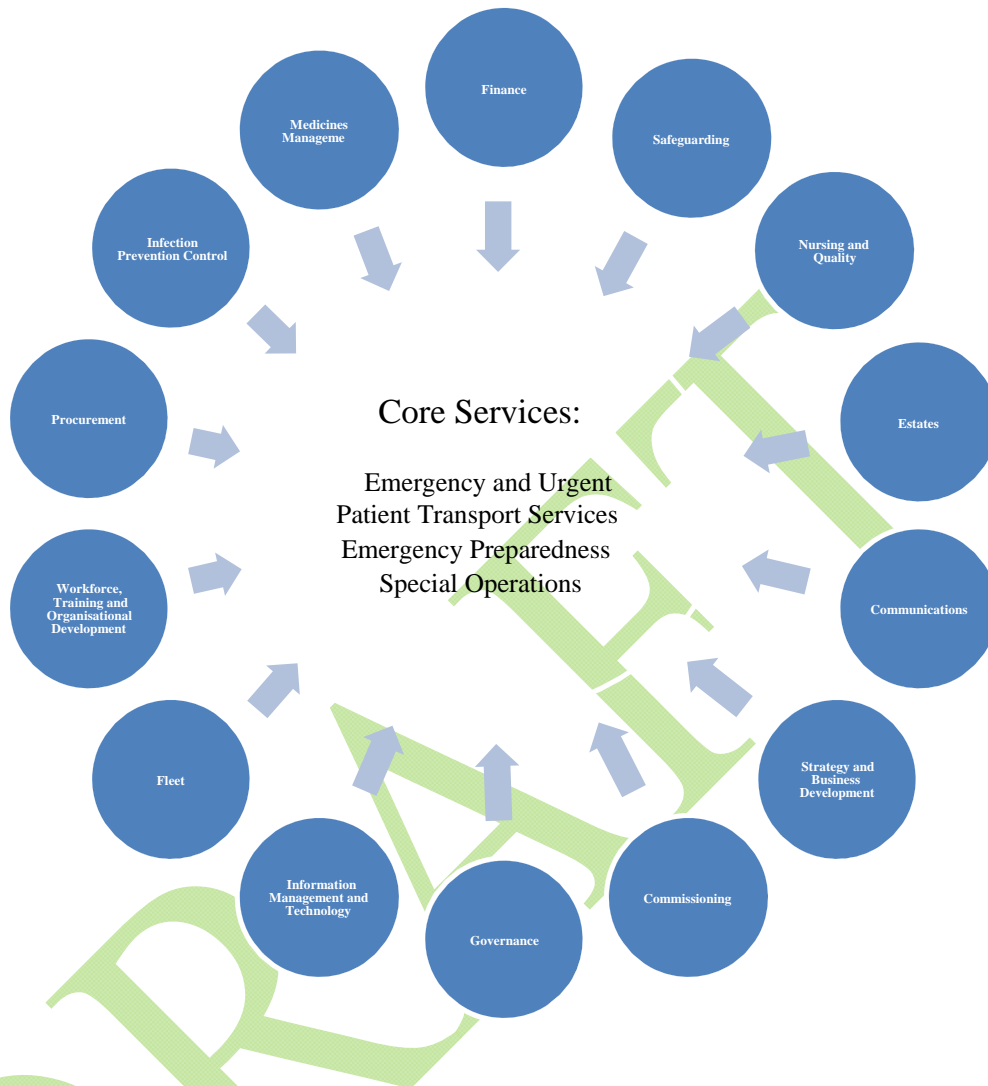This is usually related to diabetes but can be caused by other conditions.

Low blood sugar symptoms include:
Headache ▸ ▴Sweating
Shaking ▸ ▴Feeling tired
 ▴Weakness
Hunger ▸

*Apr-Nov 12 data	Blood Glucose documented before treatment			Blood Glucose documented after treatment		
	2010-2011	2011-2012	*2012-2013	2010-2011	2011-2012	*2012-2013
Birmingham	100%	100.00%	99.36%	9800%	97.79%	98.88%
Black Country	99%	100.00%	99.60%	98%	97.55%	97.62%
C&W	99%	99.60%	98.89%	99%	97.98%	97.50%
West Mercia	98%	100.00%	98.38%	97%	99.16%	98.38%
Staffs	100%	99.39%	98.10%	97%	97.12%	96.84%
WMAS	99%	99.82%	98.91%	98%	97.88%	97.91%
National Mean		98.80%	99.00%		97.90%	97.30%
Position		Joint 1st	Joint 1st		Joint 1st	3rd
Upper Quartile		Yes	Yes		Yes	Yes

*Apr-Nov 12 data	Treatment provided to patient			Direct Referral to healthcare professional		Care Bundle	
	2010-2011	2011-2012	*2012-2013	2011-2012	*2012-2013	2011-2012	*2012-2013
Birmingham	99%	98.95%	99.20%	81.24%	75.32%	97.20%	97.60%
Black Country	99%	99.28%	98.61%	73.45%	71.63%	96.97%	96.23%
C&W	99%	98.79%	98.33%	69.90%	71.94%	97.17%	95.56%
West Mercia	99%	99.83%	98.15%	70.54%	70.14%	98.99%	96.30%
Staffs	98%	96.67%	97.68%	72.12%	73.00%	94.39%	93.67%
WMAS	99%	98.70%	98.45%	74.15%	72.64%	96.91%	95.99%
National Mean		**97.90%**	**99.10%**	**64.30%**	**61.80%**	**95.40%**	**95.80%**

2.4   Review of Services and Assurances from the Board.

Core Services:

Emergency and Urgent
Patient Transport Services
Emergency Preparedness
Special Operations

During 2012/13 West Midlands Ambulance Service provided NHS services as in diagram 1. The Trust sub-contracted to 1 voluntary urgent care provider. WMAS provides patient transportation services to other NHS Trusts. To ensure excellent business continuity during times of surges in demand or in support of major incidents, the Trust has the facility to call upon a small number of ambulance sub-contractors to supplement service delivery. Sub-contractors are subjected to a robust governance review before they are utilised.

The Trust has reviewed all of the data available to us on the quality of care in all of these services.

The total service income received in 2012/13 from NHS sources represents 98% of the total service income for the Trust.

2.5   Trust Profile

West Midlands Ambulance Service (WMAS) successful became an NHS Foundation Trust on 1st January 2013. The Trust had been working towards Foundation Trust status for nearly two years before Monitor, the Foundation Trust independent regulator, approved our application.

West Midlands Ambulance Service NHS Trust was formed on 1 July 2006 by the amalgamation of the former West Midlands Ambulance Service NHS Trust, Coventry and Warwickshire Ambulance NHS Trust and Hereford and Worcester Ambulance Service NHS Trust. Staffordshire Ambulance Service NHS Trust joined in October 2007.

The Trust serves a population of 5.6 million who live in Shropshire, Herefordshire, Worcestershire, Coventry and Warwickshire, Staffordshire and the Birmingham and Black Country conurbation. The West Midlands sits at the heart of England, covering an area of over 5,000 square miles, over 80% of which is rural landscape.

The West Midlands is an area of contrasts and diversity. It includes the second largest urban area in the country, covering Birmingham, Solihull and the Black Country where in the region of 45% of the population live. Birmingham City is England's second largest city and the main population centre in the West Midlands, second only to the capital in terms of its ethnic diversity

The region is also well known for some of the most remote and beautiful countryside in the Country including the Welsh Marches on the Shropshire / Welsh borders and the Staffordshire Moorlands.

