North West Ambulance Service NHS

NHS Trust

your lifeline to health care

Delivering the right care, at the right time, in the right place

NORTH WEST AMBULANCE SERVICE NHS TRUST

QUALITY ACCOUNT

2010/2011

1 Chief Executive's Statement

Welcome to the second Quality Account published by North West Ambulance Service NHS Trust (NWAS) that covers the period April 2010 to March 2011.

I am pleased to report that the Trust has built on last year's account with a focussed emphasis on the issues of the clinical quality of the services we offer. At Board level we are advised by two experienced directors, Professor Kevin Mackway-Jones our Medical Director and Sarah Byrom our Director of Performance and Patient Experience and Director of Nursing. Between them they have championed the importance of quality at Board level and through the organisation to the staff and volunteers who deliver and support care across the North West.

The Trust has developed its own statement of what quality means for an ambulance service. This is that we aim to deliver:

Right care, Right time, Right place

This statement demonstrates the idea that excellence for this Trust is not solely about the speed of response, although this remains important, but is dependent on ensuring that the right decisions are made about delivering the care that most meet the needs of an individual patient. These decisions require a highly educated and competent workforce supported by appropriate clinical leadership. This applies in all four areas of care that we provide: emergency and non-emergency ambulance services, Control Centres and our considerable commitment to Emergency Preparedness.

I believe that we have a very good story to share about quality in NWAS over the last year. For example, we set challenging targets for improvement in our Clinical Performance Indicators and most were met. What is pleasing is the way in which they are now becoming an established part of the way that we work and we expect to show further progress next year.

Inevitably our narrow failure to meet the Category A response target is disappointing, and it is frustrating that the margin by which it was missed was very small. Undoubtedly the extended period of atrocious weather and very high levels of demand in December and early January severely affected our ability to respond to 999 calls. I want to pay tribute to all the staff of this organisation and the many volunteers who support us for the superb efforts made to deal with this challenge and I can assure the public that we will redouble our efforts to improve our response time performance in 2011/12.

Darren Hurrell
Chief Executive

2 Looking Forward to Improving Care

Last year we identified five areas where we were committed to delivering improvements in the services that we offered. In this section we will report on how we met those commitments, and identify any further progress needed. We will also report on three key areas for further development in 2011/12.

2.1 End of Life Care

Last year we stated that we were "determined to make the experience of our services as good and personalised as possible for those people nearing the end of their lives".

Significant progress has been made during the last year in relation to developing End of Life care (EoLC). The Trust was successful in securing funding to support the recruitment of an End of Life Project Lead in December 2010. There have been three key areas of development:

1. The development of Rapid Transfer Procedures and integration with a number of hospital rapid discharge procedures. The Trust has continued to operate a significant pilot in the Southport and Ormskirk area and implemented a second pilot with Tameside General Hospital in March 2010. The procedures aim to provide a 2 hour response for End of Life rapid transfer bookings, enabling patients to die in a setting of their choice.

2. Development of a web-based application called Electronic Referral and Information Sharing System (ERISS), to support the sharing of information by health professionals for EoLC patients. This will enable NWAS to alert ambulance staff to the presence of Advanced Care Planning tools such as Preferred Priorities for Care or Do Not Attempt Cardio-pulmonary Resuscitation (DNACPR) documents. This enables patient's wishes to be met and avoids unnecessary hospital admissions. NWAS has been working with in excess of 10 organisations (PCTs, GP Practices, Hospices, OOH providers and acute trusts) across the NW to pilot the ERISS application. It planned to go live with the pilot sites during mid-June 2011.

3. The production and issue of an End of Life Care Educational Guide for all NWAS frontline staff, which provides an overview of national and regional End of Life care developments, care planning tools and advice on how to care for patients at the end of their life. A series of educational events have also been organised and delivered across the North West, supported by local universities, hospices and Palliative Care Consultants. Revisions to core training and university educational programmes have been started, which will continue during 2011/12.

End of Life Care – Going Forward

The Trust will continue to develop the work undertaken during 2010/11 and expand the number of pilot sites for End of Life rapid transfers. Similarly, the Trust aims to significantly expand the information sharing for End of Life Care Planning across the North West. The education of the workforce also continues to remain a priority and work is already underway to plan and deliver a further series of educational events across the North West. The development of E-learning, including access to the national e-learning modules for End of Life Care will be also be progressed.

2.2 Frequent Callers

Last year we said that during 2010/11 we will take the first steps towards a "Single Point of Access" for urgent and emergency care. We also said that we would work with PCTs to address the issue of frequent callers who use the 999 system disproportionately

We have made good progress in partnership with our PCT colleagues in preparing for the introduction of a new means of prioritising calls and identifying the most appropriate care. This is a triage system called *NHS Pathways*. We believe that this is a positive move towards coordinated and effective care for the many people with an urgent rather than an emergency problem who now ring for an emergency ambulance because they have no alternative available.

Nationally, progress is being made towards the introduction of a single 111 number for all non-emergency health-related calls. The Trust is actively involved in this development.

In response to the issue of frequent callers, information is produced on a monthly basis identifying the source of 999 incidents by postcode. The frequent callers' information is sent to the Urgent Care lead in each PCT. Additional information is provided by request, such as further analysis to identify the type of incidents occurring nursing homes. This enables the PCT to provide advice and support to nursing homes to prevent unnecessary emergency calls.

2.3 Chain of Survival and Complementary Resources

Last year we said that during 2010/11 we will expand the Chain of Survival scheme further to cover more areas in the North West. We will also expand our network of volunteers in line with emerging health policy.

To this end, a Complementary Resources strategy was adopted by NWAS Trust Board in March 2011. This provided the basis for an additional 20 Community First Responder (CFR) teams, 20 Establishment Based Responder (EBR) teams, 125 Public Access Defibrillators, and 50 NWAS Staff Responders in 2011/12 and again in 2012/13. The strategy also involved further development of the Chain of Survival Partnership and further support has been provided by the British Heart Foundation who are providing funding for more AEDs and training staff to further this approach in 2011/12 and 2012/13.

During 2010/11, 150 Automatic External Defibrillators (AEDs) were placed with people trained to use them. The target of 125 was achieved and exceeded.

The objective of 425 people trained to use AEDs has been achieved and exceeded. The actual figure for people trained is 1,659.

In addition, the Trust supported the following developments:

- 3,809 people trained in Basic Life Support
- 286 New Community First Responders
- 501 Reassessed in AED (Establishment Based Responders - EBRs)
- 961 Reassessed CFRs
- 105 New EBR sites
- 45 New CFR Teams
- 75 New Heartstart Trainers
- 40 EBR Trainers
- 48 Field Trainers CFRs

The Trust hosted its very first Annual Community First Responder (CFR) Conference to over 200 guests and CFRs on Saturday 26 March 2011, at Lancaster University Conference Centre. It was a great success. The Community First Responders 'Year in review' was also launched at this event providing a review of the work undertaken by the Trust's CFRs over the course of the last year. This is the first time such a document has been produced and it highlights the key successes and developments over the past 12 months. The full document can be viewed on our website at:

www.nwas.nhs.uk/internet/OurServices/CommunityFirstRespondersCFRs

In 2011/12 we will deliver the second phase of the Trust's Complementary Resources Strategy:

- 20 additional Community First Responder Schemes
- 50 additional staff responders active
- 125 additional AEDs installed in public places

We will also introduce an Extended First Responder role where some individuals will be trained to higher levels to be able to deliver a broader range of immediate care until ambulance personnel arrive on scene.

2.4 Acute Stroke Care

Last year we said that: "During 2010/11 we will introduce "hyper acute pathways" for patients who could benefit from thrombolysis (clot busting) therapy in the early stages of thrombolytic stroke (stroke caused by a blood clot) at a specialist hospital. This may involve patients travelling further by ambulance, but outcomes for patients will improve as a result".

Greater Manchester fully integrated stroke service with direct access to specialist stroke centres was completed during 2010/11.

A Telestroke solution has been implemented by Cumbria and Lancashire Stroke Network for the population of the area. NWAS supports this by providing pre-alert for FAST positive patients and by the direct referral of stroke patients in Chorley/Preston to a specialist unit in Preston.

Work is continuing with the Cheshire and Merseyside Stroke network to implement a solution in that area. These developments are now offering the potential to significantly improve the care offered to stroke patients. In partnership with our hospital colleagues, we will continue to monitor closely what impact the new services have on survival rates, and on the outcomes for patients.

In 2011/12 this process will be continued by NWAS and the stroke networks to ensure that this service is embedded to deliver benefits to all patients suffering thrombolytic stroke.

2.5 Heart Attack

New developments in the treatment and care of people following a heart attack include an option for some people of a surgical procedure called Primary Percutaneous Coronary Intervention (PPCI) in the early stages. This has been clearly shown to deliver even better results.

Last year we said that during 2010/11 we will provide a rapid response, clinical assessment and direct transportation for eligible patients to nominated specialist treatment centres.

All areas of Greater Manchester are now using direct referral pathways for PPCI patients with direct access to specialist centres.

Merseyside and Cheshire have rolled out direct referral pathways to all areas, the final one being Central & Eastern Cheshire which went live in April 2011, completing the provision of direct access to PPCI for the population of that area.

Lancashire commissioners and Cardiac Network have agreed PPCI pathways and funding for the required ambulance resources for implementation in 2011.

Cumbria PPCI arrangements are not yet finalised and we are working with the Cardiac Network and commissioners to agree an implementation plan.

In 2011/12 we will continue to work with partners and our staff to thoroughly embed these new arrangements in order to deliver measurable benefits to patients. These outcomes will be reflected in the new national ambulance quality indicators.

2.6 Further developments for 2011/12

In our Quality Account we have the opportunity to describe what we are doing to improve the way we measure and manage quality in our Trust, delivering real improvements in the quality of our care. Three major developments for the Trust in the management of quality are:

1. *Introduction of the new national quality indicators for ambulance services*
   In a very positive development for ambulance services, the Department of Health have introduced a set of 13 new quality indicators to assess the quality of emergency ambulance services. These complement the existing response time measures by identifying the clinical outcomes of the care that we provide. Ambulance Trusts nationally are working together to ensure effective collection and assessment of information to allow national comparison and promote quality improvement. Performance against these indicators will be reported in next year's Quality Account.

2. *Development and implementation of the Trust's Quality Strategy*
   This year we are developing a single Trust-wide framework for all quality measures, to ensure that staff at all areas and levels of the organisation know how they are contributing to the delivery of "right care, right time, right place". This will be included within an overall Quality Strategy that will be published and approved by the Trust Board in the summer.

3. *Further development of Clinical Leadership and Education*
   The Trust identified some years ago that the delivery of good quality clinical care requires investment in clinical education and leadership.

   From this year all new paramedic staff will undertake a graduate programme. In the meantime, 900 of our existing paramedic staff have been supported to undertake part time diploma and degree programmes.

   The Trust has appointed 36 Advanced Paramedics to provide clinical leadership to clinical staff, including appraisal, audit of clinical performance and direct support on challenging cases. This has led to a significant improvement in the confidence and competence of our clinical staff. This can be evidenced by the improvements against Clinical Performance Indicators discussed in section 4.2.1

3 Formal Statements on Quality

The Trust is required to make the following formal statements within its Quality Account:

3.1 Review of services

The Trust has reviewed all the data available on the quality of care in the services provided by us in 2010/11. The income generated by the NHS services reviewed in 2010/11 represents 100 per cent of the total income generated from the provision of NHS services by the Trust for 2009/2010.

3.2 Participation in clinical audits

During 2010/11, the Trust participated in two national clinical audits and no national confidential enquiries relevant to NHS services that the Trust provides. During that period the Trust participated in 100% of national clinical audits that it was eligible to participate in.

The national clinical audits and national confidential enquiries that NWAS NHS Trust was eligible to participate in during 2010/2011 were:

- MINAP (Myocardial Ischaemia National Audit Project) a national audit of the care of patients suffering a heart attack.
- TARN: (Trauma Audit and Research Network) a national audit of the care of patients suffering acute trauma.

Ambulance services are not required to register cases for these audits, but provide appropriate information on request.

The reports of no national clinical audits were reviewed by the Trust in 2010/2011.
The reports of no local clinical audits were reviewed by the Trust in 2010/2011.

3.3 Participation in clinical research

The number of patients receiving NHS services provided or sub-contracted by NWAS NHS Trust in 2010/11 that were recruited during that period to participate in research approved by a research ethics committee was nil.

3.4 Use of the CQUIN payment framework

A proportion of NWAS NHS Trust income in 2010/11 was conditional on achieving quality improvement and innovation goals agreed between NWAS NHS Trust 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 are available electronically at www.nwas.nhs.uk.

3.5 Statements from the CQC

The Trust is required to register with the Care Quality Commission and its current registration status is that it is registered without conditions.

The Care Quality Commission has not taken enforcement action against NWAS NHS Trust during 2010/11

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

3.6 Statement on relevance of Data Quality and your actions to improve it

3.6.1 NHS Number and General Medical Practice Code Validity

NWAS NHS Trust did 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.

3.6.2 Information Governance Toolkit attainment levels

NWAS NHS Trust Information Governance Assessment Report score overall score for 2010/11 was 63% and was graded red. The assessment system changed in 2010/11 and although the overall score increased on the previous year, the amber category was removed leading to a red rating. Action plans are in place to ensure that the Trust achieves the requisite level in 2011/12.

3.6.3 Clinical coding error rate

NWAS NHS Trust was not subject to the Payment by Results clinical coding audit during 2010/11 by the Audit Commission

4 Looking back to 2009/2010 - Review of Quality Performance

The Trust has identified a range of indicators to report on the quality of care following consultation with PCTs, Overview and Scrutiny Committees and Local Improvement Networks. They have been grouped under the three aspects of clinical quality:

- Patient Safety
- Clinical Effectiveness
- Patient Experience.

4.1 Indicators of Quality – Patient Safety

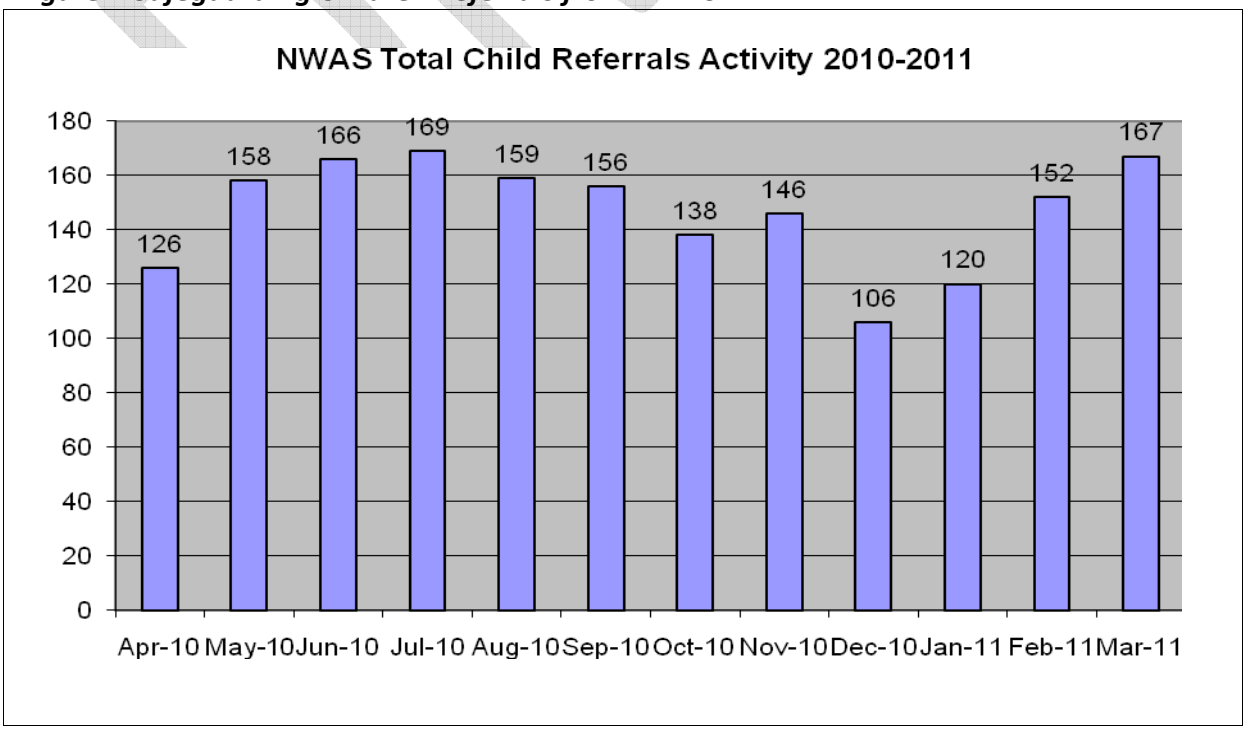
4.1.1 Safeguarding Services

The Trust takes its safeguarding responsibilities seriously and as such continuously reviews what needs to be done to make sure that arrangements are in place to safeguard the most vulnerable people it interacts with, including children and adults with conditions such as learning difficulties and relevant clinical conditions. We continue work with Safeguarding bodies across the region to support local arrangements.

The Trust has a part time Safeguarding Practice Manager, a full time Safeguarding Practitioner with a second Practitioner post approved and being recruited to and a full time Safeguarding Administrator. The team provides training and support for staff, reviews and manages referrals and supports the serious case review processes for both adults and children.

During 2010/11, the Trust has introduced a centralised safeguarding referral pathway for both adults and children and associated Policies and Procedures have been reviewed, updated and approved to reflect this significant change in process. The Trust's safeguarding activity reporting is currently supported by a secure safeguarding electronic database and the further development of paperless referral and information systems is an identified priority for the year ahead.

Figure1: Safeguarding Children Referrals from NWAS



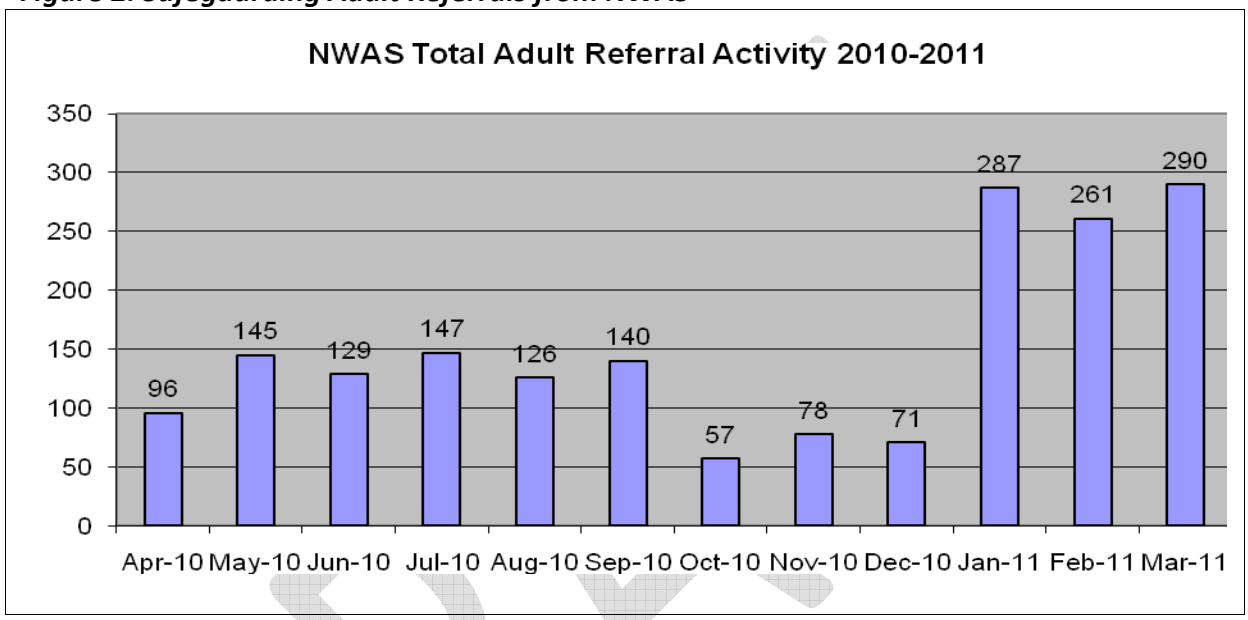
Comparative information (April to March 2009/10 and 2010/11) shows an increased rate of child referrals per month compared to the previous year. This indicates that staff are using the system more.

Vulnerable Child Referrals were in two broad categories of safeguarding concerns:

(i) **Concerns for parental capacity** due to the intake of alcohol and/or drugs or attempted drug overdose.

(ii) **Concerns for parental neglect** due to environmental related issues.

Figure 2: Safeguarding Adult Referrals from NWAS



The monthly Vulnerable Adult Referrals are shown in the figure above. Within the total there were two broad categories of safeguarding concerns:

(i) **Concern for welfare** involving health and/or social care needs assessment. Within this group, themes of neglect and mental health or emotional concerns predominate;

(ii) **Third Party incidents of abuse** involving themes of carer support, domestic abuse and care home standards.

While the majority of the referral relate to category (i), the reported levels are on the increase in both categories.

Domestic Abuse

During 2010/11 the Trust established a domestic abuse task and finish group and has now established an approach to support its clinical staff in identifying and signposting for support, those patients and their "immediate others", whom they come across in the course of their clinical duties who may be impacted by domestic abuse.

The effectiveness of this approach will be monitored through the feedback received during future mandatory awareness training and the trends identified by referral activity patterns.

The Trust has also introduced manager and employee guidance to support those employees directly affected by domestic violence.

4.1.2 Clinical Safety Incident Reporting

The Trust promotes incident reporting positively and we aim to identify learning outcomes and implement appropriate service developments to address areas of weakness.

All clinical and patient safety incidents are recorded and assessed for trend and cause analysis. This enables us to identify the underlying root cause or particular key causes of incidents and ensure the development of improvement strategies to prevent re-occurrence and to mitigate any identified risks. The Trust has an Incident Learning Forum, chaired by a Non Executive Director, which considers any identified trends and seeks assurance that appropriate action plans are in place to address weaknesses.

Clinical safety incidents are categorised by the Healthcare Governance Department to allow for National Patient Safety Agency reporting and to assist with the identification and implementation of learning outcomes.

The process for managing external clinical and patient safety incidents raised by other healthcare organisations undertaken by the Trust ensures that all incidents, however they are reported, are managed appropriately and in a timely manner. This ensures that serious issues are addressed and that lessons to be learnt are identified and actioned. This process has been greatly assisted, during the investigation stages, by utilising the clinical expertise of the Advanced Paramedics.

During the year a total of 1289 clinical and patient safety incidents were reported and resolved, which is a 20% increase from last year. Of these, a total of 353 incidents were reported to the NPSA and 15 incidents were reported using the NHS North West's Strategic Executive Information System (StEIS).

The system for reporting MHRA incidents has been reviewed to ensure that all incidents that include equipment failures are now, where appropriate, reported centrally.

Figure 3: Clinical Safety Incidents by Type 2010/11

Type of incident	No. of incidents
Access/admission/transfer issue	243
Controlled Drugs	229
Equipment Fault	136
Consent/Communication/Confidentiality	111
Medicine Management	108
Clinical Assessment	80
Clinical Treatment	74
Slips, Trips or Falls	67
Infection Control	59
Documentation	54
Manual Handling	54
Verbal Abuse	23
Sharps Injury/ Incident	17
RTC/ Vehicle	14
Physical Abuse	12
Exposure to Harmful Substance	4
Vehicle Failure	2
Abuse of Service	1

Equipment Failure	1
Totals:	1289

Figure 4: Patient Safety incidents by type 2010/11

Incident Type	No. of Incidents
Equipment Fault	65
Access/admission/transfer issue	64
Slips, Trips or Falls	53
Manual Handling	41
Clinical Treatment	39
Consent/Communication/Confidentiality	28
Medicine Management	14
Clinical Assessment	13
RTC/ Vehicle	13
Controlled Drugs	9
Documentation	6
Sharps Injury/ Incident	4
Verbal Abuse	2
Infection Control	1
Physical Abuse	1
Totals:	353

4.1.2.1 Infection Prevention and Control

Infection Prevention and Control Structure

The Trust's Medical Director fulfils the role of Director of Infection Prevention and Control (DIPC). The role is supported by the Head of Clinical Safety, and three full time Specialist Paramedics in Infection Prevention and Control (SPIPC). The team are responsible for training and supporting staff and providing assurance that stations and vehicles are clean through independent audits.

The Trust has more than 100 staff acting as Infection Control Champions, supporting the Specialist Paramedics. These are volunteer members of staff who have a particular interest in improving infection, prevention and control standards, taking a lead role in their location.

During 2010/11 the Infection Prevention and Control Policy and associated procedures were updated and approved by the Board of Directors.

Deep Cleaning arrangements for all vehicles are in place to ensure that every vehicle is taken out of service at a designated interval and given a thorough deep clean by a dedicated team using specialised steam cleaning equipment.

Healthcare Associated Infection (HCAI) Incident Reporting

During 2010/11 66 incidents were reported:

Figure 5: HCAI Incidents 2010/11

Incident type	No. of incidents
Contact with bodily fluids	22
Contaminated vehicle	13
Contaminated Equipment	11

Not Notified of patient's infection status	10
Staff welfare	6
Crew contact with known infectious disease	3
Sterile Equipment	1
Totals:	66

The Trust has learnt a number of useful lessons from this process. Examples are:

- We continue to see a growing trend in staff reporting incidents where blood, spit or vomit has been splashed into the staff's face and eyes.

These incidents are investigated and staff are offered support and an Occupational Health review. To prevent incidents such as this the use of Perspex glasses is recommended and an article has been written to reinforce this message to all staff. A review of eye protective goggles across the Trust is taking place to ensure that the most appropriate goggles are provided as standard PPE.

There have been 10 reported incidents of staff not being informed of the infectious status of patients they have been asked to transport. This is a particular issue with some nursing homes.

Wherever possible, these incidents were dealt with immediately by the SPIPC or local manager contacting the establishment and reinforcing the message that our staff must be informed about this type of risk. Action is being taken to ensure that when taking patients details Control and Planning obtain this kind of information and relay it to our staff.

- Bulletins and posters have been produced and displayed in staff areas to highlight information on correct waste management and sharps disposal following several incidents where poor practice was identified.

The Trust undertakes Infection prevention and control audits, reporting to local teams, managers and the Board of Directors.

- Quarterly Service Delivery audits of the cleanliness of vehicles (including the deep clean process) and ambulance stations.
- Quarterly independent Specialist Paramedic audits of the cleanliness of vehicles and ambulance stations.
- Random manager spot check audits of the cleanliness of vehicles and stations.

4.2 Indicators of Quality – Clinical Effectiveness (Emergency Services)

4.2.1 Clinical Performance Indicators (CPIs)

As reported last year, the Trust has developed a set of measures that identify how close staff are performing to a set of prescribed actions that are applicable in each of six clinical situations. The six areas identified are: Asthma, Cardiac Arrest Management, Hypoglycaemia (low blood sugar) Management, Pain Management, PRF (Patient Report Form) Completion and Stroke Management. We call these our Clinical Performance Indicators.

The expected interventions for each clinical condition are grouped into sets of required clinical interventions known as "Care Bundles". Clinical effectiveness is measured in terms of all the interventions in the care bundle being carried out on each patient. A score of 50% means that half of all patients seen with a condition have received the complete bundle of interventions required. The

remaining patients will have had a proportion but not all the interventions specified for that clinical condition. As the needs of individual patients vary, a score of 100% would not necessarily be expected at all times.

Progress on these CPIs is reported to each meeting of the Board of Directors. 2010/11 was the first year that NWAS established stretch targets for CPI Care Bundles. 4 of the 6 indicators achieved in excess of 10% improvement on the Q4 performance for 2009/10. An impressive 34.7% improvement was made in the treatment of low blood sugar (hypoglycaemia). Cardiac Arrest achieved a 2.6% improvement in performance from Q4 last year.

Stroke was the only indicator to perform less well compared to Q4 2009/10. There was a significant dip in performance from May to July, which reflects a reduction in the number of blood glucose measurements and respiratory rates being recorded. Improvements in these areas were made in Q3 and 4 of 2009/10. However, the addition of a new metric in July for pre-alerting Emergency Departments (against which the Trust did not perform well) limited any performance gain. A new analysis report has now been developed to help identify more easily performance issues within each bundle; enabling more rapid and focused quality improvement actions. Figure 6 provides a summary of performance for the year.

Care Bundle Topic	Q4 2009/10 Performance (%)	Q4 2010/11 Stretch Target (%)	Q4 2010/11 Actual Performance (%)	Variance from (09/10 Performance) (%)
Asthma	45.9	55.9	63.8	+ 17.9
Cardiac Arrest	50.4	60.4	53.0	+2.6
Hypoglycaemia	48.7	58.7	83.4	+34.7
Pain Management	61.8	71.8	79.0	+17.2
PRF Completion	66.6	76.6	77.7	+11.1
Stroke	66.9	76.9	58.4	-8.5

Figure 6: CPI Care Bundle Performance Q4 2009/10 against Q4 2010/11

CPIs – Going Forward

Various approaches have been introduced to encourage improved performance, including an incentive scheme that rewards local budgets for good performance. Given the success of the incentive scheme, a point based scheme is currently being developed as a proposal to help sustain and improve clinical performance during 2011/12. The proposal will consider the use of Advancing Quality monies received in 2011/12 to provide a benefit to local budgets for the points. It is also planned to agree a series of stretch targets for the care bundles for 2011/12. The proposal will be submitted to the Trust Executive Management team for further consideration during May.

