Agenda Item No. 7

Great Western Ambulance Service NHS
NHS Trust

Quality Account 2010-11

INDEX & GLOSSARY

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GLOSSARY

A&E	Accident and emergency
ABCD2	A stroke risk assessment tool
AED	Automated external defibrillator
AF	Atrial fibrillation
AMPDS	Advanced medical priority dispatch system
CAD	Computer aided dispatch
CQC	Care quality commission
DQWG	Data quality working group
EOC	Emergency control centre
FAST	Face arms speech test
FRAT	Fall risk assessment tool
GP	General practitioner
GWAS	Great Western Ambulance Service
IAED	International academy of emergency dispatch
IHCD	Institute of healthcare and development
IPC	Infection prevention and control
MINAP	Myocardial ischaemia national audit project
NICE	National Institute for Clinical Excellence
PCR	Patient care record
PCT	Primary care trust
PHT	Pre-hospital thrombolysis
PPCI	Percutaneous coronary intervention
PTS	Patient transport service
QIPP	Quality, innovation, prevention and prevention
ROSC	Return of spontaneous circulation
STEMI	ST elevation myocardial infarction
TIA	Transient ischaemic attack

CHIEF EXECUTIVE STATEMENT

The publication of the Operating Framework for the NHS in England in January 2011 firmly placed quality and outcomes at the forefront of service delivery for the ambulance service. These are exciting times for our service as we move away from a time driven model to one where, quite rightly, the outcome of the care provided is much more visible and open to scrutiny.

As an organisation we have set in place internal processes to ensure that we meet these obligations, and having joined the trust in February I am delighted to have had the opportunity to review the quality of care we provide within this Quality Account and I believe that it shows we have made significant improvements in many areas over the last 12 months.

As always, with a changing healthcare environment, we will continue to strive to meet the demands of our customers, whilst ensuring that we provide a cost effective service. We have identified a number of senior ambulance clinicians to take forward the quality agenda, working with local stakeholder groups to ensure that the local priorities contained within the Quality Account are delivered for the benefit of local people.

This is a summary report of our performance against quality measures in 2010-11 and identifies a number of our quality priorities moving forward. To improve our process in producing the Quality Account we have worked jointly with the Local Involvement Network to ensure wider consultation and engagement in the document's production. Many of the improvements delivered over the last 12 months have come about through engagement and participation with local stakeholders and we will continue to develop and shape our service through a partnership approach.

As the annual publication of the Quality Account becomes the mechanism by which we share best practice within the local NHS we will continue to embed quality and improvement initiatives throughout the trust, working with both local stakeholders through the joint Clinical Quality Review Group and staff through the Quality Committee. Our aim will be to continue to identify and maximise opportunities that provide the highest levels of clinical care in the most appropriate setting.

I confirm that to the best of my knowledge the information presented in this Quality
Account is accurate and I would welcome any comments or feedback.

(signature to be added)

Signed
Martin Flaherty OBE
Chief Executive
Great Western Ambulance Service NHS Trust

QUALITY STATEMENTS

REVIEW OF SERVICES.

During 2010-11 the Great Western Ambulance Service NHS Trust provided and/ or sub-contracted three NHS services, accident and emergency (999) ambulance services, out of hours and patient transport services.

The Great Western Ambulance Service NHS Trust has reviewed all the data available to them on the quality of care in three of these NHS services.

The income generated by the NHS services reviewed in 2010-11 represents 93% per cent of the total income generated from the provision of NHS services by the Great Western Ambulance Service NHS Trust for 2010-11.

PARTICIPATION IN CLINICAL AUDITS.

During 2010-11, 1 national clinical audit and 0 national confidential enquiries covered NHS services that Great Western Ambulance Service NHS Trust provides

During that period Great Western Ambulance Service NHS Trust participated in 100% national clinical audits and no national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Great Western Ambulance Service NHS Trust was eligible to participate in during 2010-11 are as follows;

- **Myocardial ischemia national audit project (MINAP)**

The national clinical audits and national confidential enquiries that Great Western Ambulance Service NHS Trust participated in during 2010-11 are as follows;

- **Myocardial ischemia national audit project (MINAP)**

The national clinical audits and national confidential enquiries that Great Western Ambulance Service NHS Trust participated in, and for which data collection was completed during 2010-11, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry

National Clinical Audit or national confidential enquiry	NO of Cases submitted	Number of cases submitted as a percentage of registered cases.
Myocardial ischemia national audit project (MINAP)	572*	N/A

* Number of cases registered on MINAP up to and including March 2011.

The reports of one national clinical audit were reviewed by the provider in 2010-11 and Great Western Ambulance Service NHS Trust intends to take the following actions to improve the quality of healthcare provider.

The results from the pre-hospital thrombolysis (PHT) audit form part of the larger Myocardial Ischemia National Audit Project (MINAP) audit which is inclusive of hospital data. This data is scrutinized by key stakeholder groups. The number of patient's receiving PHT during the period 2010/11 has fallen with the advent of Percutaneous Coronary Intervention (PPCI) only service from December 2010. Standards of care provision are assured through continuous data monitoring. Where deficits are identified interventions including training are initiated in order to improve patient outcome and experience.

PARTICIPATION IN CLINICAL RESEARCH.

The number of patients receiving NHS services provided or sub-contracted by Great Western Ambulance Service NHS Trust in 2010-11 that were recruited during that period to participate in research approved by a research ethics committee was one.

USE OF COMMISSIONING FOR QUALITY AND INNOVATION PAYMENT FRAMEWORK.

A proportion of Great Western Ambulance Service NHS Trust income in 2010-11 was conditional on achieving quality improvement and innovation goals agreed between NHS Gloucestershire and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework

Further details of the agreed goals for 2010-11 and for the following 12 month period is available electronically at **[provide a web-link]**

CARE QUALITY COMMISSION.

Great Western Ambulance Service NHS Service Trust is required to register with the Care Quality Commission and its current registration status is without conditions.

Great Western Ambulance Service NHS Trust has the following conditions on registration – none.

The Care Quality Commission has not taken enforcement action against Great Western Ambulance Service NHS Trust during 2010-11. Great Western Ambulance Service NHS

QUALITY STATEMENTS

Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

DATA QUALITY.

Great Western Ambulance Service NHS Trust has established a Data Quality Group to improve data quality.

The Data Quality Working Group is authorised by the Information Governance Steering Group to investigate data issues activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are required to co-operate with any request made by the group or its members in the achievement of these objectives. The group are also authorised to implement any activity which is in line with the terms of reference as part of the data quality work programme.

The DQWG will be responsible for driving improvements in the effectiveness and efficiency of the use of all data within the ambulance trust.

Together with the Information Governance Steering Group the Data Quality Working Group has responsibility for driving best practice standards in the use of data and information within the trust, and ensuring that the data is fit for purpose

NHS NUMBER AND GENERAL MEDICAL PRACTICE CODE VALIDITY.

Great Western Ambulance Service NHS Trust does not submit records during 2010-11 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

INFORMATION GOVERNANCE TOOLKIT ATTAINMENT LEVEL.

Information Governance Assessment Report score overall score for 2010-11 was 54% and was graded as not satisfactory (Red)

CLINICAL CODING ERROR RATE

Great Western Ambulance Service NHS Trust was not subject to the Payment by Results clinical coding audit during 2010-11 by The Audit Commission.

PRIORITIES FOR IMPROVEMENT

INTRODUCTION.

The NHS has made considerable progress in delivering the kind of care that patients want as measured by responsiveness and accessibility, and the NHS White paper 'Equality and excellence: Liberating the NHS' (July 2010) now focuses on the next phase in making the NHS a world class provider of quality healthcare.

For the trust, being part of the NHS journey to focus more effectively on clinical quality is a natural next step. We subscribe to a multifaceted view of quality improving clinical outcomes, keeping patients safe and improving patients' experience of care. However we believe that access and responsiveness are themselves markers of high quality care and we intend to continuously improve our current high standards in these areas.

The increasing number of older people is already having a dramatic impact on the disease profile in our community. We are often thought of as primarily a service that responds to major trauma and acute severe illness, whereas in fact, the majority of our patients, as in the rest of the NHS, comprises of people with long term medical conditions and acute mild and moderate medical problems. Given the demographic changes expected, the number of patients with these conditions will increase.

To become the quality organisation that we strive to be in a rapidly changing environment is an exciting challenge. It is the opportunity to test our thinking and ensure that our programmes of work are focused on continually improving the quality of patient care that we provide within our communities.

PATIENT EXPERIENCE.

The trust recognises the importance of ensuring that the patient experience is a positive one.

We aim to build upon the foundations we have put in place for gathering patient feedback through the use of Patient Opinion and will continue to actively market and promote this service. We will work to response agreements to ensure that all comments received trough this on-line service are responded to with five working days, and report quarterly on the volume and category of comment to the internal quality committee and through joint meetings with our lead commissioner's quality group.

We will also focus our efforts in gaining insight on our service from seldom heard groups, and working through equality and diversity networks, access and canvas these groups to better understand how the trust is viewed and where we can make improvements.

We will specifically work with stakeholder groups from the learning disability networks to understand how we can improve the patient experience for these individuals.

We recognise that patient experience with this group and other groups where cognitive impartment is a major factor can often centre on communication and assessment skills displayed by our staff. To address this we will develop a clinically suitable assessment / communication tool for use with this patient group.

In recognising the limitations of the category c survey method, we will develop and target a survey to measure the patient experience of individual patients who we do not convey to an acute hospital within the first half of the year.

Following this analysis we will develop and implement an improvement plan targeted towards addressing any areas of significant concern.

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An additional priority for the coming year will be expanding our use of individual care plans with particular emphasis on developing feedback mechanisms. We recognise that our service is often called to attend individuals for whom an agreed care plan is in place, but that the intervention we provide may not be fully integrated within other healthcare systems.

To improve this situation we will develop and trial a feedback process to primary care, whereby summary information from an attending clinician is made available. System limitations will impact on this process, and it will not be real time information, but provided retrospectively using the secure NHS network. To support this we will implement an audit of patient care records that correlate to attendance of an address where we have individual care plans in place, and review the care provided against the requirements detailed within the care plan.

These audits will be retrospective and data will be provided bi-annually to the quality committee and lead commissioner's quality group.

STROKE THROMBOLYSIS

Over the past two decades a growing body of evidence has overturned the traditional perception that stroke is simply a consequence of aging that inevitably results in death or severe disability (NICE, 2008).

Until recently, stroke was not perceived as a high priority within the NHS. However, in 2007 a National Stroke Strategy was developed by the Department of Health which outlined an ambition for the diagnosis, treatment and management of stroke, including all aspects of care from emergency response to life after stroke.

PRIORITIES FOR IMPROVEMENT

Stroke thrombolysis treatment has been shown to improve outcome in acute stroke and the trust has a crucial role in contributing to early assessment of patients that may be suitable for stroke thrombolysis.

To deliver this objective the trust needs to appropriately code possible stroke patients at the time of emergency call and the attending ambulance clinician needs to identify patients that meet the local stroke network potential stroke thrombolysis criteria. These patients then need to be conveyed to a specialist acute stroke unit as rapidly as possible.

In order to develop improvement strategies the trust carried out an audit of current performance and practice with the aim of identifying the following;

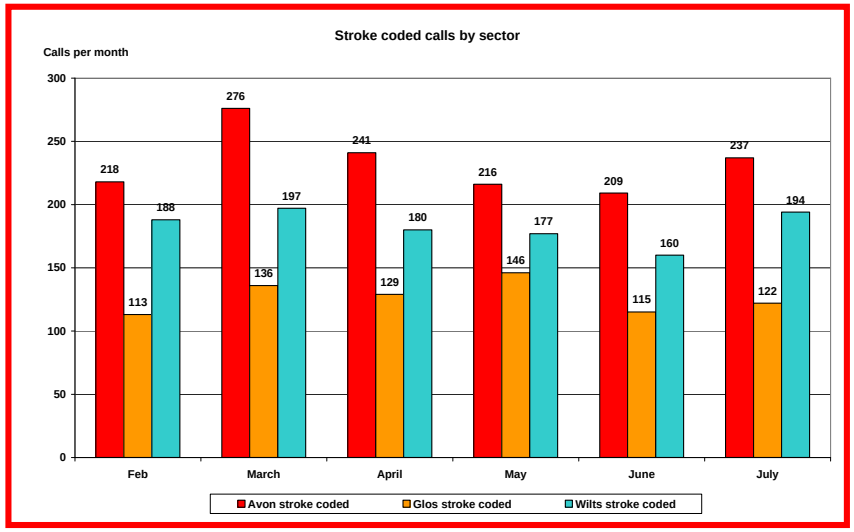
- **To identify the number of stroke coded calls by GWAS sector**
- **To compare the number of stroke coded calls with the number of cases assessed as possible stroke by the attending ambulance clinician.**
- **To identify time and day frequencies of 999 call for cases assessed as possible stroke by the attending ambulance clinician**
- **To identify the number of patients which meet the local Stroke Network potential stroke thrombolysis criteria**
- **To ascertain the percentage of people who have a sudden onset of neurological symptoms which are screened for a diagnosis of stroke using a validated tool (FAST). NICE standard-100%.**
- **To ascertain the percentage of people with persisting neurological symptoms who screen positive using a validated tool (FAST), in whom hypoglycaemia has been excluded, and who have a possible diagnosis of stroke, that are transferred to a specialist acute stroke unit within 1 hour.**

The trust reviewed information from 1st February to 31st July 2010, with the number of stroke coded calls provided by the informatics department.