Emergency and Urgent: This is perhaps the best known part of the Trust and deals with the 999 calls and responses to them. Initially, the Emergency Operations Centres (EOC) answer and assess the 999 calls. They will then send the most appropriate ambulance crew or responder to the patient or reroute the call to a Clinical Support Desk staffed by experienced paramedics. Where necessary, patients will be taken by ambulance to an A&E Department or other NHS facility such as a Walk in Centre for further assessment and treatment.

Patient Transport Services: A large part of the organisation deals with the transfer and transport of patients for reasons such as hospital appointments, transfer between care sites, routine admissions and discharges and transport for continuing treatments such as renal dialysis. PTS has its own dedicated control rooms to deal with the 800,000 patient journeys it undertakes annually, crews are trained as patient carers.

Emergency Preparedness: this is a small but important section of the organisation which deals with the Trust's planning and response to significant incidents within the region. It also aligns all

the Trusts Specialist assets and Operations into a single structure. Such assets include the staff, equipment and vehicles from the Hazardous Area Response Team (HART), Air Operations, Decontamination staff and the Mobile Emergency Response Incident Team (MERIT) The department constantly arranges training for staff and ensures the Trust understands and acts upon intelligence and identified risk to ensure we keep the public safe in terms of major incidents.

In addition they co-ordinate the Trust's response to large gatherings such as football matches, pop concerts such as the V Festival and the WMAS response to the 2012 Olympic Games in which we supported colleagues in London, Ensuring the Olympic Torch passed through the region without incident, providing medical cover for the City of Coventry Stadium and also hosted the National Ambulance Coordination Centre.

Unscheduled Call Centre: The Trust operates an unscheduled call centre coordinating the provision of primary care services to patients across the county of Warwickshire, providing services to the public by referring calls to the appropriate primary care service and health professionals which significantly improves patient experiences and reduces the number of emergency ambulance call outs. It does this by arranging for primary care services to be sent to the patient's home or arranging for the patient to visit an appropriate facility other than A&E. The unscheduled call centre co-ordinates the handling of Safeguarding referrals by operational staff.

Transformation

The Trust has established on a Transformation programme focusing on key projects. The Transformation Programme aligns everything towards strategic objectives by realising the end benefits. There are keys projects which form part of the Transformation the *Operating Model*, the *Make Ready*: and *Efficiency Metrics*

Operating Model

Our operational delivery model builds on national guidance which encouraged Ambulance Services to 'look, feel, deliver and behave differently in the future' and the recommendations from the Independent Review into the Trust's operations and finances carried out in 2009 to deliver:

- faster response for patients
- more accurate assessment of patient need
- improved healthcare advice to patients
- more appropriate response
- more effective treatment
- transport, where necessary, to the most appropriate clinical setting

Key features of the operational model are as follows:

- regional Emergency Operations Centres (EOC) operating within virtual environment
- NHS Pathways triage system and Directory of Services
- Matching demand and capacity through accurate forecasting and scheduling
- Training, organisational development and clinical supervision
- Working towards 70% paramedic skill and clinically qualified person on every vehicle
- Make Ready roll out across the Region
- streamlining operations and increasing efficiency through service design

Make Ready

Make Ready is a dedicated ambulance preparation system operating successfully in Staffordshire division with only three major ambulance stations. Currently in areas other than Staffordshire, vehicle cleaning is undertaken by a sub-contractor and also the ambulance crews at small stations located across the West Midlands. Under the make ready system, specialist non-clinical staff prepare quality assured ambulances ready for deployment at the start of the shift and will also 'make ready' replacement vehicles for a crew if an ambulance is contaminated during a shift. Based on the Staffordshire experience several significant benefits will be realised by rolling out the system across the Trust:

- maximise vehicle cleanliness and minimise cross infection
- improve medicines management
- maximise unit hour utilisation
- minimise critical vehicle failure rate of the fleet including related equipment
- reduce costs by;
  - reducing the number of locations where medical equipment, consumables and materials are stocked and sorted
  - Ensuring vehicles are only stocked to a required standard

- provide assurance regarding asset control and medical equipment servicing routines
- provide readiness arrangements for Major Incident assets and ensure ancillary staff exist to deploy and manage the physical assets allowing clinical staff to concentrate on treating patients
- larger ambulance stations will provide better facilities for staff and improved staff communications due to better access to managers
- better compliance with the deployment plan due to improved vehicle will lead to faster treatment for patients

Make Ready will be installed via a staged implementation programme of 12 ambulance hubs located strategically across the West Midlands supported by a network of Community Ambulance Stations providing facilities for crews; this transformational change will see the reach and spread of increase from 88 ambulance stations to a total of 147 sites when the transformation programme is complete. Implementation of Make Ready also involves the disposal of around 50 surplus sites.

Make Ready implementation and estates rationalisation are linked developments over the short to long term and will generate significant quality and efficiency improvements plus the provision of fit for purpose estate for a modern ambulance service with better facilities for staff.

Efficiency Metrics

By improving operational efficiencies and changes to the unit hour utilisation (A unit hour represents one hour of service by a fully equipped and staffed ambulance available for dispatch).The Trust is able to operate efficiently and is maximising the resources available to respond to patients. This will also ensure that, were appropriate, patients are treated at the most suitable location and discharged at home if able.

The development of NHS pathways and the expected benefits to be gained from releasing efficiencies within the system will ensure that the changes to the operating model can be managed in a safe and controlled manner and allow for a stability of the workforce despite and increasing activity. This option will enable the trust to improve the level of clinical care offered to patients. It will allow appropriately trained staff to be deployed effectively to the treat patients with the care they require. It will ensure that the correct level of advice is offered from the initial outset by utilising its deployment protocols efficiently and will enable a service to patients which treats them at home if necessary or conveys them to the correct location and service they required.

As a result of the Trust's transformational plus the application of sound staff management processes, the Trust will be securing significant levels of additional efficiency from its workforce.

NHS Pathways – The Journey Continues..

Background

NHS Pathways sets out to deliver a single clinical assessment tool that provides an effective assessment over the telephone in any setting taking Health related calls from the public. This can include 999, NHS Direct, GP Out of Hours, NHS 111 and any other Single Point of Access number in place and ensures every patient accessing urgent and emergency care services is effectively assessed, reducing the need for them to repeat information and helping to make sure that they are directed to the right care at the right time

Following the successful deployment of NHS Pathways in 2011, work has been continuing to 'fine tune' the system so that it provides both a safe and consistent platform for triaging calls and enabling the delivery of nationally set performance targets for the Trust.

NHS Pathways has now been in operation within WMAS for the last 18 months and a number of updates and improvements to the Pathways software have been made. Updates have also been made to the Directory of Services (DOS) to further improve the functionality and integration with the NHS Pathways assessments.

NHS 111

The NHS 111 service is being introduced to make it easier for the public to access healthcare services when they need medical help fast, but it's not a life-threatening situation. The NHS 111 service is part of the wider revisions to the urgent care system to deliver a 24/7 urgent care service that ensures people receive the right care, from the right *person*, in the right place, at the right time. In future if people need to contact the NHS for urgent care there will only be three numbers; 999 for life-threatening emergencies, their GP surgery or 111 for non-life-threatening situations.

The introduction of the new service will also help to drive improvements in the way in which the NHS delivers this care. It will enable the commissioning of more effective and productive healthcare service by providing comprehensive information on people's needs and the services they are directed to.

The service, which in the West Midlands will be provided by NHS Direct, has already started to receive its first calls ahead of the regional formal launch in March. 111 is promoted as being the number "when it's less urgent than 999". The 111 service will replace NHS Direct (0845 4647) and doctor's Out of Hours call handling services as well as attracting new callers who choose to contact the service directly.

