Annual Quality Report
2018/19
Including mandatory quality accounts
Contents

PART 1

Introducing the East of England Ambulance Service NHS Trust (EEAST) quality accounts and improvements 4
Statement of accountability: Chief Executive Officer, Dorothy Hosein 6
What is a quality account and what does it mean to EEAST and the public we serve? 7
Our current quality position 8
Care Quality Commission 10
Department of Health Core Quality Indicators 12
Statement on quality from the Board 17

PART 2

How we have prioritised our quality improvement initiatives 18
Priority 1 Patient safety 19
Priority 2 Clinical effectiveness 20
Priority 3 Patient experience 22

PART 3 – Review of 2018/19

You said, we did 23
Patient experience and feedback 26
Patient and Public Involvement 33
Progress on the quality account priorities 2018/19 34
Performance of the Trust against selected quality metrics 35
Clinical audit 50
Participation in research 52
Patient safety incidents 53
Duty of Candour 56
Workforce planning, recruitment and retention 57
Organisational development 58
Whistleblowing 59
Results from the NHS Staff Survey 60
Commissioning for Quality and Innovation (CQUIN) 62
Other quality successes in 2018/19 66
Statements from the commissioners, HealthWatch and Overview and Scrutiny committees 70
Glossary
Welcome to the East of England Ambulance Service NHS Trust Quality Account for 2018/19. This document has been approved by the Trust Board and is an accurate account of the level of quality of service provided to patients. In developing this Quality Account, we have set out a summary of achievements for 2018/19, and goals for 2019/20.

Improving quality is an overarching priority of the Trust and this report lays out plans for developing future services to improve the quality and safety of patient care and patient outcomes.

In order to help do this, the Quality Account is based on data from a range of sources. In setting the priorities for 2019/20, we have considered the NHS Long Term Plan and our Clinical Strategy as well as reviewing key clinical areas identified from 2018/19 on which to build, to further improve quality and meet patient and public expectation. We have also acknowledged the core/mandatory priorities for improvement published by the Department of Health and Social Care (DHSC). A copy will be submitted to the Secretary of State for Health and Social Care via the NHS website.

Contributions to this document
Ipswich and East Suffolk Clinical Commissioning Group (CCG) (the lead commissioner), the Community Engagement Group, HealthWatch groups and the region’s health overview and scrutiny committees (HOSCs) have been asked to provide a commentary on the provision of our quality and care to include within this document.

Where can you get hold of this document?
This Quality Account is available on the NHS website from 30th June at
https://www.nhs.uk/Services/Trusts/Overview
or write to:

East of England Ambulance Service NHS Trust
Headquarters,
Whiting Way,
Melbourn,
Cambridgeshire
SG8 6EN
Tel: 0845 601 3733

If you require this document in another format or language, please contact our Patient Advice Liaison Service (PALS) on 0800 028 3382 or by emailing eaeasnt.feedback@nhs.net
Our Trust provides emergency and urgent care services throughout Bedfordshire, Cambridgeshire, Essex, Hertfordshire, Norfolk and Suffolk.

During 2018/19 we also provided non-emergency patient transport services for patients needing non-emergency transport to and from hospital, treatment centres and other similar facilities within Cambridgeshire, parts of Essex, Bedfordshire and Hertfordshire.

We cover an area of approximately 7,500 sq miles with a resident population of almost six million people.

We employ more than 4,000 staff operating from 130 sites and are supported by more than 1,500 dedicated volunteers.

The Trust Headquarters is in Melbourn, Cambridgeshire and there are ambulance operations centres (AOC) at each of the three locality offices in Bedford, Chelmsford and Norwich who receive over 1 million emergency calls from across the region each year as well as calls for patients booking non-emergency transport.
The eastern region is made up of both urban and rural areas with a diverse population. As well as a resident population of nearly six million people, several thousand more tourists enjoy visiting our area in peak seasons each year. Our area also contains a number of airports including London-Luton and London-Stansted as well as major transport routes which increase the number of people in our region on a daily basis.

We have four areas of service provision:

**Response to 999 calls as an emergency and urgent care service**

In 2018/19, our ambulance operations centre (AOC) received 1,191,291 emergency contacts from the public.

On average, nearly 3,200 emergency 999 calls come into the ambulance service every day and are answered and managed in our ambulance operations centres.

The call handler records information about the nature of the patient’s illness or injury using sophisticated software to make sure they get the right kind of medical help. This is known as triaging, and allows us to ensure that the most seriously ill patients can be prioritised and get the fastest and most appropriate response.

Once this key information is established, the response will be selected from a range of care providers including a single clinician in a fast response car, a double staffed emergency ambulance dispatched on blue lights, or a clinical assessment conducted over the phone by an appropriate clinician for patients with conditions that do not require a face to face response. This response would include advice over the phone from a paramedic/nurse or a referral to their GP, pharmacist or walk-in centre.

**Scheduled Care Service – Patient Transport Service**

We provide a non-emergency Scheduled Care Service, more commonly known as the Patient Transport Service (PTS) to and from home to outpatient appointments at hospitals or other care centres around the region to help people who need assistance because of their medical condition or age. In 2018/19 we transported 593,313 people through this service.

**Special and partnership operations**

The Trust operates two hazardous area response teams (HART) and has a resilience and emergency planning department who work closely with critical care charities and community volunteers to respond to a variety of emergency situations.

**Commercial services**

We operate a number of services which generate income for the Trust. These include training for blue-light drivers and first aid at work. In addition there is a contact centre and a medical service which cover events, festivals and medical repatriation.
Statement of Accountability

As Accountable Officer and Interim Chief Executive of the Trust, I have responsibility for maintaining the performance and standards achieved within our services, and to support an environment of continuous quality improvement.

This is the 11th Quality Account produced by the East of England Ambulance Service NHS Trust, in line with the requirements of the Health and Social Care Act 2012. The Quality Account contains details mandated by the regulations and also identifies the measures that the Trust, in association with our NHS and public partners, has decided will best demonstrate the work that has been done to improve the standards and quality of clinical care.

The results of these measures show that much work has been undertaken this year to improve the quality of care to patients; however, there are areas in which the Trust needs to improve to ensure all patients have a positive experience in using the ambulance service.

As Accountable Officer, it is also my responsibility to ensure both the quality and accuracy of the data within this Quality Account and to confirm that it presents a balanced picture of the Trust’s performance. Therefore, to the best of my knowledge the information contained within this Quality Account for the East of England Ambulance Service NHS Trust is a true and accurate record.

Dorothy Hosein
Chief Executive Officer
What is a Quality Account and what does it mean to EEAST and the people we serve?

A Quality Account is a mandatory report about the quality of services an NHS healthcare trust provides, and is required to be completed in line with the Health and Social Care Act (2012).

Quality reports and accounts are set against the framework of three overlapping key themes which can be used to define quality of care.

The content is defined by NHS England and includes outcome results against specific indicators under five headings:

1. Preventing people from dying prematurely
2. Enhancing quality of life for people with long term conditions
3. Helping people to recover from episodes of ill health or following injury
4. Ensuring that people have a positive experience of care
5. Treating and caring for people in a safe environment and protecting them from avoidable harm
Our current quality position

Mark Twain wrote that ‘continuous improvement is better than delayed perfection.’ I think this best describes the journey for the previous 12 months. Despite challenges that the Trust faced with demand earlier in the year and the ever-changing landscape of the NHS, I have been encouraged by the Trust’s ability to maintain and improve the quality of its services to our patients and communities by our dedicated staff; whether they be on the front line directly dealing with patient care or in one of our support service teams driving our business forward.

The Trust in particular is committed to ensuring that it is able to respond positively to feedback from all its service users to improve service user experience. We have engaged with NHS Improvement to support our work around the Patient Experience Framework which will enable us to interact with service users in a much more meaningful way over the forthcoming year. This has been evidenced by our reduction in the time it takes our teams to respond to those patients and their families who ask us to investigate issues with their care. Any reduction we have made and continue to make is our commitment to provide timely answers to those who have concerns, and to do our utmost to learn any lessons that may improve our services further. I am also heartened to see the reduction in the number of Serious Incidents and harm compared to last year which has been the result of implementing lessons from the Risk Summit alongside learning from our patients who have become our courageous collaborators in improving care.

This year has seen significant reorganisation with our approach to integrated governance. The Trust’s Integrated Board Report is in its final stages of refinement and will enable the board to have greater assurance regarding all aspects of the Trust’s performance including, arguably most importantly, the quality of our clinical care.

As I write this section of the Quality Account, the Care Quality Commission have completed both our Trust’s Core Services and Well Led inspections and we are awaiting our report.
The Trust has continued to support our inspirational research and development (R&D) team and their ambitious strategy to enable better quality research in the out of hospital arena. High quality studies have been published within the last year, such as Airways2 and RIGHT-2 confirming that the Trust remains an active research partner. The Trust has also maintained a really positive relationship with the Eastern Academic Health Science Network who have been very supportive with our patient safety and quality improvement work.

The Trust’s commitment to develop innovative models of care which provide better clinical outcomes for our service users is also reflected in the role we have played along with colleagues from primary care and the acute sector in developing models of integrated service delivery, such as our Early Intervention Vehicles and our Care Home scheme. Other areas of improvement have been our staff safety huddles which have shown successful ways of sharing real-time information between staff and their line management teams.

Our values were defined and agreed on by our people and have remained true to the core principles of our business for many years. Those values are care, quality, teamwork, respect and honesty.

Whilst we move forward with our new draft strategy to align with the recently published NHS Long Term Plan, we recognise that our values continue to shape our culture and support our current strategic intent of providing a safe and effective healthcare service to all of our communities in the east of England.

Last year, our Trust Awards ceremony saw recognition in categories which aligned to the Trust values and we saw example after example of values-based care and leadership in every category. Whilst we can celebrate those who win those awards, we know that every single day our staff are developing and delivering high-quality, compassionate care to our communities.

Despite all the achievements of the last year the Trust is committed to improving the quality of our services. Central to this are the Trust’s quality priorities which have been developed following extensive consultation, and the ongoing implementation of our clinical strategy. The continuous improvement of the quality of our services will remain the Trust’s overarching priority.

Tracy Nicholls
Director of Clinical Quality and Improvement
Care Quality Commission

The Trust is required to register with the Care Quality Commission (CQC) and has been registered as a provider of services since 1st April 2010 with no conditions on registration.

The CQC has not taken enforcement action against the Trust since the previous inspection and the Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

The Trust was last inspected in early March for core services and late March 2018 for Well led in line with the new CQC inspection regime. The Trust, at time of writing, is awaiting its report following core service and well led inspections undertaken in spring 2019.

The previous inspection March 2018 and the subsequent report was published on 4 July in the same year. The full report can be found here: https://www.cqc.org.uk/provider/RYC

The CQC inspects organisations through five Key Lines of Enquiry (KLoE) to determine whether:

- we are safe
- we are effective
- we are caring
- we are response to people’s needs
- we are well-led.

The Trust received Outstanding for the Caring domain and Requires Improvement for Safe, Effective, Responsive and Well-led.

The report cited a number of recommendations for us around topics such as; risk registers and governance of their reviews, to improve performance and response times for emergency calls, ensure staff are appropriately mentored and supported including appraisals and that processes and procedures are consistently applied across the Trust.

A number of these topics have been aligned with our priorities for the coming year and within our strategic objectives - all actions and other relevant comments from the report have been included within our CQC action plans. These plans, which are monitored and reviewed by the Chief Executive Officer and Head of Quality Improvement, have been published on our website www.eastamb.nhs.uk
What is being done to improve against all domains?

Our Quality Improvement Team are driving forward the objectives of the Quality Improvement Strategy which was released in October 2018.

The team will support embedding quality improvement in all aspects of Trust business which includes staff, patient and stakeholder engagement. A reduction of clinical variation, along with embedding and establishing a Quality Improvement Faculty, will be key drivers.

Following the release of the 2018 CQC inspection report, the Deputy Director of Clinical Quality established a Quality Improvement Plan based around findings and opportunities to continue to improve.

Findings from the previous CQC visit and the CQC report are continually monitored and, during internal reviews, findings are checked against the current action plans to ensure improvement continues as required. Improvement plans are also shared with colleagues from NHS Improvement (NHSI) and the CQC.

In December 2018 all Trust action plans were reviewed and moved into one overarching integrated plan.
Department of Health Core Quality Indicators

All NHS organisations are required to report against a set of Core Quality Indicators (CQIs) relevant to their type of organisation. For ambulance trusts, both performance and clinical indicators are set as well as indicators relating to patient safety and experience.

Where information is publicly available, organisations are also required to demonstrate their performance against other ambulance services within the year.

**AMBULANCE RESPONSE TIMES (CATEGORIES 1 - 4)**

EEAST moved to the new Category 1 – 4 standards outlined within the Ambulance Response Programme in October 2017, and as such, is required to only report against these categories for 2018/19. It is not mandatory to disclose comparative performance as the two sets of standards are not comparable.

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
<th>Mean Response Time</th>
<th>90th Centile Response Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>C1</td>
<td>Immediately life threatening injuries and illnesses.</td>
<td>7 minutes</td>
<td>15 minutes</td>
</tr>
<tr>
<td>C1T</td>
<td>Immediately life threatening injuries and illnesses where the patient is transported to hospital</td>
<td>7 minutes</td>
<td>15 minutes</td>
</tr>
<tr>
<td>C2</td>
<td>Emergency</td>
<td>18 minutes</td>
<td>40 minutes</td>
</tr>
<tr>
<td>C3</td>
<td>Urgent calls and in some instances where patients may be treated in situ (e.g. their own home) or referred to a different pathway of care</td>
<td>120 minutes</td>
<td>120 minutes</td>
</tr>
<tr>
<td>C4</td>
<td>Less urgent. In some instances patients may be given advice over the phone or referred to another service such as a GP or pharmacist.</td>
<td>180 minutes</td>
<td>180 minutes</td>
</tr>
</tbody>
</table>

**AMBULANCE CLINICAL OUTCOMES: ACUTE ST-ELEVATION MYOCARDIAL INFARCTION (STEMI) AND STROKE**

Patients who undergo a pre-hospital assessment for STEMI (heart attack) or stroke, who are given specifically tailored care and placed on a treatment pathway that begins en route to hospital and continues after admission, have a higher incidence of improved overall outcome. This way of working helps people to recover from episodes of ill health or injury and supports the NHS as a whole to reduce the number of patients dying prematurely.

The percentage of patients with a pre-existing diagnosis of suspected ST elevation myocardial infarction who received an appropriate care bundle from the Trust during the reporting period.

The percentage of patients with suspected stroke, assessed face to face and who received an appropriate care bundle from the Trust during the reporting period.

An appropriate care bundle is a package of clinical interventions such as oxygen therapy and the giving of relevant drugs that are known to benefit patients’ clinical outcomes.
We joined the national initiative Sign up to Safety in 2015 with a commitment to reduce avoidable harm through continuously improving the quality of care we provide. Part of our commitment is to encourage staff to report all incidents, including ‘near misses’ that is where harm could have occurred if immediate actions were not undertaken at the time.

A patient safety incident (PSI) can be of a clinical or non-clinical nature. This chart shows the actual impact seen for each PSI since 1st April 2015:

![Patient Safety incidents - by harm](image)

Of all incidents reported in the 2018/19 financial year, 98.8% were graded as near miss incidents. This evidences proactive reporting so that steps can be taken to improve our service prior to harm occurring.

This compares to 98.9% in 2017/18, suggesting a continued low proportion of incidents causing harm to patients, despite of a high number of incidents being reported. This demonstrates a good safety culture at EEAST.

**Learning from Incidents (including deaths)**

The East of England Ambulance Service has not yet fully implemented its Learning from Incidents policy and methodology. It does however fully support the initiative to further complement its patient safety directive. It is expected that all UK ambulance trusts will have a policy in place from 1 December 2019 and be reporting data from quarter 4 of the 2019/20 financial year. This process and the launch of the policy have been included as a local priority within next year’s Quality Account.

However, it should be noted that although five cases reported resulted in severe harm, a decrease of four on the previous year, no cases were deemed to be directly attributable to a patient’s death.
NHS Number and General Medical Practice code validity
Ambulance trusts are excluded from this requirement therefore no records were submitted during 2018/19 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics.

Clinical coding error rate
As an ambulance service, EEAST was not subject to the Payment by Results clinical coding audit during 2018/19 by the Audit Commission.

Data quality
Data quality continues to be a significant focus and is monitored through the Information Management Group. As well as a Data Quality Policy, we also have a CAD Data Quality Policy which supports the activities of the Data Audit Team who complete various audits to ensure regular checks are done to verify information reported outside of the organisation.

The Information Management Group, chaired by the Director of Strategy and Sustainability who is also the Senior Information Risk Owner, meets bi-monthly and links with the Information Governance Group which also meets bi-monthly and provides assurance for all aspects relating to information.

The Trust has a number of processes in place to ensure that data included within the Quality Account is accurate and provides a balanced view. These include:

- clinical data and outcomes
  - Checked and verified by the Clinical Audit Manager prior to submission to the national audit programmes
  - Monthly checks of the Department of Health statistical reports to ensure latest comparative data is included
  - Assurance through internal governance processes to Board Level via the Integrated Board Report
- Data Security Protection Toolkit
  - Assurance provided through Information Governance Group to Trust Board via the Audit Committee
- regular scrutiny of processes and information through:
  - Quality Governance Committee
  - Clinical Commissioning Groups contracting requirements
  - Information Management Group.
Data Security Protection Toolkit

Previously NHS Trusts were required to complete a self-assessment against the Information Governance Toolkit. In 2018/19, NHS Digital replaced this with the new Data Security Protection Toolkit (DSPT).

The Data Security and Protection Toolkit is an online self-assessment tool that allows organisations to measure their performance against the National Data Guardian’s 10 data security standards.

All organisations that have access to NHS patient data and systems must use this toolkit to provide assurance that they are practising good data security and that personal information is handled correctly.

Due to the significant changes that have been made to the DSPT and the introduction of the General Data Protection Regulation and Data Protection Act (2018) many organisations have not been able to complete the DSPT fully by the required date (31st March 2019). Therefore, NHS Digital have allowed organisations to make a submission and to submit an action plan to meet the other requirements.

We fully met 27 of the 32 standards and submitted our self-assessment along with our action plan to meet the remaining five standards which has subsequently been accepted by NHS Digital. Progress against these outstanding areas will continue to be monitored through our Information Governance Group and assurance provided to the Trust Board through our Audit Committee.

EEAST completed its submission by the set date. This action plan is then reviewed by NHS Digital and accepted or declined. EEAST is currently showing as: Standards not met – plan agreed which is comparable with other organisations.
Statement on quality from the Board


During the last year we introduced regional monthly Accountability Committees to drive and monitor improvements in both the care and experience we provide for our patients. As an organisation we continue to provide a high standard of care for patients suffering from serious conditions such as stroke and heart attacks. The regional Accountability Committees however provide the opportunity for teams to share good practice and for the Executive to monitor improvements in the areas in which we are performing below the national average. For example a number of innovative approaches are currently being trialled to improve the time it takes us to reach a hospital with a stroke patient.

Using the learning from a challenging winter last year we have developed a methodology of dynamic and intelligent forecasting which enables operational managers to plan resourcing to optimise the care for our patients. During the winter of 2018/19 we significantly improved against national performance targets and most importantly improved the experience for patients.

As Chief Executive I am leading on projects with our more challenged Acute Trusts to improve and increase the alternative care pathways for patients. It is important that we use our regional role to influence and share best practice for the benefit of all patients in the East of England.

We have also developed a clear Quality Improvement Plan to target key areas of priority to improve the quality of care we provide to patients. This plan sets the foundation for a cycle of continuous improvement to enable progress towards achievement of the Trust’s strategic objectives.

Lord Carter published a review of all national ambulance services this year which offers a guide for areas of improvement in terms of productivity and efficiency and we are clear on our opportunities. As an organisation therefore we have developed a transformation plan to improve efficiencies across the organisation and we are extremely proud in particular of our innovative fleet project. Working closely with staff and trade union colleagues the EEAST team have designed a fantastic concept vehicle which provides a better experience for both patients and staff. Importantly it is also more cost efficient, sustainable and environmentally friendly. These new vehicles will be operational in early 2019.

Our staff and volunteers continue to provide outstanding care to patients, as we work in partnership with the wider health economy. I am extremely proud to be part of this organisation, the improvements made to date and the clinical focus and ethos in everything we do.

Dorothy Hosein
Chief Executive Officer
PART 2
How we have prioritised our quality improvement initiatives

The Quality Account for 2019/20 will continue to focus on the core priorities which match the mandatory indicators for ambulance trusts set by the Department of Health and Social Care (DHSC) as outlined in Part 1 which include areas defined within our soon to be launched Clinical Strategy, and taking into account the recently published NHS Long Term Plan, such as cardiovascular disease and stroke care

- We have also set a number of local priorities which have been aligned with both of these documents particularly regarding:

  - Education, support and supervision of clinical staff ‘so patients can be treated by skilled paramedics at home or in a more appropriate setting outside of hospital’ (DOH: 2019)

  - Learning disability and autism - ‘The whole NHS will improve its understanding of the needs of people with learning disabilities and autism, and work together to improve their health and wellbeing.’ (DOH: 2019)

  - Collaboration with Public Health England to understand our local health economy and to take ‘action on health inequalities’ (DOH: 2019)

  - Learning from deaths and continuing to improve on how we ‘learn lessons when things go wrong and minimise the chances of them happening again’ (DOH: 2019)

  - Extension of the Stroke Mobile Unit trial which occurred in 2018/19

We acknowledge that there are many other milestones within the NHS Long Term Plan, however many of these will be addressed through other means such as our Improvement Boards and in collaboration with our Sustainability and Transformation Partnerships (STPs) and published later in the year.

**Stakeholder engagement**
A range of stakeholders including our clinical commissioning groups (CCGs) have supported our decision to align our priorities with our Clinical Strategy and the NHS Long Term Plan.
## Priority 1 Patient safety

<table>
<thead>
<tr>
<th>Priority</th>
<th>Why we have chosen this priority</th>
<th>What we are trying to improve</th>
<th>What success will look like</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction of a Learning from Incidents Policy</td>
<td>Adoption and implementation of national guidance (NHSI).</td>
<td>The identification of learning following a patient incident whilst in the care of EEAST (if lessons are present).</td>
<td>Approved policy with identified methodology for reviewing in-scope cases.</td>
</tr>
<tr>
<td>Delivery of a compassionate and responsive service to dialysis patients through the Patient Transport Service</td>
<td>The Trust has seen an increase in complaints for this patient group within the previous 12 months as well as non-compliance with contracted pick-up times in some areas.</td>
<td>Care and experience for dialysis patients and their families/carers</td>
<td>Reduction in complaints Improvement in compliance with contracted ‘pick-up’ times.</td>
</tr>
<tr>
<td>Embed recommendations where possible from the human factors/ergonomics project within the operational setting.</td>
<td>To extend the human factors process across the whole organisation to ensure that safety systems are embedded and make systems of care more reliable.</td>
<td>Improved ergonomical and supportive environment for operational staff.</td>
<td>Introduction of ‘huddles’ at the beginning of shifts. Recruitment of staff to secure future workforce</td>
</tr>
</tbody>
</table>

**How we will monitor progress:** Progress reported bi-monthly to the Quality Governance Committee

**Responsible Lead:** Tracy Nicholls - Director of Clinical Quality and Improvement

**Date of completion:** 31st March, 2020
## Priority 2 Clinical effectiveness

<table>
<thead>
<tr>
<th>Priority</th>
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<th>What we are trying to improve</th>
<th>What success will look like</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implementation of clinical supervision</td>
<td>Placing the patient at the centre of our organisation also means we need to focus on the clinician to enable them to safely and effectively care for others. The Trust recognises that there are gaps within the provision of clinical supervision with sometimes undefined processes.</td>
<td>It is vital that staff caring for patients have the knowledge and skills they need to do their job effectively. The development of and support to staff.</td>
<td>An established model of clinical supervision. Clear guidance that details the expectations of the learner and the organisation Opportunities for staff to achieve their full potential whilst meeting the organisation need to deliver individualised patient care.</td>
</tr>
<tr>
<td>Increase the recognition of sepsis and neutropenic sepsis supported by the delivery of the sepsis care bundle to provide the highest standards of pre-hospital care.</td>
<td>We recognise that early recognition of sepsis, the need for urgent and timely interventions and transportation to hospital is a key factor for the patient’s outcome</td>
<td>Although recognition of sepsis by our staff has a high compliance rate, we would like to see a sustained high level of recognition and appropriate treatment for sepsis patients.</td>
<td>Full embedding of the NEWS2 screening tool across the organisation. High levels of compliance for the new sepsis care bundle contained within the Ambulance Clinical Quality Indicators programme</td>
</tr>
<tr>
<td>Produce a Public Health Strategy in collaboration with Public Health England</td>
<td>Following the launch of a joint consensus statement describing the intent of all NHS ambulance trusts, together with partner agencies, to increase collaboration to support improved health and wellbeing among the most vulnerable people in society (2017), we are working with Public Health England (PHE) to produce a Public Health Strategy as part of our commitment.</td>
<td>Providing data to PHE will enable us to build a better picture of the population within the region and to work to reduce health inequalities. Using their data more will enable us to have a better understanding of our resident population and their health needs. This is turn will enable us to work with partnership agencies to implement the plans held within our Clinical Strategy and those defined within The NHS Long Term Plan.</td>
<td>Re-launch Make Every Contact Count. Workforce wellbeing – build on the existing platform Develop an evaluation framework Introduce feedback focus groups designed to reflect local health and population needs.</td>
</tr>
</tbody>
</table>

**Clinical Effectiveness**

- Increase the recognition of sepsis and neutropenic sepsis supported by the delivery of the sepsis care bundle to provide the highest standards of pre-hospital care.
- Develop greater system intelligence through the use of public health data to inform population health management and the development of urgent and emergency care services and become key stakeholders in the development of Population Health Management.
<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>Stroke Mobile Unit – trial within Norwich and Ipswich areas</td>
<td>Although still being evaluated, the success indicated from initial reviews has prompted the Trust to trial other geographical areas within the region.</td>
<td>Care, treatment and experience as well as clinical outcomes for patients suffering a stroke within the Norwich and Ipswich areas.</td>
<td>Improved compliance with current national guidelines in providing acute stroke care within the nationally defined timeframe which should lead to better outcomes for the patients.</td>
</tr>
<tr>
<td>Launch of the Trust’s Clinical Strategy</td>
<td>Coinciding with the release of The NHS Long Term Plan, the Clinical Strategy will support the Trust’s ambition to deliver better patient care and ensure everyone in our communities receives this whenever and wherever they need it.</td>
<td>The Strategy will reinforce putting the patient and clinician at the heart of the organisation through three core aims:</td>
<td>Approved Clinical Strategy with defined clinical plans, Key Performance Indicators to measure progress and measurable outcomes</td>
</tr>
</tbody>
</table>
|                                                                         |                                                                                      | • Providing individualised safe and effective patient care  
• Supporting and developing our staff  
• Improving outcomes for the patient through delivery of innovative and quality evidence-based practice  
The overarching strategy will contain a number of plans such as; learning disabilities, cardiac care, acute stroke, trauma etc which will include milestone objectives within each. |                                                                                                                                                                                                                                                                                                       |

**How we will monitor progress:** Progress reported bi-monthly to the Quality Governance Committee

**Responsible Lead:** Tracy Nicholls - Director of Clinical Quality and Improvement

**Date of completion:** 31st March, 2020
### Priority 3 Patient Experience

<table>
<thead>
<tr>
<th>Priority</th>
<th>Why we have chosen this priority</th>
<th>What we are trying to improve</th>
<th>What success will look like</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obtain feedback from harder to reach groups of patients such as those with Learning Disabilities, Dementia and younger people</td>
<td>We recognise that some patients do not participate in our survey feedback process and that our current survey form does not conform to the Accessible Information Standards. These patients can provide valuable information on the service they have received and how we can improve their experience and care.</td>
<td>A more user friendly survey form for patients to provide valuable feedback on their care and experience.</td>
<td>Implementation of a more user-friendly feedback form that conforms with the Accessible Information Standards and which is relevant to all patient groups. Younger person survey – outcome data to drive change for improvement.</td>
</tr>
<tr>
<td>Launch of the Learning Disabilities and Autism Workplan</td>
<td>Following work undertaken with Public Health England and evaluating information provided through the national Learning Disabilities benchmarking process in 2018, we acknowledge that the Trust needs to improve in how we care for and treat patients with particular conditions.</td>
<td>The care and experience of patients with Learning Disabilities / Autism when using the ambulance service both in an urgent and emergency setting and also when being conveyed by Patient Transport Services.</td>
<td>A comprehensive collaborative workplan in EasyRead format with defined milestone objectives.</td>
</tr>
<tr>
<td>Improving experience and quality of care for people with Learning Disabilities / Autism</td>
<td>By better understanding the needs of this particular groups of patients and their families/carers, we can provide a better service</td>
<td>High quality of care and experience when being treated and/or transported by EEAST. Provide a safe and inclusive arena in which patients and their families can raise concerns and provide views on what their needs are.</td>
<td>Development of a network of Learning Disabilities / Autism groups that supports feedback through a series of ‘pop-up’ focus groups. Following engagement, launch of a co-produced range of feedback tools that addresses important areas for this particular group of patients</td>
</tr>
</tbody>
</table>

**How we will monitor progress:** Progress reported bi-monthly to the Quality Governance Committee

**Responsible Lead:** Tracy Nicholls - Director of Clinical Quality and Improvement

**Date of completion:** 31st March, 2020
## PART 3
Review of 2018/19

### You said, we did

It remains important to us to act in a timely manner upon feedback we receive, whether it is a concern or compliment. This part of the report shows the response we made in acting on some of the things you, the public said, and what we did about it.

<table>
<thead>
<tr>
<th>You said</th>
<th>We did</th>
<th>What this means</th>
</tr>
</thead>
<tbody>
<tr>
<td>The ambulance service was called out to a lady who fell in her home. The paramedic arrived, lifted the patient from the floor and into her bed. The family member was not happy with the assessment completed for the patient. Several hours later the patient had extreme leg pain, another ambulance was called and she was transported to hospital.</td>
<td>As part of the investigation we spoke to the family member and apologised for the distress that was caused as a result of the incident. We reviewed all of the documentation and spoke with the crew regarding the incident. The clinician reported that he considered a hospital assessment for the patient but was influenced by the patient and her partner both asking to remain at home as the patient’s partner was planning on taking the patient to a routine GP appointment later that day. The clinician gave worsening advice that if the pain got worse, they were to call 999 again.</td>
<td>The clinician was given advice and support regarding dealing with difficult assessments of patients with previous conditions. He has also been provided with advice on how to assess patients suffering with dementia as they will often struggle to provide accurate pain analysis. Safety netting patients to the Out of Hours GP, their own GP or alternative Health Care Practitioners (HCP) when they are left at home was also discussed at length with the clinician.</td>
</tr>
<tr>
<td>Patient transport patients continually reported that transport was late and that the drivers did not know the area.</td>
<td>The concerns raised were investigated and it was found that the volume of journeys being organised was too large for the control room the vehicles were being dispatched from. The control room was being run from Essex for Bedfordshire patients. This resulted in poor dispatching decisions and delays for patients.</td>
<td>It was recognised that controlling Bedfordshire patient transport would be best served locally; A new control room was set up in Bedford in October 2018. The control room is being led by local staff who are more familiar with the area and we believe that this, along with new systems in place, has improved the service to our patients. Since this date we have seen a decrease in complaints from Bedfordshire patient transport patients.</td>
</tr>
<tr>
<td></td>
<td>You said</td>
<td>We did</td>
</tr>
<tr>
<td>---</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>3</td>
<td>A grandson reported his concerns about the clinical treatment his grandmother had received following her journey with patient transport. His grandmother had suffered an injury to her leg whilst being collected by patient transport. He was also not very happy that his grandmother was not wearing her coat and was freezing cold to touch.</td>
<td>The investigating manager reviewed the journey details and could see that it was undertaken by a private ambulance service. The private company were contacted, and the crew members provided statements and were interviewed by the head of training for the private company. During the interview they discussed the incident in depth, and it was highlighted that there was a lack of vehicle familiarisation and communication from the crew. The head of training identified that at no point did the crew members blame each other for the incident and they both showed patient care and compassion when dealing with the patient’s injuries. The crew had also reported the incident themselves via the appropriate routes.</td>
</tr>
<tr>
<td>4</td>
<td>The patient stated that they had suffered a headache for four days and decided to call an ambulance. The crew member was very dismissive of the pain the complainant was in and didn’t seem concerned. The complainant saw the doctor soon after the ambulance assessment and was sent straight to the accident and emergency department. The complainant suffered a brain haemorrhage and was rushed straight to a London hospital for surgery.</td>
<td>A full investigation was carried out and as part of the investigation the investigating manager received a statement from the attending paramedic and spoke to them regarding the aspects of the complaint. From the paramedic’s statement, they have stated that they do not feel they were rude at any time towards the patient and were trying to do a full and thorough assessment.</td>
</tr>
<tr>
<td>You said</td>
<td>We did</td>
<td>What this means</td>
</tr>
<tr>
<td>----------</td>
<td>--------</td>
<td>-----------------</td>
</tr>
<tr>
<td><strong>5</strong> You said</td>
<td>The complaint was discussed at a Serious Incident (SI) panel. Which requested that a Root Cause Analysis (RCA) be undertaken - this included a review of the Computer Aided Dispatch (CAD) records, 999 call audits, trust incident log, hospital delay report and the dispatch records. The original 999 call was audited and it was determined that the correct coding was selected - a category 3 hear and treat call. A clinician attempted to call on two occasions, but the line was engaged on both attempts. The call therefore was defaulted to a face to face response with a category 3 coding. Unfortunately, at this time the Trust had implemented its Surge plan at level amber. One ambulance was dispatched but had to be diverted and an ambulance eventually arrived almost four and a half hours after the original 999 call.</td>
<td>There were several lessons learnt and recommendations raised as a result of this incident. One issue was the difficulty in processing the original 999 call from the third-party caller, who had difficulty providing and giving minimal information to the call handler. Call handlers will be given further training in communication techniques for callers with communication barriers. There will also be a review of the triaging codes regarding priority symptom codes to identify further training that could be given to call handlers regarding which priority symptom to choose if no changes are identified with the triage system. Hospital handover delay had a significant impact on the availability of ambulance resources to attend to the patients. The Trust will continue to work closely with healthcare partners and commissioners to try and reduce hospital handover delays. This incident will also be highlighted at the local A&amp;E delivery board to raise awareness of the hospital delays on the wider communities.</td>
</tr>
<tr>
<td><strong>6</strong> You said</td>
<td>A full investigation was carried out and as part of the investigation the Investigating manager received a statement from the paramedic and spoke to him regarding the aspects of the complaint. The paramedic apologised that his attitude and the way he questioned both the patient and complainant caused offence.</td>
<td>Staff involved were made aware of the importance of good customer service and the standards the Trust expects. Upon further reflection the paramedic realised that his attitude on this occasion fell short of the Trust expectation. He has been reminded that the way he presents himself and communicates with patients and their relatives can be perceived in a different manner than expected. He will be more careful in future and consider the appropriate communication techniques.</td>
</tr>
</tbody>
</table>
Patient experience and feedback

The Patient Experience team co-ordinate all complaints, concerns, compliments and comments for the Trust, in line with the NHS Complaints Regulations 2009.

The feedback, both positive and negative, is managed by the department and enquirers are kept informed throughout the process and informed of the outcome of their feedback.

Compliments
Compliments always far outweigh the number of complaints received, and in 2018/19, 2,145 compliments were received regarding the service, an average of 178 a month.

Compliments are reported to the Trust Board and also emailed to the individual staff members with the local management teams copied in so that they can be acknowledged and recorded on the staff members personnel file.
Complaints
We received 1,216 complaints in 2018/19 compared to 1,620 in 2017/18. This a decrease of 24%.

Complaints regarding clinical treatment and assessment have decreased by 16% when compared to 2017/18, along with most other types of complaint. The most significant decrease relates to the number of ambulance delay complaints; the number of complaints relating to emergency ambulance delay has decreased by 49%. Our priority has been, and is still, to increase the number of qualified staff, which aims to mitigate the ever increasing demand on the service whilst providing patients with the most appropriate response first time.

<table>
<thead>
<tr>
<th>Service Line</th>
<th>2016-17</th>
<th>2017-18</th>
<th>2018-19</th>
<th>% change: 2017-18 to 2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency and Urgent Care Service</td>
<td>966</td>
<td>979</td>
<td>602</td>
<td>-38%</td>
</tr>
<tr>
<td>Patient Transport Service (Scheduled care)</td>
<td>493</td>
<td>568</td>
<td>484</td>
<td>-14%</td>
</tr>
</tbody>
</table>

A review of the Trust’s complaints handling process is an ongoing process completed by the Community Engagement Group. To date, the reviews are very positive with comments passed that EEAST has a robust, comprehensive complaints handling process in place. This is also highlighted by the Trust not having any upheld complaint investigated by the Parliamentary and Health Service Ombudsman during 2018/19.

“You would like to know why the Call Handler suggested that you contact your GP the next day or get myself to hospital.”
Patient Advice and Liaison Service
The Patient Advice and Liaison Service (PALS) is an informal mechanism for patients, their relatives or carers to comment on services or raise a concern, and we aim to deal with all comments received via PALS with similar standards of responsiveness and thoroughness as employed for complaints.

Concerns
A concern can be described as negative feedback which has not been, or is not required to be, dealt with as a formal complaint. It does not necessarily require a written response and can be resolved verbally if appropriate.

Comments and PALS
At times we receive comments, are asked a question or sought advice regarding sign-posting within the wider NHS or social care network. These comments are logged and responded to as appropriate or sent onto the relevant department if it is information only:

- In 2017/18 the Trust received 377 contacts relating to negative concerns or feedback, an increase of 62% from 233 during 2016/17. These were all investigated and feedback provided, either verbally or in writing
- The Trust received 250 PALS contacts relating to comments, questions or other feedback, including requests about lost property; this is a slight decrease of 8% from the numbers recorded during 2016/17
- This makes 627 PALS enquiries received, an increase of 23% from 507 reported during 2016/17.

Parliamentary and Health Service Ombudsman (PHSO)
Although the vast majority of complaints are successfully resolved through the Trust’s complaints process, complainants are able to refer their complaint to the Parliamentary and Health Services Ombudsman (PHSO) if they feel their complaint has not been resolved and the Trust has exhausted all avenues of resolution. In 2018/19 the Trust received six referrals compared to thirteen in 2017/18 a decrease of 53%.

Of the six referrals received in 2018/19, none have been upheld demonstrating that EEAST continues to have a comprehensive complaints’ handling process and performs well.

![PHSO Referrals by Quarter](image.png)

To date, two cases referred in 2018/19 remain open with the PHSO.
Patient surveys
The Trust has a well-established system of obtaining feedback from patients, mostly operated via a Patient Survey team that acts independently from departments delivering patient services. The patient survey system includes the use of the Trust’s Community Engagement Group; the involvement of such volunteers has proved to be of great value, especially with design of patient surveys and reporting to external patient groups. The design of all patient experience surveys is carried out with great care to ensure that all respondents involved are able to take part and feedback on the service received.

The Trust has an annual patient survey programme which includes continuous, rolling surveys for emergency services, the Patient Transport Service, the Patient Transport Clinical Assessment and Advice Service (PTCAAS), the Emergency Clinical Advice and Triage (ECAT) service and the Birmingham community healthcare call handling service. Ad-hoc patient experience projects are also conducted each year, with such projects focusing on specific topic areas (such as dementia and the Emergency Intervention Falls Vehicle - a new service or an area of care that is being developed), or an area where there may be a value in re-auditing.

Patient survey results are analysed and written into full/standard reports which are then distributed to the service managers to monitor patient satisfaction and identify areas for improvement. Monthly patient survey figures are also presented as part of the ‘dashboard’ used by the Trust Board to oversee organisational performance. Full patient survey reports are presented at senior Trust groups, with such groups ensuring appropriate governance, reviewing patient experience results and managing any actions. Patient survey reports are then published on the Trust’s internal and external websites.

As part of each patient experience questionnaire, the Trust collects data on the patient’s Key Performance Indicator (KPI). The KPI is used as a method of calculating the overall satisfaction of the patient in relation to the service they have received and is used as a benchmark across the Trust. The KPI result is calculated by dividing the proportion of ‘very satisfactory’ and ‘satisfactory’ responses (numerator) by the overall number of responses (denominator).

The Trust also collects data using the ‘Friends and Family Test’ (FFT) score. The FFT is a quality priority and also a national directive, with the Trust required to report the FFT results to both the commissioners and NHS England. The FFT is a response to the question ‘How likely are you to recommend our service to friends and family if they needed similar care or treatment?’ The FFT score is calculated by dividing the proportion of ‘extremely likely’ and ‘likely’ responses (numerator) by the overall number of responses (denominator). Alongside the KPI, the FFT score is used as a general performance marker and a means to benchmark across the Trust.

The tables below show the year to date KPI and postal FFT figures for the Trust:

<table>
<thead>
<tr>
<th>Trust Patient Experience Results: April 2018 to January 2019</th>
<th>Overall Satisfaction</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of patients</td>
<td>KPI Performance</td>
</tr>
<tr>
<td>-----------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>Emergency Services</td>
<td>1136/1150</td>
</tr>
<tr>
<td>Patient Transport Service</td>
<td>1475/1665</td>
</tr>
<tr>
<td>Emergency Clinical Advice and Triage</td>
<td>188/219</td>
</tr>
<tr>
<td>Birmingham Community Healthcare Call Handling Service (April to September 2018)</td>
<td>81/87</td>
</tr>
<tr>
<td>All Services</td>
<td>2880/3121</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Trust Patient Experience Results: April 2018 to January 2019</th>
<th>Friends and Family Test</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of patients</td>
<td>FFT Performance (postal)</td>
</tr>
<tr>
<td>-----------------</td>
<td>--------------------------</td>
</tr>
<tr>
<td>Emergency Services</td>
<td>1142/1158</td>
</tr>
<tr>
<td>Patient Transport Services</td>
<td>1639/1808</td>
</tr>
<tr>
<td>Emergency Clinical Advice and Triage</td>
<td>210/234</td>
</tr>
<tr>
<td>Birmingham Community Healthcare Call Handling Service (April to September 2018)</td>
<td>89/95</td>
</tr>
<tr>
<td>All Services</td>
<td>3080/3295</td>
</tr>
</tbody>
</table>

Further information on our results can be found in our published patient survey reports at [www.eastamb.nhs.uk](http://www.eastamb.nhs.uk)
The FFT question is included on all Trust postal patient experience surveys, which run alongside the ‘real-time’ FFT feedback forms. The Trust is required to provide all ‘see and treat’ emergency services (ES) patients (i.e. those we do not convey) and all patient transport service (PTS) patients with the opportunity to provide feedback on the service received. In addition to the above, a ‘real-time’ ES early intervention vehicle patient survey has been implemented within the Norwich, Great Yarmouth and Waveney and North East Essex area. The ‘real-time’ results to the FFT question are submitted to NHS England and the commissioners on a monthly basis.

Every survey also encourages comments from patients and all comments received are written up as part of the reporting process. The number of positive comments received always far outweigh the number of negative comments. However, it is often the negative comments which are the most useful from the perspective of learning and finding areas for possible improvement. These comments are passed to the Patient Experience Team for further action as appropriate.

**Future patient survey strategy**

The Trust is committed to developing its patient experience and engagement activity and continually seeks to identify new methods of collecting information and feedback from patients in relation to their experiences. The Trust will continue to undertake the continuous, rolling patient experience surveys (‘real-time’ and postal) along with any ad-hoc patient experience projects as part of the patient survey programme.

This will make sure that contractual requirements are met but also ensure the successful implementation of various Trust strategies (e.g. for Dementia, Learning Disabilities and End of Life Care). Patient satisfaction levels will continue to be reported as KPI and FFT scores and used as general performance markers for the Trust.

During 2019/20, the Trust’s main service areas will continue to actively collect feedback from patients:

**Emergency services**
- Postal survey to random samples of 999, GP urgent and the emergency clinical advice and triage patients will continue, with monthly management reports and annual Trust reporting.
- Specific surveys of patients in relation to certain aspects of the ES (e.g. projects in relation to dementia, young patients, mental health, end of life care, along with the emergency intervention falls vehicle, patients with learning disabilities and autism) are planned for the forthcoming year.
- Face to face discovery interviews to continue.

**Patient Transport Services**
- Postal survey of patients organised by contract to continue, with rolling management reports (quarterly or monthly depending on contract).
- During 2019/20 a project on the experiences of PTS and ES patients living with dementia is also programmed to take place.
- Face to face discovery interviews to continue.

**Birmingham Community Healthcare Call Handling Service**
- A postal survey to random samples of patients who have used the Birmingham Community Healthcare call handling service provided by the Trust will continue during 2018/19.
Comments received from patients and their families

"You are contacting us to express your family's gratitude regarding the three paramedics who attended your mother on New Year's Eve. Your mother had sustained a dislocated hip after a heavy fall. The crew who attended were compassionate, gentle and utterly professional in every aspect of their endeavours, you were in awe of their ability, especially in relieving the enormous pain she was suffering. Your Mother is 97 this month, and very ladylike, and their respect for her dignity was admirable. They are truly a great credit to the organisation."

"An ambulance had been called to attend to your 19-month old daughter who was struggling to breathe. The crew were quick with her observations and made her feel at ease in 25 minutes you were taken to hospital. you would like to say thank you to the crew members for their help and looking after your daughter."

"I would like to thank the Ambulance Paramedics who attended you. Their professional help and support was much appreciated. You have continued to make good progress on their very sound advice."

"Thank the crews who assisted your mum. On this occasion your mum didn't need to go to hospital, you would like to thank the crew for their advice, it really helped your mum cope with everything and has opened your eyes to more options that she previously did not know about. You felt the crews were extremely knowledgeable and helped put your mind at ease during a difficult time."

"Would like to thank the driver, he was very helpful, accommodating and made you feel comfortable during the journey."

"The most professional and outstanding treatment our staff gave to your husband this morning. You would like us to thank them on behalf of you both, and praise them for their dedicated service. We should be very proud of them. You yourself worked in the NHS for many years (now retired), you really appreciate the paramedics and the Ambulance Service. The RRV arrived first, swiftly followed by the ambulance, who were also so kind and helpful."
Patient & Public Involvement

The Trust Patient and Public Involvement (PPI) team conduct a number of patient interviews every year. The purpose is to gauge public opinion on the services that we provide. This empirical evidence allows the Trust the opportunity to evaluate the experience of our service users and to utilise this information during the processes of service design, implementation and delivery ensuring that the patient voice is heard throughout the process.

The PPI team visits identified patients in their own homes and films patient interviews. These patients relate their journey from the initial 999 call to the hospital handover. These interviews, recorded onto DVD, are an important tool for highlighting the authentic patient voice within the Trust and are shown at Board meetings and are regularly used in staff training.

Although the responses can be very mixed, the majority of evidence is of a positive experience.

Carer interview
“A crew arrived very quickly, we were very impressed. They asked us all the questions and we explained she was living with dementia. They were very good on the phone. The vehicle pulled up and there were 3 of them. We get into the back of the vehicle, she got very anxious because it was a small area. The only familiar thing in the back of the vehicle was myself who was holding her hand. The one behind was asking her questions, 2 by the side all doing different things. You could see in her face she was anxious...They did get there eventually after we jollied things up. Trying to find things to engage her with in the back of the vehicle.

The new vehicles you have coming in have colour and music in the back, these are all positive moves.”

Dementia hub, Bury St Edmunds

Patient interview
“The paramedic said she’d go in the ambulance with me and asked one of the crew to drive her car. I thought, someone’s taking control of the situation. I’m not sure they realise how much that reduces the stress on me. I don’t know what’s going on and I rely on them getting it right and doing what they have to do.

I can’t fault the service. From my experience, on the three occasions I’ve used it, it has been 1st class.”

Patient Hertfordshire
Progress on the quality account priorities 2018/19

The following section provides feedback and evidence on the progress of last year’s work on our key quality priorities and our performance.

The content is defined by NHS England and includes outcome results against specific indicators under five headings:

1. Preventing people from dying prematurely
2. Enhancing quality of life for people with long term conditions
3. Helping people to recover from episodes of ill health or following injury
4. Ensuring that people have a positive experience of care
5. Treating and caring for people in a safe environment and protecting them from avoidable harm

With the exception of the time standards to our calls, no thresholds have been set by the DH to denote ‘poor’ clinical performance for the ACQIs.

However, in collaboration with our Clinical Commissioning Groups we have set our own targets as part of our A&E contract to encourage improvement in clinical care.
**Response Times**

**Ambulance Response Programme**

Since the mid-1970s, ambulance services were required to attend Red 1 and Red 2 (Category A) telephone calls within eight minutes of receipt of the call 75% of the time.

The standard also meant that an ambulance had to be dispatched immediately for Red 1 calls and within 60 seconds of the call being connected to the ambulance service for Red 2 calls - the ‘clock was stopped’ when the first ambulance service-dispatched emergency responder arrived at the scene.

In July 2017, following an extensive ambulance service trial known as the Ambulance Response Programme (ARP), Sir Bruce Keogh (National Medical Director, NHS England) formally wrote to the Secretary of State for Health recommending the roll out of ARP to every ambulance service in England. The full document can be found at https://www.england.nhs.uk/wp-content/uploads/2017/07/ambulance-response-programme-letter.pdf

In summary, his proposals included extending the time that ambulance services were allowed when connected to the call so that a better understanding of the patient’s condition and therefore the type of response that is required could be assigned.

He proposed that a new Category 1 – 4 system was implemented (determined by clinical condition/emergency), as shown on the right, with varying response times for each category.

Changes also meant that for those patients who needed to go to hospital, the ‘clock was stopped’ when a vehicle transporting a patient i.e. an ambulance arrived on scene rather than the first emergency resource arrived.

Keogh’s recommendations were accepted and an extensive roll out began with EEAST going live with the new standards on 18th October 2018. Due to these changes, we are only able to report on the new standards and not able to report on our comparative performance for last year, as supported by NHSI within their guidance letter issued in December 2018.

<table>
<thead>
<tr>
<th>Category</th>
<th>National standard</th>
<th>How long does the ambulance service have to make a decision</th>
<th>What stops the clock</th>
</tr>
</thead>
</table>
| Category 1 | 7 minutes mean response time | The earliest of:  
- The problem being identified  
- An ambulance response being dispatched  
- 30 seconds from the call being connected | The first ambulance service dispatched emergency responder arriving at the scene of the incident  
(There is an additional Category 1 Transport (C1T) standard to ensure that these patients also receive early ambulance transportation) |
| Category 2 | 18 minutes mean response time | The earliest of:  
- The problem being identified  
- An ambulance response being dispatched  
- 240 seconds from the call being connected | If a patient is transported by an emergency vehicle, only the arrival of the transporting vehicle stops the clock. If the patient does not need transport, the first ambulance service dispatched emergency responder arriving at the scene of the incident stops the clock. |
| Category 3 | 120 minutes 90th centile response time | The earliest of:  
- The problem being identified  
- An ambulance response being dispatched  
- 240 seconds from the call being connected | If a patient is transported by an emergency vehicle, only the arrival of the transporting vehicle stops the clock. If the patient does not need transport, the first ambulance service dispatched emergency responder arriving at the scene of the incident stops the clock. |
| Category 4 | 180 minutes 90th centile response time | The earliest of:  
- The problem being identified  
- An ambulance response being dispatched  
- 240 seconds from the call being connected | Category 4T:  
If a patient is transported by an emergency vehicle, only the arrival of the transporting vehicle stops the clock. |
Timely responses

The table below summarises the Trust’s performance against the national response time standards. Published further information for all ambulance services can be found here: www.england.nhs.uk/statistics

<table>
<thead>
<tr>
<th>Category</th>
<th>Definition</th>
<th>National standard</th>
<th>EEAST Performance (hh:mm:ss)</th>
</tr>
</thead>
<tbody>
<tr>
<td>C1</td>
<td>Immediately life threatening injuries and illnesses.</td>
<td>7 minutes mean response time</td>
<td>00:08:02</td>
</tr>
<tr>
<td></td>
<td></td>
<td>15 minutes 90th centile response time</td>
<td>00:14:32</td>
</tr>
<tr>
<td>C1T</td>
<td>Immediately life threatening injuries and illnesses where the patient is transported to hospital</td>
<td>7 minutes mean response time</td>
<td>00:12:53</td>
</tr>
<tr>
<td></td>
<td></td>
<td>15 minutes 90th centile response time</td>
<td>00:23:26</td>
</tr>
<tr>
<td>C2</td>
<td>Emergency</td>
<td>18 minutes mean response time</td>
<td>00:25:01</td>
</tr>
<tr>
<td></td>
<td></td>
<td>40 minutes 90th centile response time</td>
<td>00:51:28</td>
</tr>
<tr>
<td>C3</td>
<td>Urgent calls and in some instances where patients may be treated in situ (e.g. their own home) or referred to a different pathway of care</td>
<td>120 minutes 90th centile response time</td>
<td>03:09:48</td>
</tr>
<tr>
<td>C4</td>
<td>Less urgent. In some instances patients may be given advice over the phone or referred to another service such as a GP or pharmacist.</td>
<td>180 minutes 90th centile response time</td>
<td>03:31:39</td>
</tr>
</tbody>
</table>

The Trust continued to experience significant loss of productive ambulance hours to delays in arrival to clear at hospital. Looking at handover to all departments (not just A&E) 7 per cent (34 thousand occasions) exceeded one hour.

During the year, EEAST transported circa 49,000 patients to emergency departments and only 38% of these were handed over in 15 minutes (where handover was recorded). That equates to circa 59,000 hours in delays at hospitals which equals just under 5,000 12-hour ambulance shifts.

Through an independent service review commissioned by NHS Improvement and NHS England, investment has been identified and will form the basis of transformation plans for Rota lines over the next two years which will enable achievement of national standards and an efficient and sustainable operating model. The Trust continues to recruit to the student paramedic programme following the Trust recruitment plan.
Heart attack care
Heart disease causes more deaths in the UK each year than any other single disease or condition and most of these deaths are caused by a heart attack.

Because of the life-threatening risk with a heart attack, providing patients with a pre-hospital assessment for a STEMI and administering an appropriate care bundle means a significant improvement on patient outcomes, thereby supporting the NHS to reduce the number of patients dying prematurely and to help people to recover from episodes of ill health or following injury.

STEMI care bundle
The mandatory quality indicator for ambulance services relating to this topic is the provision of an appropriate care bundle; recording of two pain scores, giving aspirin to break down the clot, giving glyceryl trinitrate (GTN) to dilate the coronary arteries and providing pain relief. The patient care record is audited against all of these criteria and deemed to be either compliant or non-compliant.

The table below shows our result against the national average and the best and worst scores achieved by ambulance services within England – it should be noted that the latest national data published is for January 2019. It also shows our achievement against the threshold target set by our commissioners within our A&E contract.

EEAST were the second highest performing ambulance trust for this time period however we acknowledge that this could improve further and are raising awareness regarding the documentation of two pain scores which seems to be the largest area of non-compliance. We have also included a Pain Score Audit within the programme for 2019/20 to look at this documentation further.

<table>
<thead>
<tr>
<th>Heart attack care</th>
<th>Latest data available January 2019</th>
<th>Locally agreed target</th>
<th>Average 2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>National average</td>
<td>Highest score</td>
<td>Lowest score</td>
</tr>
<tr>
<td>STEMI Care Bundle</td>
<td>79.6%</td>
<td>94.1%</td>
<td>63.7%</td>
</tr>
</tbody>
</table>

As a result of our sustained high level of performance throughout the year, the CCGs have increased our threshold by 9% to 95% for 2019/20.
Patients conveyed to a Primary Percutaneous Coronary Intervention (PPCI) Centre
Although the time it takes to take a STEMI patient to a specialist Primary Percutaneous Coronary Intervention (PPCI) treatment centre is not a quality metric for the Quality Account, we report our achievement on a month by month basis to both NHS Digital and our commissioners. For 2018/19 NHSE abolished the call to PPCI < 150 minutes and released two new joint indicators ambulance trusts and these centres both of which are measured in hours and minutes. Due to the way that this data is published, we are unable to report the highest and lowest scores against these indicators, the table below demonstrates EEAST’s performance against the national average. Please note that the latest published data is for January 2019.

<table>
<thead>
<tr>
<th>Heart attack care</th>
<th>Latest data available January 2019</th>
<th>National average</th>
<th>EEAST Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean average time from call to catheter insertion for angiography</td>
<td>2:09</td>
<td>2:13</td>
<td></td>
</tr>
<tr>
<td>90th centile time from call to catheter insertion for angiography</td>
<td>2:55</td>
<td>3:01</td>
<td></td>
</tr>
</tbody>
</table>

* It should be noted that this outcome is based on ‘unvalidated, preliminary data from the Myocardial Ischaemia National Audit Project (MINAP)’. Also, as hospitals do not have a deadline period for submitting their data to MINAP, outcome results will change throughout the year.

Case study – STEMI
We were called to a 66-year-old-lady who was experiencing a sudden onset of chest pain whilst at home. She had no previous cardiac medical history. The pain was of sudden onset with pain radiating to her next and left shoulder and arm.

She was pale but not vomiting.

The ambulance crew completed their assessment which included; pulse, blood pressure, respiratory rate, oxygen saturations, GCS (Glasgow Coma Score, to identify consciousness levels), temperature, blood sugar levels, pain scores before and after treatment, and a 12 Lead ECG.

The crew identified from the ECG that the patient was showing signs of a heart attack (ST Segment Elevated Myocardial Infarction – STEMI) and commenced the protocol for treatment in line with the Trust and national guidelines.

Aspirin, GTN (Glyceryl Trinitrate Spray), Clopidogrel (antiplatelet drug) and morphine and entonox used for pain relief were all given.

The PPCI (Primary Percutaneous Coronary Intervention) pathway was activated by the crew calling the nearest specialist, designated cardiac hospital that have a catheter laboratory in the patient’s area to pre alert the hospital team of imminent patient arrival for immediate surgical intervention.

The patient was conveyed under ‘blue lights’ to the PPCI centre for treatment.
Stroke care
Stroke is the third biggest cause of death in the UK and the largest single cause of severe disability - more than 150,000 people in England will have a stroke each year. Most people affected are over 65, but anyone can have a stroke including children and babies.

Face-arms-speech-time (FAST, is a simple test to help people recognise the signs of stroke and understand the importance of emergency treatment. The faster a stroke patient receives treatment (the care bundle), the better the chances are of surviving and reducing long term disability.

Stroke care bundle
This quality metric relates to the percentage of suspected stroke patients (assessed face to face) who receive an appropriate care bundle; recording of blood pressure (BP), FAST test and blood sugar levels (BM). As for heart attacks, the patient care record is audited against all of these criteria and deemed to be either compliant or non-compliant.

The table below shows our result against the national average and the best and worst scores achieved by ambulance services within England – it should be noted that the latest national data published is for January 2019. It also shows our achievement against the target set by our commissioners within our A&E contract.

It should also be noted that national results are available approximately four months after Trust data is available and therefore comparisons between the two must be made with extreme caution.

The CCGs have held our threshold for 2019/20 at 98.0%.

Stroke Timeliness
Patients who are cared for in a defined stroke unit with organised stroke services are more likely to survive, have fewer complications, and return home and regain independence quicker than patients on a general medical ward.

Although the time it takes to convey a stroke patient to a specialist Hyper Acute Stroke Unit (HASU) is not a quality metric for the Quality Account, we report our achievement on a month by month basis to both NHS Digital and our commissioners.

Previously our performance was assessed against the percentage of FAST positive stroke patients (assessed face to face) potentially eligible for stroke thrombolysis, who arrive at a hyper acute stroke unit (HASU) within 60 minutes of call.

<table>
<thead>
<tr>
<th>Stroke care</th>
<th>Latest data available January 2019</th>
<th>Locally agreed target</th>
<th>Average – 2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>National average</td>
<td>Highest score</td>
<td>Lowest score</td>
</tr>
<tr>
<td>Stroke Care Bundle</td>
<td>98.4%</td>
<td>99.3%</td>
<td>96.2%</td>
</tr>
</tbody>
</table>

The CCGs have held our threshold for 2019/20 at 98.0%.
For 2018/19 NHSE abolished this indicator and released three new indicators for ambulance trusts which are measured in hours and minutes. Due to the way that this data is published, we are unable to report the highest and lowest scores against these indicators, the table below demonstrates EEAST’s performance against the national average. Please note that the latest published data is for January 2019.

Although not the lowest scoring ambulance trust, we are below the national average and our clinical leads are working with the audit department and operational teams to review those cases that did not meet the 60 minute target. However, it should be noted that for some patients, this will not be able to be achieved due to where the stroke centre is sited in relation to where they have a stroke.

<table>
<thead>
<tr>
<th>Stroke care</th>
<th>Latest data available January 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>National average</td>
</tr>
<tr>
<td>Mean average time from call to hospital arrival</td>
<td>1:13</td>
</tr>
<tr>
<td>Median time from call to hospital arrival</td>
<td>1:06</td>
</tr>
<tr>
<td>90th centile time from call to hospital arrival</td>
<td>1:49</td>
</tr>
</tbody>
</table>

It should also be noted that not all strokes are identified at the time of call due to the information provided to the call taker, or the patient may deteriorate before or after the crew arrive. Our clinical audit software has been amended so that we can interrogate the data further to determine what the causes are for not meeting the national average and to set recommendations for improvement.

**Case Study – STROKE**

A 999 call was made to the service to attend a 46-year-old-lady with a history of strokes and transient ischaemic attacks (TIA) whose husband had noticed that she had reduced speech and right sided weakness.

The crew arrived on scene and assessed the patient, whose symptoms included an abnormal facial droop, arm drift and speech. The crew identified a time critical medical event and put into place the stroke pathway of treating and getting the patient to definitive hospital care at the nearest specialist HASU (Hyper Acute Stroke Unit), within four and a half hours of onset of symptoms and 60 minutes from time of first call for help to the emergency service.

Observations and recordings of pulse, blood pressure, respiratory rate, oxygen saturations, GCS (Glasgow Coma Score, to identify conscious levels), temperature and blood sugar level were made.

A pre alert call to the nearest HASU was made by the crew giving patient details and observations to the receiving Stroke Team whilst the patient was driven under blue light emergency conditions.

The ambulance arrived at hospital 58 minutes after receiving the 999 call and 90 minutes after symptoms onset, despite the 21 minute journey time under ‘blue light’ conditions to the nearest Hyper Acute Stroke Unit to the patient’s address.
Cardiac arrest care

A cardiac arrest occurs when the heart suddenly stops pumping blood around the body. Someone who is having a cardiac arrest will suddenly lose consciousness and will stop breathing or stop breathing normally. Unless immediately treated by cardio pulmonary resuscitation (CPR) and early defibrillation, this always leads to death within minutes. It is possible to survive and recover from a cardiac arrest if you get the right treatment quickly.

Around two thirds of cardiac arrests outside of hospital happen in the home, but nearly half of those that occur in public are witnessed by bystanders. With each minute that passes in cardiac arrest before defibrillation, chances of survival are reduced by about 10%.

This year we set out to improve the Trust’s outcomes from cardiac arrest and work towards an increase in Return of Spontaneous Circulation (ROSC) and ‘survival to discharge’ figures. Although the indicators displayed in the table below are not quality metrics for the Quality Account, we report our achievement on a month by month basis to both NHS England and our Commissioners. Latest available national data is for January 2019.

<table>
<thead>
<tr>
<th>Cardiac arrest care</th>
<th>Latest data available January 2019</th>
<th>Locally agreed target 2018/19</th>
<th>Average 2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>National average</td>
<td>Highest score</td>
<td>Lowest score</td>
</tr>
<tr>
<td>Return of Spontaneous Circulation (pulse) – All patients</td>
<td>30.6%</td>
<td>36.4%</td>
<td>22.8%</td>
</tr>
<tr>
<td>Return of Spontaneous Circulation (pulse) – