



West Midlands Ambulance Service



NHS Foundation Trust



## West Midlands Ambulance Service NHS Foundation Trust

### QUALITY ACCOUNT

Quality Report 2014-15  
Summary Review of 2013-14

Trust us to care.



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## INTRODUCTION

Welcome to our Quality Account Summary, which aims to take the key highlights from the full Annual Report, The Quality Account 2013/14 which can be found at: <http://www.wmas.nhs.uk> in the section `About Us` clicking on Publications and selecting Quality Accounts.

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

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

***“Delivering the right patient care, in the right place, at the right time, through a skilled and committed workforce, in partnership with local health economies”***





## PART 1

### 1.1 Statement on Quality from the Chief Executive

Welcome to the West Midlands Ambulance Service NHS Foundation Trust's Quality Report which reviews 2013-14 and sets out our priorities for 2014-15. This account is an assessment of the quality of care patients received when they were in our care. The report details our commitment to delivering high quality care first time for the benefit of patients.

At the end of each financial year, it is always appropriate to look back and reflect on the past 12 months. There is no doubt that we have faced another very busy and challenging year. This is evident in our patient response year-end figures which show an excellent response to Red 1 calls, but unfortunately we narrowly fell short of the target for Red 2 calls for the first time in six years. Although we missed the target by an average of only 12 seconds, I am committed to ensuring all of our performance standards return to those expected from WMAS.



The pressures that our staff are now asked to work under is greater than at any previous time. To their outstanding credit they have operated to the highest standards and given everything in order to improve the quality of care for patients. I would therefore like to take this opportunity to record my gratitude to all of our staff and volunteers for the contributions that they have made in delivering patient care to the West Midlands.

We must not forget that the year has also brought success; we have increased the number of frontline clinical staff, which is an immense achievement in such challenging financial times. Even more clinicians will join the Trust during the next twelve months to further boost our frontline capability. We have also completed the rollout of the Make Ready Hubs which means vehicles are refuelled, cleaned and restocked for use by staff when they arrive for duty.

In November, WMAS was asked by local commissioners to step-in and take over the NHS 111 service across the majority of the West Midlands. I am delighted that in a very short time we were able to make significant improvements to the way the call centre operates for those patients seeking urgent medical assistance.

The Trust has continued to work with commissioners and stakeholders to make improvements to the service by addressing call demand increases, hospital turnaround delays and underfunding. It is only by dealing with these issues in a prompt and professional manner that we will ensure improvements for patients in the future.

On behalf of West Midlands Ambulance Service, I would like to present this Quality Account, we welcome your feedback and if you have comments on this Quality Account or the Trust in general we would be pleased to receive them.

*a. c. marsh.*

**Dr Anthony C. Marsh. QAM SBStJ DSci (Hon) MBA MSc FASI  
Chief Executive Officer**



## 1.2 Foreword from the Chair

I am very pleased to be able to review the past 12 months and be in a position to present this year's Quality Account in our first full year as an NHS Foundation Trust.

This year has been another extremely demanding one for the Trust with many challenges to overcome to ensure the highest standard of care to patients across the West Midlands region.

The high quality clinical care that is given to our patients on a daily basis remains exceptional and I wish to thank all our staff and volunteers for their dedication and hard work in support of this objective.



With staff, governor and stakeholder support, we continue to move forward with our ambitious programme for developing our ambulance service. Our governors, who contribute their time, experience and support to the Trust, have done exceptionally well to take on board the huge amount of information necessary to fulfil their role. With that knowledge, the Council of Governors has played a significant role during the first twelve months helping to shape the service and we look forward to continuing to work with them as we move forward with our strategy and vision to improve services for patients further.

We are continuing to take forward our innovative programme of capturing feedback from patients about their experiences of using our services. This information is used to inform our planning priorities for the coming year. I would encourage all of our patients to record their views on the service provided so that we can enhance the patient experience for all concerned.

Finally, I would like to take this opportunity to thank the executive team and my non-executive colleagues for their leadership and valuable expertise. The year ahead will be no less challenging. However, I believe that by working together we can make progress on our aim of delivering the best health care in the ambulance sector of the NHS. West Midlands Ambulance Service NHS Foundation Trust has achieved an excellent reputation based on high quality clinical care and performance and we intend to build on this in the years to come.

**Sir Graham Meldrum. CBE OStJ**  
**Chair**  
**West Midlands Ambulance Service NHS Foundation Trust**



## PART 2

### 2.1 Priorities for Improvements and Statements of Assurance.

#### 2.1.1 Patient Safety

Priority 1: Falls Pathway	
Rationale	Falls can have a devastating impact on quality of life and the Trust is committed to providing a safe environment where patients are protected from avoidable harm. This Trust wants to ensure that when our staff have face to face contact with someone who has fallen, the Trust will ensure that an appropriate referral is made to the correct service in order to ensure that person is assisted in the prevention of a fall in the future. This year we plan to develop further the falls pathway by focusing on working in collaboration in local areas after engagement with our patients and scrutiny boards and building on the Directory of Services for prevention and appropriate.
Measures & reporting to board;	Qtr. 1 : From the baseline of Calls WMAS received in 2012-13 related to falls to develop locally agreed pathways with participating CCGs and scope areas with falls services Qtr. 2: Areas without timely falls pathways and services to be raised with commissioners Qtr. 3: Education of local WMAS staff with Virtual learning Environment (VLE) Qtr. 4: Demonstrate referrals for each participating area made
Target	Increase referral to appropriate participating falls team by 25% See a reduction in attendance to Falls by 10%
By When?	31 March 2014
Outcome	Patient Safety will improve by identifying, managing and reducing falls
Baseline	TBC in Qtr1
Lead	Clinical Quality Manager with Directory of Service Leads
End of Year Review	
<p>Local engagement with commissioners has continued throughout the year. Virtual learning Environment (VLE) was not identified as the most appropriate method on this occasion therefore education has been increased locally (face to face) and regionally through regular briefing articles.</p> <p>Pathways for WMAS to refer into have been scoped across the region. The only fit for purpose scheme that has been commissioned is via the Staffordshire Telemed desk. This has been set up for 6 months and in this time 84 patients have been eligible to be referred to the falls team. The impact of this has yet to be realised for re-contact of the same patients to WMAS. The intention is now to demonstrate this scheme to other commissioners across the region as best practice. <b>ACHIEVED</b></p>	

Priority 2: Lower Limb Fractures	
Rationale	The purpose of this initiative is to introduce a KPI nationally to measure and improve the quality of care given to patients who suffer lower limb injuries.
Measures monthly reporting to board	KPI measures: Assessment of circulation distal to site of fracture recorded Two Pain Scores Recorded (before & after treatment) Analgesia administered
Target	>85% compliance with KPI measures
By When?	31 March 2014
Baseline	TBC in Qtr1
Lead	Head of Clinical Practice & Trauma Lead
End of Year Review	
<p>The National mean for this new KPI is 43% and WMAS achieved 35.4%. This was introduced as a pilot during 2013/14 and will need to be taken forward to 2014/15 to achieve improvements - <b>NOT ACHIEVED</b></p>	



### 2.1.1 Patient Safety (continued)

Priority 3: Cannulation	
Rationale	<p><b>Cannulation</b> (use for administering drugs and/or fluids directly into a patients blood vessel) is one of the highest risk procedures which can cause Healthcare Associated Infection that the Ambulance Service performs.</p> <p>In the cannulation packs there are 2 stickers which identify to the receiving hospital staff whether Aseptic No Touch Technique (ANTT) was possible. This enables the receiving hospital to make a judgement based on risk whether to remove or leave in the cannula.</p>
Measure reporting to board	20 observations done by Clinical Team Mentors during mentored shifts in each area in the Region per quarter, which will give 100 observations per quarter
Target	95% use of stickers and communication of Aseptic or Emergency inserted
By When?	31 March 2014
Outcome	Engagement with receiving units to assure them of WMAS commitment to reduce the risk of HCAI
Lead	Head of Clinical Practice Infection Prevention and Control
Baseline	95% use of stickers and communication of Aseptic or Emergency insertion
End of Year Review	
The Trust achieved 95% compliance and will continue to monitor this priority as part of the Infection Prevention & Control Committee's work plan. <b>ACHIEVED</b>	

### 2.1.2 Clinical Effectiveness

Priority 4: Onset of symptom time	
Rationale	Where Ambulance clinicians document time of onset of symptoms for patients suffering from a stroke we want to show that there has been a decrease in the time to getting the patient to the computerised tomography (CT Scan). This would improve patient outcome by reducing the time to thrombolysis treatment. This would assist in the reduction of the disabling effects a stroke can have on patients.
Monthly Board report	Onset of stroke symptoms are documented in all hyper acute stroke cases
Target	90% target of hyper acute stroke patients have an onset of symptom time recorded where known
By When?	31 March 2014
Outcome	Improved access to hyper acute stroke services
Lead	Head of Clinical Practice and Cardiac and Stroke
Baseline	TBC at 87%
End of Year Review	
This target has not been achieved therefore this will be measured during 2014-2015. Further recommendations will be made to ensure improvement – <b>NOT ACHIEVED</b>	



## 2.1.2 Clinical Effectiveness (continued)

Priority 5: General Pain Management	
Rationale	Pain is defined as an “unpleasant sensory and emotional experience associated with actual or potential tissue damage” *. The patient deserves appropriate assessment and management of pain, minimising any adverse physical or psychological effects. Documenting the pain score allows WMAS to ascertain whether pain assessment has been achieved.
Monthly Board report	Qtr.1 : Develop general Pain management Guidelines to include scoring Qtr. 2&3: develop a pain workbook with e-learning and this will be uploaded to the Virtual Learning site to assist with pain management Qtr. 4: Documentation to increase by 10% from baseline for Qtr. 4
Target	An e-learning package will be developed and increase pain scoring documentation by 10% of the baseline
By When?	31 March 2014
Outcome	Better patient experience and clinical effectiveness
Lead	Clinical Quality Manager
Baseline	39%
End of Year Review	
This target has not been achieved therefore this will be measured during 2014-2015. Further recommendations will be made to ensure improvement: An e-learning package will be developed to increase pain scoring documentation from 24.08% <b>NOT ACHIEVED</b>	

Priority 6: Trauma	
Rationale	WMAS was instrumental in the implementation of a regional trauma care system that rapidly identifies major trauma patients and delivers them to specialist Major Trauma Centre (MTC) hospitals. Since the system went live in March 2012 the majority of major trauma patients are now taken directly to MTCs, others are transferred later from supporting Trauma Unit (TU) hospitals by a medic led team and WMAS will continue to monitor the effectiveness of the Trauma Triage tool in 2013-14.
Quarterly Board report	The patients that trigger the level 1 or 2 of the triage tool will be directly taken to a major trauma centre when they satisfy the criteria to do so
Target	95% of the time
By When?	31 March 2014
Outcome	Improvement in outcomes for this patient group (evidence produced by national Trauma Audit and Research Network)
Lead	Head of Clinical Practice and Trauma Lead
Baseline	80 per month directly to major trauma centres
End of Year Review	
This target has not been achieved therefore this will be measured during 2014-2015. Further recommendations will be made to ensure improvement:  Patients that trigger the Level 1 or 2 of the triage tool will be directly taken to a Major Trauma Centre when they satisfy the criteria to do so 95% of the time (currently achieving 91.46%) <b>NOT ACHIEVED</b>	





### 2.1.3 Patient Experience

Priority 7: Patient Survey	
Rationale	Patient care is at the centre of everything we do and it is important to the Trust to ensure that we collect the views of service users to inform us of the quality of care we deliver. The Trust continues to learn from patients', carers' and members of the public's experience so we can see where the service user has reported good experience and, on occasion poor service. In 2012/13 the current Patient Survey incorporates the following question 'would you recommend this service to friends and family'.
Measure reporting to board	Through quarterly patient surveys, as well as an online survey and engagement with Health Watch and Foundation Trust Governors to include the Friends and Family Recommendation test
Target	5000 patients
By When?	31 March 2014
Outcome	Learn from patients and improve the patient experience
Lead	Head of Patient and Public Experience
Baseline	Target 5000 patients
End of Year Review	
Through quarterly patient surveys, as well as an on-line survey and engagement with Health Watch and Foundation Trust Governors to include the Friends and Family recommendation test. The Survey including Friends & Family was shared as 7267 targeted surveys. <b>ACHIEVED</b>	
Priority 8: WMAS dignity challenge	
Rationale	Respecting people's dignity should include a zero tolerance of all forms of abuse and patients deserve the same respect/privacy: People should feel able to complain without fear of retribution, engagement with family members and carers as care partners; where people are lonely and isolated and in need of care they should be referred to the right service at the right time.
Measure reporting to board	Qtr. 1: scope and Baseline Qtr. 2: Raise awareness of the WMAS Dignity campaign amongst staff Qtr. 3&4: Staff signed up to the dignity challenge
Target	To have dignity champions up by 25%
By When?	31 March 2014
Outcome	Improve awareness of dignity in the Trust improving patients experience
Lead	Clinical Quality Manager
Baseline	3 champions identified in Qtr1
End of Year Review	
Recruitment of 27 Equality and Dignity Champions. This work has been scheduled for further development of the role during 2014/16 <b>ACHIEVED</b>	



**2.1.3 Patient Experience (continued)**

Priority 9: Renal Patients	
Rationale	During 2013/14 we will be working with the University Hospitals of Birmingham Foundation Trust (UHB) as part of a transformation project which is seeking to improve the patient experience for renal patients through our Quality Governance Committee (QGC) we will seek assurance that quality standards are being met, and where they are not, what actions are in place to improve performance
Measure reporting Qtrly to board	Monthly reporting from CGQC to the Trust Board demonstrating performance levels. Q2 – Recommendations and outcomes from UHB transformation transport trial. Q3 – Implementation of service redesign.
Target	To have improved performance standards against relevant and specific renal standards in accordance with contracts. To have reduced levels of complaints from renal dialysis patients by 25%.
By When?	31 March 2014
Outcome	Improvements in patient experience and wellbeing
Lead	General Manager PTS
Baseline	TBC in Qtr1
End of Year Review	
The trial allowed WMAS the opportunity to review procedures of transporting patients but most importantly provided learning on the best care the ambulance service can provide. This learning now forms part of contract improvement plans that have already began implementing new ways of working. The introduction of additional resources to support the contract has resulted in a reduction of – 76% March 2014. <b>ACHIEVED</b>	



## 2.2 Performance Summary for year to date 2013-14

April 2013- March 2014	Red 1 - 75% - 8 min	Red 2 - 75% - 8 min 75%	Red 19 - 95% - 19min	Green 2 - 90%-30mins	Green 4 - 90% - triage in 60mins
Financial Month	Red 1- 08 Min Performance	Red 2 - 08 Min Performance	Red - 19 Min Performance	Green 2 Performance	Green 4 Performance
April	81.2%	73.4%	97.3%	93.1%	99.6%
May	83.0%	77.0%	97.9%	94.9%	99.6%
June	83.4%	77.2%	97.9%	92.9%	99.7%
July	77.1%	71.5%	96.8%	86.2%	99.7%
August	80.0%	74.6%	97.1%	89.2%	99.5%
September	82.3%	73.8%	97.1%	87.5%	99.5%
October	77.6%	72.7%	97.0%	85.7%	99.7%
November	76.6%	72.2%	96.9%	86.0%	99.6%
December	79.5%	70.8%	86.6%	86.6%	99.5%
January	80.5%	73.6%	96.9%	90.3%	99.7%
February	79.6%	71.9%	96.2%	85.4%	99.3%
March	80.2%	73.9%	97.0%	88.6%	99.6%
<b>Grand Total</b>	80.0%	73.6%	97.0%	88.6%	99.6%
<b>National Target</b>	75%	75%	95%	90%	90%
<b>WMAS Performance</b>	<b>80.0%</b>	<b>73.6%</b>	<b>97.0%</b>	<b>88.6%</b>	<b>99.6%</b>

**Red 1:** Respond to 75% of calls within 8 mins

These are for the most life threatening conditions, the most time critical patients

**Red 2:** Respond to 75% of calls within 8 mins

These calls may be life threatening but less time-critical and should receive an emergency response within 8 minutes irrespective of location in 75% of cases.

**Red 8 Mins:** Respond to 75% of calls within 8 mins

**Red 19 Mins:** Respond to 95% of calls within 19 mins

**Green 2:** Respond to 90% of calls within 30 mins

**Green 4:** Triage 90% of calls in 60 mins

**Referral Target:** Target 90% achieved 91.9%

Significant efforts were made to achieve the targets. Despite this, WMAS continues to employ the highest Paramedic skill mix in the country with a Paramedic present in over 95% of crews every day. This is significantly higher than some other Services. We are actively recruiting over 300 student and graduate Paramedics this year, which will further boost our capacity to respond and our clinical performance for patients. We experience comparatively short ambulance back up delays to Paramedic response cars, in comparison to other Trusts and this year have seen a downturn in complaints. Furthermore, WMAS does not receive adverse media coverage that has been reported elsewhere, e.g. we do not use of taxis or police cars to convey emergency patients.



## 2.3 Clinical Performance Indicators (CPI) and Ambulance Quality Indicators (AQI)

To ensure patients of the West Midlands receive quality care from their Ambulance Service a set of key Performance Indicators and Ambulance Quality Indicators have been set nationally. These help set our policies and guidelines and develop our organisational culture that places quality at the top of the Trust's agenda. The following details the figures for each CPI/AQI and highlights the national mean percentage and the position of WMAS against other Trusts.

### 2.3.1 Outcome from Cardiac Arrest

The Ambulance Quality Indicator includes measurements for 2 elements:

- Return of Spontaneous Circulation (ROSC) at hospital (i.e. the patient has a pulse on arrival at hospital)
- Survival to hospital discharge (i.e. the patient has survived the cardiac arrest and been discharged from hospital)

The patient groups that the above measures are:

- The overall group refers to all patients in cardiac arrest where resuscitation has been commenced (by WMAS Clinicians).
- The comparator group is referring to those patients in cardiac arrest where resuscitation has been attempted, where the arrest was witnessed by a bystander, the rhythm that the patient was initially presenting with was ventricular fibrillation/ ventricular tachycardia (VF/VT) and the aetiology presumed to be cardiac. The comparator group look specifically at cases where a person is witnessed to go into cardiac arrest, and are found to be in a cardiac rhythm that is able to be defibrillated on arrival.
- The comparator group give rise to the more meaningful data but numbers are inevitably small, so even one case can alter results by several percentage points.

The number of patients where resuscitation has been attempted has increased to 3861 for 2013/14 this is a 32.7% increase compared with last year's number of attempts. The number of patient arriving at hospital with return of spontaneous circulation has increased to 927 patients during 2013/14 this is a 13% increase when compared with last year. The number of patients who survived to discharge has improved to 253 cases this year which is an improvement of 16.6%. The Trust has demonstrated a year on year improvement in the number of patients surviving to be discharged and will continue strive to improve this during the next financial year.

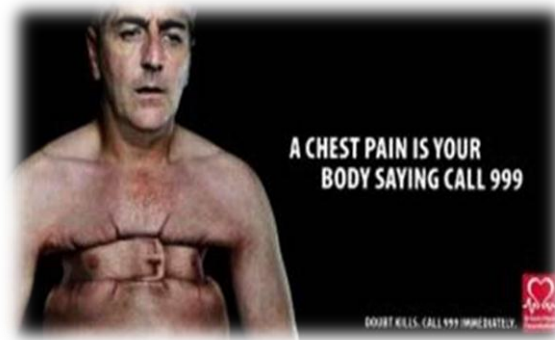
ROSC at Hospital	Overall Group	Comparator Group
2013-2014 (April 2013-March 2014)		
<b>Birmingham</b>	24.19%	43.93%
<b>Black Country</b>	23.83%	39.44%
<b>C&amp;W</b>	28.16%	40.63%
<b>West Mercia</b>	24.13%	32.94%
<b>Staffs</b>	23.51%	42.53%
<b>WMAS</b>	24.48%	40.10%
<b>National Mean</b>	26.06%	46.46%

Survival to Hospital Discharge	Overall Group	Comparator Group
2013-2014 (April 2013-March 2014)		
<b>Birmingham</b>	6.45%	22.43%
<b>Black Country</b>	7.42%	21.13%
<b>C&amp;W</b>	5.31%	17.19%
<b>West Mercia</b>	6.06%	15.29%
<b>Staffs</b>	7.17%	24.14%
<b>WMAS</b>	6.55%	20.29%
<b>National Mean</b>	8.84%	25.53%



### 2.3.2 Acute ST-elevation myocardial infarction (STEMI)

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



- Aspirin - this is important as it can help reduce blood clots forming.
- GTN – this is a drug that increases blood flow through the blood vessels within the heart. (improving the oxygen supply to the heart muscle and also reducing pain).
- Pain scores – so that we can assess whether the pain killers given have reduced the pain.
- Morphine – a strong pain killer which would usually be the drug of choice for heart attack patients.
- Analgesia – Sometimes if morphine cannot be given Entonox, a type of gas often given in childbirth, is used.
- Call to Balloon - 75% of patients that have Primary Percutaneous Coronary Intervention (PPCI) should do so within 150 minutes of the initial call. This treatment is provided at a specialist heart attack center.

The Care Bundle requires each patient to receive each of the above. The AQIs include measurements for the management of STEMI cases. The indicator has the following components:

- The percentage of patients suffering a STEMI who are directly transferred to a centre capable of delivering primary percutaneous coronary intervention (PPCI) and receive angioplasty within 150 minutes of call.
- The percentage of patients suffering a STEMI who receive an appropriate care bundle.

	Aspirin Administered		GTN administered		2 Pain Scores Documented	
	2012/13	2013/14	2012/13	2013/14	2012/13	2013/14
<b>Birmingham</b>	96.54%	97.72%	97.17%	96.58%	88.05%	90.87%
<b>Black Country</b>	97.06%	97.46%	94.96%	97.83%	89.50%	93.48%
<b>C&amp;W</b>	98.24%	98.99%	97.06%	95.98%	82.94%	87.44%
<b>West Mercia</b>	97.12%	94.12%	95.67%	93.56%	90.87%	88.52%
<b>Staffs</b>	91.95%	94.62%	91.95%	92.47%	86.21%	93.55%
<b>WMAS</b>	95.98%	96.45%	95.31%	95.29%	87.70%	90.83%
<b>National Mean</b>	*	*	*	*	*	*

	Morphine administered		Analgesia administered		SPO2 documented		Care Bundle	
	2012/13	2013/14	2012/13	2013/14	2012/13	2013/14	2012/13	2013/14
<b>Birmingham</b>	73.90%	80.37%	77.04%	81.28%	100.00%	100.00%	67.92%	73.74%
<b>Black Country</b>	84.87%	89.49%	87.39%	89.86%	99.58%	99.64%	79.41%	82.25%
<b>C&amp;W</b>	88.24%	90.45%	88.82%	89.95%	99.41%	98.99%	75.29%	78.89%
<b>West Mercia</b>	92.79%	84.87%	91.83%	84.87%	99.52%	100.00%	81.73%	71.99%
<b>Staffs</b>	79.31%	83.51%	81.61%	84.95%	99.62%	100.00%	68.58%	74.55%
<b>WMAS</b>	82.59%	84.89%	84.35%	85.41%	99.67%	99.81%	73.81%	75.66%
<b>National Mean</b>	*	*	*	*	*	*	77.80%	80.30%

	Call to Needle		Call to Balloon	
	2012/13	2013/14	2012/13	2013/14
<b>WMAS</b>	29.41%		85.74%	89.43%
<b>National Mean</b>	44.44%		88.82%	89.45%

\* No National Mean Available.



### 2.3.3 Stroke / Mini Stroke (TIA)

The AQI for this area is compromised of;

- Blood pressure – a raised blood pressure may be a contributing factor for stroke.
- Blood glucose level - as patients with an altered level may present with the same symptoms as a stroke.



**FAST test** – this is an assessment of the following:

- **F**acial weakness - can the person smile? Has their mouth or eye drooped?
- **A**rm weakness - can the person raise both arms?
- **S**peech problems - can the person speak clearly and understand what you say?
- **T**ime to call **999**

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

The AQIs include measurements for the management of all stroke cases, which amounts to approximately 700-800 cases per month.

The indicator has two components:

- The percentage of FAST positive stroke patients (assessed face to face) potentially eligible for stroke. Thrombolysis, who arrive at a hyper acute stroke centre within 60 minutes of call.
- The percentage of suspected stroke patients (assessed face to face) who receive an appropriate care bundle.

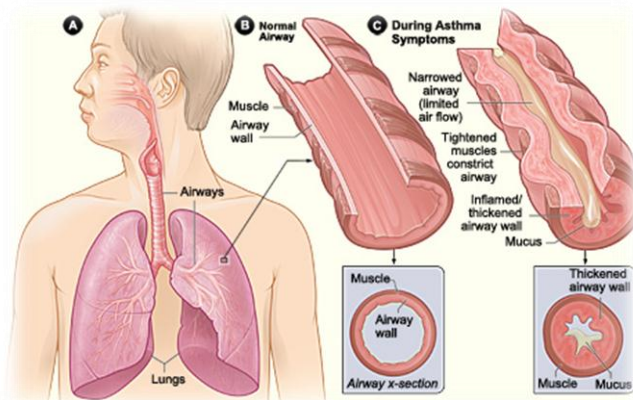
	FAST Documented		Blood Glucose documented		Blood Pressure documented	
	2012/13	2013/14	2012/13	2013/14	2012/13	2013/14
<b>Birmingham</b>	97.58%	97.85%	98.05%	97.38%	99.94%	99.91%
<b>Black Country</b>	97.71%	97.61%	98.72%	98.21%	100.00%	99.94%
<b>C&amp;W</b>	95.43%	95.10%	95.97%	97.80%	100.00%	99.80%
<b>West Mercia</b>	96.70%	95.56%	98.28%	98.04%	100.00%	99.93%
<b>Staffs</b>	94.41%	95.36%	97.48%	97.74%	100.00%	100.00%
<b>WMAS</b>	96.55%	96.31%	97.92%	97.83%	99.99%	99.93%
<b>National Mean</b>	*	*	*	*	*	*

\* No National Mean Available.



### 2.3.4 Asthma

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



- **Respiratory rate** – how frequently the patient takes a breath, usually measured as times per minute.
- **Peak expiratory flow rate (PEFR)** prior to treatment - a device is used to determine and measure the flow of breathing out and indicates the amount of narrowing of the tubes. Measuring this before treatment allows doctors in the hospital to assess how bad the asthma attack was and what further treatment may be required.
- **PEFR** after treatment – this shows how effective the treatment given has been.
- **SpO2** before treatment - this shows the amount of oxygen present in the blood.
- **Oxygen** – whether we gave oxygen as a treatment.
- **Salbutamol** – The most commonly used treatment for patients with asthma.

	Care Bundle for the AQI		FAST+ patients transported to a hyper acute	
	2012/13	2013/14	2012/13	2013/14
<b>Birmingham</b>	95.86%	95.41%	Data recorded regionally	
<b>Black Country</b>	96.54%	95.93%		
<b>C&amp;W</b>	91.51%	93.10%		
<b>West Mercia</b>	95.02%	93.71%		
<b>Staffs</b>	92.23%	93.19%		
<b>WMAS</b>	94.63%	94.24%	62.07%	58.68%
<b>National Mean</b>	95.63%	96.28%	63.45%	63.63%

	Respiratory Rate documented		Peak Flow documented		SPO2 documented	
	2012/13	2013/14	2012/13	2013/14	2012/13	2013/14
<b>Birmingham</b>	100.00%	99.79%	85.18%	82.80%	99.68%	99.25%
<b>Black Country</b>	99.86%	99.87%	87.00%	86.24%	99.73%	99.47%
<b>C&amp;W</b>	100.00%	99.63%	85.55%	85.00%	100.00%	99.81%
<b>West Mercia</b>	99.84%	99.85%	88.30%	85.34%	100.00%	99.85%
<b>Staffs</b>	99.58%	99.86%	86.11%	82.22%	99.31%	99.58%
<b>WMAS</b>	99.86%	99.81%	86.36%	84.19%	99.72%	99.56%
<b>National Mean</b>	99.00%	99.10%	80.60%	79.50%	94.70%	95.50%

	Salbutamol administered		Oxygen administered		Care Bundle	
	2012/13	2013/14	2012/13	2012/13	2013/14	
<b>Birmingham</b>	95.92%	98.18%	96.46%	98.50%	81.42%	81.09%
<b>Black Country</b>	96.03%	97.62%	96.72%	97.88%	83.99%	84.13%
<b>C&amp;W</b>	93.81%	98.52%	93.81%	98.33%	81.43%	83.89%
<b>West Mercia</b>	96.57%	94.29%	95.63%	95.83%	85.80%	81.33%
<b>Staffs</b>	94.17%	94.86%	95.14%	96.67%	82.22%	77.64%
<b>WMAS</b>	95.39%	96.75%	95.70%	97.50%	82.90%	81.50%
<b>National Mean</b>	97.30%	97.90%	96.50%	97.70%	76.70%	75.50%



### 2.3.5 Hypoglycaemia

This is when the amount of glucose (sugar) in the blood is lower than the normal range. This is usually related to diabetes but can be caused by other conditions.

Effective recording of blood sugars enlightens the patient receives the right treatment quickly and allows monitoring of effectiveness of treatment and informs clinicians the appropriate way forward for that individual patient.



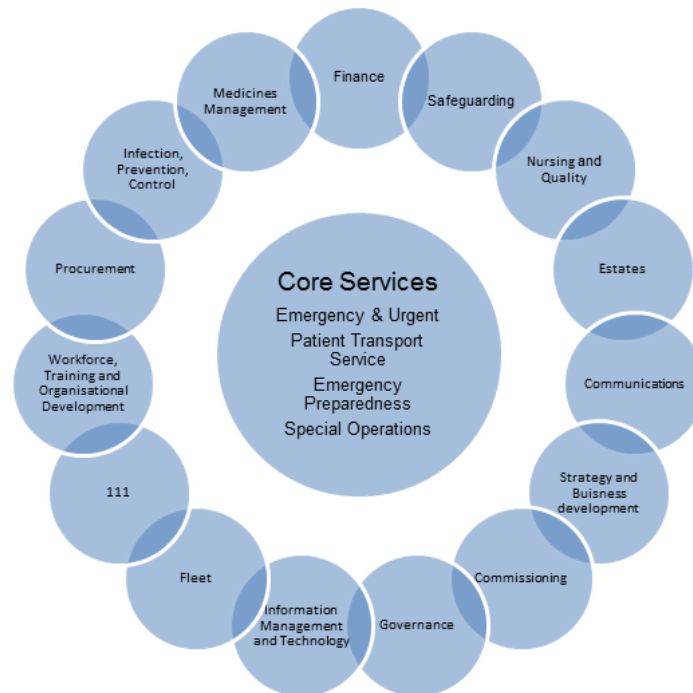
	Blood Glucose documented before treatment		Blood Glucose documented after treatment	
	2012/13	2013/14	2012/13	2013/14
<b>Birmingham</b>	98.93%	99.57%	97.44%	98.40%
<b>Black Country</b>	99.34%	99.47%	96.96%	98.81%
<b>C&amp;W</b>	97.59%	100.00%	97.78%	98.89%
<b>West Mercia</b>	98.15%	98.46%	98.30%	98.61%
<b>Staffs</b>	98.32%	98.06%	97.20%	99.17%
<b>WMAS</b>	98.55%	99.11%	97.50%	98.75%
National Mean	99%	99.10%	97.30%	97.20%

	Treatment provided to patient		Direct Referral to healthcare professional		Care Bundle	
	2012/13	2013/14	2012/13	2013/14	2012/13	2013/14
<b>Birmingham</b>	97.76%	99.15%	74.79%	70.83%	95.41%	97.54%
<b>Black Country</b>	98.54%	99.60%	71.56%	74.74%	95.50%	98.15%
<b>C&amp;W</b>	98.89%	99.44%	70.74%	66.48%	95.00%	98.33%
<b>West Mercia</b>	98.30%	99.07%	69.29%	70.22%	95.68%	96.91%
<b>Staffs</b>	97.90%	98.89%	76.05%	83.89%	94.12%	96.11%
<b>WMAS</b>	98.22%	99.22%	72.76%	73.50%	95.16%	97.39%
National Mean	99.10%	99.00%	61.80%	70.20%	95.80%	95.60%





## 2.4 Review of Services and Assurances from the Board



During 2013/14 West Midlands Ambulance Service provided NHS services as above The Trust sub-contracted to 1 Voluntary Urgent Care Provider. WMAS provides Patient Transportation Services to other NHS Trusts. To ensure excellent business continuity during times of surges in demand or in support of major incidents, the Trust has the facility to call upon a small number of Ambulance Sub-contractors to supplement service delivery. Sub-contractors are subjected to a robust governance review before they are utilised.

The Board of Directors has strong governance arrangements in place that have been embedded over a number of years, the Board of Directors has reviewed all of the data available and is assured that this account is an accurate account on the quality of care in all of these services.

The total service income received in 2013/14 from NHS sources represents 98% of the total service income for the Trust. More detail relating to the financial position of the Trust is available in the Trust's 2013/14 Annual Report.

## 2.5 Trust Profile

### 2.5.1 Geographical Area & Population

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

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

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



## 2.5.2 About the Trust

West Midlands Ambulance Service became a NHS Foundation Trust on 1<sup>st</sup> January 2013, following authorisation by the regulator Monitor and received its licence as a Health Service Provider in April 2013.

The Trust has a budget of approximately £200 million per annum. It employs over 4,000 staff and operates from 15 Operational Hubs and over 100 Community Ambulance Stations together with other bases across the Region. The average age of the Operational Fleet is, for the first time, now under five years old. In total the Trust utilises over 800 vehicles including Ambulances, Response Cars, Non-Emergency Ambulances and Specialist Resources such as Motorbikes and Helicopters.

The Trust is supported by a network of Volunteers. More than 800 people from all walks of life give up their time to be Community First Responders (CFRs). CFRs are always backed up by the Ambulance Service but there is no doubt that their early intervention has saved the lives of many people in our communities. WMAS is also assisted by Voluntary organisations such as the British Red Cross, St. John Ambulance, BASICS doctors, water-based Rescue Teams and 4x4 organisations.

In November 2014, it was agreed that the Trust should take over from NHS Direct and manage the **NHS 111 Service** in Birmingham, Solihull, the Black Country, Shropshire, Herefordshire, Coventry and Warwickshire.

**Emergency and Urgent:** This is perhaps the best known part of the Trust and deals with the 999 calls. Initially, one of the two Emergency Operations Centres (EOC) answers and assesses the 999 call. They then send the most appropriate Ambulance Crew or Responder to the patient or direct the patient to the most appropriate service. Where necessary, patients will be taken by ambulance to an A&E Department or other NHS facility such as a Walk in Centre for further assessment and treatment.

**Patient Transport Services (PTS):** A large part of the organisation deals with the transfer and transport of patients for reasons such as hospital appointments, transfer between care sites, routine admissions and discharges and transport for continuing treatments such as renal dialysis. A dedicated control rooms deals with the Non-emergency Patient Transport Services (NEPTS), it is the largest business area for the Trust and the largest business area within Commercial Services. Commissioning of NEPTS is predominantly the responsibility of Clinical Commissioning Groups, with some exceptions which are commissioned by Acute Trust's. The construction of NEPTS' contracts varies which is normally based on an annual cost and volume agreement including tolerance and marginal cost arrangements for over and under activity.

**Demand:** NEPTS usually completes approximately 850,000 patient journeys each year; however in 2013/14, 640,000 journeys were undertaken due to the loss of a major NEPTS contract.

The majority of the contracts held by WMASFT have experienced a lower level of activity than expected which is mostly due to a commissioner focus upon transport provision to an agreed Eligibility Criteria. Resultantly, WMASFT see a lower number of more mobile patients transported by NEPTS; however a corresponding increase in higher mobility patients such a stretcher and wheelchair patients.



**Emergency Preparedness:** This is a small but important section of the organisation which deals with the Trust's planning and response to significant incidents within the Region as well as co-ordinating a response to large gatherings such as football matches and festivals. It also aligns all the Trust's Specialist assets and Operations into a single structure. Such assets include the staff, equipment and vehicles from the Hazardous Area Response Team (HART), Air Operations, Decontamination staff and the Mobile Emergency Response Incident Team (MERIT). The department constantly arranges training for staff and ensures the Trust understands and acts upon intelligence and identified risk to ensure we keep the public safe in terms of major incidents.

**Make Ready** is a dedicated ambulance preparation system operating successfully in most of the Trust that was implemented during 2013. Under the Make Ready system, specialist non-clinical staff clean, prepare and stock the ambulances ready for the start of each shift. They also 'Make Ready' replacement vehicles for crews if an ambulance is contaminated during a shift. This realises the following benefits:

- Maximize vehicle cleanliness and minimize cross infection.
- Improve medicines management.
- Maximize unit hour utilization.
- Minimize critical vehicle failure rate of the fleet including related equipment.
- Ensuring ambulances are stocked to the required standard from a reduced number of locations.

This results in better use of consumables reducing the waste of out of date stock.

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





### Police award for ‘Make Ready’ Hub

The “Secured by Design” accreditation is the official UK Police flagship initiative developed by ACPO (Association of Chief Police Officers) and is based upon the principles of ‘designing out crime’ and is for recognition of build and layout, designed to reduce the opportunity for crime and anti-social behaviour.

The Trust was presented the award for its newly-built premises in Hollymoor Way in Rubery. It is the first of four Hubs to receive such accreditation; the other three will follow at the recently constructed premises in Erdington, Willenhall and Coventry at dates to be confirmed.



Receiving the award on behalf of West Midlands Ambulance Service, Barry Thurston, Director of Service Delivery, said: “It’s a credit to the staff and the teams who have worked so hard on the ‘Make Ready’ scheme for the past two years. It is a validation of the efforts that are being recognised in this way.”

**Emergency Operations Centres** deal with approximately 76,000 999 calls each month, over 95% of which are answered within 5 seconds. Each 999 call is triaged through NHS Pathways in order to ensure that the correct categorisation is reached to meet the needs of the patient. As part of the NHS Pathways licencing agreements we are required to audit 1% of all emergency and urgent calls processed to which they are required to achieve an average audit compliance of over 86%. Of all the calls audited, we can confirm that the Trust has a compliancy rate of 95% indicating that the 999 calls we manage are appropriately triaged. The audit process is used to identify training needs and requirements and is also a useful tool for future developments within NHS Pathways. The Trust is currently participating in a trial regarding patients in a state of peri-arrest. As part of this trial the call assessors are required to evaluate a patients breathing when they are unconscious. An early indication is, that as a result of this trial, the Trust is better suited to respond and categorise patients that are not in an actual cardiac arrest but a delay in responding could result in the patient going into Cardiac arrest situation.





## NHS 111

NHS 111 was introduced back in March 2013 to the general public to make access to health services easier. The service had a difficult start across the country including the West Midlands where NHS Direct were the chosen provider. In the summer of 2013 NHS Direct took the decision to rescind the 111 contract so NHS England approached WMAS to be the 'step in provider' for the West Midlands and Staffordshire Doctors Urgent Care for Staffordshire.



In the summer of 2013 NHS Direct took the decision to rescind the 111 contract so NHS England approached WMAS to be the 'step in provider' for the West Midlands and Staffordshire Doctors Urgent Care for Staffordshire.

On the 11<sup>th</sup> November 2013, the contract was transferred to WMAS from NHS Direct along with the workforce and the estates.

With the Festive season approaching, the main objectives were to keep the service stable, maintain a high level of public access and more importantly provide a safe service to the public. WMAS achieved this by answering 95.4% of 73314 calls taken within 60 seconds. We also worked in partnership with our Out of Hours (OOHs) colleagues to stream line 111 calls directly into the OOH's to provide early GP intervention making the patient's journey more efficient. In addition, we supported other 111 services hosted by Ambulance Service Trusts over the festive period at times of high demand.

WMAS 111 is now providing a safe and stable service. One of the main changes was to introduce a clinical model which ensures that a Clinician is readily available to answer queries from call takers within the Call Centre. All new members of staff to 111 receive 8 weeks training which includes First Person on Scene (FPOS).

We achieved our first landmark with our 250,000<sup>th</sup> call on the 7<sup>th</sup> March 2014. We also publically launched the Service on the 11<sup>th</sup> March 2013 and invited members of the press and media into the call centre to see 111 in action and to share our good news story of 111's first baby to be delivered with the help of our staff.

The service is experiencing steady growth per month and on the back of the public launch we fully expect to see a more significant rise in call volumes moving forward. We continue to achieve our call answering performance targets which ensuring caller receive a timely and effective call response.

We will continue to work with our Commissioners and other Providers to ensure that we identify and support improvements in meeting the healthcare needs of people within the West Midlands. Our aim is to reduce the 8% of patients we currently send to A&E departments and the 12% we send 999 ambulances to, we will do this by listening to our patients, identifying the right local service required and ensuring we work with Commissioners to bridge any gaps in those services.



We also use complaints, Health Professional Feedback and internal incidents to help drive improvements and quality. Themes identified recently include being sent to the wrong Health Care Provider and Dental patients calling 111 in the Out of Hour's period with very little dental provision.



## 2.6 Divisional Profiles

### 2.6.1 Black Country Division

This overview is intended to provide relative information for various bodies, in understanding the composition, operational make up, and challenges that face the West Midlands Ambulance Service in the Black Country.

The resident population of the Black Country is approximately 1.1 million people and has seen population increases in recent years; there is also a large transient population that travels through the area on a daily basis due to a busy road and rail network.

The area stretches across approximately 150 sq. miles, and is mainly urbanised with multiple borough. The Black Country operating division has 4 Clinical Commissioning Groups (CCGs), with whom the ambulance service interact on a frequent basis. The CCGs are Dudley, Sandwell and West, Walsall and Wolverhampton.



The ambulance service is strategically located in three areas where the main ambulance hubs are sited. An ambulance hub is a unit or building where staff report to centrally, ambulances are prepared, cleaned and repaired, and where training and education takes place. From these ambulance hubs, the ambulances are strategically placed in line with a dynamic operational status plan, based on the emergency activity, and ensure that the ambulance resources are best positioned to meet the daily patient demand.

The Trust occupies a variety of locations across the area as Community Ambulance Stations and standby sites. Many of these sites are based in existing estates owned by the other emergency service providers and this encourages interoperability and good working relationships when attending the same incident.

Black Country is also the site of the Trust Headquarters in Brierley Hill (Dudley area) which accommodates one of the two Emergency Operations Centres, where emergency calls are received and triaged. The regions 111 service provision is under temporary contract to the Trust and is also located in Brierley Hill.



## The People to Know



**Nick Henry** – General Manager Black Country Division based at Willenhall Hub with responsibility for the Accident and Emergency performance and delivery within the area. Nick joined the former WMAS as a cadet in 1990 and has progressed through the Trust holding many posts during this term of service.

**Mark Chapman** is the Area Manager for the South of Black Country which comprises of Dudley and Sandwell where there are two Hubs situated. Based at Dudley Hub, Mark is responsible for 2 Assistant Area Managers, 2 Hospital Ambulance Liaison Officers, 5 Operational Area Support Officers and 241 Operational staff. The fleet consists of 34 Ambulances and 15 operational Rapid Response Vehicles which are based in the South Area. The area provides operational cover to Dudley, Stourbridge, Halesowen, West Bromwich and Oldbury.



**Paul Baylis** is the Area Manager for the North of Black Country which comprises of Wolverhampton and Walsall. Based at the central Willenhall Hub, Paul is responsible for an Assistant Area Manager, 2 Hospital Ambulance Liaison Officers, 5 Operational Area Support Officers and 205 operational staff. The fleet consists of 30 ambulances and 15 operational Rapid Response Vehicles which are based in the North Area. The area provides operational cover to Wolverhampton, Bilston, Walsall and Aldridge.



## Performance

### Overview by HUB –

Post code activity is variable on daily basis, however, historical data proves that certain areas are busier than others and the status plan is adapted to meet the demand based on this data. The following is a snapshot of current performance data:

**Dudley** - DY1 (Dudley) is the busiest in volume and best performing area with over 90% of calls attended within targets, DY8 (Stourbridge) is the next busiest and performance has been historically challenging. DY5 (Brierley Hill) and DY2 (Netherton) are the next busiest areas, and performance has been consistently strong to both postcodes.

Current performance achieving year to date at 77.9%

**Sandwell** – DY4 (Tipton) lies between Sandwell Borough and is the fourth busiest area in Black Country, performance in this area is currently good. B70 and B71 (West Bromwich) are the next busiest, followed by B66 (Smethwick). Performance is historically strong in all areas, Sandwell covers the border between Black Country and Birmingham and the performance is linked through the Birmingham Cross City CCG area.

Current performance achieving year to date at 80.08%

**Willenhall** – WV10 (Bushbury), WS3 (Bloxwich) and WS2 (Walsall) are historically the 3 busiest areas of the Black Country and performance has been challenging. However, this year has seen marked improvement with WS2 particularly impressive at nearly 90% achievement of target. The North area has 4 of the 5 busiest postcode areas in the Black Country, reprioritising sites in the status plan and improved allocation of resources has shown a positive impact on performance.

Current performance achieving year to date at 77.5% Walsall and 76.9% Wolverhampton

**Total Red 2 performance for Black Country year to date 78.4%**

**There is a Performance improvement plan in place across the Division and the main Points are;**

- Reduce sickness to 4% to release manpower to A&E.
- Paramedic on every ambulance, increasing ability to treat patients in the community
- Reduce Job cycle times from current levels of 93 minutes to 87 minutes
- Increase staffing and resource to match the demand profile
- Report weekly to an operational board chair by the CEO
- In addition to the above the Division is encouraged to use appropriate alternative care pathways through a 'clinical hub' in the 111 call centre, allowing clinician to clinician referral and improving Hospital avoidance for those patients that can be better cared for elsewhere.





## 2.6.2 West Mercia Division

This overview is intended to provide relative information for various bodies, in understanding the composition, operational make up, challenges that face the Trust in the West Mercia Division. West Mercia Division covers the counties of:

- Herefordshire
- Worcestershire
- Shropshire

The population of West Mercia is in excess of 1.1 million and stretches across 2,868 square miles with a combination of both rural and urban communities. This area accounts for more than 50% of the geographical size of the Trust.

West Mercia has six Clinical Commissioning Groups (CCG's), with whom the Ambulance Service interact with on a frequent basis. The CCGs are Shropshire, Telford and Wrekin, Herefordshire, South Worcestershire, Redditch and Bromsgrove and the Wyre Forest.

There are 5 ambulance hubs which are supplemented by Community Posts. An ambulance hub is a location where staff report to centrally, ambulances are prepared, cleaned and repaired, and where training and education takes place.



From these ambulance hubs, the ambulances are strategically placed in line with a dynamic operational plan that changes each hour. This plan is based on emergency activity and ensures that the ambulance resources are best positioned to meet the daily patient activity.

The Trust occupy a varied assortment of properties to support this deployment ranging from prefabricated building to fixed buildings, and we do link in with our sister emergency services colleagues in assisting with accommodation where applicable to the operational plan. Many of these premises' are occupied by Community Paramedics in Rapid Response Vehicles.



## The People to Know



**Michelle Brotherton** – General Manager for West Mercia Division with responsibility for the Accident and Emergency clinical and operational performance and ensuring safe and effective care to patients. Michelle joined the ambulance service in 1993 as an ambulance cadet, and has subsequently progressed through the Trust holding many posts during this term of service, including Education and Training, Patient Transport Services and Community Response.

**Adrian Ball** – Area Manager at Worcester Hub is responsible for 5 x Operational Ambulance Support Officers and in excess of 150 x Operational Staff and a fleet including 26 x Ambulances and 12 x Rapid Response Vehicles managed through the Worcester Hub, which provides operational cover principally to South Worcestershire and Wyre Forest.



**Dug Holloway** – Area Manager at Bromsgrove Hub is responsible for 78 x Operational Staff and a fleet including 8 x Ambulances and 4 x Rapid Response Vehicles managed through the Bromsgrove Hub, which provides operational cover principally to Bromsgrove and Redditch areas.

**Debbie Small** – Area Manager at Hereford Hub is responsible for 5 x Operational Ambulance Support Officers and in excess of over 100 x Operational Staff and a fleet including 13 x Ambulances and 9 x Rapid Response Vehicles managed through the Hereford Hub, which provides operational cover throughout Herefordshire



**Barry McKinnon** – Area Manager at Shrewsbury Hub is responsible for 5 x Operational Ambulance Support Officers and in excess of 100 x Operational Staff and a fleet including 15 x Ambulances and 5 x Rapid Response Vehicles managed through the Bromsgrove Hub, which provides operational cover principally to Shropshire County.



## Performance

Post code activity is a variable each week and is dependent on the activity in that post code area. A snapshot is provided in this briefing which relates to the performance of each County for the month of April 2014. **It is important to note this provides a snapshot only for one month and is not reflective of the annual performance for each postcode area.** Many areas of West Mercia present challenges due to the geographical spread of communities and maximising alternative community strategies to provide prompt response to patients are utilised.

### Worcestershire

The busiest postcode is B98 (Redditch) which is the best performing postcode also for Red 2 calls. This is a similar theme with postcodes WR14 (Malvern), WR11 (Evesham) and DY 11 (Wyre Forest).

The most challenged postcodes based on call volume are DY 10 (Wyre Forest), WR 9 (Droitwich), and WR10 (Persnore). Red 2 performance for April 2014 sits above the national target at 78.2%.

### Herefordshire

The busiest postcode is HR1 (central Hereford) which is the best performing postcode also for Red 2 calls. This is a similar theme with postcodes HR2 (South Western of Hereford City) and HR4 (North West of Hereford City). The most challenged postcodes based on call volume are HR6 (Leominster area) and HR9 (Ross). Red 2 performance for April 2014 sits below the national target at 71.7%.

### Shropshire

The busiest postcode is TF1 (Telford) and TF2 (North East of Telford Central) and SY 3 (Shrewsbury West) is the best performing postcode also for Red 2 calls.

The most challenged postcodes based on call volume are SY1(North Shrewsbury) and TF 3 (South of Telford Central). SY1 is not normally an area that presents a challenge. Red 2 performance for April 2014 sits below the national target at 68.9%.

## **A Performance improvement plan is in place across the Division – Summary of main points**

Every effort is made by local operational management teams to constantly improve performance in order for patients to receive the most timely response and clinical care. This includes aiming to achieve:

- A reduction in sickness to 4% to maximise available resources
- Providing a Paramedic on every ambulance, increasing ability to treat patients in the community – Current rosters are designed to have a Paramedic on every vehicle. This will also reduce the number of resources being sent to incidents, keeping them available for other calls
- Reducing Job cycle times
- Recruit to achieve the budgetary establishment of requirement staff for the area of 563 whole time equivalent Operational staff (Paramedics and Technicians)
- Recruiting Community Responders to challenged areas
- Encouraging Defibrillation sites both within the Community and at sites of high population and public concentration
- Report weekly to an operational board chair by the Chief Executive Officer



### 2.6.3 Staffordshire Division

This overview is intended to provide relative information for various bodies, in understanding the composition, operational make up, challenges that face the west midlands ambulance service in Staffordshire.

The Staffordshire population is 1.1 million resident in the county, and a large transient population that travels through the county on a daily basis. The county stretches across 1,050 sq miles, and has a mixture of rural and Urban Communities.

The County has six Clinical Commissioning Groups, with whom the ambulance service interact on a frequent basis. The CCGs are North Staffordshire, Stoke on Trent, Stafford and Surrounds, Cannock Chase, East Staffordshire, South East Staffordshire and Seisdon Peninsula.



The ambulance service is strategically located in three areas where the main ambulance hubs are sited. An ambulance hub is a centre where staff report to centrally, ambulances are prepared, cleaned and repaired, and where training and education takes place.

From the ambulance hubs, the ambulances are strategically placed in line with a dynamic operational plan that changes each hour, this plan is based on emergency activity, and ensures that the ambulance resources are best positioned to meet the daily patient activity.

The Trust occupy a varied assortment of properties to support this deployment ranging from prefabricated building to fixed buildings and we do link in with our sister emergency services colleagues in assisting with accommodation where applicable to the operational plan. Staffordshire is also the site of one of the two Emergency Operations Centres, where emergency calls are received and triaged.



## The People to Know



Lee Washington – General Manager for Staffordshire Division based at Tollgate Stafford with responsibility for the accident and Emergency performance and delivery within the County. Lee joined the ambulance service in 1980 in Staffordshire as a trainee ambulance man, and has subsequently progressed through the Trust holding many posts during this term of service

John Vernon is The Area manager Based at Tollgate Stafford, a area manager for Tollgate John is responsible for 1x Assistant Area manager, 5 Operational Ambulance Support Officers and 132 Operational staff. There are 17 Ambulances and 10 Operational Rapid response vehicles based at Tollgate. Tollgate provides operational Ambulance cover to Stone, Stafford Borough, Cannock and the surrounding Areas Rugeley and Uttoxeter



Michelle Kelly is the Area Manager at Lichfield she is responsible for the Halo at Burton, and currently has 75 operational Staff at Lichfield. The fleet at Lichfield comprises of 15 Operational Ambulances and 6 Rapid response vehicles, Michelle is accountable for providing cover to Burton and Tamworth areas as well

Sean Coleman Area manager at Stoke On Trent Sean is responsible for 1x Assistant Area manager, 5 Operational Ambulance Support Officers and 208 Operational staff. Fleet there are 28 Ambulances and 15 Rapid response vehicles based at Stoke. Stoke provides operational cover to the whole of North Staffordshire





## Performance

### Overview by HUB –

Post code activity is a variable each week and is dependent on the activity in that post code area. A snapshot is provided in this briefing which indicates that instability

**Tollgate** – busiest postcode area WS11 (Cannock) which is the best performing post code also. Most challenged post code ST15 (Stone north). The post activity is not a stable measure as volume and performance changes continually by week, Current challenges overnight closure of Stafford hospital, creates some deficit in performance, 111 activity at weekends challenging in volume . Insufficient alternative care pathways in the area resulting in more transports to A&E

### Performance

Performance sits below national targets at 72%

**Stoke** - busiest postcode area ST5 (Newcastle), ST4 (Trentham) the best performing post code also. Most challenged post code ST7 Kidsgrove/Audley). Other challenges EMS operating level at University Hospital North Staffordshire remains high which creates issues with handovers. Increased 111 activity at weekends impacts on the accident and emergency performance Operational performance above national standards at 77% Looking relocate the hub

**Lichfield** - busiest postcode area B77 (Tamworth), DE14(Burton) the best performing post code also. Most challenged post code B79 (Tamworth). Other challenges the sesidon peninsula is covered by Black County Ambulance crews rather than Staffordshire so different dynamics. Majority of the hospitals sit outside of the Staffordshire Boundary Lichfield new hub in build due for completion Sept 2014 site Eastern Avenue

### A Performance improvement plan is in place across the Division – Summary of main points

- Reduce sickness to 4% to release manpower to A&E
- Paramedic on every ambulance, increasing ability to treat patients in the community
- Reduce Job cycle times from current levels of 97 minutes to 80 minutes
- Increase resources into South Staffordshire by demonstrating activity increase
- Report weekly to an operational board chair by the CEO
- In addition to the above the Division are looking to implement a tried and tested operational triage tool for clinicians to use to best utilise alternatives to hospitals admissions.



## 2.6.4 Arden Division

### Introduction

This overview is intended to provide information to support the understanding of the composition and operational challenges that face the West Midlands Ambulance Service in Arden.

Arden consists of a population of 845,000 residents in the county with a large transient population that travels through the county on a daily basis. The county has a mixture of both rural and urban communities.

The County has three Clinical Commissioning Groups (CCGs), with whom the ambulance service interact on a frequent basis. These are:

1. Coventry & Rugby CCG,
2. South Warwickshire CCG
3. Warwickshire North CCG



The Arden Division Emergency & Urgent ambulance provision is located at two hubs/buildings, one in Coventry and the second in Warwick. An ambulance hub is a centre where staff report to at the start of their shift, where ambulances are prepared, cleaned and repaired (fleet on site) by the make ready team and where training and education takes place. Ambulances are mobilised from these hubs to response posts situated at strategic points throughout the Arden County. The 'Make Ready' team ensure that all operational vehicles are fully equipped and cleaned, ready for the start of each shift to provide the correct environment for patient care.

Ambulances are moved on a dynamic basis and in line with our System Status Management operational plan that changes each hour. This plan is based on emergency activity, and ensures that the ambulance resources are best positioned to meet the daily patient activity.

The Trust occupies a varied assortment of properties to support this deployment ranging from prefabricated to fixed buildings. We also link in with our partner emergency services colleagues in assisting with accommodation where applicable to the operational plan e.g. Fire Service. All ambulances calls in Arden are received and processed by our Emergency Operations Centre based at Stafford, then assigned to the nearest ambulance to the incident.



## People to Know



Ham Patel – General Manager for the Arden Division based at the Coventry Hub and has responsibility for the delivery of Accident and Emergency performance for the Arden County. Ham joined the ambulance service in 1987 in the previous West Midlands organisation as a patient carer, progressing to a Paramedic and then through to several management positions within the Trust to the post of General Manager for the last 14 years.

Martyn Scott - Area Manager based at the Warwick Hub and is responsible for five Ambulance Support Officers and 108 operational staff. Martyn joined the ambulance service in 2003 as an Emergency Care Practitioner with a background of an Accident & Emergency Nurse and Community First Responder. The fleet at Warwick includes fourteen Ambulances, one 4x4 ambulance, seven Rapid Response Vehicles (cars) and three Major Incident vehicles, which provides emergency and urgent cover in South Warwickshire and surrounding areas.



Aston Watkins - Area Manager based at the Coventry Hub and is responsible for five Ambulance Support Officers with a staff establishment of 195 operational staff. Aston joined the London Ambulance Service in 1992 and moved to this Trust in 1999, progressing through the ranks to his current position. The Coventry fleet includes thirty six ambulances, one 4x4 ambulance and seventeen Rapid Response Vehicles (cars) based at Coventry, which provides emergency and urgent cover in Coventry, Rugby and North Warwickshire and surrounding areas.

Nigel Wells - Assistant Area Manager based at the Coventry Hub and assists the Area Manager in the delivery of operational requirements. Nigel joined the ambulance service in 1982 as an ambulance man at Hereford & Worcester, moved to Warwickshire in 1998 as a Station/Control Manager and progressed through to his current position, supporting Aston.







## **Performance**

Post code activity is variable each week and is dependent on the activity that presents in that post code area each hour of the day. This activity dictates the level of resources required.

### **Coventry Hub Area**

This includes Coventry City and Rugby and falls into the Coventry and Rugby CCG service area. These are the busiest areas in terms of activity and require greater resources than other areas. Activity is challenged during weekends as 111 calls are assigned to 999 ambulances due to insufficient alternative pathways at weekends. Post code activity is variable within these areas and resourcing is achieved by identifying the busiest post codes to ensure calls are serviced appropriately to maintain patient safety.

The main hospital for ambulance transports is University Hospital of Coventry & Warwickshire, which is also the nominated Major Trauma, Percutaneous Coronary Intervention (PCI) and Stroke Unit for the whole of Arden and surrounding areas.

North Warwickshire sits in the North Warwickshire CCG area and presents a problem in its geography as well as insufficient alternative care pathways in the area, resulting in more transports to hospital. This is further impacted by the restrictions in the type of patient/conditions/injury that are accepted by George Eliot hospital based at Nuneaton, therefore this group of patients are required to be transported to University Hospital of Coventry & Warwickshire. This has the effect of depleting resources available in the area. Rapid responses cars are strategically based within the area 24 hours, seven days a week, to ensure cover is maintained at all times.

Current year to date Red 2 performance is 77.8% (National Target=75%).

### **Warwick Hub Area**

This hub sits in the South Warwickshire CCG service area and services our largest rural area in Arden. Performance is challenged due to travel distances and lower numbers of ambulances as the activity is lower than that in the Coventry area. Post code activity is again variable within these areas and resourcing is achieved by identifying the busiest post codes for each day to ensure calls are serviced appropriately to ensure patient safety. However, popular towns for tourism, such as Stratford upon Avon has a transient annual population, which places pressure on resources as activity increases, especially in the summer months. Rapid responses cars are strategically based within the area 24 hours, seven days a week, to ensure cover is maintained at all times.

Current year to date Red 2 performance is 75.9% (National Target=75%).



## Performance Improvement Plan

This is in place to cover each hub area and include the following points to introduce stability and the delivery of performance by month and quarter.

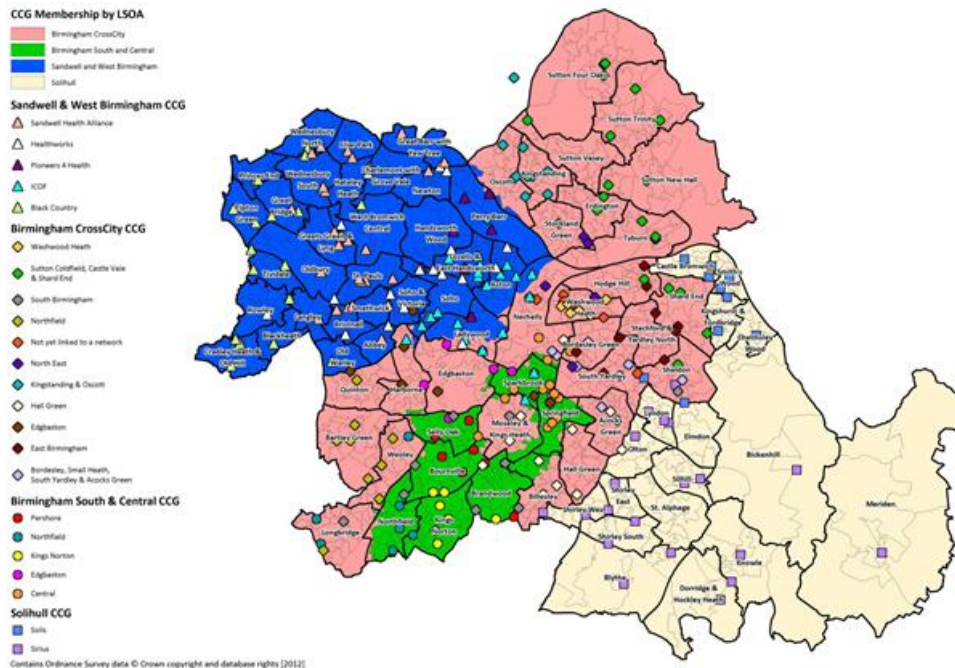
- a) Reduce sickness to 4% to release manpower to operations
- b) Achieve a Paramedic on every ambulance, thus increasing the ability to treat patients in the community more effectively through alternate pathways to ensure the patient is treated at the right place for their condition. This is currently running on an average of 98%.
- c) Reduction of job cycle times from current levels of 87 minutes to 80 minutes
- d) Increase/realign resources to match increase in predicted activity levels to ensure the delivery of a safe service
- e) Report weekly to an operational board chaired by the Chief Executive Officer.

We are continually working with health partners and the Health & Overview Scrutiny Committees to further improve services together for the benefit of our population.



## 2.6.5 Birmingham Division

This overview is intended to provide relative information for various bodies, in understanding the composition, operational make up, challenges that face the west midlands ambulance service in Birmingham and Solihull



The Birmingham/Solihull population is circa 1.3 million residents in the area, and a large transient population that travels into the city centre and returns in evening on a daily basis. The conurbation stretches across 445 sqKM, and is in the main an urban profile.

The Conurbation has 4 Clinical Commissioning Groups, with whom the ambulance service interact on a frequent basis. The CCGs are Birmingham Cross city, Birmingham South and Central, West Birmingham and Sandwell, Solihull.

The ambulance service has strategically located its 2 main ambulance hubs to facilitate both response times ease of supplemental cover, there is also a satellite community Ambulance station at Aston fire station which has a close proximity to the city centre.

An ambulance hub is a centre where staff report to centrally, ambulances are prepared, cleaned and repaired, training and education also takes place. From these ambulance hubs, the ambulances are deployed and strategically placed in line with a dynamic operational plan, the plan changes hourly and depicts the changing activity, this plan is based on emergency activity and historical data, and ensures that the ambulance resources are best positioned to meet the daily patient activity.

The Trust occupies a varied assortment of properties to support this deployment, ranging from prefabricated building to fixed buildings we also link in with the other emergency services and health care provider colleagues in assisting with accommodation where applicable and that is conducive to adherence to the operational plan.



## The People to Know



**Nathan Hudson** – General Manager for Birmingham Division based at Hollymoor Hub with responsibility for the accident and Emergency performance and delivery within the County. Nathan joined the ambulance service in 2005 and has subsequently progressed through posts during his term of service.

**Dean Jenkins** - As Area Manager for Erdington Dean is responsible for 1 Assistant Area manager, 5 Operational Ambulance Support Officers and 258 Operational staff. There are 32 Ambulances and 12 Operational Rapid response vehicles based in either community Ambulance stations or at Erdington. Erdington provides Ambulance cover to the North Birmingham and Solihull area in the main.



**Phil Calow** - Assistant Area manager who holds responsibility for the Community Paramedic CA's sites and staff. Phil ensures that all monthly, quarterly, yearly audits requirements are completed for all sites.

**Dax Morris** - Area Manager at Hollymoor Hub. Dax is responsible for 1 Assistant Area manager, 5 Operational Ambulance Support Officers and 206 Operational staff. There are 30 Ambulances and 10 Operational Rapid response vehicles based in either community Ambulance stations or at the Hub. Hollymoor provides Ambulance cover to the South Birmingham area



**Tim Hughes** - Assistant Area manager who holds responsibility for the Community Paramedic sites and staff. Tim ensures that all monthly, quarterly, yearly audits requirements are completed for all sites.

**Tony Iommi** is the Assistant Area Manager based at Aston Community Ambulance station. Tony is responsible for circa 74 Operational staff. The Aston site puts out 9 operational Ambulances per day and 4 Rapid response vehicles based at other local community Ambulance stations or at Aston Fire station. Aston provides Ambulance cover to Birmingham city centre. Tony also manages the City Centre Treatment Unit (CCTU) that serves the main Birmingham City centre night life hotspots on a Friday and Saturday night providing on the spot medical attention to the night-time economy revellers.





## Performance

### Overview by HUB –

**Erdington** – Erdington Hub became operational in September 2013. The busiest postcode area B23 (Erdington) which is unfortunately not the best performing post code. Most challenged post code B90 (Solihull area). The post activity is not a stable measure as volume and performance changes continually by week, Current challenges resource into the outlying areas of Birmingham north due to the shift of resources to the city centre . 111 activities during weekdays and at weekends is challenging in volume. Insufficient alternative care pathways in the area resulting in more transports to A&E and subsequent protracted delays in hospital Performance

Performance is currently 81.2 Birmingham cross city CCG achieving YTD national target and 74.1% for Solihull CCG .9% below national standard.

**Hollymoor** – Hollymoor hub became operational in July 2013. The busiest postcode area B31 (Northfield) B29 (Selly Oak) the best performing post code. Most challenged post code is B14 (Maypole). Other challenges increasing job cycle times across the whole of Birmingham conurbation.

111 activities during weekdays and at weekend's impacts on the accident and emergency performance, current Operational performance above national standards at 78.8%.

**Aston satellite CAS station** – Aston replaced the existing site of Henrietta Street and went live on the 21<sup>st</sup> May 2014. Aston is the only interoperability site working closely with West Midlands Fire



## 2.7 Major Trauma Network

In March 2012 a Regional Trauma Care system was introduced to ensure that people who suffer major trauma injuries get access to the best possible Emergency Trauma Care. WMAS has been a major stakeholder in the planning and implementation of this system. This has included setting up a dedicated Trauma Desk in our Control Room, staffed by experienced Critical Care Paramedics.



All WMAS Clinicians have received additional training in Trauma Care and specialist trauma care equipment has been supplied to all front line Ambulances and Response Cars.

The Major Trauma Centres in our regional system have recently undergone a peer review process led by the National Clinical Director for Trauma Care, Professor Moran. Feedback has been excellent including the statement that we have "The best Trauma Network in England". There is also evidence to show that the probability of surviving major trauma is rising in our region since the introduction of the Trauma Networks.

Our system was particularly praised for providing a high level of pre-hospital care. Peer review reports recognised that there is excellent integration of clinical governance between West Midlands Ambulance Service (WMAS), the Air Ambulance Services and the Major Trauma Network. Medical Consultant advice and Senior Paramedic Control Room advice is available to crews 24/7 and the medical support (MERIT) system is one of the best developed in England.

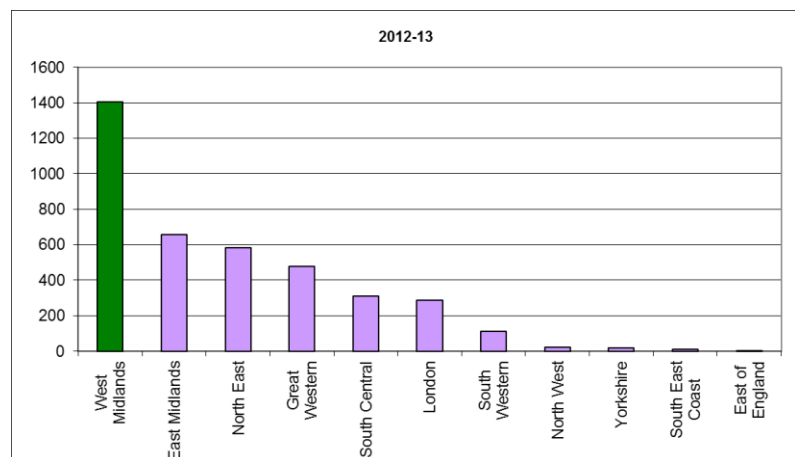
## 2.8 Participation in Clinical Research 2013/14

The involvement of Ambulance Trusts in Research studies is an important step forward in providing evidence of best practise within pre-hospital care, and thus providing evidence to support improved patient care, treatment and outcomes. WMAS are committed to supporting Research and were the highest recruiting Ambulance Trust during the year 2012-13.

During 2013-14 WMAS has been involved with eight research studies.

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

*This graph identifies the number of patients receiving relevant health services provided or sub-contracted by the provider during the reporting period that were recruited during that period to participate in research approved by a research ethics committee within the National Research Ethics Service(a). The number is 432 for 2013-14*





**Summary of Research Studies:**

Sponsor		Summary of Study	
Warwick University	<b>Pre-hospital Assessment of a mechanical compression device</b>	<b>To evaluate the effect of using a LUCAS 2 device rather than manual chest compressions during resuscitation by ambulance clinicians after out of hospital cardiac arrest.</b>	<b>The LUCAS 2 device undertakes chest compressions on patients whose heart has stopped i.e. have had a Cardiac Arrest. The study aims to show whether use of such a device improves outcome for patients and is cost effective.</b>
AstraZeneca	Atlantic Study	The study delivered in collaboration with UHCW, was an international, randomized, parallel-group, double-blind, placebo controlled phase IV study	Aim : to evaluate efficacy and safety of pre-hospital vs. in-hospital initiation of ticagrelor therapy in STEMI (heart attack) patients planned for Primary Percutaneous Coronary Intervention
Warwick University	Out of Hospital Cardiac Arrest Research	Information collected by the Department of Health has shown there to be wide geographical variation in the number of people that survive an OHCA.	This project will try to find out the reasons behind such big differences in outcome. And will provide feedback to ambulance services to allow benchmarking and quality improvement work.
Warwick University	Dispatch	Aims to develop refine and validate a decision support tool to assist Ambulance Service dispatchers in the early identification of cases of major trauma from emergency calls.	The development of this tool has the potential to lead to improvements in the deployment of specialist resources within the West Midlands Major Trauma Network and to target life-saving and life-enhancing treatments to patients who may benefit most
Warwick University	Warwick Spinal Immobiliser	A new spinal immobilisation device has been designed at Warwick University. This study aims to determine if the new device is more effective than the existing collar and blocks, or the Kendrick Extrication Device	If effective this device will remove the need to apply cervical collars, thereby reducing patient anxiety/claustrophobia. The new device has also been designed to reduce risk in relation to airway management and reduce movement between vertebrae.
University College London	A Study of Major System reconfiguration in Stroke Services	This research aims to support and analyse reconfiguration of stroke services in four regions of England (London, Manchester, Midlands and East of England).	In doing so, it aims to identify lessons that will guide future reconfiguration work in this and other settings.
Pennine Care NHS Foundation Trust	The Development of a Parental Suicide Bereavement Training Pack	The aim is to develop a training pack for Health Care Professionals to support them with a parent bereaved by suicide.	The study involves interviews with Health Service staff and also parents bereaved by suicide.
Warwick University	Developing the concept of Emergency Preparedness through the experience of the Paramedic	The aim of developing an understanding of emergency preparedness through the experiences of pre-hospital health-care professionals.	This study will be carried out via interviews with volunteers and will inform future education and training needs with regard to emergency preparedness



## 2.9 National Confidential Enquiries

National Confidential Enquiries (NCE) are special enquiries that seek to improve health and health care through a national collection of evidence on specific aspects of care, the enquiry identifies any shortfalls in this, and disseminates recommendations based on these findings. During 2013/14 there was no National Confidential Enquiries with a focus on Ambulance Trusts.

## 2.10 Goals agreed by Commissioners in 2013-14

A proportion of West Midlands Ambulance Service's income in 2013/14 was conditional upon achieving quality improvement and innovation goals agreed between the Trust and its Emergency and Urgent Commissioners through the Commissioning for Quality and Innovation payment framework. Further details of the agreed goals for 2013/14 and for the following 12 month period are available online at:

[http://www.monitor-nhsft.gov.uk/sites/all/modules/fckeditor/plugins/ktbrowser/\\_openTKFile.php?id=3275](http://www.monitor-nhsft.gov.uk/sites/all/modules/fckeditor/plugins/ktbrowser/_openTKFile.php?id=3275)

Use of the Commissioning Quality Innovation Schemes (CQUIN) for 2013/14

The Trust worked closely with commissioners and agreed these key areas of innovation that would have a positive impact on the patients who use our service. The projects were maintained to ensure milestones were achieved and the outcome for patients resulted in an improved quality of the service.

### 2013/14 CQUIN Indicators

Goal Number	Goal Name	Description of goal	Goal weighting	Expected value of goal	Quality Domain(s)
5.1 (13/14)	Make Ready (2nd year of a 2 year project)	This is a two year CQUIN to support the development of a comprehensive make ready scheme in a phased approach that will result in a total of 5 make ready areas across the region implemented fully by March 2014.	20%	CQUIN Value = £830,764 5% penalty imposed for not meeting the Red 2 operational threshold (£41,538) <b>Total realised = £789,226</b>	Safety Effectiveness
6.1 (13/14)	Hear and Treat (2 year project)	Clinical education provide Clinical support and guidance to all staff Ensure EOCs become Centres of Clinical excellence Migration from a culture of Ambulance Dispatch to a culture of Clinical Care Co-ordination. Support of the new NHS 111 service until service is running as business as usual.	25%	CQUIN value = £1,038,455 3% penalty for not meeting 8% Hear and Treat target (£31,153) <b>Total realised = £1,007,302</b>	Innovation Effectiveness Experience
7.1 (13/14)	Acute Admission Avoidance Scheme	Demonstration of engagement with all health services  Provided data as requested and proactively contributed to ensuring robust action plans are in place for the above determined frequent service users and develop a plan for wider escalation and implementation	35%	CQUIN value - £1,453,837 <b>CQUIN fully achieved</b>	Experience Innovation Safety
8.1 (13/14)	Safety Thermometer (1 year Contract)	Development of an Ambulance specific safety thermometer tool that influences change and drives harm-free care in partnership with other West Midlands providers	10%	CQUIN value -£415,382 <b>CQUIN fully achieved</b>	Safety innovation Effectiveness Experience
9.1 (13/14)	Integrated End of Life Register (2 year project)	Implementation of a flag system for the Ambulance Service that enables people who have anticipated end of life care needs to be cared for in their Preferred Place of Care (PPC) and respecting their Do Not Attempt Cardio Pulmonary Resuscitation Order (DNACPR).	10%	CQUIN value - £415,382 <b>CQUIN fully achieved</b>	Safety Experience Effectiveness





## 2.11 Care Quality Commission (CQC)

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

The Care Quality Commission has not taken enforcement action against West Midlands Ambulance Service during 2013/14. During January 2014, the CQC carried out a review of the service that included; inspections of premises and ambulances, interviews with patients, staff and managers, feedback from partner organisations and local authority scrutiny and safeguarding committees and review of all our compliance with other regulatory bodies.

The final report available from [www.cqc.org.uk](http://www.cqc.org.uk) or the Trust website [www.w31mas.nhs.uk](http://www.w31mas.nhs.uk) confirms the Trust remains compliant with all the requirements of registration except for a minor failure in Outcome 4 - 'Care & Welfare of people who use our Service'. The CQC determined the Trust was required to provide a short term plan for improvements in operational performance targets as some patients, whilst receiving excellent treatment from staff, had experienced delays in response times.

The Trust Senior Team agreed a plan to improve response times by July 2014 and this forms part of the Trust's Operational Plan for 2014/16.

West Midlands Ambulance Service did not submit records during 2013/14 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The Trust is not required to submit this data as it relates to admissions, outpatient appointments and A&E attendances in NHS Hospitals.

## 2.12 Data Quality

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

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

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



## 2.13 Participation in Clinical Audits

The Trust is a member of the National Ambulance Service Clinical Quality Group which develops National Clinical Performance Indicators and National Clinical Audits. The Trust has a comprehensive Local Clinical Audit Programme which includes both National and Local Audits.

The Trust submits data to the Department of Health Ambulance Quality Indicators and to the National Co-coordinator for Clinical Performance Indicators. In addition to these submissions, the Trust produces Local Performance indicators to enable local areas to implement improvements. The Trust is committed to developing links with Local Hospitals to access patient outcomes for patients in pre-hospital cardiac arrest.

During 2013/14, four National Clinical Audits covered NHS Services that WMAS provides. WMAS participated in 100% of the National Clinical Audits that it was eligible to participate in which were;

- National Non-Conveyance Audit (NANA)
- Ambulance Quality Indicators (Clinical)
- Clinical Performance Indicators
- Myocardial Infarction National Audit Programme (MINAP)

The Trust's Local Clinical Audit Programme covers the following subjects, which were identified from any trends highlighted.

- Management of Mental Health
- Deliberate Self-Harm
- Patients Discharged at Scene
- Feverish Illness in Children
- Management of Head Injury
- Management of Asthma
- Management of Peri-Arrests
- Management of Obstetric Emergencies
- Clinical Records Documentation
- Appropriateness of Medicines Management
- Management of Spinal Immobilisation
- Management of Morphine Administration

Following the results of the National Clinical Audits, the Trust has taken the following actions:

- Introduction of a new pain scorer throughout the Trust
- Workshops held to provide further information on the management of Acute Coronary Syndrome.
- Communication through the Trust local newsletters
- Communication through Clinical Notices

Following the results of the Local Clinical Audits, the actions that the Trust has taken includes:

- Changes to the educational programme for staff
- Communication through the Trust newsletters
- Communication to staff through the Clinical Performance & Governance Managers
- Posters developed for stations highlighting the main areas that require improvement
- Audits of equipment available on vehicles
- Implementation of clinical reviews on station
- Development of workshops to provide information to staff
- Review of the clinical record used by the Trust

The progress of the actions is monitored by the Clinical Audit & Research Programme Group.



## 2.14 NHS Number and General Medical Practice Code Validity

The Trust did not submit records during 2013/14 to the Secondary Uses service for inclusion in the Hospital Episode Statistics to be included in the latest published data.

## 2.15 Information Governance Toolkit Attainment Levels

West Midlands Ambulance Service Information Governance Assessment Report overall score for 2013/2014 was 80% and was graded satisfactory.

## 2.16 Clinical Coding Error Rate

West Midlands Ambulance Service was not subject to the Audit Commissions Payment by Results Clinical Coding Audit during 2013/2014.

## 2.17 Patient Safety and Serious Incidents

A patient safety incident is defined as 'any unintended or unexpected incident(s) that could or did lead to harm for one or more person(s) receiving NHS funded healthcare'.

During 2013/14, the Trust reported 885 patient safety incidents with 599 of them reported to the National Reporting and Learning Service (NRLS) as either having caused harm (92) or had the potential to cause harm (near miss).

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

In 2013/14, the Trust identified 21 SIs requiring high level investigation with themes related to:

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

Learning from these Incidents is very important to the Trust. All SI's require the completion of a Root Cause Analysis (RCA) which seeks to identify contributory factors, root causes, learning for both individuals and the organisation and most importantly the provision of recommendations to prevent recurrence.

All RCA reports and their themes are reviewed by the Trust's Learning Review Group (LRG) which consists of a multi-disciplinary membership with an open invite to our Commissioners and the Trust's Non-Executive Directors. The LRG ensures learning from all adverse incidents is taken forward into action across the Trust.

More detailed information relating to all patient safety incidents is available in the Trust's Patient Safety Annual Report for 2013/14 published on the Trust website.



## 2.18 Patient Experience

### 2.18.1 Complaints and Contacts

#### Complaints

The Trust has received to date in 2013/14 417 complaints compared to 471 in 2012//13, a decrease of 11.5% (54). The main reason for a complaint being raised relates to Response (Delay in the arrival of an Emergency or Non-Emergency vehicle).

Breakdown of Complaints by Service Type YTD:

	2011-2012	2012-2013	2013-2014	Variance 12/13 - 13/14
<b>EOC</b>	90	144	135	-9
<b>EU</b>	160	211	188	-23
<b>PTS</b>	61	109	88	-21
<b>Out Of Hours</b>	1	0	0	0
<b>Other</b>	1	7	6	-1
<b>Total</b>	<b>313</b>	<b>471</b>	<b>417</b>	<b>-54</b>

#### Upheld Complaints

The table below indicates that of the 383 closed complaints, 159 were classed as upheld. If a complaint is upheld, learning will be noted and actioned locally and will also be fed into the Learning Review Group for regional learning to be identified and taken forward.

	Total	Upheld	Not Upheld	Part Upheld
<b>Call Management</b>	40	18	17	5
<b>Attitude and Conduct</b>	65	17	29	19
<b>Clinical</b>	86	33	39	15
<b>Driving and Sirens</b>	9	4	2	3
<b>Response</b>	152	80	40	33
<b>Other</b>	31	7	22	2
<b>Total</b>	<b>383</b>	<b>159</b>	<b>149</b>	<b>77</b>

**PALS Concerns** have increased year on year with 1152 concerns raised in 2013/14 compared to 997 in 2012/13, an increase of 15.5% (155). The main reason for a concern being raised related to 'response' which includes response emergency ambulance delays and issues with non-emergency patient transport arrangements.

#### Ombudsman Requests

The majority of complaints were resolved through Local Resolution and therefore did not proceed to an independent review with the Parliamentary and Health Service Ombudsman. During 2013/14 12 independent reviews were carried out compared to 11 in 2012/13. 6 were closed with no further action, 2 were partly upheld, 1 reviewed with no recommendations and the other required a further apology and to be provided with a £250 remedy. 4 cases remain open and are still under investigation by the Ombudsman.



### Patient Feedback/ Surveys

The Trust has received 76 completed surveys through the Trust website and has targeted surveyed:

- 200 Emergency Patients through a postal survey sent to randomly selected patients in May 2013. 73 completed the survey.
- 2705 Emergency Patients through a postal survey sent to randomly selected patients in March 2014. Patients have been asked to return their completed survey no later than 18 April 2014,
- 57 have completed the Patient Survey whilst members of the Patient Experience Team have been attending Renal Units in Coventry and Warwickshire and the Heartlands Hospital.
- 4562 Non-Emergency Patients have been asked to complete the Non-Emergency Patient Survey on 25 and 26 March 2014.

### Patient Engagement

The Patient Experience Team continues to engage with Renal Patients, with focus meetings being undertaken at Castle Vale Dialysis Unit. The Team has also undertaken engagement across the region in 2013/14 with 18 events attended that have included attendance at Healthwatch Events, Elderly Focus Groups, Mother and Toddler Groups.

### Compliments

The Trust has received 972 compliments in 2013/14 compared to 911 in 2012/13. It is pleasing to note that the Trust has seen an increase of 9% (61) in Compliments received.

The Trust has a dedicated compliment email address [compliments@wmas.nhs.uk](mailto:compliments@wmas.nhs.uk) which is available to members of public via the Trust website and PALS leaflets.



More detailed information relating to Patient Experience is available in the Trust's Patient Experience Annual Report for 2013/14 published on the Trust website.



### 2.18.2 Learning from Complaints and Contacts

The Trust promotes learning from complaints and concerns that have been raised by members of the public in order that such incidents do not recur in the future to improve patient care.

Learning can take a number of dimensions:

- Individual learning with the members of staff concerned via case reviews
- Trust wide learning through revised training, introduction or removal of equipment or systems, revised procedures and protocols
- Weekly Briefing or Clinical Times articles

Individual learning will be noted on justified cases to the staff by the means of a case review or additional training. Memorandums may also be issued to groups of staff on improvements to the service. There have been a number of cases where additional notes have been added to a patient's record to improve the patient experience.

#### Examples of Regional Learning during this period:

You said	We did
<b>A number of concerns have been raised regarding the inappropriate parking of Trust vehicles and the use or non-use of sirens whilst attending emergency calls.</b>	<b>Article featured in the weekly brief in relation to parking appropriately and the use of Sirens</b>
<b>3 week old child struggling to breath, complainant was advised that they did not warrant an emergency response and to take the child to the Out of Hours GP</b>	999 calls reviewed by a Clinician for consideration for review at the NHS Pathways National Group
<b>An 18 month old child scalded. Complainant did not receive much assistance when calling 999, was informed it did not warrant an ambulance</b>	We have implemented a change in the guidance for handling 999 calls relating to children who have experienced burns which now results in an ambulance response each time.
<b>A patient fell in the street and could not move, the crew proceeded to sit the patient up. They later were identified as having a spinal injury and sitting could have made this worse.</b>	Spinal Injury care included on the Mandatory Training for all emergency and urgent staff
<b>When transporting a patient to hospital the stretcher was not secured correctly</b>	Articles to remind staff of the importance of securing patients featured in the Weekly Briefing and Clinical Times
<b>Concerns about the length of time patients who had fallen had to wait for an Ambulance (Green2 survey)</b>	Reminded all staff in the Emergency Operations Centre to undertake a welfare telephone call with the patient and to advise of and apologise for any delays whilst checking on the condition of the patient. If the patient has worsened then the call will be upgraded to a more urgent response required.
<b>A number of patients have raised concerns about a delay in the arrival of their non-emergency ambulance transport and the lack of knowledge regarding conditions such as dementia</b>	Notes added to the patient's master booking details within the electronic booking system. E.g. Dementia, risk of falls etc New assistant managers recruited and escalation process reviewed and reiterated.
<b>A patients address in a rural area of the West Midlands could not be located with the use of a satellite navigation system</b>	Special notes linked to a patients address within the Emergency Operations Centre



## **Patient Stories**

The Trust learns from hearing the experience of patients and their families and the Board of Directors welcomes patients who would like to share their experience face to face with them.

The following represent examples of shared experiences; more information on Patient Stories is available in the Patient Experience Report published on our website.

### **Trust Board Meeting - January 2014**

My 9 month old daughter Annabelle had a febrile convulsion on Monday 5th August 2013 at 15:34 hours, having never witnessed anything like it, my partner and I were petrified, and immediately rang 999. As we connected to the operator she stopped breathing, and turned completely grey. My partner relayed all this information to the operator who was fantastic at calming him down and explaining exactly what we needed to do. They talked us through CPR, and she started breathing again, however was foaming at the mouth and still very poorly. Unbelievably, the Paramedic then walked through the door and it had only been 3 minutes since the call was made, very shortly after a second Paramedic came and they both looked after Annabelle brilliantly, making many different observations and putting us all at ease (by this point there were emotional grandparents, uncles and neighbours in our front room!)

The Ambulance then arrived, and the two teams exchanged information. I went with my daughter while my partner followed us in the car. I thought that I'd have to hold Annabelle in the back of the Ambulance, however, there was a brilliant harness that meant she could still see me and I was able to comfort her, but she was completely safe and the Paramedics could also assess her en-route.

I would like to say a huge thank you to all involved, from the Ambulance Controller, to all the Paramedics, and the Student who was brilliant and will make a brilliant Paramedic.

Annabelle is now back to her normal self and I'm sure me and her Daddy will get over the whole episode soon!



## Trust Board Meeting in March 2014 a PALS complaint resulted in an article in the Trusts Weekly Briefing

The topic concerned infection prevention and control after a member of the public observed the conduct of an ambulance Crew at an incident in a public place it was a reminder about hygiene and it stated that;

- All staff are reminded of the importance of good personal hygiene standards which includes hand hygiene
- All Operational Staff (E&U / PTS) must carry an individual hand sanitizer bottles at all times and must be used at all of the relevant opportunities to sanitise hands to ensure patients and staff are safe from all avoidable infections, with special emphasis when performing any invasive procedures.
- Hands must also be free of false nails, nail varnish and stoned rings as all can harbour micro-organisms.
- Staff must also remember to remove any wrist watches and roll up long sleeved clothing when washing their hands with soap and water.
- The sanitising wipes provided on vehicles must be used in the first instance if soap and water are not available and hands are visibly soiled or have been in contact with any suspected infectious diarrhoea and vomiting (D&V)
- If any staff have a problem using alcohol based products, alternatives are available from Distribution
- And for further concerns to contact the lead for the Trust in infection prevention and control.



## Patient feedback via PALS regarding Non-Emergency Patient Transport Service

### What you said

- Why was there a delay in collecting me to/from my appointment? – I was sitting waiting; no-one told me what was happening.

### What we did

- Put a staff notice out to all in the Non-Emergency Operations Centre (NEOC)

Following a number of recent complaints, please read the below email for a reminder that if we are running late for an appointment we should be contacting the patient, even if the clinic will see them later. This task can be delegated to a call taker as long as they are aware of the issues.

If we are running late for a patient's appointment and we cannot contact the clinic please can we still contact the patient to let them know what is happening? Sometimes the patient can make alternative arrangements, but if not then at least they will be aware that there is a problem and we are still trying to contact the clinic.

This will at least reduce the potential distress levels of patients who may already be under stress due to their condition.





## 2.19 Workforce and Organisational Development

### 2.19.1 Our People

The Trust is making progress towards the achievement of 70% Paramedic skill mix. The Trust aims to achieve an average increase in Paramedic skill mix from 61% for 2013/2014 by increasing the number of Paramedics from an average of 1322 to 1615 i.e. 67% of Operational Staff by 2016/2017.

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

2013/14	Appraisals	Mandatory Training	
WMAS	69%	81%	
<b>Staff Development</b>		2014/15	Planned
Graduate Paramedic Recruitment		50	
Technician to Paramedic Conversion		40	
Student Paramedic Year 2		136	
Student Paramedic Year 1		280	
ECA to Tech Year 2		21	
HCRT to Tech Year 2		30	

Working in partnership with Staff side the Trust continues to develop a Health and Wellbeing Strategy and action plan to ensure that health and well-being of staff is supported.

Managers and staff are being supported to update and develop their skills. The Trust are supporting up to 50 Managers to complete an Engaging Leaders Programme of Management Development. The Trust wants to see a 5% improvement in staff recording that they feel valued and engaged in Staff survey results as well as assurance that there is an increase in the number of staff with reviewed personal development plans. The Trust also wants evidence that staff are supported to receive the appropriate level of training as per the training plan.

Measure of Progress	Baseline (2013/14)	Target 2014/15	Target 2015/16
<b>Strive to achieve a 4% sickness level by end local target by March 2015</b>	5.3%	4%	4%
<b>Reduce long term absence rate of over 28 days from 3.6% to 2.5% by 31 March 2015</b>	3.5%	2.5%	2.5%
<b>Increase our Paramedic skill mix levels towards a 70% target by 2016/17 to enable more patients to be treated at scene</b>	61.08%	56.68%	61.47%
<b>Average time from advert to appointment is maintained at 15 weeks</b>	15 weeks	15 weeks	15 weeks
<b>Increase by 10% of BME Student paramedics graduating from Coventry, Staffordshire and Worcestershire Universities by 2016 (2011 -5 year target)</b>	<b>2011/12 Baseline</b> Coventry 6% UoW: 0% Staffs: NA	Coventry 12% UoW 5% Staffs 5%	<b>2015/16</b> Coventry 16% UoW: 10% Staffs: 10%
<b>Actively promote and encourage BME development to encourage a higher % of staff appointed at Band 7 and above. (Was 4.39% March 2013)</b>	6.02%	7.5%	9%



All managers have attended a Leadership Programme or are supported to complete an Engaging Leaders Programme (5 year development plan covering 2013/14 to 2018/19)	57 people	42 people	42 people
Increase the number of staff with reviewed PDPs in place	64%	85%	85%
Staff are supported to receive necessary mandatory clinical update training in accordance with our training needs analysis	83%	85%	85%
Annually deliver programmes according to the agreed Training Days Analysis (TDA) Plan	94%	85%	85%

**Leadership Award for Barbara**

Barbara Kozłowska Head of Organisational Development, was presented with the Health Education West Midlands Leadership Development Champion Award at a ceremony at Aston Villa Football Club on November 6<sup>th</sup>. The award was in recognition of her local and national support for leadership development, and for designing and delivering the highly successful ‘Engaging Leaders’ programme.



Barbara said: *“I feel very proud to be nominated for this award, on behalf of an organisation that takes leadership development very seriously indeed. Effective leadership is at the core of a values-based organisation driving a healthy culture of a fully engaged and empowered staff. We have seen only too clearly how poor leadership can impact on a NHS organisation, very graphically depicted in the Francis Report.”*



*“I believe that developing our current and future leaders is the single most impactful action that an organisation can put its resources into. It is a huge achievement for the West Midlands Ambulance Service to be recognised for its commitment to leadership development.”*

Barbara is seen above on the right being congratulated by Kim Nurse, Director of Workforce & Organisational Development



### 2.19.2 Staff Survey

As in previous years, the National Staff Survey was conducted for WMAS by Quality Health. A total of 850 questionnaires were sent to randomly selected staff across the whole of the Trust. There were weekly reminders in the Weekly Briefing, together with reminder letters sent out by Quality Health to individuals to help the return rate. The Survey closed on the 2<sup>nd</sup> of December 2013.

The responses from staff are reported as 28 key findings and include the calculation of an overall staff engagement score. The staff engagement score incorporates staff's perceived ability to contribute to improvements at work, whether they would recommend the Trust as a place to work or receive treatment, and the extent to which they feel motivated and engaged in their work.

The Trust's overall staff engagement score in 2013 was 3.16 out of 5, compared to 3.28 in 2012. The national average staff engagement score in the ambulance service trusts in 2013 was 3.19.

The key findings in which the Trust has shown the largest improvement are:

- Fewer staff are working extra hours
- Fewer staff are experiencing harassment, bullying or abuse from other staff
- More staff are having equality and diversity training

The Trust achieved scores which placed it in the best 20% of ambulance service trusts in half of the 28 outcomes. However the areas where the Trust's performance is outside of this 20% are a clear indicator of where improvements need to be made. As part of the Trust's action plan, following the national staff survey for 2013, the Trust has developed an aligned bespoke survey to further delve into the findings.

The full Survey results were published on the 26<sup>th</sup> of February 2014 on the NHS Employers website - <http://www.nhsstaffsurveys.com/Page/1006/Latest-Results/2013-Results/>

Follow the link for a copy of the WMAS Summary Report for survey results  
<http://www.wmas.nhs.uk/Pages/QualityAccounts.aspx>

### 2.20 Equality & Diversity

Equality and Diversity is built into everything that we do from our policies, practices and strategies, to public engagement and consultation events, where we regularly ask our local communities how we can improve our services and practices.

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

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

We have also published our Equality Data Analysis report 2013/2014 and will continue to publish our data with comprehensive analysis annually, in order to meet our Public Sector Equality Duty (Equality Act 2010)

As demonstrated within the report, we will improve the way we make informed decisions about our policies and practices, which are based on evidence, and the impact of our activities on equality and the protected characteristic groups. For Further information please follow the link Equality Data Analysis report 2013/14 <http://www.wmas.nhs.uk/>



## 2.21 Sustainable Development Management Plan

The Trust is committed to serving the local community by providing effective, modern and efficient healthcare services. In providing this service the Trust consumes resources and produces waste materials, which have an effect on the local, regional and global environment and may ultimately, impact on the health of the people to whom the Trust provides a service.