 As part of the NHS 111 service, there will be a proportion of calls that will be re-directed (transferred) to the ambulance service for an ambulance dispatch. These calls will be transferred electronically and simply appear on the Ambulance dispatchers screen for them to then dispatch an ambulance resource without delay. This is a new concept for WMAS where the WMAS Call Handler has no involvement in the call.

The Trust continues to work closely with both the provider and the Commissioners to ensure that the service is safe and robust for patients.

Major Trauma Network

In March 2012 a regional trauma care system was introduced to ensure that people who suffer major trauma injuries get access to the best possible emergency trauma care. WMAS has been a major stakeholder in the planning and implementation of this system. This has included setting up a dedicated trauma desk in our control room staffed by experienced Critical Care Paramedics.

All WMAS clinicians will receive additional training in trauma care and specialist trauma care equipment has been supplied to all front line ambulances and response cars.
In addition a doctor led helicopter team in the day has been supplemented by a night time doctor led car team that results in 24 hour support at major trauma cases.

In the 12 months since go live more than 2000 patients have been taken to Major Trauma Centres by WMAS and the doctor led pre hospital teams have attended more than 500 trauma cases with over 300 of these attended at night indicating an unmet need for this service prior to go live.

WMAS was praised by Professor Willett the National Clinical Director for Trauma in a recent visit as being the best prepared ambulance service in the country and he said that our doctor led pre hospital service is an example of good practice that should be implemented nationally.

Based on evidence from overseas where trauma systems have already been implemented, the West Midlands could expect to see an additional 40-60 patients survive per year following major trauma incidents.

2.6   Award winning service

2.7   Participation in Clinical Research 2012/13

The number of patients receiving relevant health services provided or sub-contracted by [name of provider] in 2012/13 that were recruited during that period to participate in research approved by a research ethics committee was [insert number].(nb this will be updated for the final Quality Account)

During 2012-13 WMAS has been involved with seven research studies.

Five of these are portfolio studies. The National Institute for Health Research (NIHR) portfolio comprises clinical research studies which are of high quality and clear value to the NHS.

The other 2 studies include a research database and Collaboration for Leadership in Applied Health Research and Care (CLAHRC) study. CLAHRC studies are collaborative partnerships between a university and the surrounding NHS organisations, focused on improving patient outcomes through the conduct and application of applied health research. They will create and embed approaches to research and its dissemination that are specifically designed to take account of the way that health care is increasingly delivered across sectors and a wide geographical area. These studies are also supported by the NIHR.

The involvement of ambulance trusts in research studies is an important step forward in providing evidence of best practise within pre hospital care, and thus providing evidence to support improved patient care, treatment and outcomes.

Summary of studies:
Pre-hospital randomised assessment of a mechanical compression device in cardiac arrest-The study is sponsored by Warwick University (Warwick Clinical Trials Unit). Its aim is to evaluate the effect of using a LUCAS 2 devise which is a mechanical device that delivers cardiac compression in the event of a patient having a cardiac arrest, that is, on patients whose heart has stopped .This is in comparison to manual chest compression by ambulance clinicians for out of hospital cardiac arrest, looking at outcomes for patients.

This study started recruiting in April 2010 and has now been extended to June 2013 due to slower than expected national recruitment. It includes patients within the Birmingham, Black Country and Coventry & Warwickshire areas.

Optimisation of the management of stroke and TIA (Transient Ischemic Attacks – a "mini stroke") is a study that continues this year and is sponsored by Birmingham University which is a CLAHRC project

This involves reviewing data related to TIA and Stroke management from local GPs, the Ambulance Service, and local hospital out patients, inpatients and A&E services as well as patients and comparing these data against "optimum care". This comparison will ascertain the reasons why actual care deviates from recommended practice and result in the identification of key barriers to optimum care.

The results from the above will be used to inform local commissioners of care, GPs, specialists and patients regarding gaps in and barriers to optimal care. This information will then be used to support a service improvement programme to improve the care of patients with the conditions stroke or `mini stroke` TIA

Medicated Sleep and wakefulness is a study is sponsored by Warwick University which continues this year. This is a study of stakeholder views on the management of sleep 'problems' and the appropriate role of sleep medications in management policies and practices. Some of WMAS staff are taking part in interviews and focus groups. This study will contribute to future national policy and practice regarding sleep and wakefulness promoting drugs, and to broader debates on the public health and safety aspects of sleep for society.

Exploring, understanding and reducing emergency cancer admissions- The study seeks to explore the experiences of patients with lung cancer and a comparative group of patients with chronic obstructive pulmonary disease (COPD) who have had an emergency admission. To gain an overall understanding of the incident, the experience of carers and health professionals (including WMAS ambulance personnel) involved with individuals' care will also be explored. Participants will be recruited for interviews from three hospitals in the West Midlands and WMAS.

Sponsored by Warwick University it is hoped that the insights from this research will facilitate the development of community and hospital services designed to reduce or avoid emergency admissions, and to improve hospital management following admission of these patient groups. This study aims to understand patients' experiences of the time leading to admission, the admission process itself and their experiences in the immediate period following admission.

Informing delivery of care through research evidence; an investigation of randomised control trial implementation in pre-hospital emergency care - This study sponsored by Swansea University. It aims to assess the number and progress of Randomised Controlled Trials (RCTs) in pre-hospital emergency care, to describe factors which facilitate and hinder their implementation and influence in this field. RCTs are the most effective method for evaluating healthcare interventions; however within ambulance services they are infrequent and often mediocre.

This research project will provide a real understanding of the factors affecting implementation, as well as barriers and facilitators to the number, progress and quality of trials. Outputs will include recommendations at both practice and policy levels that will inform emergency pre-hospital care internationally

Atlantic study- This study involves use an anti-platelet drug for STEMI which is a type of heart attack. This is for patients prior to receiving Primary Percutaneous Coronary Intervention (PPCI). The trial aims to show whether use of this drug sooner i.e. in the pre hospital setting rather than in hospital, improves patient outcomes.

WMAS is working in conjunction with University Hospital Coventry & Warwick with paramedics in the area of Coventry and Warwickshire, and is the first commercial trial that WMAS has been involved in.

Out of hospital cardiac arrest research database-This is a research database being developed by Warwick Clinical Trials Unit and sponsored by Warwick University. Funding has been provided by the Resuscitation Council UK and the British Heart Foundation It will be a national research database for which all ambulance trusts will provide data.

Cardiac arrest is the term used to describe sudden cessation of heart function. After cardiac arrest occurs, blood stops being circulated to the vital organs and consciousness is lost within seconds. Unless resuscitation is started promptly and an effective circulation re-stored death will occur within a few minutes.

Each year about 30,000 people receive resuscitation for an Out of Hospital Cardiac Arrest (OHCA) in the United Kingdom from which only about one in twenty people survive to go home from hospital. Information collected by the Department of Health has shown there to be wide geographical variation in the number of people that survive an OHCA. In simple terms people in some parts of the country are twice or three times more likely to survive than in other areas. These apparent inequalities in survival are a major public health concern.

This project will try to find out the reasons behind such big differences in outcome. It aims to inform the development of a standardised approach to collecting information about OHCA and how patient outcomes are followed up to confirm if a resuscitation attempt was successful. It aims to explain the reasons why survival rates vary between regions and to provide feedback to ambulance services to allow benchmarking and quality improvement work.

2.8 National Confidential Enquiries

During 2012/13 there were no National Clinical Enquiries with a focus on Ambulance Trusts. The Trust was invited to participate in one national confidential enquiry covered by the NHS services that West Midlands Ambulance Service provides.

2.9   Goals agreed by Commissioners in 2012-13

A proportion of West Midlands Ambulance Service income in 2012/13 was conditional upon achieving quality improvement and innovation goals agreed between the Trust and its emergency and urgent commissioners through the Commissioning for Quality and Innovation payment framework. Further details of the agreed goals for 2012/13 and for the following 12 month period are available online at:
http://www.monitor-nhsft.gov.uk/sites/all/modules/fckeditor/plugins/ktbrowser/_openTKFile.php?id=3275

Use of the Commissioning Quality Innovation Schemes (CQUIN) for 2012/13
The Trust worked closely with commissioners and agreed 4 key areas of innovation that would have a positive impact on the patients who use our service. The projects were maintained to ensure milestones were achieved and the outcome for patients resulted in an improved quality of the service.

No	CQUIN Goal	CQUIN Detail	Expected value	Achievement of Set Target
1	NHS Number	Use of NHS Number for Urgent and Emergency patients to facilitate the measurement of clinical outcomes	£976,905	Successful up to Qtr. 3, On target for Qtr. 4 to be confirmed April 2013
2	Make Ready	This is a two year CQUIN to support the development of a comprehensive make ready scheme in a phased approach that will result in a total of 5 make ready areas across the region implemented fully by March 2014	£1,367,667	Successful up to Qtr. 3, On target for Qtr. 4 to be confirmed April 2013
3	High service users	The CQUIN provides for assertive pro-active management of people who are frequent users of the 999 emergency ambulance service.	£976,905	Successful up to Qtr. 3, On target for Qtr. 4 to be confirmed April 2013
4	Community Life Support and Defibrillation	Improving return of spontaneous circulation (ROSC) rates following cardiac arrest through Community and Partnership Engagement	£586,143	Successful up to Qtr 3, On target for Qtr 4 to be confirmed April 2013

2.10 Care Quality Commission

West Midlands Ambulance Service is required to register with the Care Quality Commission and its current registration status is fully compliant without restrictions.

The Care Quality Commission has not taken enforcement action against West Midlands Ambulance Service during 2012/13

The Trust has been registered to date with the CQC without conditions since 2010. This included compliance with the Health and Social Care Act 2008 and Hygiene code (HC2008).

During February 2013 the CQC carried out a review of the service that included; inspections of premises and ambulances, interviews with patients, staff and managers, feedback from partner organisations and local authority scrutiny committees and review of all our compliance with other regulatory bodies. We await the CQC report to be published and WMAS is confident that this organisation still remains compliant with all the requirements of our registration under the Health & Social Care Act (2008).

2.11 Data Quality

West Midlands Ambulance Service did not submit records during 2012/13 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data

West Midlands Ambulance Service takes the following actions to improve data quality.

For the clinical indicators, the clinical audit department completes the data collection and reports. The patient group is identified using standard queries based on both the paper Patient Report Forms and the Electronic Care System. These clinical records are then audited manually by the Clinical Audit Team using set guidance. The data is also clinically validated and then analysed following an office procedure that is available to the Clinical Audit Team and is held on the central Clinical & Quality network drive.

Initial checking:
- For the clinical indicators, the clinical audit team completes the data collection and reports.
- The Patient Report Forms/Electronic Care Summary records are audited manually by the Clinical Audit team.
- A process for the completion of the indicators is held within the clinical audit department on the central network drive
- A clinician then reviews the data collected by the Clinical Audit Team.
- The data is then analysed and reports generated following a standard office procedure. A second person within the clinical audit team checks for any anomalies in the data.
- The results are checked against previous month's data checking for trends and consistency.
- The clinical indicators are reported through the Trust Clinical Performance Scorecard.
- The reports are then disseminated to the Trust Board, Commissioners and Service Delivery meetings

2.12 Participation in Clinical Audits

The Trust has a comprehensive Clinical Audit Programme which includes both national and local audits.

The Clinical Audit Department have been consistently reporting, and feeding into the development of the National Clinical Performance Indicators (CPI's) since their implementation in 2008. In addition to this the department has been supporting the Trust Clinical Audit Programme which ensures local and national requirements are met.

From April 2011 the new Ambulance Quality Indicators (AQI) were introduced for all Ambulance Trusts, these are focussed on patient's outcomes. There are four areas that are relevant to the Clinical Audit Department, these are:

- Outcome from Cardiac Arrest – Return of Spontaneous Circulation
- Outcome from Cardiac Arrest – Survival to discharge
- Outcome from acute ST elevation myocardial infarction (STEMI)
- Outcome from Stroke for ambulance patients

To provide assurance to the Trust the CPI's and AQI's are reported on a monthly basis. This provides information to managers and staff to highlight areas of good practice and where required improvements to be made through local action plans.

Reporting on clinical performance has been amended to ensure consistency of reporting throughout the Trust and to ensure the clinical performance of the trust is clear for all audiences. The clinical performance scorecard has been developed and has been updated on a monthly basis to report on the Clinical Performance Indicators and the Ambulance Quality Indicators. This has now been further expanded to report on all Quality Account projects, and the work completed within the Clinical & Quality Directorate. The report is presented to Trust Board, Clinical & Quality Governance Committee and is available on the Trust Intranet.

The clinical audit programme includes clinical audits that have been prioritized by the Clinical Audit Programme Group and include:

- Management of Controlled Drugs
- Management of Prescription Only Medicines
- Patient Group Directions (PGDs)
- Examining the delivery of Mental Health Care
- Infection Control - Vehicle Cleanliness
- Infection Control - Station Cleanliness
- Infection Control – Cannulation
- Infection Control - Hand washing Audit
- Management of Asthma
- Clinical Records Documentation
- Care of Patients Discharged at Scene
- Managing Acute Coronary Syndrome
- Deliberate Self Harm
- Feverish Illness in Children
- Management of Head Injury
- Management of Peri-Arrests
- Management of Obstetric Emergencies
- Management of Medicines Management

2.13 NHS Number and General Medical Practice Code Validity

West Midlands Ambulance Service did not submit records during 2012/13 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

2.14 Information Governance Toolkit Attainment Levels

West midlands Ambulance Service Information Governance Assessment Report overall score for 2012/13 was 78% and was graded satisfactory in 2012/13.

2.15 Clinical Coding Error Rate

West Midlands Ambulance Service was not subject to the Payment by Results clinical coding audit during 2012/13 by the Audit Commission.

2.16 Serious Incidents

Serious Incidents (SIs) are events that place, or could have placed, the Trust at significant risk. The risk may, for example, be clinical, organisational, financial or reputation. Whilst the primary focus is on patient safety, the criteria for an SI also applies to staff, visitors, contractors and members of the public if on NHS property/business.

2012-13 Serious Incidents to date
During 2012-13 the Trust identified 25 Serious Incidents (SI) requiring investigation.

General themes relate to:

- Clinical assessment and management of patients
- Management of calls into the Trust (such as Health Care Referrals and 999's) – This includes the use of the NHS Pathways triage system
- Allegations made against persons working on behalf of the Trust in regard to their professional conduct

Learning from SI's
All SI`s require completion of a Root Cause Analysis (RCA) which seeks to identify contributory factors, root causes, learning for both individuals and the organisation and provide recommendations to prevent reoccurrence.

General approaches to learning from SI`s include:

- Communication of key learning points through education, training and awareness including the use of the Trust`s Clinical Times as a form of communication
- Clinical case reviews and reflection of the practice by individuals
- Development and review of clinical risk assessments to ensure identified risks are managed through the Trusts clinical risk management process.
- Amendment to policies procedures and practices

- All Root Cause Analysis reports and their themes are reviewed by the Trust`s Learning Review Group which consists of multi-disciplinary membership which has an open invite to our commissioners and the Trust`s non-executives

In addition to specific learning and recommendations monitored through the Trusts 'SI learning log' some generic learning has been undertaken.

This year the Trust intends to further increase its internal scrutiny of recorded evidence of action taken following investigation recommendations.

2.17 Patient Experience

Complaints

The Trust has received to date in 2012/13 (as at 28 February 2013) 439 complaints compared to 313 (as at 31 March 2012) in 2011//12, an increase of 40.2% (126). The main reason for a complaint being raised relates to Response (Delay in the arrival of an Emergency or Non-Emergency vehicle).

Breakdown of Complaints by Service Type YTD:

	2010-2011	2011-2012	2012-2013	Variance 11/12 - 12/13
EOC	53	90	126	36
EU	132	160	204	44
PTS	77	61	100	39
OOH	0	1	0	-1
Other	11	1	9	8
Total	**273**	**313**	**439**	**126**

Justified Complaints (As at 28 February 2013)

The table below indicates of the 362 closed complaints 181 (50.0%) were classed as Justified. If a complaint is Justified learning maybe noted by the staff member in the form of a case review or Trust wide learning where possible.

	Total	Justified	Non Justified	Part Justified
Call Management	96	49	40	7
Attitude and Conduct	67	35	24	8
Clinical	73	31	29	13
Driving and Sirens	14	5	6	3
Response	93	58	28	7
Other	19	3	15	1
Total	**362**	**181**	**142**	**39**

PALS concerns have increased year on year with 907 concerns raised in 2012/13 (YTD as at 28 February 2013) compared to 810 in 2011/12, an increase of 12.0% (97). The main reason for a concern being raised related to Response (to include response times (delays), transport arrangements).

Ombudsman Requests

The majority of complaints were resolved through Local Resolution and therefore did not proceed to an independent review with the Parliamentary and Health Service Ombudsman (PHSO). During 2012/13 8 independent reviews were carried out compared to 4 the previous year. The Trust currently has one case open with the PHSO.

Patient feedback/ Surveys

The Trust has received 108 completed surveys through the Trust website and has target surveyed the following:

2000 Emergency Patients – A postal survey was sent to randomly selected patients in March 2013. Patients have been asked to return their completed survey no later than April 2013. 149 have completed the Patient Survey whilst member of the Patient Experience Team have been attending Engagement Events across the Region.

3709 Non-Emergency Patients have been asked to complete the Non-Emergency Patient Survey with 430 patients returning their feedback to date.

Patient Engagement

The Patient Experience Team continues to engage with Renal Patients across the Region, with focus meetings being undertaken at Castle Vale Dialysis Unit.

The Patient Experience Team has improved its engagement across the Region in 2012/13 with 29 events attended to date (as at 28 February 2013). Examples of events are as follows:

- Speak Easy Now
- Hereford College (with Hereford LINK)
- Health and Well Being Events in Wolverhampton and Brierley Hill
- Gypsy Traveller Event

Compliments

The Trust has received 843 compliments in 2012/13 (as at 28 February 2013) compared to 712 in 2011/12. It is pleasing to note that the Trust has seen an 18% (131) increase in Compliments received compared to the previous year.

2.18 Workforce and Organisational Development

The Trust is making progress towards the achievement of 70% paramedic skill mix. The Trust aims to achieve an average increase in Paramedic skill mix from 60% for 2012/2013 by increasing the number of paramedics from 1176 to 1304 i.e. 67% of operational staff for 2013/2014.

The Trust has worked hard to avoid vacancies in key areas that can lead to operational difficulties and adverse patient outcomes. In order to achieve this, the Trust has reduced the average time from advert to appointment from 20 to 15 weeks.

2012/13	Appraisals	Mandatory Training
WMAS	60%	97%

*figure accurate of 13.3.13

Staff Development	2012/13	2013/14 Planned Forecast
Technicians to Paramedics	100	40
Emergency Care Assistants to Technician	40	30
Paramedic to Advanced Paramedic	96	108
Trauma Training	97%	Completed

Working in partnership with Staff side the Trust continues to develop a Health and Wellbeing Strategy and action plan to ensure that health and well-being of staff is supported. Reduction in average long term absence rate of over 4 weeks from 3% to 2.5% by 31 March 2013

Managers and staff are being supported to update and develop their skills. The Trust are supporting up to 50 Managers to complete an Engaging Leaders Programme of management development. The Trust want to see a 5% improvement in staff recording that they feel valued and engaged in Staff survey results and the Trust want assurances that there is an Increase the number of staff with reviewed personal development plans to be in place from 90% to 95% by March 2013. The Trust also wants evidence that staff are supported to receive the appropriate level of training as per the training plan which equates to 18,746 mandatory training days to be delivered

Staff Survey

The Trust facilitates a Survey of its staff every year based on the National Staff Opinion Survey. The Trust Board receive a direct report on the results of the survey. The Survey is delivered through a cross directorate working party, including representatives from all parts of the trust and Trade Unions, to agree the key priorities based on the results. There are usually two action plans, one more strategic, owned by the Trust Board, and one with more tangible aspects, which is delivered through the working group. The action plan designed and delivered in 2012/13 (Built on results of the 2011 survey) covered areas such as Feeling valued by the Trust, Communication and Bullying and Harassment. To read more on the WMAS staff survey for 2012 please use the following URL;
http://nhsstaffsurveys.com/cms/uploads/Individual%20Trust%20reports%202012/NHS_staff_survey_2012_RYA_full.pdf

2.19 Equality & Diversity

We are always working toward equality and diversity to the heart of the organisation, working and engaging with our patients, volunteers, staff, public members, governors and local interest groups. Equality and diversity is built into everything that we do from our policies, practices and strategies, to public engagement and consultation events, where we regularly ask our local communities how we can improve our services and practices.

Diversity in employment produces a workforce sensitive to the different needs of the community that we serve and have developed a vision for ensuring equality, diversity and inclusion, in both employment and service delivery which reflects `respect, dignity and fairness to all`

The Trust has endorsed the Equality Delivery System (EDS),[1] which is an NHS Equality and Diversity framework, to assist in delivering better outcomes for patients and staff, we have been able to identify and consider further steps which will meet the needs of our staff and service users who share the relevant protected characteristic group.

We have also published our Equality Data Analysis report 2012/2013[2] and will continue to publish our data with comprehensive analysis annually, in order to meet our Public Sector Equality Duty (Equality Act 2010)[3] as demonstrated within the report will improve the way we make informed decisions about our policies and practices, which are based on evidence, and the impact of our activities on equality and the protected characteristic groups.

For Further information please follow the link Equality Data Analysis report 2012 http://www.wmas.nhs.uk/

"Respect, Dignity and Fairness for All"

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[1] Equality Delivery system 2010 http://www.eastmidlands.nhs.uk/about-us/inclusion/eds/

[2] Equality Data Analysis report 2012/13 http://www.wmas.nhs.uk/

[3] Equality Act 2010 http://www.legislation.gov.uk/ukpga/2010/15/contents

Part 3

3.1 Priorities for Improvements 2013-14

The Trust has set the priorities for 2013/14 following engagement with patients, users and communities and the guiding principle has been "*no decision about me without me*". The Trust is committed to ensure we have a process that reviews and maintains the quality of care to ensure provides high standard of care.

The projects we have selected are aimed at focusing a culture of safety and the integration of quality improvement into the everyday workings of the Trust.

Patient Safety Priorities 2013-14

Priority 1: Falls Pathway	
Rationale	Falls can have a devastating impact on quality of life and the Trust is committed to providing a safe environment where patients are protected from avoidable harm. This Trust want ensure that when our staff have face to face contact with someone who has fallen, the Trust will ensure that an appropriate referral is made to the correct service in order to assess that person assist in the prevention of a fall in the future. This year we plan to develop further the falls pathway by focusing on working in collaboration in local areas after engagement with our patients and scrutiny boards and building on the Directory of Service on prevention and appropriate referral in this area ensuring that people get referred to the right place at the right time for a better outcome.
Measures & reporting to board;	Qtr. 1 : From the baseline of Calls WMAS received in 2012-13 related to falls to develop locally agreed pathways with participating CCGs and scope areas with falls services Qtr. 2: Areas without timely falls pathways and services to be raised with commissioners Qtr. 3: Education of local WMAS staff with VLE Qtr. 4: Demonstrate referrals for each participating area made
Target	Increase referral to appropriate participating falls team by 25% See a reduction in attendance to Falls by 10%
By When?	31 March 2014
Outcome	Patient Safety will improve by identifying, managing and reducing falls
Baseline	TBC
Lead	Clinical Quality Manager with Directory of Service Leads

Priority 2: Lower Limb Fractures	
Rationale	The purpose of this initiative is to introduce a KPI nationally to measure and improve the quality of care given to patients who suffer lower limb injuries.
Measures monthly reporting to board	KPI measures: Assessment of circulation distal to site of fracture recorded Two Pain Scores Recorded (before & after treatment) Analgesia administered
Target	>85% compliance with KPI measures
By When?	31 March 2014
Baseline	TBC
Lead	Head of Clinical Practice &Trauma Lead

Priority 3: Cannulation

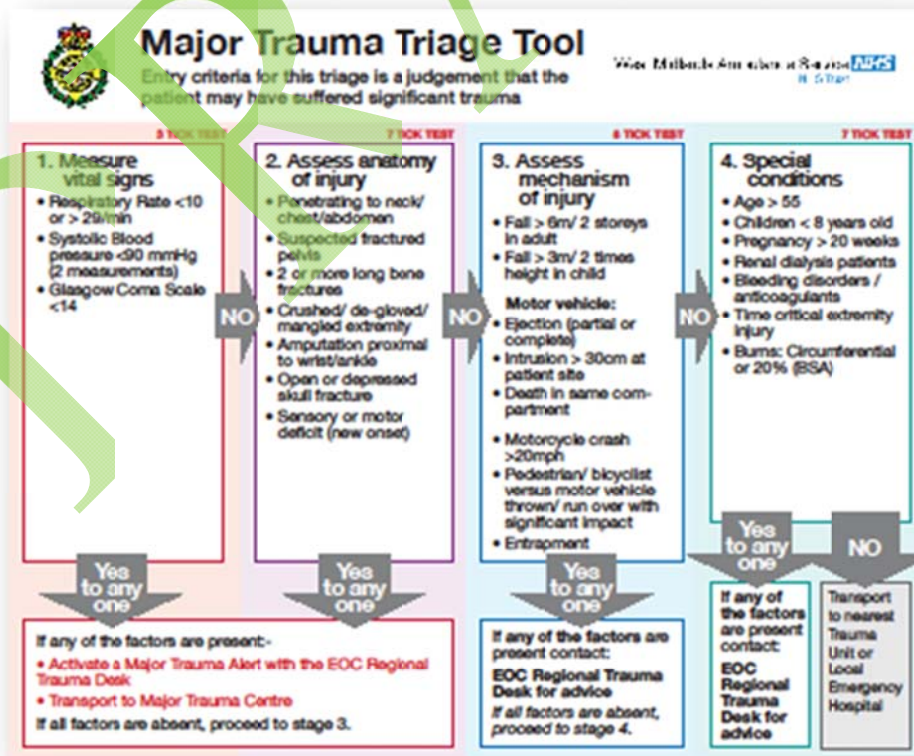|	
Rationale	Cannulation is one of the highest risk procedures which can cause Healthcare Associated Infection that the Ambulance service performs. Cannulation packs are provided so staff are able to use Aseptic No Touch Technique (ANTT) whenever the situation allows this to happen. In the packs there are 2 stickers to identify to the receiving hospital staff whether ANTT was possible – There is a Red sticker for insertions that were Emergency inserted so part of the ANTT was not performed and a Green sticker for where the full ANTT was performed. This enables the receiving hospital to make a judgement based on risk whether to remove or leave in the cannula. Insertions are observed and audited by Clinical Team Mentors during mentoring shifts, the use of the sticker and documentation of 'emergency' or 'aseptic' is audited, to ensure staff are using the stickers and passing the information on to receiving units which is essential in reducing the risk of harm occurring to patients. Improving the use of the stickers and communication of this will be through raising awareness, on-going engagement with staff and encouraging a culture where improving patient safety, quality and protecting them from infection is part of everyone's everyday role.
Measure reporting to board	20 observations done by Clinical Team Mentors during mentored shifts in each area in the Region per quarter, which will give 100 observations per quarter
Target	95% use of stickers and communication of Aseptic or Emergency inserted
By When?	31 March 2014
Outcome	Engagement with receiving units to assure them of WMAS commitment to reduce the risk of HCAI
Lead	Head of Clinical Practice Infection Prevention and Control
Baseline	TBC

Clinical Effectiveness Priorities 2013-14

Priority 4: Onset of symptom time	
Rationale	Where Ambulance clinicians document time of onset of symptoms for patients suffering from a stroke we want to show that there has been a decrease in the time to getting the patient to the computerised tomography (CT Scan). This would improve patient outcome by reducing the time to thrombolysis treatment. This would assist in the reduction of the disabling effects a stroke can have on patients.
Measure reporting monthly to board	Onset of Stroke Symptoms are documented in all Hyper Acute Stroke Cases
Target	90% target of Hyper Acute Stroke patients have an onset of symptom time recorded where known
By When?	31 March 2014
Outcome	Improved access to Hyper Acute Stroke Services
Lead	Head of Clinical Practice and Cardiac and Stroke
Baseline	TBC at 87%

Priority 5: General Pain Management	
Rationale	Pain is defined as an "unpleasant sensory and emotional experience associated with actual or potential tissue damage" *. The patient deserves appropriate assessment and management of pain minimising any adverse physical or psychological effects for the patient. Documenting the pain score is a measurement allows WMAS to measure if pain assessment has been achieved.
Measures reporting to board	Qtr. : Develop general Pain management Guidelines to include scoring Qtr. 2&3: develop a pain workbook with E Learning and this will be uploaded to the Virtual Learning site to assist with pain management Qtr. 4: Documentation to increase by 10% from baseline for Qtr. 4
Target	An Learning package will be developed and Increase pain scoring documentation by 10% of the baseline
By When?	31 March 2014
Outcome	Better patients experience and clinical effectiveness
Lead	Clinical Quality Manager
Baseline	39%

*Royal College of Anaesthetists *Acute Pain Management: scientific Evidence 2009*

Priority 6: Trauma	
Rationale	WMAS was instrumental in the implementation of a regional trauma care system that rapidly identifies major trauma patients and delivers them to specialist Major Trauma Centre (MTC) hospitals. Since the system went live in March 2012 the majority of major trauma patients are now taken directly to MTCs, others are transferred later from supporting Trauma Unit (TU) hospitals by a medic led team and WMAS will continue to monitor the effectiveness of the Trauma Trigger tool in 2013-14.
Measure reporting Qtrly to board	The patients that trigger the level 1 or 2 of the trigger tool will be directly taken to a major trauma centre when they satisfy the criteria to do so
Target	95% of the time
By When?	31 March 2014
Outcome	Improvement in outcomes for this patient group (evidence produced by national Trauma Audit and Research Network)
Lead	Head of Clinical Practice and Trauma Lead
Baseline	80 per month directly to major trauma centres

Patient Experience Priorities 2013-14

Priority 7: Patient Survey	
Rationale	Patient care is at the centre of everything we do and it is important to the Trust to ensure that we collect the views of service users to inform us of quality of care we deliver. The Trust continues to learn from patients, carers and members of the public experience so we can see where the service user has reported good experience and on occasion's poor service. In 2012/13 the current Patient Survey incorporates the following question 'would you recommend this service to friends and family`.
Measure reporting to board	Through quarterly patient surveys, as well as an online survey and engagement with Health Watch and Foundation Trust Governors to include the Friends and Family Recommendation test
Target	5000 patients
By When?	31 March 2014
Outcome	Learn from patients and improve the patient experience
Lead	Head of Patient and Public Experience
Baseline	TBC

Priority 8: WMAS dignity challenge	
Rationale	Raise awareness of dignity and increasing sign up to the WMAS dignity in care challenge. To respect people's dignity should include a zero tolerance of all forms of abuse and patients deserve the same respect one would want for oneself or a member of one's family; patients merit personalised care and where possible a level of independence, choice and control; everyone should be listened to and allowed to express their needs and wants; at all times people have a right to privacy: People feel able to complain without fear of retribution when things go wrong and there should be engagement with family members and carers as care partners; where people are lonely and isolated and in need of care they should be referred to the right service at the right time.
Measure reporting to board	Qtr. 1: scope and Baseline Qtr. 2: Raise awareness of the WMAS Dignity campaign amongst staff Qtr. 3&4: Staff signed up to the dignity challenge
Target	To have dignity champions up by 25%
By When?	31 March 2014
Outcome	Improve awareness of dignity in the Trust improving patients experience
Lead	Clinical Quality Manager
Baseline	TBC in Qtr1

This is a patient story from a renal dialysis patient who dialyses three times a week at her local dialysis unit. She is a diabetic who was going for dialysis from hospital prior to planned surgery for the following day;

"The Ambulance transport arrived at the hospital early at about 5pm so I hadn't eaten, this was a problem, but the ward nurses said they would get me something to eat when I returned as long as I was back before midnight

"I arrived at the dialysis unit early but I was not on the machine dialysing until about 6.45pm, which meant that because I had arrived early I had to wait in reception for an 1hr & 30minutes and I would finish at about 11pm. An ambulance arrived to pick me up, I said I only had 6 or 7 minutes left & the driver said that he would be in reception "

Unfortunately this was not the case as the driver was asked to take another patient home by a fellow driver and the lady was upset by this

"The Driver did come back, to take me back to the hospital, however he had to drop off another patient, which he did first, so I didn't arrive back on the Ward until well after midnight and by this time I was officially nil by mouth.

"As I am diabetic, my sugar levels are tested at the start and end of the dialysis session, and I believe that my sugar was recorded as 3.9 at the end of the session. The nurses would not normally allow me to leave without having a cup of sweet tea and some biscuits, but they could not because this would make me later still. The hospital staff were made aware of my sugar level, they referred to the doctors who decided I had to eat and since I should have been first on the list, they would sort out the list in the morning"

"The end result was my operation was changed to being last on the list for my operation Instead of first. This also meant that I could not go home the same day & I took up a hospital bed for another night. If I had been first on list for surgery, as was originally planned, I may have been able to go home the same day"

"When I made the ambulance manager aware of what had happened she responded really quickly and she advised me that she had made It clear to all Drivers (and these two drivers specifically were spoken to) to ensure that drivers did not make such changes between themselves. If they were requested by medical staff to make such changes, they should get approval. I was impressed by the speed with which this was dealt with, and I must say that I was getting constant complaints prior to this incident,"

"In addition to these measures I know that some changes to the scheduling of staff were put into operation. Since this has been dealt with, I have not had a single complaint about this type of problem; I think that this speaks for itself"

"It is key to make sure everyone who Is Involved Is made aware of what happens."

One of the stories that led us to priority 9 for 2013/14

Priority 9: Renal Patients	
Rationale	Following patient complaints and patient survey WMAS decided this imperative priority for 2013/14. Renal patients that require dialysis three times a week tends to be for the rest of their lives. Renal patients can experience long days when attending hospital for dialysis treatment due to many reasons. For those renal patients that are eligible for ambulance transport we seek to ensure that ambulance transport is not the exclusive cause for their delays in order to improve the patient experience and support them to get home within a reasonable time. Despite the complexity of each individual contract in the region WMAS have developed standard governance checks for the region when WMAS are exclusively responsible for the delay.
Measure reporting Qtrly to board	Standard 1: Patients arrive to their renal dialysis appointment no later than 15mins after the booked appointment time Standard 2: Patients are to be collected no later than 60mins after booked pick up time. Standard 3: Patients are to spend no longer than 60mins on our vehicles, within ten miles from pick up to drop off.
Target	Standard 1: Year to End 90% Standard 2: Year to End 90% Standard 3: Year to End 95%
By When?	31 March 2014
Outcome	Improvements in patient experience and wellbeing
Lead	Clinical Quality Manager
Baseline	TBC

Proposed CQUIN Priorities for 2013/14

No	CQUIN Goal	CQUIN Detail	Expected value
1	Acute Admission avoidance	TBC	TBC
2	Integrated End of life register	TBC	TBC
3	Patient Safety Thermometer	TBC	TBC
4	Year 2 Make ready scheme	TBC	TBC

Annex 1: Statements from NHS Commissioning Board or relevant commissioning groups (as determined by the NHS (Quality Accounts) Amendment Regulation 20120

Annex 2: Local Healthwatch, Overview and Overview and Scrutiny Committees

Annex 3: Statement of directors` responsibilities in respect of the Quality Report

Further information

Further information and action plans on all projects can be obtained by contacting the lead clinician named on the project

Further information on performance for local areas is available as an Information Request from our Freedom of Information Officer or from the leads for the individual projects.

Progress reports will be available within the Trust Board papers every three months with the end of year progress being given in the Quality Report to be published in June 2014.

If you require a copy in another language, or in a format such as large print, Braille or audio tape, please call West Midlands Ambulance Service on 01384 215 555 or write to:

West Midlands Ambulance Service
Regional Headquarters
Millennium Point
Waterfront Business Park
Brierley Hill
West Midlands
DY5 1LX

You can also find out more information by visiting our website: **www.wmas.nhs.uk**

If you have any comments, feedback or complaints about the service you have received from the Trust, please contact the **Patient Advice and Liaison Service (PALS)** in the first instance; **01384 246370**

Trust us to care.

GLOSSARY OF TERMS

Abbreviation	Full Description
A&E	Accident and Emergency
ABP	Annual Business Plan
ACDC	Active Compression Decompression
ACLS	Advanced Cardiac Life Support
ACPO	Association of Chief Police Officers
AD	Active Directory
AED	Automated External Defibrillator
AFA	Ambulance Fleet Assistant
AfC	Agenda for Change
AMI	Acute Myocardial Infarction
AMPDS	Advanced Medical Priority Despatch System
AQI	Ambulance Quality Indicators
ARMS	Ambulance Risk Management Standards
ARP	Ambulance Radio Project
ARV	Alternative Response Vehicle
ASN	Ambulance Service Network
ASD	Annual Skills Development
BASICs	British Association of Immediate Care Doctors
BC	Black Country
BME	Black and Minority Ethnic
C&W	Coventry and Warwickshire
CAD	Computer Aided Dispatch
CAT	Category
CBRN	Chemical, Biological, Radiological, Nuclear
CC	Call Connect
CCGs	Clinical Commission Groups
CDP	Career Development Plan
CEN	Committee of European Normalisation
CfH	Connecting for Health
CFMS	Counter Fraud and Security Management Service
CFR	Community First Responder
CHD LIT	Coronary Heart Disease Local Implementation Team
CNST	Clinical Negligence Scheme for Trusts
CPI	Clinical Performance Indicator
CPO	Community Paramedic Officer
CPR	Cardio Pulmonary Resuscitation
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CRES	Cash Releasing Efficiency Savings
CSD	Clinical Support Desk
CSU	Commissioning Support Unit
CTS	Courier Transport Service
DCA	Double Crewed Ambulance
HDU	High Dependency Unit
DGH	District General Hospital
DH	Department of Health
DN	District Nurse
E&U	Emergency & Urgent
EBITDA	Earnings Before Interest, Tax, Depreciation and Amortisation
ECA	Emergency Care Assistant
ECIST	The Emergency Care Intensive Support Team

GLOSSARY OF TERMS

Abbreviation	Full Description
ECPAG	Emergency Call Prioritisation Advisory Group
ECP	Emergency Care Practitioner
ECR	Extra Contractual Referral
ECS	Emergency Care System
ED	Executive Director
EDI	Equality, Diversity and Inclusion
EDS	Equality Delivery System
EFL	External Financing Limit
EIA	Equality Impact Assessment
EISEC	Enhanced Information System for Emergency Controls
EHR	Electronic Health Record
EMB	Executive Management Board
EOC	Emergency Operations Centre
EPO	Emergency Planning Officer
EPRR	Emergency Preparedness, Resilience and Response
ERMA	Emergency Response Management Arrangements
ESR	Electronic Staff Record
FAAW	First Aid at Work
FAST	Face, Arm, Speech Test
FY	Financial Year
FT	Foundation Trust
FTN	Foundation Trust Network
FTGA	Foundation Trust Governors Association
GP	General Practitioner
HALO	Hospital Ambulance Liaison Officer
HART	Hazardous Area Response Team
HCAI	Healthcare Acquired Infections
HCRT	Health Referral Team
HCSW	Health Care Support Worker
HPA	Health Protection Agency
HPC	Health Professions Council
HQ	Headquarters
HSE	Health and Safety Executive
ICD	Incident Command Desk
ICCS	Integrated Control and Command System
ICP	Immediate Care Point
ICT	Information and Communications Technology
IG	Information Governance
IGT	Information Governance Toolkit
IHCD	Institute of Health Care Development
IIP	Investors in People
ILCOR	International Liaison Committee on Resuscitation
IMAS	Interim Management and Support
IM&T	Information Management and Technology
IMR	Internal Management Review
IOSH	Institute of Safety and Health
IPC	Infection Prevention and Control
IRU	Incident Response Unit
IWL	Improving Working Lives
JESIP	Joint Emergency Services Interoperability Programme
JRCALC	Joint Royal Colleges Ambulance Liaison Committee

GLOSSARY OF TERMS

Abbreviation	Full Description
KA34	Department of Health Korner Return
KPIs	Key Performance Indicators
KSF	Knowledge & Skills Framework
LAN	Local Area Network
LAT	Local Area Teams
LDC	Leadership Development Centre
LINKs	Local Involvement Networks
LMS	Logistics Medical Service
LSMS	Local Security Management Specialist
LUCAS	Lund University Cardio Assist System
MAA	Midlands Air Ambulance
MAU	Medical Assessment Unit
MEOC	Mobile Emergency Operations Centre
MERIT	Medical Emergency Response Incident Team
MINAP	Myocardial Infarction Audit Project
MISU	Major Incident Support Unit
MIU	Major Incident Unit
MP	Millennium Point
MP	Member of Parliament
NARU	National Ambulance Resilience Unit
NASMeD	National Ambulance Service Medical Directors
NED	Non Executive Director
NHSCB	National Health Service Commissioning Board
NHSE	National Health Service Executive
NHSLA	National Health Service Litigation Authority
NHSP	National Health Service Pathways
NICE	National Institute for Health and Clinical Excellence
NLC	National Leadership Council
NOS	National Operation Standards
NpfIT	National Programme for IT
NSF for CHD	National Service Framework for Coronary Heart Disease
OOH	Out of Hours
ONS	Office for National Statistics
ORCON	Operational Readiness Consultants
PALS	Patient Advice and Liaison Service
PbR	Payment by Results
PDR	Personal Development Review
PCC	Primary Care Clinic
PCI	Primary Percutaneous Coronary Intervention
PCT	Primary Care Trust
PFI	Private Finance Initiative
PHTLS	Pre-Hospital Trauma Life Support
PIs	Performance Indicators
PLS	Paramedic Life Support
POMIS/STOMIS	Purchase Order & Stores Management Information Systems
PoP	Point of Presence
PPEG	Public & Patient Engagement Group
PRF	Patient Report Form
PSIAM	Priority Solutions Integrated Access Management
PTS	Patient Transport Service
QIA	Quality Impact Assessment

GLOSSARY OF TERMS

Abbreviation	Full Description
QIPP	Quality, Innovation, Productivity and Performance
REAP	Resourcing Escalatory Action Plan
RIDDOR	Reporting of Injuries, Diseases and Dangerous Occurrences Regulations
ROSC	Return of Spontaneous Circulation
RPST	Risk Pooling Scheme for Trusts
RRV	Rapid Response Vehicle
SfBH	Standards for Better Health
SCR	Serious Case Review
SHA	Strategic Health Authority
SI	Serious Incident
SLA	Service Level Agreement
SOC	Strategic Operations Centre
SOM	Standard Operating Model
SOP	Standard Operating Procedure
SPC	Statistical Process Control
SPA	Single Point of Access
SR0	Senior Responsible Officer
SSAG	Staff Survey Action Group
SSP	System Status Plan
STEIS	Strategic Executive Information System
STEMI	ST Elevation Myocardial Infarction
STREAM	Strategic Reperfusion Early After Myocardial Infarction)
SWOT	Strengths, Weaknesses, Opportunities & Threats
TAS	Telephone Answering Service
TMIU	Temporary Minor Injury Unit
TUPE	Transfer of Undertakings (Protection of Employment) Regulations 2006
UCS	Unscheduled Care Service
UHB	University Hospital Birmingham
UHCW	University Hospital Coventry & Warwickshire
UHU	Unit Hour Utilisation
UHNS	University Hospital North Staffs
UKTFT	United Kingdom Transport for Transplants
UPS	Uninterruptible power supply
USAR	Urban Search and Rescue
UTC	University Technical College
VAS	Voluntary Aid Services
VCS	Voluntary Car Service
WAN	Wide Area Network
WBA	Work Based Assessment
WDC	Workforce Development Confederation
WM	West Mercia
WMAS	West Midlands Ambulance Service
WNAA	Warwickshire and Northamptonshire Air Ambulance
WTE	Whole Time Equivalent
YTD	Year to Date