4.2.2 Thrombolysis/Reperfusion

As national arrangements have now changed since last year's Quality Account, the Trust is currently unable to provide details of 2010/11 performance in relation to reperfusion performance. The validation of data (nationally) is not completed until the end of September 2011. Trusts are officially notified of their performance soon after validation has been completed. Performance will be reported publicly to the Board of Directors.

4.3 Indicators of Quality – Patient Experience

4.3.1 Access (Emergency Services only)

Ambulance services have always been judged by the speed with which they respond to 999 calls, and this is a critical measure of the quality of care. In 2010/11, Ambulance services in England were required to report on their response times for three different categories of calls.

Category A (Red)	Immediately life-threatening
Category B (Amber)	Serious but, not immediately life-threatening
Category C (Green)	Other

For Red calls, Trusts are expected to respond to at least 75% within 8 minutes of the call being received and 95% within 19 minutes of being received. The target for Amber calls is 95% within 19 minutes. This is measured as a total figure for the whole of the North West. There is variation in performance between urban and rural areas because of the variation in the spread and density of populations.
The Trust aims to pick up 95% of 999 calls within 5 seconds of receipt.

Over the last two years our year end position has been:

Indicator	Target	Performance 07/08	Performance 08/09	Performance 09/10	Performance 10/11
Response time (A8)	75%	75.61%	74.32%	73.04%	73.64%
Response time (A19)	95%	97.54%	96.47%	95.44%	95.66%
Response time (B19)	95%	90.99%	87.62%	85.89%	87.00%
Call pick-up	95%		94.72%	95.2%	96.60%

Although performance on all four measures has improved, it is again disappointing to note that the main target, A8, was again not met. This does, not, however show the full picture. We have improved the way in which our resources are deployed and used, and are now responding to more patients, more quickly, than ever before. This is demonstrated by the fact that for the North West as a whole we met the 75% target in all but one quarter of the year. The target was met for the full year in Cumbria and Lancashire.

	Quarter 1 Apr-Jun 2010	Quarter 2 Jul-Sep 2010	Quarter 3 Oct Dec 2010	Quarter 4 Jan-Mar 2011
Response time (A8)	75.96%	76.09%	67.95%	75.21%

Performance in Quarter 3 was severely affected by a significant rise in demand compared with that expected, and an extended period of very severe weather. Excluding the four weeks in December when weather conditions and demand were at the most challenging, the Trust's performance for the year would have been 75.15%, meeting the national target.

The NWAS Board has paid tribute to the superb efforts of staff in the Control Centres and on the Road to continue to deliver a remarkable level of service in exceptionally difficult circumstances. The

Board also registered its thanks to the many agencies and voluntary bodies, including the Voluntary Ambulance Services and Mountain Rescue Teams, who worked so hard to support the Trust and the populations we serve.

The Trust has not been in a position to meet the Category B target for some years now. An independent capacity review led by the PCTs who commission ambulance services in the North West confirmed that the Trust is not resourced to a level to meet this target. For 2011/12 a national policy decision has been made to remove the B category and new arrangements are currently being made to transfer calls previously placed in category B into a remodelled set of categories. This will allow ambulance services to provide a more flexible and appropriate response that better meets the individual needs of patients.

Should you require further information at a more local level please contact the Trust as detailed on the inside back page.

Patient Transport Service/Planned Care

With the adoption of a single contract for PTS services from April 2011 the Trust will now be able to report on performance against a single set of quality standards for this service. This will be reported publicly to Board meetings through the year and then included in next year's Quality Account.

4.3.2 Patient and Public Engagement

One of the major challenges for this Trust is that it covers a huge geographical footprint and so has a very large and diverse range of stakeholders and communities. The Trust is committed to engaging positively with as wide a range of groups and individuals as possible in order to provide services that meet the needs of the communities we serve. The Board has approved an engagement strategy that sets out how we aim to go about this. As well as statutory bodies such as Overview and Scrutiny Committees (OSCs) and Local Involvement Networks (LINks), the Trust actively engages with and responds to a wide range of bodies, linked to specific locations and groups, as well as regularly contributing to Health Melas, PRIDE and other community events across the region.

The biggest single event for 2010/2011 has been a formal consultation on the Trust's application for Foundation Trust Status. Managers from the service attended public meetings and other events throughout the North West to explain our proposals and seek feedback and comment. The report on the findings has been submitted to the Board of Directors and is available on the website www.nwas.nhs.uk.

One of our key tasks for the year ahead is to recruit a large public membership that represents the whole region for FT status. This will build on our already successful Critical Friends network which has proved invaluable as a resource to gain the views of the public and to support to the Trust in a number of areas.

Other highlights from 2010/11 have included:

- regular meetings with the Liverpool Somalian community, resulting in the recruitment of 5 out of an initial 8 BME appointments to the Trust's Patient Transport Service,
- liaison with the Deafness Network resulting in a partnership event for children of deaf and deaf adults. Feedback received included requests for SMS texting and the development of an emergency service pictorial communication handbook (building on the success of the Patient Transport Service version). The texting service is now going national following the local pilot and the pictorial handbook is in production, developed in partnership with Salford City Council.

- engagement with the Lancashire Council of Mosques resulting in the training of 144 individuals from ethnic minority groups in Heart start and basic first aid training
- the Trust's own E&D Celebration of Diversity in the Community event. This was delivered with NHS partners resulting in opportunities to work with learning disability and mental health groups. Feedback on all aspects of the patient journey and work of the service has been used to improve access to services and patient experience.

The Trust seeks information about patient experience in many different ways. Perhaps the most noteworthy this year has been the Patient Experience programme developed with special funding from the CQUIN programme. Some of the findings are shown below to give a picture of the way in which the Trust is approaching this vital issue:

NWAS Patient Experience programme 2010/11

The Trust launched a programme of patient experience work in the autumn of 2010 to understand satisfaction levels and the patient experience of Category A and B patients brought into hospital via ambulance. The intended outcome of this scheme was to inform a long term sustainable programme for gathering information and measuring patient satisfaction of emergency patients. An initial analysis of complaints data was undertaken to gain an understanding of current patient feedback.

A real time face to face patient survey was undertaken in A&E departments for Category A and B patients following handover. A crowd sourcing programme (online and interactive form of staff consultation) was simultaneously introduced and an initial pilot study of both areas was completed in Bolton in the summer of 2010.

The full face to face programme involved a total of five hospital A&E's: Bolton, Liverpool, Countess of Chester, Blackpool and Furness General. It was delivered by staff and critical friends using mainly touch screen devices which were wirelessly linked to the Trust's analysis web software. 313 patients were interviewed. The crowd sourcing work involved a number of staff who were provided with a unique log on to a secure website where they could give their opinions and rate discussion topics to produce a different set of perspectives and make suggestions on what good patient experience looked like.

This was supplemented by two other methods, a short term marketing campaign to encourage feedback from any service users of the emergency service (via on line survey or telephone) and a retrospective survey.

There were high levels of public satisfaction levels demonstrated with 41% of those participating responding very positively to defined statements but also evidence that patients and their representatives found it difficult to describe what they expected from the service. The issues highlighted related to waiting times, handover and vehicle comfort.

The staff crowd sourcing was successful with staff enthusiastic about this type of approach and useful insight obtained regarding staff perspective of patient experience, public expectations and other service issues. Key themes included improved patient education and knowledge, better call filtering, and improved staff communication skills, increased use of senior clinical advice, improved communication between senior team and front line staff and greater celebration of success.

This was the first of this type of consultation and the Trust learned a great deal from the process. A service improvement plan and proposed sustainable programme have now been developed to take the Trust's patient experience agenda forward into 2011 and beyond. The Trust would particularly

like to thank the Critical Friends Network Core Group members who gave their time to support the initiative, and all staff who contributed.

4.3.3 Complaints, PALS and Compliments

In 2010/11 the Trust received a total of 483 complaints, 2007 PALS contacts and 712 compliments. A monthly breakdown is shown below.

COMPLAINTS													
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
2008/2009	27	32	33	37	20	41	37	32	31	34	26	22	372
2009/2010	31	27	39	51	41	34	40	51	41	47	73	78	553
2010/2011	42	41	40	43	30	50	35	46	43	36	33	44	483

PALS													
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
2008/2009	121	124	102	139	106	129	147	104	110	136	137	160	1515
2009/2010	145	99	144	174	111	151	184	152	116	134	187	213	1810
2010/2011	159	140	195	155	161	130	112	173	150	173	185	274	2007

COMPLIMENTS													
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
2009/2010	63	41	62	57	73	45	53	67	35	62	47	65	670
2010/2011	62	67	66	62	56	66	61	67	46	68	50	77	748

Figure 8: Complaints, PALS and Compliments Data 2008/09, 2009/10 and 2010/11

The total number of complaints has fallen. In last year's Account we identified a spike of complaints in February and March 2010 that arose from the recent bad weather. That trend has settled in the last year and no spike arose this year. Both compliments and PALS show an increase in numbers compared to the same period in 2009/2010.

Patient Transport Service - Complaints

During 2010/11, 35.8% of complaints were about the Patient Transport Service. The main areas of concern as detailed below are delays in transport and failure to transport:

Complaints Categories	Cumbria Lancs	Cheshire Mersey	GM	Total	PTS Control	PTS Ops	VCS
Delay in PTS Transport	5	10	55	**70**	68	1	1
Failure to Transport (PTS)	6	7	40	**53**	48	5	0
Staff Conduct	8	1	5	**14**	0	12	2
Inappropriate Care	1	1	7	**9**	0	9	0
Staff Attitude	1	3	4	**8**	2	5	1
Transport Other	1	0	6	**7**	4	3	0
Communication	1	0	5	**6**	4	2	0
Driving Skills	1	0	1	**2**	0	2	0
Equipment problem or failure	0	1	0	**1**	0	1	0

Other	1	0	0	**1**	0	1	0
Totals:	**25**	**23**	**123**	**171**	**126**	**41**	**4**

Figure 9: PTS Complaint categories and geographical/service area data

Patient Transport Service – PALS

Figure 9 above shows the monthly breakdown of PALS concerns for the Patient Transport Service. As can be seen from Figure 10 below, the main areas of PALS concern for the Patient Transport Service are delays out of hospital and non arrival of transport, followed by communication and information and delays into hospital.

PALS Categories	Cumbria Lancs	Cheshire Mersey	GM	Total	PTS Control	PTS Ops	VCS
Delays out of Hospital (PTS)	37	61	146	**244**	234	8	2
Non arrival of Ambulance	11	30	126	**167**	147	19	1
Communication and information	20	88	51	**159**	153	5	1
Delays into Hospital (PTS)	27	35	75	**137**	116	11	10
Problems with transporting Patients	14	25	60	**99**	70	26	3
Attitude Staff	25	37	24	**86**	18	51	17
Expression of Concern	23	18	19	**60**	42	14	4
Non Provision of Ambulance	16	24	17	**57**	53	4	0
Care/ Treatment Given	2	8	12	**22**	5	17	0
Driving Standards	9	3	8	**20**	1	14	5
Other	2	9	5	**16**	11	5	0
Early arrival of Ambulance	0	4	5	**9**	9	0	0
Lost Property	0	5	3	**8**	2	6	0
Vehicle issues	2	2	0	**4**	1	2	1
Confidentiality	1	1	0	**2**	0	1	1
Discrimination	1	0	0	**1**	1	0	0
Totals:	**190**	**350**	**551**	**1091**	**863**	**183**	**45**

Figure 10: PTS PALS categories and geographical/service area data

By the nature of the informal, simpler and quicker service PALS is often best placed to resolve concerns and comments within or up to 2 working days (690 of a total of 1084). A further 136 were resolved within 3-5 working days and another 111 within 6-10 working days. 26 PALS concerns were referred to become complaints. See Figure 11 below.

PALS working days to resolve	Cumbria Lancs	Cheshire Mersey	GM	Total
0 - 2 working days	128	205	357	**690**
3 - 5 working days	38	34	64	**136**
6 - 10 working days	18	43	50	**111**

11 - 20 working days	4	32	55	**91**
20+ working days	1	34	21	**56**
Totals:	**189**	**348**	**547**	**1084**

Figure 11: No of working days taken to resolve PALS contacts, broken down into geographical areas

PALS referred to Formal Complaints													
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	**Total**
CL	1	0	1	0	1	0	0	0	0	0	0	0	**3**
CM	1	0	0	0	0	0	1	2	0	2	0	1	**7**
GM	4	1	1	2	1	0	0	1	0	2	2	2	**16**

Figure 12: No of PALS referred to complaints broken down into month and geographical areas

Paramedic Emergency Service – Complaints

The main areas of concern have focussed on delay in emergency response, followed by inappropriate care and thirdly, staff attitude. Staff attitude was recorded as the main area of concern in the 2009/10 Quality Account and there has been a slight improvement this year.

Complaints Categories	**Cumbria Lancs**	**Cheshire Mersey**	**GM**	**Total**	**CFR**	**Control**	**PES Ops**
Delay in emergency response	34	48	40	**122**	0	109	13
Inappropriate Care	12	22	27	**61**	0	4	57
Staff Attitude	14	12	23	**49**	0	5	44
Communication	3	2	9	**14**	0	6	8
Staff Conduct	4	5	5	**14**	0	1	13
Failure to Convey (PES)	5	2	5	**12**	0	11	1
Staff Comments	1	1	4	**6**	0	0	6
Other	2	2	1	**5**	0	3	2
Driving Skills	0	1	3	**4**	0	0	4
Policy/Procedure	1	0	3	**4**	0	2	2
Confidentiality	0	0	2	**2**	0	1	1
Discrimination	0	0	2	**2**	0	0	2
Misuse of Sirens	0	0	2	**2**	0	0	2
Delay in emergency transfer	0	0	2	**2**	0	1	1
Equipment problem or failure	1	0	0	**1**	0	0	1
Failure to Transport (PTS)	0	0	1	**1**	0	1	0
Formal complaint	0	0	1	**1**	0	0	1
IT or Technical problems	0	0	1	**1**	0	1	0
Damage or loss to property	0	0	1	**1**	0	0	1

Medical Records	1	0	0	**1**	0	0	1
Sirens	0	0	1	**1**	0	0	1
Transport Other	1	0	0	**1**	0	0	1
Totals:	**79**	**95**	**133**	**307**	**0**	**145**	**162**

Figure 13: PES Complaints categories and geographical/service area data

Paramedic Emergency Service – PALS

The numbers of Paramedic Emergency Service PALS cases have increased significantly in 2010/11 compared to 2009/10. The main areas of concern focussed on communication and information, followed by lost property and finally response times, closely followed by staff attitude (see Figure 14 below). It is noteworthy that staff attitude does not seem to have been such a major focus with complainants during the past twelve months.

PALS Categories	Cumbria Lancs	Cheshire Mersey	GM	Total	CFR	Control	PES Ops
Communication and information	31	84	49	**164**	1	88	75
Lost Property	15	71	42	**128**	0	2	126
Response Times (PEC)	22	62	27	**111**	0	105	6
Attitude Staff	22	50	38	**110**	0	15	95
Expression of Concern	29	35	12	**76**	0	30	46
Care/ Treatment Given	11	32	28	**71**	0	2	69
Driving Standards	12	12	12	**36**	0	1	35
Misuse of Sirens	6	4	14	**24**	0	1	23
Non- Provision of Ambulance	15	4	3	**22**	0	22	0
Other	0	6	6	**12**	0	4	8
Confidentiality	0	4	1	**5**	0	0	5
Discrimination	0	4	1	**5**	0	2	3
Non-arrival of Ambulance	0	0	5	**5**	0	4	1
Delays out of Hospital (PTS)	1	1	1	**3**	0	1	2
Problems with transporting Patients	2	1	0	**3**	0	0	3
Vehicle issues	0	0	3	**3**	0	0	3
Delays into Hospital (PTS)	0	0	1	**1**	0	0	1
Early arrival of Ambulance	0	0	1	**1**	0	1	0
Totals:	**166**	**370**	**244**	**780**	**1**	**278**	**501**

Figure 14 PES PALS categories and geographical/service area data

PALS working days to resolve	CL	CM	GM	Total
0 - 2 working days	86	162	132	**380**

3 - 5 working days	28	48	37	**113**
6 - 10 working days	34	39	22	**95**
11 - 20 working days	13	53	31	**97**
20+ working days	4	63	21	**88**
Totals	**165**	**365**	**243**	**773**

Figure 15: No of working days taken to resolve PALS contacts, broken down into geographical areas

As previously reported PALS is often best placed to resolve concerns and comments within or up to 2 working days (380 of a total of 773). A further 113 were resolved within 3-5 working days and another 95 within 6-10 working days. A total of 50 PALS concerns were referred to become complaints, see Figure 16 below.

PALS referred to Formal Complaints													
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	**Total**
CL	1	2	0	0	0	0	0	0	2	1	3	1	**10**
CM	1	2	1	5	2	0	3	5	2	1	0	0	**22**
GM	1	5	1	4	1	0	0	2	0	2	1	1	**18**

Figure 16: No of PALS referred to complaints broken down into month and geographical areas

Lessons learned

An essential aspect of the handling of complaints and PALS enquiries is to ensure that lessons are learned to ensure that the same mistakes are not repeated. The Trust has well-developed mechanisms to ensure that this happens, and has an Incident Learning Panel that reviews complaints and other incidents to ensure that the necessary processes have taken place. The Trust is publishing a detailed "4 C's" report to cover complaints, compliments, concerns and comments that have been received this year. This contains much more detail than is possible here, and this can be accessed on the website or on request from the Trust.

5 Statements from commissioning PCT, LINk and OSC

5.1 Overview and Scrutiny Committee

5.2 NHS Blackpool

5.3 Local Improvement Network

If you have any questions or concerns following reading this report please do not hesitate to contact the Trust.

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Should you wish to access any of the Trust publications mentioned in this Quality Account they can be accessed on the Trust website at www.nwas.nhs.uk.