All patient care records (PCR) received by the audit department for interventions between these dates with a diagnosis of stroke or a FAST tool completed were reviewed by the trust audit team

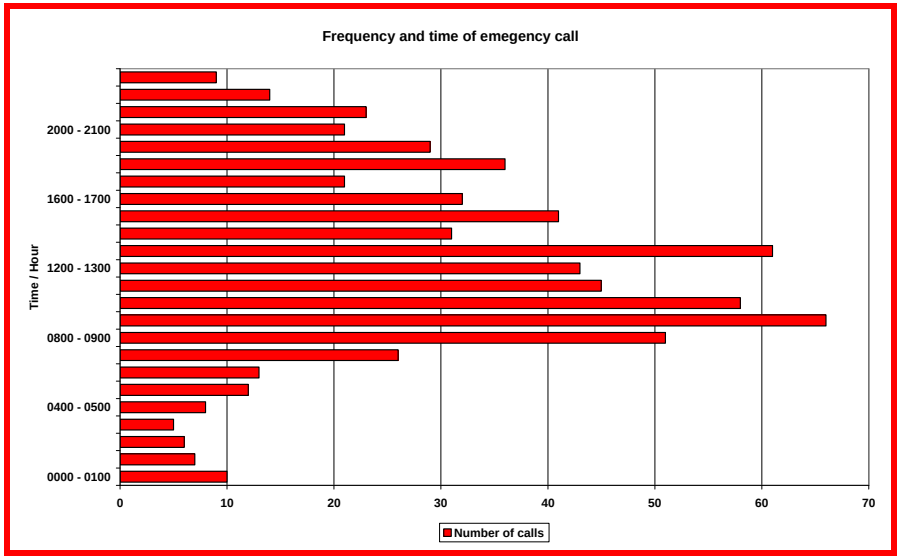
PRIORITIES FOR IMPROVEMENT

During the period there were 3254 calls coded as stroke with the attending clinician diagnosing 668 cases, a ratio of approximately 5:1.



There were 120 cases where the onset time was not recorded or not known and another 7 cases where FAST was not recorded.

There were 104 cases that meet the local stroke network criteria thrombolysis criteria of 3.5hours between the onset of symptoms and arrival at hospital



In support of the new clinical quality indicators for 2011-12 the trust will strive to continue to improve outcome from stroke for ambulance patients. This will be delivered by increasing 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 and increasing the percentage of suspected stroke patients (assessed face to face) who receive an appropriate care bundle.

Components of the care bundle for suspected stroke patients, in line with national guidelines, are

- **FAST assessment recorded**
- **Blood glucose recorded**
- **Systolic and diastolic blood pressure recorded**

The higher the percentage of FAST positive stroke patients arriving at a hyperacute stroke centre within 60 minutes and the higher the percentage of suspected stroke patients receiving a care bundle the better.

Patients should be arriving at the hyperacute stroke centre as soon as possible so that they can be rapidly assessed for thrombolysis, delivered following a CT scan in a short but safe time frame; this has been demonstrated to reduce mortality and improve recovery. Eligibility criteria, particularly in relation to the therapeutic time window, will vary between local services, depending on the availability of local expertise e.g. intra-arterial clot lysis. And we have been working extensively with healthcare partners within out stroke network to optimise service availability. The improved provision of this service supports the NICE national quality standard that indicates this is an effective measure of the ambulance service's contribution to the stroke pathway.

CARDIAC ARREST AND SURVIVAL TO DISCHARGE.

The NHS Operating Framework 2011-12 builds upon the requirement of ambulance services to not only include the performance of return of spontaneous circulation (ROSC), which it has historically reported as part of the clinical performance indicator audit cycle but to also follow this up and find out how well the patient does in hospital. This is referred to as the *survival to discharge* outcome measure.

The survival to discharge outcome measure reflects the effectiveness of the whole urgent and emergency care system in managing out of hospital cardiac arrest and is a more robust measurement of whole systems solution.

We will also record and report against an Utstein comparator group, which are all patients who had resuscitation (Advanced or Basic Life Support) commenced or continued by the trust following an out-of-hospital cardiac event of presumed cardiac origin, where the arrest was bystander or emergency medical service witnessed and the initial cardiac rhythm was ventricular fibrillation or ventricular tachycardia.
Whilst survival to discharge outcome measures reflect the effectiveness of the whole urgent and emergency care system in managing out of hospital cardiac arrest the Utstein survival rate applies to a subset of all cardiac arrest patients and provides a more comparable measure of management of cardiac arrest for

patients where timely and effective clinical care can particularly improve survival.

To report on survival to discharge performance requires information sharing with our acute trust partners and the trust has been agreeing the necessary arrangements to facilitate data transfer which does not affect patient confidentiality, but allows us to record, monitor and make publically available the outcome measure achieved.

We recognise that this strategy is much more than just recording the outcome data. Rather, it is about developing continual improvement to ensure that the service we provide and the whole system approach is as optimal as possible for the patients we serve.

As such, the trust has formed an internal Cardiac Arrest Working Group with the remit of developing initiatives designed to improve the outcome for patients that suffer an out of hospital cardiac arrest. These initiatives include implementation of the new Resuscitation Council guidelines, promoting schemes designed to increase the availability of early access to defibrillators and additional staff training designed to improve the quality of cardio-pulmonary resuscitation.

We are also working nationally on revised out-of-hospital guidelines for managing cardiac arrest. Likewise over the next year we will continue to liaise with partner groups such as the Avon, Gloucestershire, Wiltshire & Somerset Network Reperfusion Group on overarching strategies designed to improve likelihood of a successful outcome from out of hospital cardiac arrest, and develop initiatives include developing procedures for direct conveyance to centres providing Primary Percutaneous Coronary Intervention (PPCI) and the use of evidence based practice such as patient cooling.

EMERGENCY CONTROL CENTRE.

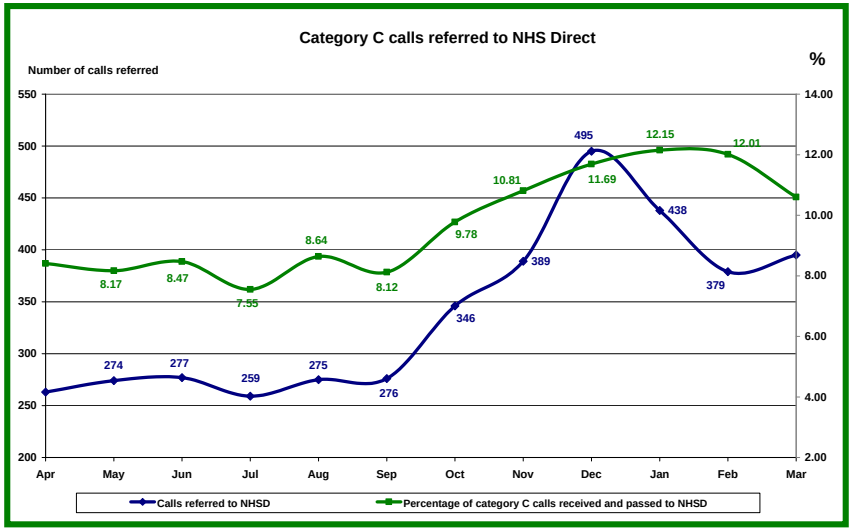
The trust operates three Emergency Operations Centres (EOC's), with Avon acting as the primary centre for emergency and urgent care call handling. Additional support is provided by the other EOC based within Gloucestershire and Wiltshire who also have principle dispatch and allocation within their local areas.