To reduce this impact the Trust is committed to continuous improvement in environmental performance and the prevention of any actions that may cause damage or do not support attempts to improve the sustainability of the environment.

Fuel usage is one of the key environmental impacts and the Trust is working towards reducing vehicle weights and emissions. Following the collation of recent information sourced this highlighted an increase in fuel usage, predominantly due to the increased travel requirements and demands on the service. This does impact on the Trusts carbon footprint and further improvements are expected with the changes in fleet designs being implemented over the next 5 years.

In addition the Trust has utilised the NHS BREEAM (HTM 07-07 GM) tool to improve the feasibility/benefits within new builds. All buildings with a total area greater than 1,000 m<sup>2</sup> that require an Energy Performance Certificate have been assessed against the tool. The Trust has considered where energy efficiency initiatives can be best deployed, these include:

- Thermostats and timer devices
- High efficiency boilers
- Low energy light bulbs
- Movement Sensors
- Insulation
- Solar power generation

The Trust has increased its premises considerably over the last 2 years to address the needs of the local population therefore the energy usage has increased. Once identified the energy efficiency data from 2013/14 will be used as a baseline to set a decreasing target for future years to achieve improvements.

The Trust has continued to invest in its staff ensuring resilience through progressive recruitment and education programmes ensuring that the skill mix to provide the service will be sustainable.

In the case of procurement the Trust has sourced its requirements from NHS approved sources ensuring all companies contracted have an environmental management system. All resources procured are considered for recycling capacity and their potential impact on the trust waste management stream capacity and carbon footprint.

Recycling is an area that continues to develop; the Trust's segregation of waste generated from clinical care and information technology hardware is carried out effectively. The Trust is now focussing on the domestic waste generated through its administration of the organisation which includes in the main paper and card products. The segregation of this waste is sporadic across the various sites and during 2014/15 this will be improved.



## PART 3

### 3.1 Priorities for Improvements 2014-15

The Trust has agreed the following priorities for 2014/15 after engagement with patients, users and communities and the guiding principle has been “**no decision about me without me**”. The Trust is committed to ensuring a process that reviews, maintains and improves high standards of care.

#### 3.1.1 Patient Safety

<b>Priority 1 Single Limb Fractures (Previously Lower Limb Fractures)</b>	
<b>Rationale</b>	During 2013/14 the Trust along with other Ambulance Trusts developed and implemented measurements for evaluating the effectiveness of care for patients with lower limb fractures. The Trust aimed to ensure documentation (detailed below) was recorded for 85% of relevant patients. This was not achieved; the Trust achieved 35.4% against a national ambulance mean of 45%. Therefore this priority has been carried over to 2014/15 and will aim to achieve the nationally agreed target.
<b>Measures reporting to QGC &amp; EMB</b>	<p>The figures above relate to the figures for last year when the CPI was only concerned with lower limb fractures, going forward the CPI criteria has been widened to include all single limb fractures.</p> <p>Extremity fractures are commonly seen in pre hospital care. They demonstrate a wide variety of injury patterns which depend on the patient’s age, mechanism of injury, and pre-morbid pathology.</p> <p>This CPI has the following 4 elements:</p> <p><b>F1</b> Two pain scores recorded (pre and post treatment)  <b>F2</b> Analgesia administered  <b>F3</b> Immobilisation of limb recorded  <b>F4</b> Assessment of circulation distal to fracture site recorded</p> <p>And one care bundle:</p> <p><b><u>FC Care bundle for single limb fracture (F1 + F2 + F3 + F4)</u></b></p> <p><b><u>Evidence:</u></b>            UK Ambulance Services Clinical Practice Guidelines (2013) Section 4, <i>Trauma – Limb trauma</i></p> <p><b><u>Inclusion Criteria:</u></b>            Adult patients (age ≥ 18 years) with a suspected fracture of a single limb.</p>
<b>Target</b>	Target 85%
<b>By When?</b>	31 March 2015
<b>Outcome</b>	The target of 85% is achieved
<b>Baseline</b>	35.4%
<b>Lead</b>	Head of Clinical Practice -Trauma



<b>Priority 2: Maintaining Neonate Temperature</b>	
<b>Rationale</b>	<p>Hypothermia for babies that have just been born and become cold can have major implications. There is evidence that emphasises the importance of close physical contact with the mother for temperature regulation during initial postnatal days.</p> <p>Currently due to safety reasons WMAS cannot encourage skin to skin contact with mother during transfer in an ambulance as there is no product on the market that meets both European Safety standards and the requirement of the ambulance service.</p> <p>Current Trust thermometers are not always accurate when measuring new born temperatures and the Trust will strive to ensure the right equipment is available in order to monitor current practices.</p>
<b>Measures reporting to QGC &amp; EMB</b>	<p>Qtr1</p> <ul style="list-style-type: none"> <li>- Establish a working group to include midwifery and new mothers group representation</li> <li>- Establish exactly what new products are either in the market place or under development</li> <li>- Identify midwifery/neonate unit(s) to support initial trial and future audit</li> <li>- Identify and obtain suitable thermometers that take new born temperatures accurately</li> <li>- Develop an audit tool to measure compliance with recording of new born temperature</li> </ul> <p>Qtr2 &amp; 3</p> <ul style="list-style-type: none"> <li>- Work with suppliers to develop/trial equipment for safe transfer of the baby in mothers arms</li> <li>- Establish a baseline with current equipment in trial areas using the above audit tool (July 2014)</li> <li>- Evaluate baseline in partnership with midwifery/neonate unit</li> <li>- Promote the need for accurate recording and management of neonate temperature (Aug 2014)</li> <li>- Commence trials (Sept 2014)</li> <li>- Continue to audit for improvements.</li> </ul> <p>Qtr4</p> <p>Evaluate and make recommendations for Trust equipment requirements and education and training.</p>
<b>Target</b>	Suitable equipment is available to allow new born skin to skin contact and monitor temperature
<b>By When?</b>	31 March 2015
<b>Outcome</b>	New born babies will arrive at hospital suitably warmed with accurate recordings in place
<b>Baseline</b>	No suitable product available for skin to skin contact in an ambulance/Inadequate temp recording
<b>Lead</b>	Obstetric & Neonate lead

### 3.1.2 Clinical Effectiveness

<b>Priority 3: General Pain Management (2<sup>nd</sup> Year of Project)</b>	
<b>Rationale</b>	<p>This target has not been achieved therefore this will be measured during 2014-2015. Further recommendations will be made to ensure improvement.</p> <p>Pain is defined as an “unpleasant sensory and emotional experience associated with actual or potential tissue damage” *. The patient deserves appropriate assessment and management of pain, minimising any adverse physical or psychological effects. Documenting the pain score allows WMAS to ascertain whether pain assessment has been achieved.</p>
<b>Monthly Board report</b>	<p>Qtr.1 : Develop general Pain management Guidelines to include scoring</p> <p>Qtr. 2&amp;3: develop a pain workbook with e-learning and upload to the Virtual Learning site</p> <p>Qtr. 4: Documentation to increase by 10% from baseline for Qtr. 4</p>
<b>Target</b>	An e-learning package will be developed and increase pain scoring documentation by 49% of the baseline
<b>By When</b>	31 March 2014
<b>Outcome</b>	Better patient experience and clinical effectiveness
<b>Lead</b>	Clinical Quality Manager
<b>Baseline</b>	39%



<b>Priority 4: Timely and Effective Transfer</b>	
<b>Rationale</b>	<p>The Trust has established that with the improved skill set of Ambulance Clinicians and the drive to keep more people at home the time on scene has increased greatly</p> <p>This increase in time is resulting in a lack of available resources to respond to other patients requiring a 999 response. The extended time on scene can be proportioned to a number of reasons, including, difficulty in accessing alternative care pathways, extended skills requiring extended time, or Trust policies and procedures implemented may have resulted in increased paperwork or ineffective use of resources on scene.</p> <p>This priority addresses the length of time a responder car has to wait for a double crew ambulance to transfer a patient to a definitive place of care. We aim to establish how this delay could be reduced thus allowing the release of the responder car back on the road to deal with the next emergency.</p>
<b>Measures reporting to QGC &amp; EMB</b>	<p>Qtr1</p> <ul style="list-style-type: none"> <li>- Identify baseline for the average length of time a responder car has to wait for a double crew ambulance</li> <li>- From the baseline the target will be decided</li> <li>- Ops lead to be established to lead project</li> <li>- Performance cell line of reporting to be established</li> </ul> <p>Qtr2&amp; Qtr3</p> <ul style="list-style-type: none"> <li>- Identify areas of significant delays above the average waiting time for back up</li> <li>- Develop action plan for areas with above average waiting times</li> <li>- Implement action plan and establish improvements</li> </ul> <p>Qtr4 -Implement action plan and establish improvements</p>
<b>Target</b>	Waiting times for backup will be in line with the baseline or below for 50% of all back up requests
<b>By When?</b>	31 March 2015
<b>Baseline</b>	To be confirmed in quarter one
<b>Lead</b>	Head of Clinical Practice – Vulnerable Persons with an identified Ops lead
<b>Priority 5: Timely and Effective care delivered on scene - commissioning</b>	
<b>Rationale</b>	<p>The extended time on scene can be proportioned to a number of reasons, including, difficulty in accessing alternative care pathways, extended skills requiring extended time, or Trust policies and procedures implemented may have resulted in increased paperwork or ineffective use of resources on scene.</p> <p>This priority addresses the commissioning of services ensuring that the directory of service (DOS) allows our crews to refer into alternative pathways in a timely manner</p>
<b>Measures reporting to QGC &amp; EMB</b>	<p>Qtr1</p> <ul style="list-style-type: none"> <li>- Average time on scene to be established</li> <li>- Each DOS lead to identify conditions associated with over average time on scene in their area</li> <li>- Complete in-depth reviews and evaluate clinical conditions that appear to have increased time on scene above the average</li> <li>- Top clinical conditions to be reported to Clinical Steering Group (internal) and Clinical Quality Commissioning Group (external) to be agreed for improvement</li> </ul> <p>Qtr2</p> <ul style="list-style-type: none"> <li>- Identify standard lists of reasons for delays</li> <li>- Clinically audit review of sample</li> </ul> <p>Qtr3 - Identify partners and actions to support improvement</p> <p>Qtr4 - Implement action plan and establish improvements</p>
<b>Target</b>	Delays on scene due to priority areas identifies are reduced to be confirmed in Qtr2
<b>By When?</b>	31 March 2015
<b>Baseline</b>	To be confirmed in Qtr2
<b>Lead</b>	Head of Clinical Practice – Vulnerable Persons with the directory of service leads



<b>Priority 6: Timely and Effective Care on scene - clinical and training</b>	
<b>Rationale</b>	<p>The Trust has established that with the improved skill set of Ambulance Clinicians and the drive to keep more people at home the time on scene has increased greatly.</p> <p>This increase in time is resulting in a lack of available resources to respond to other patients requiring a 999 response. The extended time on scene can be proportioned to a number of reasons, including, difficulty in accessing alternative care pathways, extended skills requiring extended time, or Trust policies and procedures implemented may have resulted in increased paperwork or ineffective use of resources on scene.</p> <p>This priority aims to address the clinical process, and training requirements, for the identified clinician ensuring the right models are being adopted and training delivered appropriately to address any gaps identified for improvement</p>
<b>Measures reporting to QGC &amp; EMB</b>	<p>Qtr1 &amp; 2 Using the information gathered for average time on scene and the identified clinical conditions associated with over average time on scene in their area the Clinical Steering Group (internal) and Clinical Quality Commissioning Group (external) will identify and agree the top clinical areas for improvement and leads in those area will be identified</p> <p>Qtr3&amp;4 – clinical leads will review policies and process for improvement and feedback to Clinical Steering Group (internal) and Clinical Quality Commissioning Group (external)</p> <p>Training will deliver an action plan for session delivery for 2015-16</p>
<b>Target</b>	Delays on scene due to priority 4 cases are reduced
<b>By When?</b>	31 March 2015
<b>Baseline</b>	To be confirmed in Qtr2
<b>Lead</b>	Head of Clinical Practice – Vulnerable Persons to lead with clinical and training leads identified

### 3.1.3 Patient Experience

<b>Priority 7: Successful implementation joint working/engagement with other NHS Trusts within the West Midlands area of the Friends and Family Test (FFT)</b>	
<b>Rationale</b>	<p>The NHS wants to ensure that patients have the best possible experience of care. The Friends and Family Test (FFT) is a way of gathering patient feedback about this experience and helping to drive improvement in NHS services. To successfully implement FFT the ambulance service with assistance for the Clinical Commissioning Group (CCG) will engage with Acute Trusts to ensure patients conveyed to Emergency Departments are given the opportunity to give feedback on their experience of care at the ambulance service stage of their patient journey. The feedback will give the Ambulance Service invaluable information on what patients think of the service, which can be used to help make improvements if required. With the implementation of 'You said, we did'.</p>
<b>Measures &amp; reporting to board;</b>	<p>Qtr 1 – Awaiting guidance from NHS England expected in June 2014. Forge relationships with Acute Trusts through the CCG.</p> <p>Qtr2, 3 &amp; 4 - Evidence of engagement with NHS Trusts and successful implementation with 5 Acute Trusts, 1 in each Division of the Region.</p>
<b>Target</b>	Awaiting guidance of the % of patients that should be targeted. However implemented in 5 Trusts across the Region.
<b>By When?</b>	March 2015
<b>Outcome</b>	Success implementation of the FFT in line with NHS England Guidance
<b>Baseline</b>	TBC in Quarter one, June 2014
<b>Lead</b>	Head of Patient Experience





<b>Priority 8: Addressing Health Inequalities (3 year project)</b>	
<b>Rationale</b>	<p>"Health inequalities are preventable and unfair differences in health status between groups, populations or individuals. They exist because of unequal distributions of social, environmental and economic conditions within societies, which determine the risk of people getting ill, their ability to prevent sickness, or opportunities to have access to the right treatments.</p> <p>In terms of overall health, the West Midlands appears there are clear health inequalities between areas, with indicators showing lower levels of health tending to be clustered in the metropolitan and urban areas.</p>
<b>Measures &amp; reporting to board;</b>	<p>Qtr 1 &amp; 2</p> <ol style="list-style-type: none"> <li>1. Identify the key Public Health Priorities within the region</li> <li>2. Work with Public Health teams to; <ul style="list-style-type: none"> <li>• Determine which priorities WMAS may be able to support improvements</li> <li>• Determine what Trust performance data is available or required</li> <li>• Identify 3 Health Inequality priorities that WMAS can have the most impact on</li> </ul> </li> </ol> <p>Qtr 3</p> <ol style="list-style-type: none"> <li>1. Identify partners and develop the 3 action plans for improving the patient experience and reducing health inequalities</li> </ol> <p>Qtr 4</p> <ol style="list-style-type: none"> <li>1. Implement the 3 action plans for monitoring and review during 2015/17</li> </ol>
<b>Target</b>	To be determined once priorities have been set
<b>By When</b>	31 March 2015
<b>Outcome</b>	WMAS will work proactively against three key priorities determined in partnership with the health and wellbeing boards.
<b>Baseline</b>	TBC in Qtr2
<b>Lead</b>	Qtr 1&2 EDI Lead then To be determined once priorities have been set

<b>Priority 9: Patient engagement focusing on the under 18s</b>	
<b>Rationale</b>	<p>Patient and public engagement has been on the NHS agenda for many years however the impact has been disappointing. There have been a great many public consultations, surveys, and one-off initiatives, but the service is still not sufficiently patient-centred. In particular there has been a lack of focus on engaging patients in their own clinical care, despite strong evidence that this could make a real difference to health outcomes. This priority wishes to address a more strategic approach to shift beliefs, attitudes and behaviours and we want to target the under 18 patient group. This would allow not only enhance patient experience by allowing the organisation to understand this group better but also patient awareness of what the ambulance service is about targeting mother and baby groups, schools and colleges</p>
<b>Measures &amp; reporting to board;</b>	<p>Qtr 1 Action plan presented to the board for the coming year of engagement opportunities</p> <p>Qtr2, 3 &amp; 4 Evidence of engagement</p>
<b>Target</b>	Attendance at 12 patient engagement events involving under 18s
<b>By When?</b>	March 2015
<b>Outcome</b>	Feedback from under 18s at 12 engagement events
<b>Baseline</b>	2
<b>Lead</b>	Head of Patient Experience



### 3.2 Proposed CQUIN Priorities for 2014/15

(Developed March/April 2014)

No	CQUIN Goal	CQUIN Detail	Weighting % of CQUIN	Expected value
1	Hear and Treat 2 <sup>nd</sup> Year of project.	Monitor overall effectiveness of the Clinical education programme within centres (based on the Trusts Strategic Objectives), provide Clinical support and guidance to all staff and to ensure that the current Dispatch focussed EOCs become Centres of Clinical excellence to further support the Trusts Objective of Accurately assessing the patient needs and direct resources appropriately (right care, first time, all of the time). Migration from a culture of Ambulance Dispatch to a culture of Clinical Care Co-ordination. Support of the new NHS 111 service until service is running as business as usual. This Cquin is further supported by the gap analysis within the DOS and exception reporting on those areas not being fully utilized.	20	<b>£882,135</b>
2	Pre- Alert Hyper- Acute Stroke Pathways	A pathway is in place between WMAS and the receiving Hyper-Acute Stroke Unit (HASU), in line with the Midlands and East Stroke service specification The Ambulance Paramedic service links with the receiving hospital when they have a suspected stroke patient, providing a system of pre-alert to enable potential stroke patients (FAST positive) to be met on arrival.	22	<b>£970,348</b>
3	Integrated End of life register – 2 <sup>nd</sup> Year of project.	People that are near there end of life should, where possible, have an advanced plan stipulating pre-planned pathway of care to ensure that a person gets the most appropriate care first time. Care at the end of a person's life is critical to get right. People are being encouraged to indicate where they wish to die at the end of their life. Sometimes, people ring 999 for an ambulance as the point of death approaches – it is important that the Ambulance Service respect the wishes of the person who is dying. The pre-agreed plan of care should be implemented rather than transporting the person inappropriately to an acute unit.	18	<b>£793,921</b>
4	Learning from Safeguarding concerns	There is a need to ensure safeguarding practices support the needs of vulnerable children and adults. Therefore this indicator is aimed at ensuring that providers continue to embed safeguarding into practice, implement lessons learnt following a safeguarding event, reflect on practice and ensure that the voice of the child/adult is heard.	10	<b>£441,067</b>
5	Friends and Family test	<ul style="list-style-type: none"> <li>• Implementation of staff FFT</li> <li>• Early Implementation</li> <li>• Phased Expansion</li> </ul>	20	<b>£882,135</b>
6	Reduce Re-contact rates	Ambulance re contact rate following discharge from care.	10	<b>£441,067</b>
			<b>100</b>	<b>£4,410,674</b>



## Annex 1: Statement from the Lead Commissioning Group

The Quality Account is a thorough account of WMAS activity during the period.

The trusts have identified areas for development and have established a plan for delivery.

CQUIN targets were achieved for 2013-14 and subject to minor alterations, will be agreed for 2014-15.

Performance, at a regional level, of KPIs is good. There are actions in place to address Red 2 which should both achieve and sustain performance."

### **Gail Fortes Mayer**

Regional WMAS Commissioner

## Annex 2: Statement from the Council of Governors

In many areas it is pleasing to see how WMAS not only responds and adapts to the problems it faces on a daily basis but also looks ahead to see what can be improved. A dynamic organisation that puts its patients first. However, it would appear somewhat surprising that it falls down in what on principle would be seen as areas of basic skill or documentation. The higher end skills of its staff would seem to be well maintained and mentored, but the foundation blocks appear to be slipping slightly, again, we as Governors, can only comment from an almost lay point of view. Overall it is an excellent report, but we would highlight the following points for good or bad.

### **2.1 Priorities for Improvements and Statements of assurance from the board for Projects from 2013-14.**

Pain scoring would seem to be an issue here in General Pain Management and Lower Limb Fractures and we can see that the Trust is planning to take steps to improve, but is this an issue of failure to take pain scores or a failure to document. This again would appear as a basic skill?

There is mentioned a new pain scoring technique. Has this also been passed onto the Trusts Community First Responders who are first on scene and occasionally start the documentation process?

[Response; Pain assessments will be rolled out to CFR's to ensure continuity throughout.](#)

**P9 2.2** We note the failure to reach 2 targets but are aware that the Trust is looking at this dynamically for improvements to be made.

**P21 2.7** We note the excellent work the Trust is doing with stakeholders to improve patient experience and quality of treatment.

### **Priorities for Improvements 2014-15**

**Priority 1** Does not have an outcome % marked down. The target is 85%, with achievement so far of only 35%; again we would see this as a basic documentation or patient assessment skill?

**Priority 2** P33 3.1 Again we note the excellent work of the Trust in its perception of a problem and immediately researching ways to improve.

**Priority 3** We note this is an area where improvement is required and suggest Governors monitor this through the Patient Quality Panel.

**Priority 4,5 and 6.** We note the Trust is looking at this problem dynamically and attempting to tackle it from different angles

**Priority 7** Excellent work

**Priority 8** We would like to see a presentation and explanation of this to the Governors, it sounds good (We think, but does it detract from the problem that we are basically poor at maintaining our own individual health, or is that too simplistic?)

**Priority 9** Good

Overall an excellent report from an excellent Trust but with a few niggling concerns.

John Davies, Chair of Patient Quality Panel on behalf of the Council of Governors



## Annex 3: Local Healthwatch, Overview and Overview and Scrutiny Committees

### Healthwatch Dudley

I feel there is more commentary required to support some of the data presented in order to quantify the results, on the face of it some of the data could reflect negativity when in fact there is a genuine rationale for missing certain targets i.e. the bundle for asthma patients i.e. when they are patients too poorly to have the peak flow recorded, there were a few examples throughout the document where explanation/interpretation would have been useful.

[WMAS Response: Additional supportive dialogue has been included.](#)

I think the document would be even better if WMAS could capture patient (and public) experience and engagement rather than just statistics about the number of complaints, the process for learning lessons from complaints is not evident nor is the involvement of patients in service design PTS and NHS 111 for example

[WMAS Response: The QA now has more dialogue of the 'you said- we did'](#)

I had a discussion with Marie after the event regarding closer working relationship with Healthwatch as we have strong network and links into patients, patient groups and voluntary forums all of which are potential users of WMAS services. Sophia gave some great examples of work WMAS are doing to reach lesser heard voices yet this was not reflected in the paper.

[WMAS Response: Meetings are currently being arranged with each Healthwatch to discuss joint working.](#)

### Healthwatch Solihull

WMAS Priorities: It is clear that the trust is working very hard towards its planned priorities and goals amidst a year of change and adjustments for ambulance crews and teams. The transfer of the 111 contracted services appears to be out performing its predecessor NHS Direct in terms of quality and turnaround times. Although this is in its early stages, still the clinical model being used appears to be adding stability to the service by having a clinician available on every pod within the call centres. Performance targets and continued publicity around the 111 services needs to continue to ensure the take up and peoples understanding of what it provides is well understood.

Patient Safety Lower limb fractures – this will be taken into 2014/15 with a rethink about compliance with national KPI. Improvements in this priority should be a lot clearer in terms of what that looks like. 35.4% WMAS achievement leaves a shortfall against the national mean of 43% suggesting more work can be done to improve this priority.

[WMAS Response: There is an action plan in place to improve performance in this CPI that includes raising awareness with staff and including prompts on the EPRF system](#)

Patient Experience and Engagement - The most valuable sort of information in any health organisation is the real time experiences of people who use those services. Engagement and consultation form part of that role. Whilst it remains a trust priority going forward it has not been doing as well as it could, with the issues concerning 'Make Ready' and the very understated changes affecting the location of where ambulances would be stationed or moved to has not always been communicated effectively as could have been.

[WMAS Response: The implementation of FFT will help with this concern raised.](#)

HWS hopes the trust has learned some lessons from this recent change and plans to ensure a more proper informed model is adopted in the future particularly with any decisions made around the (Hyper) Acute Stroke Units of which key WMAS are leading on.

[WMAS Response: The Commissioning Support Unit based at Sandwell and West Birmingham Trust has developed a robust model for the changes to Stroke services. The Trust is working with Commissioners and HoEFT to ensure that any changes to clinical pathways are appropriately managed, commissioned and introduced](#)



Patients complaining of waiting times with fractures longer than 30 minutes should be an exception rather than the norm and we would want to see the Trust doing everything it can to reduce the long waiting times. Three Local Healthwatch can be a valuable resource in this area and suggest the WMAS looks at a model of co-production in engaging with the public jointly with this resource.

#### Workforce and Organisational Development

Highly skilled well trained staff and clinicians are vital to any emergency service. High pressure environments result in a raft of stress related conditions that spiral if not managed by the organisation. Reducing longer term sickness absence should be a priority for the trust as the figures currently run at 3.5%.

#### Healthwatch Hereford

This draft is much easier to read and more focused on achieving improvement than some other trusts' Quality Account drafts. Our observations are intended to highlight "obvious" questions prompted for the reader, or to promote clarity.

Inconsistent use of results data v's ticks and crosses in Status column. Prefer that actual data should be used consistently where possible.

[WMAS Response: Thank you for this feedback we have amended where possible](#)

P6 General Pain Management – this talks only about pain assessment – what about actual pain management?

Definition against "Red19 Mins" is ambiguous or incorrect. This wording was changed recently in the Healthwatch reports for greater clarity for non-expert readers.

General observation:

Some reporting of high level performance data is grouped inconsistently. For example "West Mercia" results are an average for three large counties, whereas more "local" single county figures are given for other data. This is frustrating for anyone attempting to make comparisons between areas or drill down into the figures. Some sceptical readers might interpret this as allowing undesirable results to be obscured.

[WMAS Response: Apologies if this is confusing we hope the final version of this document is clearer, more information is available in the Trust's Annual Report which will be published in July 2014.](#)

Patient safety – Serious Incidents. There appears to have been a very large reduction. This begs the question of how this was achieved.

Of the listed contributory factors, how many were relevant to the 18 SIs mentioned? Were some more prevalent than others and hence worthy of special corrective action?

[WMAS Response: The number of Serious Incidents reported during 2013/14 has not greatly reduced and a more detailed explanation will be published on our website within the Trust's Annual Patient Safety Report.](#)

Complaints – assuming that figs for 2013/14 were for an incomplete year, these should be adjusted pro-rata for better comparison with other years.

[WMAS Response: Figures updated and refer to full years.](#)

If only 40% of complaints were "upheld", what were the main reasons for others being rejected?

The NEPTS survey was commissioned for dates (~25 April) now past. Results should be included in the report.

[Response; All complaints are taken seriously based on the outcome of the investigation the remaining were either not upheld \(no case to answer\) or part upheld \(elements justified\)](#)

The Compliments paragraph is confusing.

[WMAS Response: This has been amended](#)

Why is the target Paramedic mix lower in 2014/15 than 2013/14? Ditto TDA figures?

[WMAS Response: This is due to the increased recruitment of student paramedics during 2014/15](#)

Sustainable Development Management Plan – refers to an NHS initiative, but with nothing given about any action plans.

[WMAS Response: This section has now been completed and should read more clearly](#)



#### Priorities 2 and 3 - Neonate

These are important for Herefordshire which, we understand, has nearly the highest birth at home rate in England at about 4% (approx. 60 babies per year), so it's vital that WMAS is trained and equipped properly.

#### Priority 8 – Addressing Health Inequalities

Unlike the rest of the report, this reads as rather a vague and long-winded extract from a text book. Suggest re-writing in a style more consistent with the rest of the document.

One of the bullet points asserts that “Tackling health inequalities means tackling climate change.” – This is not obviously the case and is open to debate. There is nothing about what WMAS will do other than vague notions of partnership working.

[WMAS Response: More details regarding how the Trust is tackling Health Inequalities will be made available via Board reports once the work with Commissioners, and HealthWatch has been completed.](#)

Priority 9 – Under 18s we welcome this priority as under 18s can be a forgotten group in the healthcare system.

#### **Healthwatch Worcestershire**

Do the priorities of the provider reflect the priorities of the local population?

The local Clinical Commissioning Groups (CCGs) have the flexibility to reflect their population's priorities and those of Worcestershire Health and Well Being Board in the Trust's contract, and particularly the Commissioning for Quality and Innovation Payment framework (CQUIN). Migration from a culture of despatch to clinical care coordination including NHS111 (CQUIN 1); Stroke pathways (CQUIN 2); End of Life care (CQUIN 3); learning from safeguarding concerns (CQUIN 4) and implementing the Family and Friends test (CQUIN 5) reflect issues raised with Healthwatch during 2013/14.

The additional support required to achieve the national targets, 'Lower Limb Fractures documentation' (Priority 1), and 'Timely and Effective Transfer' (Priorities 4 and 5) are particularly important for rural Worcestershire as these safety concerns have also been raised during 2013/14.

The Neonate Priorities (2 and 3) could benefit by the Trust working with the Worcestershire Maternity Services Forum as new and reconfigured services are introduced in Worcestershire during 2014/15.

Working with local Health and Well Being Boards to address health inequalities (Priority 8) is supported, but particular inclusion of mental health and learning disability would be welcomed.

Priorities 7 and 9 re patient experience and specifically under 18s would also benefit from more involvement with local Healthwatch and the CCGs to achieve best practice and use of resources across the West Midlands.

[WMAS Response: Meetings are now being arranged with each Healthwatch to discuss joint working](#)

Are there any important issues missed in the Quality Account?

The Statement on Quality from the Chief Executive was still to be provided along with several status and target figures at the briefing on April 28th. Some errors were also highlighted for correction.

It was suggested that the timeline for responding to complaints could be included and learning and improvements from these, serious incidents, patient stories and public engagement work would demonstrate a culture of effective quality improvement.

[WMAS Response:; The QA has now been extended with more dialogue of the ' you said – we did'](#)

Providing more trends, national figures and benchmarking against other Trusts e.g. safeguarding training, would assure public confidence in the service, especially as the Trust is a member of the National Patients' Panel.

[WMAS Response: The Trust's Safe Guarding Annual Report provides more comprehensive information and will be published on our website in July.](#)

Has the provider demonstrated they have involved patients and the public in the production of the Quality account?



The Trust's Patient Experience Team reports through to the Quality Governance Committee of the Board and may benefit from closer working with local established Healthwatch as it is still at an early stage in proactive working with patients and the public.

Response ; As above, the 'you said-we did' dialogue has been extended.

The Trust had had a low response to patient Feedback Surveys from emergency patients and it is appreciated that this may be difficult. With the introduction of the Friends and Family test in June 2014 it may be possible to receive more feedback from this part of the service as well as non-emergency patients and callers to the important NHS111 service.

WMAS Response: The Trust is awaiting guidance for the implementation of FFT. The Trust will be looking to engage with Hospitals to implement the FFT and hopefully increase responses.

Staff should also be encouraged to participate in surveys and contribute to service improvements.

WMAS Response: Staff have recently undertaken a survey through Clever Together asking how they think they could improve Patient Experience. The results will be shared with the Operations Team to review consideration for implementation.

Is the Quality Account clearly presented for patients and the public?

The document would benefit from a good introductory summary from the Chief Executive, highlighting achievements and areas to be improved.

In the statistical charts West Mercia should be defined but it would be far more helpful to include the individual counties as otherwise the public of Worcestershire cannot gain assurance and confidence that the Ambulance Trust is safe and effective for the local population, particularly as some of the charted performances have declined.

It would be also be helpful to show the Performance Summary for the year by the same County definitions along with explanatory comments so that the 2014/15 Priorities are shown to relate.

WMAS Response: This information is included in a monthly report sent to Health Overview and Scrutiny Committees. The Trust is happy to share this further with Healthwatch.

A good glossary is provided and most abbreviations have been spelled out on their first use, which is helpful, although this does not apply to VLE, ANTT, and OHCA.

The length and complexity of the document may discourage readership. It is unfortunate that the content is prescribed by the Department as the main areas of concern for the public could be in a much shorter publication with the details in the Annual Report, rather than the Trust having to produce two extensive documents.

### **Healthwatch Coventry**

We have found producing this challenging due to the incomplete nature of the document we have received this year and time frame for response set by WMAS.

Other NHS trusts provide us with an early draft of the document for us to give initial feedback - this has the benefit that this feedback can be taken into account in the drafting. They then provide a complete version of the document for us to write our commentary. We would like WMAS to adopt this approach and ask for another version of this year's document which contains the missing data and text. If you are able to do this we will revise our commentary and get this agreed at our June Steering Group meeting (3rd June). If you are not able to send a more complete draft of the document then the attached commentary stands as our submission for inclusion, and we will publish this in June. Please let the Healthwatch Chief Officer, Ruth Light (r.light@vacoventry.org.uk) know how you will proceed.

The version of the draft quality account Healthwatch Coventry received to enable us to compose this commentary was not complete. It did not contain all of the data, outcomes of CQUIN goals, or the statement of quality by the Chief Executive. Therefore we cannot comment on a lot of the performance data. This is



regrettable and could have been avoided by a shift in the timeline used by WMAS. Other trusts provide us with an early draft of their Quality Accounts and then a further complete draft for us to write our commentary. Whilst the document has a pretty comprehensive glossary it is technical and therefore we did not find it easy to read. As quality accounts are public documents this is a shame.

[WMAS Response: The Trust will engage earlier with HOSC and Healthwatch for 2014/15 reviews](#)

#### Last year's priorities

The dignity challenge has been identified for further work but does not appear in the priorities for the coming year.

Positive work is detailed with regard to work to address issues regarding patient transport for renal patients at University Hospital Birmingham. It is a great shame that this work has not been extended to cover renal patients in Coventry or the learning used in our locality. Our evidence from patients is that renal patients continue to experience long waits and delays in their patient transport service. This was first flagged up by our predecessor organisation Coventry Link in 2011, yet we are not aware of progress. This is both a service quality and commissioning issue.

#### Other performance information

The Trust seems to be experiencing some challenges with meeting all of its targets for emergency ambulance response time targets, however we are not clear from the document what actions are being taken to address this.

Other information including complaints and PALS data indicates issues with other response times including patient transport therefore action is needed.

[WMAS Response: The Trust does have a comprehensive action plan to improve performance during 2014/15 which will be monitored and reported on extensively during the year.](#)

We would like more analysis of complaints and PALS data in the document. We are not sure that the category 'part upheld' is helpful.

[WMAS Response: The Patient Experience Annual Report will be published in July 2014 with more comprehensive information](#)

Whilst the size and reach of the trust presents some challenges in terms of patient engagement the evidence of patient engagement presented is thin. Attendance at events and meetings will not necessarily bring useful engagement or feedback.

[WMAS Response: This is engagement for the Patient Experience Team. There are various forms of engagement across the Trust. The Trust is currently working to pull this information together.](#)

We would like more evidence about what has been changed as a result of feedback or patient engagement work.

[WMAS Response: 'you said-we did' has been extended and the Trusts Patient Experience Annual Report will be published to provide further information.](#)

The patient feedback examples show actions aimed at addressing communication with patients rather than looking at the bigger issues. We hope that methods other than staff bulletins/articles are used to communicate with staff and ensure best practice.

We wonder why the target for paramedic skills has been reduced for 2014/15 and note that the response rate (39%) for the staff survey was not very high. The Trust should look into why this is.

[WMAS Response: The skill mix is reduced due to the high recruitment of student paramedics during 2014/15. There is a partnership working group looking at the response rate and results of the Staff Survey with a view to improvements.](#)

#### Priorities for the coming year

The Trust provides a number of services including patient transport and NHS 111, and covers some very different localities, with different populations and geography. We would therefore like to see more focus on the individual service elements and local geographical areas (including Coventry) in the quality account and for these to be reflected in the priorities.

[WMAS Response: We have included Divisional Profiles which we will expand on during the year.](#)





The format used for priorities for the coming year is clear and importantly provides a framework to set out how progress will be measured, which is very important.

However, we would expect that the patient experience related priorities were further developed than they are. Leadership from the Board is very important, however we cannot see from the information provided what the rationale is for the pieces of work around engaging with young people, or what it is hoped to achieve from this.

[WMAS Response: These have now been updated](#)

We would like WMAS to adopt the Healthwatch Coventry/Healthwatch Warwickshire Good Engagement Charter, which we launched in September 2013. We are asking Trusts to make a pledge setting out actions they will put in place to develop their good engagement practice and will seek discussion on this with the Trust.

[WMAS Response: This will be picked up with one to one meetings with Healthwatch.](#)

We would like a priority added to this quality account around improving the quality and patient experience of patient transport in Coventry and suggest that a Board member meets with renal patients and with managers at University Hospital Coventry and Warwickshire to understand the broader issues with patient transport provision.

[WMAS Response: Thank you for this, we will ensure that it is picked up at a senior level](#)

### **Healthwatch Birmingham**

Healthwatch Birmingham recognise that Quality Accounts are a useful contribution to ensuring NHS providers are accountable to patients and the wider public about the quality of the services they provide. We welcome the opportunity to comment on the draft Quality Report for West Midlands Ambulance Service NHS Foundation Trust.

The Report demonstrates that the Trust has performed well against most of the targets set against priorities in the last year.

The performance data on response rate performance is presented in West Midlands-wide form rather than the broken down format used for other activity. This means we have been unable to assess response rate performances for Birmingham compared with other parts of the West Midlands. We note that variable response rate performance, particularly when comparing rural and urban parts of the region, was raised by members of the public and community groups with the Trust at its last Annual General Meeting. We recommend the Trust provides this data as part of its future Quality Reports.

The Report captures the challenge the Trust faced taking on the NHS 111 service part-way through the year. It demonstrates that a lot of hard work was done to bring the service up to standard. Whilst there is further work the Trust has identified, we are pleased to see the progress in this part of the service.

Healthwatch Birmingham was pleased to contribute intelligence to the January 2014 CQC service review. The reported minor failure linked to delays in response times chimes with some of the patient feedback we had received. This is also reflected in the Patient Experience section of the Quality Report where delays, including in non-emergency patient transport, are noted as the main reason for patient concerns being raised with PALS. We look forward to seeing the impact of the improvement plans referred to in the Quality Report.

We note that Serious Incident Root Cause Analyses are reviewed by the Trust's Learning Review Group, with an "open invite" to the Trust's Non-Executive Directors to attend. The Trust might further demonstrate Board assurance in these areas by indicating how often Non-Executive Directors took up the open invite, and reporting on how lessons learned are reviewed by the Board.

[WMAS Response: Thank you, we hope the Patient Experience and Patient Safety Annual Reports published in July on our website will provide the additional information you have requested.](#)

Healthwatch Birmingham looks forward to seeing how the Trust implements the plans and learning raised in this Quality Report.



### Warwickshire HOSC

Response on behalf of the Quality Accounts Task and Finish Group set up by Warwickshire County Council's Adult Social Care and Health Overview and Scrutiny Committee with Warwickshire Healthwatch.

We welcome the opportunity to comment on the Trust's 2014-15 QA, Summary Review of 2013/14, although the Group would like to record their disappointment that they have not had the opportunity to work with WMAS over the year on their QA, as foreseen in the process introduced locally in September 2012. Warwickshire County Council has undertaken to approach quality accounts in a different way, and have established working groups with partner organisations to look in-depth at Warwickshire and Coventry's Trusts' Quality Account – both in monitoring performance over the year and in working with the Trusts to identify priorities for the year ahead. This approach was introduced to make the production of quality accounts a more meaningful process and to enable stakeholders to work together to develop a better understanding of quality within the Trusts delivering services to the people of Coventry and Warwickshire.

This commentary, although formally presented by Warwickshire County Council, reflects the views, input and contributions of those members of Warwickshire County Council and Warwickshire Healthwatch. In looking forward, the County Council will be continuing to work jointly with District/Borough Councils, Warwickshire Healthwatch, Coventry City Council and Coventry Healthwatch to engage with the Trust to look at the quality of care provided and ensure patients and the public can hold local health providers to account for the quality of their services. This will assist with the concerns that currently exist about the lack of a relationship at a local level.

Reflecting on Quality Priorities set for 2013/14

The Group was not given an opportunity to feed into the production of the QA, but they did have a full day visiting various sites of the WMAS, which gave a very useful insight into different aspects of the work done by the Trust and to speak to a range of staff working in different areas. They agreed the following points:

In the commentary provided on the 2013/14, the Group made it clear that the QA should be a public-facing document which should set out clearly the quality improvement journey of the Trust, with a balance between how the past year's priorities have been met and where they have not, what has been put in place to address this and setting out the reasoning behind the new priorities that have been selected for the next year. It is still not clear who the audience is for this document, i.e. the public, partners or commissioners, and this is an area where the Group could have worked with the Trust to improve the document and to ensure the document explained the work of the Trust in a simple, proper, clear and concise way.

QA need to clearly show how service users, staff and others with an interest in the organisation help the Trust to evaluate the quality of its services and determine the priorities for improvement. This QA, again, has a strong focus on performance data that the Trust are measured against anyway, and there needs to be more evidence on how lessons learnt from staff and patients has been used to drive improvements, and how these have been embedded into the service.

[Response ; Agreed, the 'what you said – we did' has been extended to support this.](#)

The QA is full of acronyms that are unfamiliar to anybody who is not a clinician. The use of tabulations, acronyms and formulae point the Quality Account to clinicians and the Department of Health and are unfamiliar to anybody who is not a clinician. The 'quality story' of the Trust should be right at the front of the document, supported by the more technical information that is required to be provided.

The Trust Profile is useful to show the strategic and geographical extent of the area covered by the Trust, but there is no local aspect that would allow "the man down the street in Warwickshire (or Solihull or Staffordshire)" to read the document and understand what the quality journey of a patient in this area is like.

[WMAS Response: Local Divisional information now sits in the Quality Account under Divisional Profiles.](#)

The Group raised concerns about perceptions by the public in relation to response times, which were clear from the number of queries and complaints being received by Healthwatch and Councillors. This is not included in the QA document, and would have been a good priority for the Trust – putting in place better communication around targets for response times, to manage public expectation and to publicise the work



being done in communities, particularly rural communities around community responders, working with GPs and defibrillators.

[WMAS Response: Divisional profile Reports from the General Manager included in the QA, giving Local response to performance questions raised and the General Managers Performance Improvement Plans.](#)

The Group welcomes the focus on engagement within the Patient Experience priorities, but again there needs to be clearer indication of what successful engagement will look like and how this will be achieved, and how it will influence service improvement and development.

[WMAS Response: This will be included in future documents](#)

There needs to be a greater focus on working with partners to deliver the priority for all stakeholders in helping people to living independently in their own homes and avoiding unnecessary hospital admissions.

[WMAS Response: The Trust is committed to working with partner organisations and will ensure that this is fully reflected in all publications](#)

It was clear from the discussions held with a number of staff across different areas of service within the WMAS that the organisation is innovative and on a continuous path of improvement, which staff are central to, but this is not evident from the QA. The Trust should include a summary of their work on continuous learning.

The work of the WMAS requires strong working relationships with other Trusts and stakeholders across the region, and while it is evident from discussions with staff, this is not evident within the QA. This is another area where closer working between the Group and the Trust could build on these strong foundations and bring about improvements that would feed into the priorities for local organisations across the region to integrate services, improve general practice and help people to live independently for longer.

[WMAS Response: The Trust is pleased that Healthwatch recognise the CQUIN selected reflect issues raised with them and welcomes working with Healthwatch in 2014/15 to promote further understanding](#)

### **Healthwatch Shropshire**

Healthwatch Shropshire is pleased to be invited to consider and comment on the Trust's Quality Account 2013-14.

We were pleased to read that the number of official complaints has decreased; however, it is disappointing that the number of PALS concerns has increased. We were encouraged that three of the Trust's priorities for 2014-15 concern patient experience and engagement.

It is positive that the Trust was graded as satisfactory in the Information Governance Toolkit for 2013-14 and that the overall score of 80% is higher than some other local NHS Trusts and is a slight improvement on last year. However, there are other local NHS Trusts with higher scores.

It is encouraging that the Trust has a strong commitment and involvement in research studies including the recruitment of patients for research.

To ensure that staff training needs are identified and addressed we recognise that annual appraisals are a crucial part of this process. So it is disappointing to note that staff annual appraisal rates are low at 69%, representing a significant reduction from 93% in 2011/12 as stated in last year's Quality Account. The figure of 81% mandatory training completed is also a disappointing drop from 93% in 2011/12.

It is disappointing that at the time we were invited to consider and comment on the Account, details of achievement against commissioners' quality improvement and innovation goals were not available for comment.

We note that WMAS figures have been broken down into areas; however, it is not possible to isolate Shropshire's figures which are incorporated in the West Mercia area.

We look forward to continuing to develop the working relationship with the Trust and using our patient experience data to contribute to the ongoing improvement in patient care.



### **Telford and Wrekin Health & Adult Care Scrutiny Committee**

The Telford and Wrekin Membership of the Joint Health Scrutiny Committee is a sub-committee of the Health and Adult Care Scrutiny Committee. The main focus of the work of the Joint Health Overview and Scrutiny Committee during 2013/14 has been the need to reconfigure health services to reduce the demand on the acute hospital and the role of the community hospitals in achieving this.

The Committee has welcomed the approach of the local health economy which has resulted in the Future Fit Programme and the West Midlands Ambulance service is represented on the programme Board.

The Committee has received the monitoring reports from provided by the Trust. No formal issues have been raised with the Trust based on this information however there have been discussions through the West Midlands Regional Scrutiny Network.

The Committee has received update reports from the CCG on the performance of the WMAS 111 service.

### **HOSC Worcester**

#### **Overall Comments**

The draft quality account appears aimed at a professional audience. For a public-facing document there needs to be more consistent clarity, with less jargon and more explanation of clinical terms.

The report contains a lot of statistics and matrices but lacks written commentary to put this data into context, or show how well the service has been performing, or of equal importance, where the problems are and how those problems are being fixed.

Much of the information provided within the Quality Account regarding Worcestershire is grouped under West Mercia, which Worcestershire Councillors do not find helpful when trying to establish what the information means for those they represent. The Trust has advised that Worcestershire specific performance information can be produced on occasion and the Worcestershire HOSC will be taking up this offer in the future. HOSC would like the Trust's quality accounts to include performance information specific to Worcestershire and suggest that this could be tailored to each area through a separate appendix.

In many cases HOSC is unable to comment on performance because final data is awaited and the target achievement is therefore marked as 'to be confirmed'. Whilst understanding that this is unavoidable due to legal timescales for publishing Quality Accounts, HOSC will look to discuss actual performance with the Trust in the future. However, it is reassuring to note from the QA and the monthly performance bulletins that the region as a whole is performing well.

The use of colour in performance tables in some cases does not transfer well to black and white printing.

[WMAS Response: format and colour have been modified.](#)

#### **Priorities for Improvements 2013-14**

HOSC is unable to comment on performance against priorities where the status is absent, pending March 2014 figures.

#### **Performance Summary for year to date 2013-14**

It would be helpful to have further commentary on the performance figures, to show the Trust's view and interpretation, and how the information will be used.

There is concern that what appears to be a marginal failure in response times in Worcestershire is not referred to in the report. The Trust's Action Plan to improve response times is welcomed.

[WMAS Response: Now sitting in the Quality Account are Divisional Profiles, supported with Performance Improvement Plans.](#)

#### **Clinical Performance indicators and Ambulance Quality Indicators**

Commentary and explanation around performance tables would be helpful. West Mercia performance has slipped in several areas, with no explanation given in the report.

Relating to the performance table on cardiac arrest, it is unclear what the 'comparator group' means.



Outcomes from cardiac arrest are disappointing and HOSC members would like to encourage more defibrillators in rural areas.

[WMAS Response: The percentage unfortunately does not represent the increased number of patients that have survived to discharge this year within Birmingham and Solihull. Further explanatory dialogue given in Cardiac Arrest report in the QA.](#)

#### Trust Profile

The Trust profile would benefit from including population figures for each area within the 5.6 million population served.

It would be helpful to list the locations of the region's major trauma centres.

[Response; The 3 adult MTCs in our region are UHNS- Stoke, UHB - Birmingham and UHCW Coventry with a paediatric MTC at BCH in Birmingham. In terms of improvement, 9 more patients have survived this year than last. The number are 55 survival to discharge from 2012-13 to 64 from 2013-14.](#)

#### Goals agreed by Commissioners in 2013-14

HOSC is unable to comment, as none of the goals indicate whether the target has been achieved.

#### Care Quality Commission

HOSC will look to monitor progress against the short-term plan required by the CQC regarding delays experienced by some patients, which meant a minor failure in outcome 4 – 'care and welfare of people who use our service'.

It would be helpful to know why the Trust did not submit records during 2013/14 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics.

[WMAS Response: An explanation has now been included.](#)

#### Patient safety and Serious Incidents

It would be helpful to have comparison data and more commentary, to put into context the number of serious incidents reported.

#### Patient Experience

The Trust is commended on the number of compliments it receives, which should be boosted within the report, along with some analysis.

The 'what you said', 'what we did' patient feedback is helpful and more could be included.

Priorities for Improvement

[WMAS Response: The 'you said-we did' has now been extended](#)

#### (Clinical Effectiveness)

There are more than one priority for two areas (neonatal temperature and timely and effective care), which could perhaps be streamlined into one priority for each area?

[WMAS Response: The two priorities now sit as one](#)

It would be useful to include in the rationale for 'timely and effective transfer' that part of the aim behind this target is to avoid unnecessary conveyance of patients to Accident and Emergency Units. It is understood that Worcestershire performs particularly well in this area, which could be referred to in the report.

[WMAS Response: Fully agreed – dialogue extended](#)

#### Patient Experience

The wording of the rationale for priority 8 'Addressing Health Inequalities' implies that WMAS is a member of the region's Health and Wellbeing Boards.

#### Glossary

Some of the report's abbreviations, for example VLE are not included in the glossary.

[WMAS Response: This has been amended](#)

#### Board Meetings

The Board is encouraged to hold its meetings in an environment which assists public engagement.



### **Staffordshire Health Scrutiny commentary**

We are directed to consider whether a Trust's Quality Account is representative and gives comprehensive coverage of their services and whether we believe that there are significant omissions of issues of concern.

There are some sections of information that the Trust must include and some sections where they can choose what to include, which is expected to be locally determined and produced through engagement with stakeholders.

We focused on what we might expect to see in the Quality Account, based on the guidance that trusts are given and what we have learned about the Trust's services through health scrutiny activity in the last year.

We also considered how clearly the Trust's draft Account explains for a public audience (with evidence and examples) what they are doing well, where improvement is needed and what will be the priorities for the coming year.

Our approach has been to review the Trust's draft Account and make comments for them to consider in finalising the publication. Our comments are as follows.

We support the inclusion of the Trust's Vision, Values and Strategic Objectives.

However the Statement on Quality is still to be completed in the draft and would wish to see detail on why the Account has been produced and who has been involved.

Also a list of services provided would support the Account.

We note that Account includes details of the Priorities for Improvement however we comment on the incomplete data in many areas. We also would like to see more detail included in relation to how and why chosen.

In relation to the Performance Summary the Account would benefit from more detail concerning action planning to improve and we do raise concerns over the levels of performance achieved.

The graphics included in the section para 2.3 are appreciated and clearly illustrate the conditions to the reader.

We support the inclusion and level of detail in the Trust's Profile.

The CQUIN information is noted, however the achievements are yet to be confirmed.

[WMAS Response: Thank you for your comment; we hope that the amendments to the final version of this account provides greater clarity.](#)



## Annex 4: Statement of Sharing and Caring Together – Francis Inquiry

In February 2013, Robert Francis published his report following the Public Inquiry into the failings at Mid Staffordshire NHS Foundation Trust.

West Midlands Ambulance Service NHS Foundation Trust is working with partners across the Local Health and Social Care Economy to ensure that wherever possible, we take a joined up approach to our response.



We have committed to holding regular meetings with our partners, so that we can talk about the progress we are making and learn from each other through sharing best practice.

Partners will also take the opportunity to come together to share issues, risks and concerns and to collectively address these where appropriate to do so. We have specifically committed to work together to:

- Provide assurance to our Boards
- Identify areas of concern that we can address together
- Communicate with our stakeholders
- Share best practice

As within the report recommendations, partners recognise that they are accountable for implementation of the recommendations and will be open and transparent about plans and progress to achieve the following outcomes:

- A safe, committed and compassionate caring service
- Patient first
- Responsibility, enforcement and compliance with fundamental standards including professional standards and those managed through contracts)
- Effective governance
- Effective handling of complaints
- Effective public involvement and engagement
- Effective scrutiny
- Effective delivery and monitoring of training
- An open and transparent culture
- A caring culture with specific focus on care of the elderly

### **SIGN UP TO SAFETY**

The Trust will sign up to the Secretary of State's ambition to reduce avoidable harm by half over the next three years. Agreed plans will incorporate work already initiated as part of the Trust's patient safety work and will expand on that through engagement with HealthWatch, Commissioners and other Providers.

### **FREEDOM TO SPEAK**

The Trust will continue to encourage staff and patients to tell us when things are not right and will ensure that any recommendations from the Robert Francis review titled 'freedom to speak up' are incorporated within the Trust at all levels.



## Annex 5: Statement of directors` responsibilities in respect of the Quality Report

WMAS Board of Directors has taken steps to gain assurance that the content of this Quality Account Report meets the requirements set out in the NHS Trust Foundation Trust Annual Reporting Manual 2013/14. It is assured that the content of this Report is not inconsistent with the Internal and External sources of information including;

- Board minutes and papers for the period April 2013 to May 2014 at the May 2014 Board Meeting.
  - Papers relating to Quality reported to the Board over the period April 2013 to March 2014.
  - Feedback from the commissioners dated ...2014.
  - Feedback from governors dated ....2014.
  - Feedback from local Healthwatch organisations dated...2014.
  - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, presented to ..... Trust Board and Annual General Meeting.
  - The 2012 national staff survey.
  - The Head of External Audit annual opinion over the trust`s control environment - ...
  - Care Quality Commission quality and risk profiles from April 2013 to March 2014.
- This Quality Report presents a balanced picture of the West Midlands Ambulance Service NHS Foundation Trusts' performance during 2013/14 and the Board of Directors agree;

- the performance information reported in the Quality Report is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Report has been prepared in accordance with Monitor`s annual reporting guidance (which incorporates the Quality Accounts regulations) (published at [www.monitor-nhsft.gov.uk/annualreportingmanual](http://www.monitor-nhsft.gov.uk/annualreportingmanual) ) as well as the standards to support data quality for the preparation of the Quality Report.

The Directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the Board

.....29 May 2014.....Date.....Chairman

.....29 May 2014 ...Date.....Chief Executive





## Annex 6: A copy of the External Audit limited assurance report

### Independent Auditors' Limited Assurance Report to the Council of Governors of West Midlands Ambulance Service NHS Foundation Trust on the Quality Report

We have been engaged by the Council of Governors of West Midlands Ambulance Service NHS Foundation Trust to perform an independent limited assurance engagement in respect of West Midlands Ambulance Service NHS Foundation Trust's Quality Report for the year ended 31 March 2014 (the "Quality Report") and certain performance indicators contained therein.

#### Scope and subject matter

The indicators for the year ended 31 March 2014 subject to limited assurance consist of those national priority indicators mandated by Monitor:

Category A call – emergency response within 8 minutes on page 9

Category A call- ambulance vehicle arrives within 19 minutes on page 9

We refer to these national priority indicators collectively as the "indicators".

#### Respective responsibilities of the Directors and Auditors

The Directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual* issued by Monitor.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that: the Quality Report is not prepared in all material respects in line with the criteria set out in the

NHS Foundation Trust Annual Reporting Manual; the Quality Report is not consistent in all material respects with the sources specified in Monitor's *2013/14 Detailed Guidance for External Assurance on Quality Reports*; and the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the *NHS Foundation Trust Annual Reporting Manual* and the six dimensions of data quality set out in the *Detailed Guidance for External Assurance on Quality Reports*.

We read the Quality Report and consider whether it addresses the content requirements of the *NHS Foundation Trust Annual Reporting Manual*, and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Report and consider Board minutes for the period April 2013 to May 2014;

- Papers relating to quality reported to the Board over the period April 2013 to May 2014;
- Feedback from the Commissioners dated May 2014;
- Feedback from local Healthwatch organisations dated May 2014;
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009;
- The 2012 national patient survey;
- The 2012 national staff survey dated;
- Care Quality Commission quality and risk profiles dated April 2013 - March 2014;
- The Head of Internal Audit's annual opinion over the trust's control environment dated May 2014

and we consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively, the "documents"). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Council of Governors of West Midlands Ambulance Service NHS Foundation Trust as a body, to assist the Council of Governors in reporting West Midlands Ambulance Service NHS Foundation Trust's quality agenda, performance and activities. We permit the



disclosure of this report within the Trust's Annual Report for the year ended 31 March 2014, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and West Midlands Ambulance Service NHS Foundation Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

#### Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised)- 'Assurance Engagements other than Audits or Reviews of Historical Financial Information' issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

Evaluating the design and implementation of the key processes and controls for managing and reporting the indicators

- Making enquiries of management
- Testing key management controls
- Limited testing, on a selective basis, of the data used to calculate the indicators back to supporting documentation
- Comparing the content requirements of the *NHS Foundation Trust Annual Reporting Manual* to the categories reported in the Quality Report
- Reading the documents.

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

#### Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Report in the context of the criteria set out in the *NHS Foundation Trust Annual Reporting Manual*.

The scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by West Midlands Ambulance Service NHS Foundation Trust.

#### Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2014: the Quality Report is not prepared in all material respects in line with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual*, the Quality Report is not consistent in all material respects with the sources specified above, and the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the *NHS Foundation Trust Annual Reporting Manual*.

Grant Thornton UK LLP  
Colmore Plaza Colmore Circus Birmingham  
29th May 2014



## Annex 7: Glossary of Terms

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



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



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



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



#### Further information

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

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

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

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

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

You can also find out more information by visiting our website: [www.wmas.nhs.uk](http://www.wmas.nhs.uk)

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