All three centres operate on a single Computer Aided Dispatch (CAD) system, telephony and policies and procedures, thus creating a virtual EOC through the trusts operational area.

The EOC manages approximately 280,000 calls per year with a performance threshold of 95% of all calls to be answered within 5 seconds. From April to December 2010 the trust performance was 95.37%.

Emergency calls are triaged (processed) using the Advanced Medical Priority Dispatch System (AMPDS), which is governed by the International Academy of Emergency Dispatch (IAED) which requires a compliance threshold of 90% across 6 key areas within each emergency call for achievement of 'Centre of Excellence' status. The trust has consistently achieved this, with a compliance of 93.66% in 2009 and 93.96% in 2010.

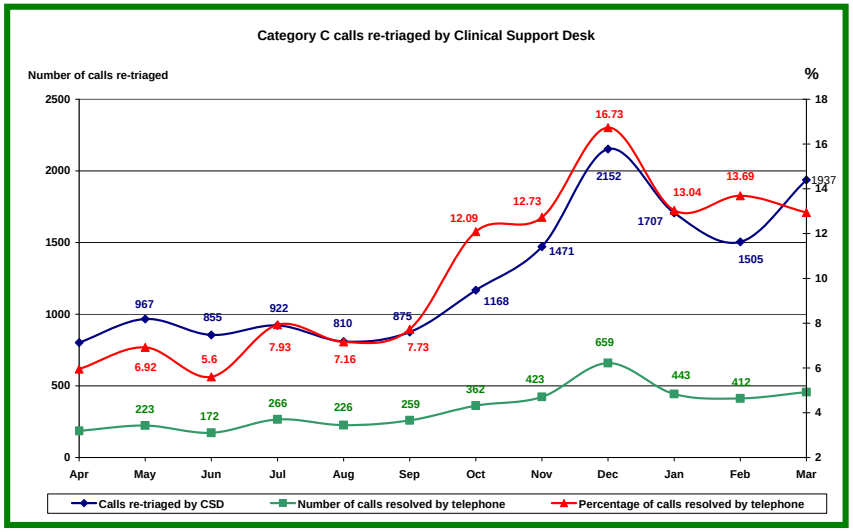
In addition to providing call handling and dispatch, the EOC manages a Clinical Support Desk. This is a new function and supports a team of senior trust clinicians to analyse category C calls and refer patients into an alternative more appropriate treatment pathway such as NHS Direct. This process means that the trust does not need to dispatch a vehicle to respond, freeing up these vital resources for other more urgent cases and helping to reduce inappropriate transfer of patients to hospital emergency departments.



There are seven dispatch desks operating 24hrs a day, 365 days a year that manage approximately 150 ambulance resources. They are responsible for the efficient and effective

allocation of these resources and in 2010 the average time taken to dispatch a resource was only 45 seconds.

The development of the clinical support desk within 2010 is allowing the trust to respond more appropriately to patients needs. Over and above the calls that are referred on to NHS Direct, using decision support software, it is able to match the patient's health care needs with the appropriate level of service.



The next phase for the trust will be to develop the Clinical Support Desk to further increase the level of support available to ambulance clinicians by providing additional access to alternative healthcare pathways suitable patients.

OUT OF HOURS SERVICE.

The trust operates an Out of Hours Service that provides an emergency doctors' service to any person registered with a GP in Gloucestershire. This service covers an area of 1,047 square miles and a population of approximately 590,000. The service operates from the Triservices Centre at Quedgley, Gloucestershire, which takes calls, and prioritises the clinical response.

The difficult weather conditions experienced by the area over the last few years has seen the trust invest in seven 4x4 vehicles to support the out of hours services, and these are based at Staverton Ambulance Station along with the mobile doctors and urgent care assistants.

More and more we have been working to improve the quality of the care we provide by ensuring that the patient experience is as seamless as possible as their care is passed through the different healthcare providers and to support this we work very closely with other services to ensure that the highest standard of care is given.

When a member of the public contacts their own doctor in the evening or at weekends the doctors' surgery telephone is

automatically diverted to us and answered by one of our call takers who will then obtain as much information about the patient as possible so that the call can be prioritised.

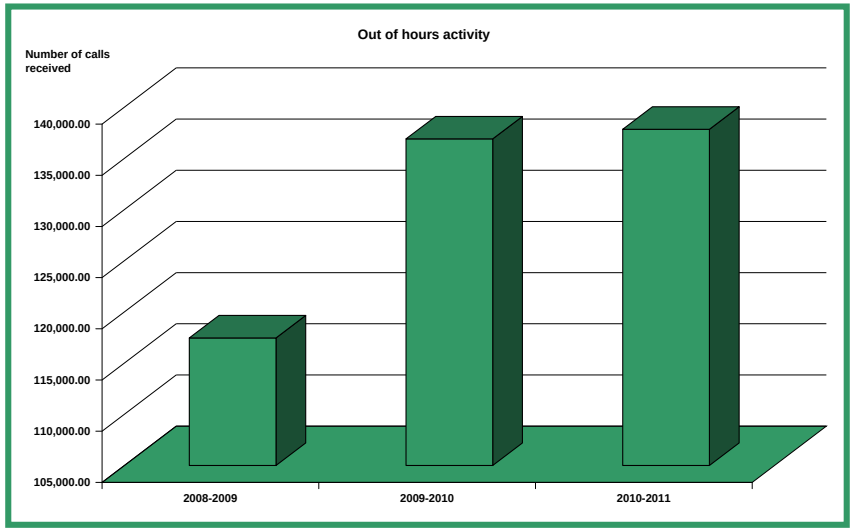
Our doctor then calls the patient back and makes a telephone assessment of the patient's condition to decide if the patient needs to be seen at a primary care centre, needs a home visit, needs to attend accident and emergency department or needs an ambulance to be sent.

From 6.00pm to 8.00am every weekday and all weekend and public holidays we;

- **Take telephone calls from the public who wish to see a doctor or district nurse.**
- **Dispatch the 'home visits' to the mobile doctors and pass on requests for a district nurse.**
- **Have a number of nurses and paramedics to support the call handling staff and overnight triage doctor in helping patients.**
- **Provide an overnight doctor from 11:00pm to 8:00am to assess the calls being received and decide on the best care pathway for the patient.**

Where a home visit is required the doctor will decide if it is an emergency, urgent or routine home visit and the dispatcher will then send the patient's information to one of our vehicles and the mobile doctor and their assistant will drive to the patient.

Despite the number of calls we receive increasing year on year, we have consistently improved our service when measured against a number of internal indictors that record how quickly we manage the call and visit the patient.



Percentage	08/09	09/10	10/11
Calls answered <60 secs	94	95	94
Triage <20 minutes	92	96	97
Triage <60 minutes	99	99	99
Visit time <1 hour	90	98	99
Visit time <2 hours	92	94	96
Visit time <6 hours	97	95	96

The trust is proud of the quality of the out of hours service that it provides for the people of Gloucestershire, and we will actively engage with other stakeholders as the NHS responds to the forthcoming changes over the next few years. We would hope to build on and expand our service.

PATIENT TRANSPORT SERVICE.

The Patient Transport Service (PTS) provides non-emergency transport for patients to and from hospitals or other healthcare facilities

Although most journeys are pre-planned increasingly the purchasers of our service require some patients to be transported within a few hours notice, especially those being discharged from hospital.

Our ambulance vehicles provide for those people who often need greater care and assistance especially where their mobility is poor. All are equipped with ramps or tail-lifts and are double-crewed. They are capable of carrying people who need the assistance of two people and they can also carry up to two people travelling in their own wheelchairs.

All our ambulance care assistants have received comprehensive training to be able to offer the highest quality of care to the people they transport and look after.

In addition a number of our ambulances are also equipped to carry patients who need to lie down or who may need the highest level of supportive care. These vehicles incorporate stretcher trolley beds as well as a range of other specialist equipment. The intermediate care assistants who operate these vehicles have received the department's highest level of training that enables them to manage patients who, for example, may have undergone cardiac procedures or who require spinal immobilisation.

The last twelve months have seen impressive changes to the way the patient transport service operates within the trust. As a directly commissioned service we now have a number of contracts with the NHS organisations across the area of Avon, Gloucestershire and Wiltshire. The largest of these contracts, to supply PTS services to Bristol, North Somerset and South

Gloucestershire, was awarded after a competitive process on the open market and has generated a significant degree of investment.

As a result the department now has resources operating 24 hours a day and 7 days a week. The dedicated Control and Operations centre has also extended its working hours to 7 days a week. We have also renewed fifty percent of our vehicles and introduced mobile data technology to improve the way that resources are deployed and performance monitored.

In building on this success we have been able to increase the number of staff we employ to over 260 people

The trust now undertakes nearly 300,000 non-emergency patient journeys each year and the PTS department is planning to increase this number through the acquisition of new business.

With planned rationalisation of public services and a reorganisation of the way NHS services are commissioned there will be many challenges ahead. However we believe that the service developments that have taken place in the last year and the quality of the service we are now able to offer puts us in a strong position to respond to the needs of patients and grow our business in the forthcoming years.

COMMUNITY FIRST RESPONDERS.

Community first responders are volunteers recruited by the trust to respond to life threatening medical incidents within their local communities.

They attend an accredited training course, either the IHCD first person on scene course or the community responder course in conjunction the St John Ambulance. As well as covering medical emergencies both courses equip the responder with the skills to carry out basic life support and use of an automated external defibrillator (AED).

After successfully completing the training the volunteers then spend time with operational front line staff, attending at least two observation shifts on either a rapid response vehicle or an ambulance. This not only introduces the volunteers to the operational processes of the trust but allows them to gain experience of dealing with emergency situations whilst under the supervision of clinically trained staff.

They respond, under normal driving conditions, to incidents usually within a 3 mile radius of their home address and are always supported up by a trust clinician who will take over the direct care of the patient.

Life threatening emergencies that are attended by community first responders include;

- **cardiac arrests**
- **chest pains,**
- **breathing problems**
- **convulsions**
- **haemorrhages**
- **the unconscious patients**

Currently the trust has 300 active Community First Responders, with an average attendance of 380 life threatening emergencies per month.

The community first responder plays a vital role in our response strategy for the delivery of a local quality service, and we are engaging with local communities & voluntary organisations in an attempt to boost the number of volunteers with the specific aim of providing 24/7 cover in key areas.

MANAGEMENT OF ST ELEVATION MYOCARDIAL INFARCTION.

The trusts objective in the management of STEMI is to provide early reperfusion treatment to restore normal coronary blood flow and so reverse ischaemia and limit infarction. Restoration of coronary blood flow can be achieved by either the provision of thrombolysis or primary percutaneous coronary intervention (PPCI).

The trust responds to patients with a STEMI by;

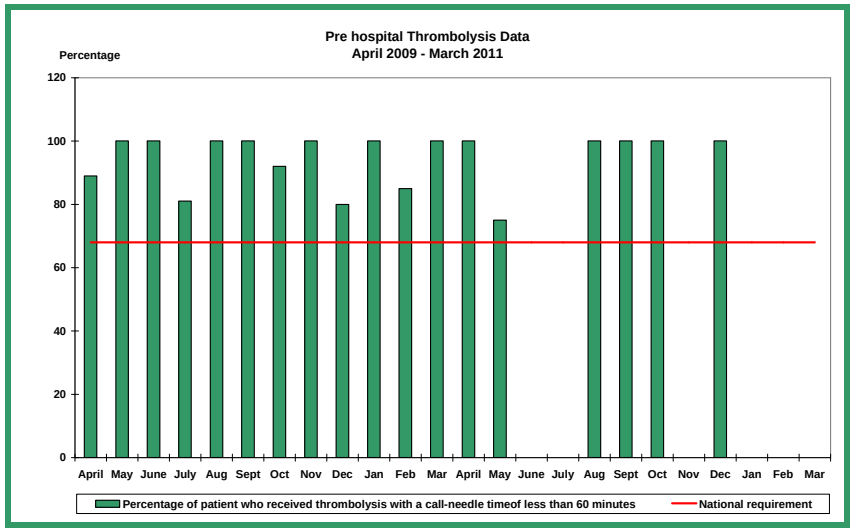
- **Categorising potential STEMI cases as a life threatening 999 response**
- **Ensuring a defibrillator is available on all emergency ambulance resources**
- **Providing appropriate advice over the telephone whilst an ambulance is on route, including advising the administration of aspirin**
- **On arrival, administering anti-platelet drug therapy, nitrates and oxygen**
- **Administering analgesia**
- **Facilitating optimum reperfusion therapy**

For reperfusion treatment to be most effective it must be provided as quickly as possible after onset of the acute event.

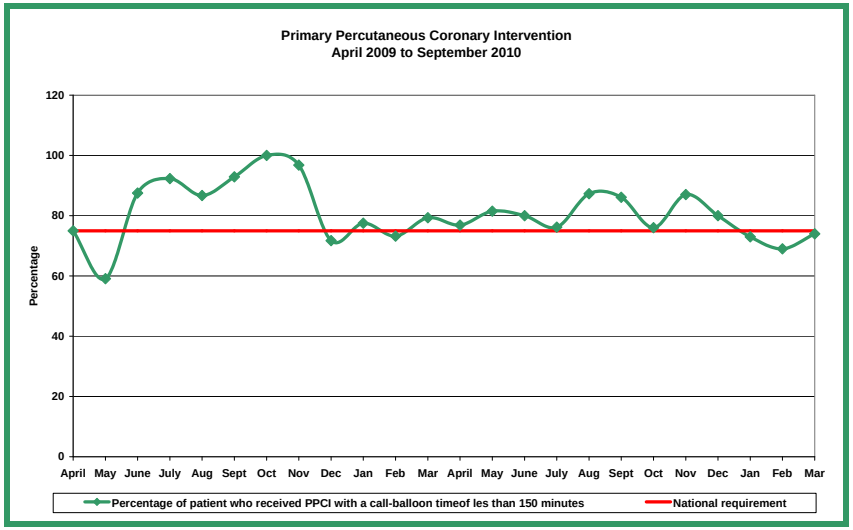
REVIEW OF QUALITY PERFORMANCE

The trusts reperfusion performance is measured against call-to-needle time for thrombolysis and call-to-balloon time for PPCI. The performance targets are considered 'shared' targets between us and the hospital providing PPCI service.

The national performance target for thrombolysis is: 68% of eligible STEMI patients that receive thrombolysis, do so with a call to needle time of within 60 minutes. For PPCI the performance target is: 75% of eligible STEMI patients that receive PPCI do so with a call to balloon time of within 150 minutes.



Evidence suggests that patients who have suffered a heart attack have a greater chance of survival and recovery if they are treated in a specialist centre that provides PPCI. Working with clinical networks the trust has developed the availability of cardiac services to a level which means that from 1st January 2011 all eligible STEMI patients will be taken to a hospital that provides PPCI



MANAGEMENT AND THE PREVENTION OF STROKE.

Stroke has a major impact on individual lives and on the nation's health and economy.

REVIEW OF QUALITY PERFORMANCE

Strokes are a blood clot or bleed in the brain which can leave lasting damage, affecting mobility, cognition, sight or communication.
The trust responds to patients with a stroke by;

- **Categorising potential stroke cases as a life threatening 999 response.**
- **Telephone triage of the Face Arms Speech Test.**
- **On arrival administer oxygen therapy if indicated.**
- **Rapidly assess if the patient meets the pre-hospital criteria for stroke thrombolysis assessment.**
- **Minimise the call to hospital time by taking eligible patients, as an emergency, to a hospital providing stroke thrombolysis services.**

For those people who call 999 when they first experience symptoms, thrombolysis can be an effective treatment where it can be delivered within four and a half hours. The trust has recognised that not only does it have a role to play in the acute care of patients suffering a stroke, but also in supporting stroke prevention measures.

The trust has implemented a number of initiatives designed to contribute to stroke prevention
Clinicians have received training in the assessment and referral of patients suffering from a suspected transient ischaemic (TIA). A TIA can be a precursor to a stroke and we have incorporated the NICE recommendation to assess the risk of subsequent stroke using the ABCD^2 scoring tool

Unrecognised atrial fibrillation (AF) or high blood pressure greatly increases the risk of stroke. The trust has implemented an initiative that enables our clinicians to notify a patient's GP of incidental findings of either AF or a high blood pressure reading. Patients that are treated at home and found to have either AF or a high blood pressure reading are also provided with an information leaflet.

Patient Transport Service conveys around 300,000 patient journeys per year. These service users are a 'captive audience' for the dissemination of stroke prevention literature and the PTS staff are encouraged to actively disseminate stroke prevention literature obtained from the Stroke Association.

DEMENTIA CARE

The trust developed an action plan for implementing the national Dementia Strategy "Living Well with Dementia. This strategy aimed to improve awareness, provide early diagnosis

and intervention and the provision of high quality care for those individuals and their carers. It is broken down into seventeen objectives, and the trust has been able to target actions against six of these objectives, shown in the following table;

Objective	Action
Improving public and professional awareness and understanding	Introduce a basic information leaflet for all staff. Write a feature article in the trust clinical journal. Provide access to a dementia training module through external resources Provide access to a dementia e learning platform
Good quality information for those diagnosed with dementia and their carers	Produce and implement a leaflet for patients and carers identifying local and national resources of information and support.
Enabling easy access to care, support and advice following diagnosis	Liaise with all PCT dementia leads to ensure all care plans are shared with the trust Work with PCT dementia leads to agree access to alternative pathways for care including; community care, safe haven/ respite beds and sitting services.
Implementing the carer's strategy.	Provide clinicians with information on local and national support services in order to support carers
Improved end of life care for people with dementia.	Share clinical alerts process PCT dementia lead to ensure all end of life wishes are captured on the dispatch system
An informed and effective workforce for people with dementia	PCT dementia communication tools to be used by clinicians to reduce the patient fear and anxiety whilst building confidence and trust.

The implementation of this piece of work has supported the national strategy through an improved awareness and quality of care. In addition, the trust is able to ensure the individual and carer will receive the right care in an environment they are familiar with reducing stress and anxiety for all involved. We have also been able to avoid unnecessary hospital admissions, which in turn have resulted in cost saving for the NHS.

Dementia awareness training has been included on the emergency care assistant induction programme and the patient transport service training. In addition access to e-learning has been implemented with approximately one third

of clinical staff taking part and a dementia module is planned as part of next year's statutory mandatory training day.
In delivering against the action plan the trust has had their work recognised within the Department of Health publication "Living well with dementia: A National Dementia Strategy. Good Practice Compendium – an assets approach"

INDIVIDUALISED CARE PLANS.

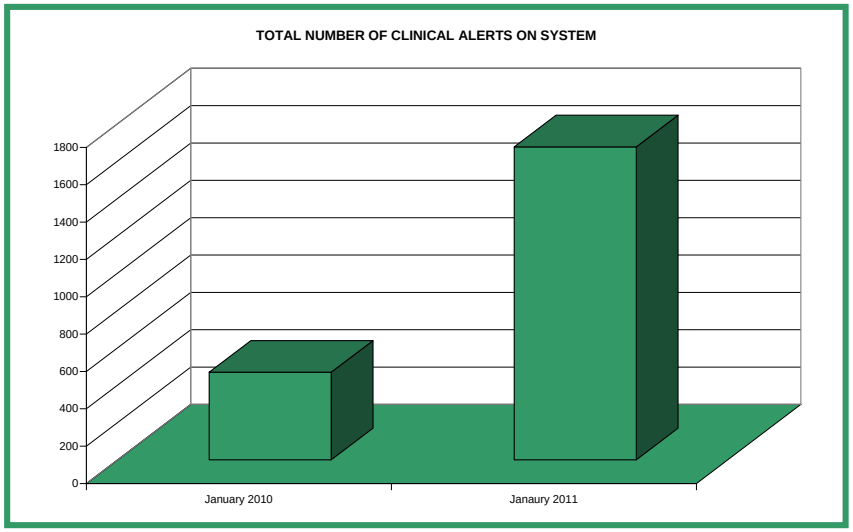
As a trust we are committed to developing and implementing clinical strategies to support national guidance and recommendations that respond to the needs of the public. As part of the previous Darzi review "Taking Healthcare to the Patient" and the more recent Quality, Innovation, Prevention and Productivity (QIPP) work programme the focus has changed to shifting settings of care in both urgent and emergency care.

Over the past eighteen months the trust has begun to identify areas where information sharing between ourselves and our healthcare partners would have a positive impact on the individual needs of patients. As a result of this work we recognised that information sharing would support patients receiving the care they need in an agreed and planned approach, and also in a care setting appropriate for their needs such as their home.

Currently patient information is received via secure fax, letter or secure email and then transferred into a usable format and stored to a restricted database. The information is then securely faxed or emailed to the Avon Emergency Operations Centre where the details are added to the individual address on the computer aided dispatch system (CAD). Secure confirmation is then sent back to the alerts administrator. This allows the attending clinician to carry out care in an agreed manner, responding to the patient's or carers individual wishes.

	Number of new care plans added	Number of care plans reviewed	Number of alerts removed
Jun	**100**	**-**	**16**
Jul	**109**	**99**	**51**
Aug	**151**	**210**	**47**
Sep	**181**	**12**	**31**
Oct	**110**	**68**	**53**
Nov	**205**	**50**	**17**
Dec	**129**	**75**	**4**
Jan	**229**	**30**	**25**
Feb	**209**	**-**	**-**
Mar	**270**	**-**	**-**

Future investment will see this process further streamlined so that all data exchange is electronic using secure NHS email and supporting a local data upload to the dispatch system. We have actively promoted this process with NHS stakeholders, embedding it into trust activity and we have seen a significant increase in the number of individualised care plans we now have on the system.



FALLS MANAGEMENT.

The NHS South West's strategic framework ambitions for 2008-2010 set a goal to reduce emergency admissions as a result of a fall by 30% from a 2006-07 baseline by March 2010. As part of this strategy they suggested a systematic approach to falls and fracture prevention.

Working with our local NHS partners we have been able to develop a clinical pathway to support the wider health community and refer patients into falls services or as a minimum through to their GP. This has allowed patients to be treated in their own home, and reduce the number of patients being unnecessarily transported to hospital. Additionally, use of the pathway and the triage assessment tool has been to allow our health care partners to provide early intervention; secondary falls prevention systems, as well as preserving health and independence for this patient group.

The triage assessment tool is based on the national falls risk in older people tool (FRAT) that has been adapted to an emergency service user friendly edition.

ACCIDENT AND EMERGENCY SERVICES.

We are continuing to build on last year's performance, following the development plan agreed as part of the trust's overall strategy and vision. As part of this approach we have

instigated major changes to the way we plan and deliver our emergency response service, amending our resource plans to better reflect demand and patients' need. As with any major change the path has not been smooth and we have seen this impact on our time based performance standards.

Reassuringly our clinical performance indicators have shown very positive improvements, part of the move towards quality-based outcomes. A major contribution to the overall service we provide is how we deal with initial contact with patients, normally on the telephone. Our call connect performance shows that we continue to be in the vanguard of best practice measured nationally, an achievement of which we are rightly proud but also determined to improve. Similarly, the clinical desk project has been re-invigorated and shown how we can achieve real improvements in patient experience, something that will be critical for our future success.

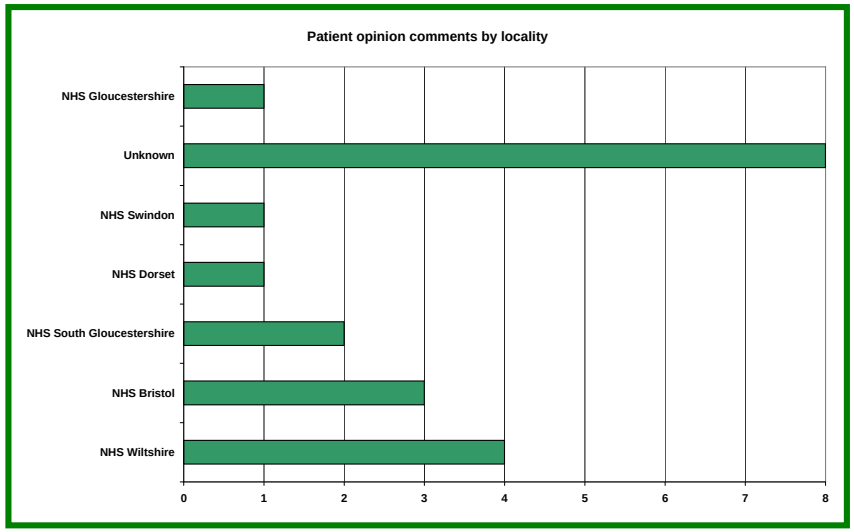
We acknowledge that there is room for improvement in providing equality of care across our region, particularly in the rural areas, and are investing in community based programmes as well as co-responder schemes to supplement the emergency service we provide. Similarly the changes we have made in A&E operations have still to bed in and provide the increase in service quality for which we strive. Encouragingly our air support unit and civil contingency operations are going from strength to strength, allowing us to be better prepared to respond to some of the more difficult incidents faced by an ambulance service.

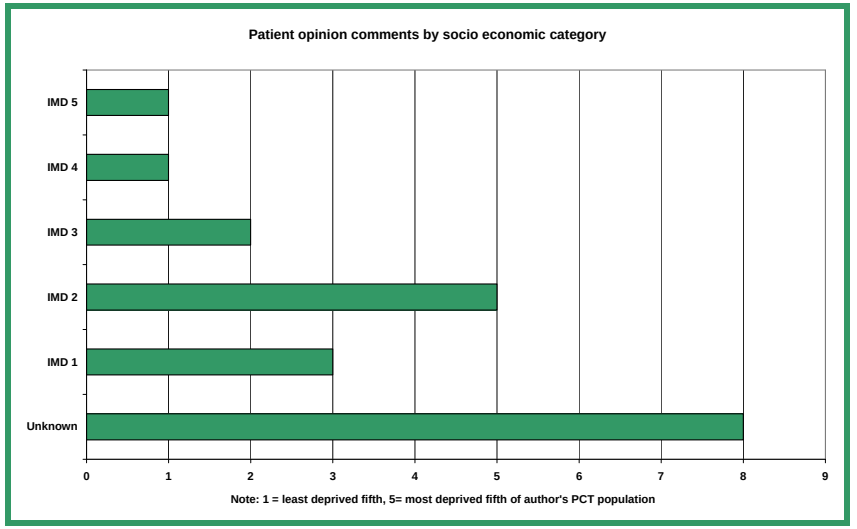
Our focus is very much on the future, in particular the changes to patient outcomes as the metric by which we will be judged. We do not yet know the full impact of this transformation but we are determined to ensure that we deliver the highest levels of clinical care to everyone, achieving a safe, timely and appropriate service to those who need it. We are involved with our stakeholders in mapping out the future and we see real opportunities to improve delivery, for example by means of more effective triage and referral to alternative pathways that better match the requirements of our patient. In sum some encouraging signs but we understand that we have much still to achieve.

PATIENT EXPERIENCE

As part of our commitment to improving patient experience we were the first ambulance service in the UK to subscribe to an online user feedback service called Patient Opinion. This is a social enterprise initiative, led by a Sheffield GP and originally funded by the Department of Health. In subscribing to Patient Opinion we believe that patient stories are a really valuable method of assessing how the public judge the quality of our service. We have implemented a marketing campaign, publicizing the availability of the service via local GP practices, local commissioners and through a targeted media release. We have also included promotional material within our A&E, patient transport and out of hour's fleet

REVIEW OF QUALITY PERFORMANCE





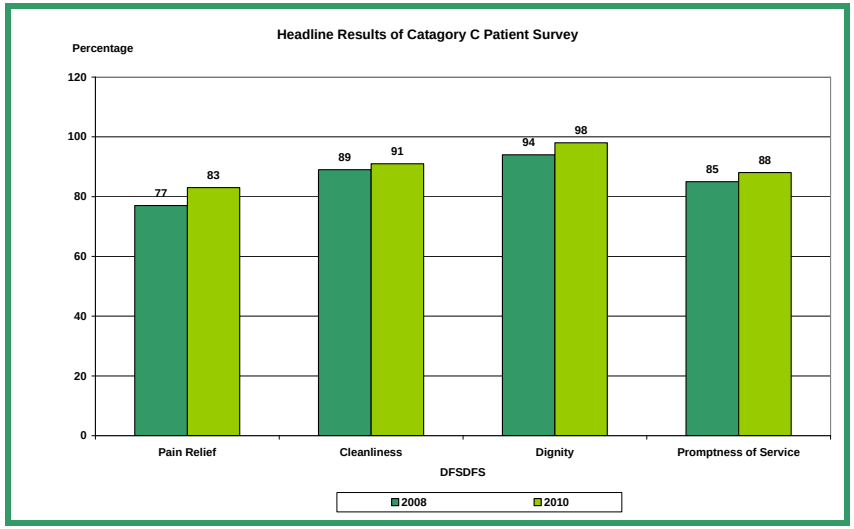
We also recognise that the 'seldom heard' groups (e.g. minority ethnic communities, particularly those who do not speak English, faith communities, travellers, gay men and women, transsexual and transgender individuals) often find traditional mechanisms for providing feedback challenging, and we are currently working with umbrella organisations to improve our stakeholder engagement and promote the use of Patient Opinion.

Currently the majority of comments are coming from patients and relatives within our least deprived areas, and are predominantly positive in their comments.

We have also undertaken a quality survey of Category C patients based on a sample of 850 service users who accessed the service in July 2010. This excluded children aged less than 18 years of age and those known to be deceased. We achieved a response rate of 28% (240/850) by the cut off date of the 1st December 2010.

The same methodology as the 2008 survey was used so that we could undertake some comparative analysis. (Results from 2008 are shown in brackets.)

The headline results show that the trust has improved the care it delivers to Category C service users through the provision of a high quality service in areas such as pain relief 83% (77%), cleanliness 91% (89%) , dignity 96% (94%) and promptness of response 85% (88%)



INFECTION PREVENTION AND CONTROL

The trust has expanded team resources this year with an emphasis on embedding infection prevention and control principles in every day clinical practice and ensuring audit compliance with hand hygiene and all aspects of the trust policy.

Areas of significant achievements for this year have included;

- **All new job descriptions now contractually oblige staff to comply with IPC policies and procedures.**
- **A standard cleaning contract for premises and healthcare associated areas has been awarded.**
- **A sluice refurbishment programme has been completed.**
- **A new audit programme to assure staff compliance with the trust IPC policy including the cleanliness of our vehicles and buildings has been implemented with results being reported to the quality committee**

- **Patient transport vehicles are now included within the 'make ready' team deep clean programme.**

Through the quality committee the trust board is assured that there has been continual improvement since the satisfactory inspection carried out by the Care Quality Commission in 2009.

SAFEGUARDING CHILDREN AND VULNERABLE ADULTS.

The trust has continued to ensure that safeguarding principles are embedded in every day clinical practice and to ensure compliance with all aspects of the Public Protection and Safeguarding policy.

In addition the trust has continued to work with the local safeguarding boards and to submit Individual management reviews for all serious case reviews to ensure lessons are learnt and embedded into future learning initiatives.

Areas of significant achievement in safeguarding children and vulnerable adults for this year have included

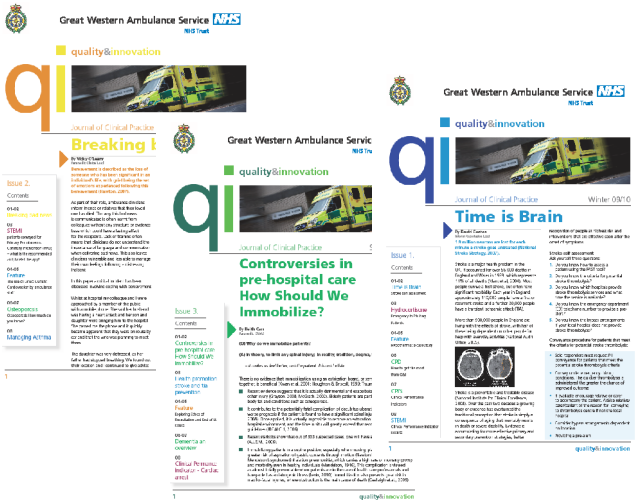
- **Inclusion of safeguarding contractual obligations in all new job descriptions to make safeguarding the responsibility of all trust employees**
- **Ensuring that all prospective and employed staff is verified in relation to Criminal Records Bureau checks**
- **Through staff education and awareness programmes facilitate a steady increase of referral rates**
- **Development of safeguarding advice and information for employees on the trust intranet**

QUALITY AND INNOVATION.

In 2010 the trust launched the first edition of Quality and Innovation, an in-house journal of clinical practice. It is published quarterly and is designed to share essential clinical messages and evidence based information to all our staff that has contact with patients.

Quality and Innovation recently celebrated its first anniversary and last year published some 31 articles written by both trust clinicians and external agencies.

REVIEW OF QUALITY PERFORMANCE



Topics covered have included Osteoporosis written by the National Osteoporosis Society, Hydrocortisone Emergencies in Pituitary patients written by the Pituitary Foundation, Dementia written by the Alzheimer's Society. Local articles such as Controversies in pre-hospital care - how should we immobilise? which also won article of the year, and a feature on other subjects included breaking bad news, have also featured.

In addition to the publication, the trust has also held a number of conferences for staff with guest speakers covering subjects on dementia - including a carer's perspective, end of life care and spinal immobilisation.

STATEMENTS FROM STAKEHOLDERS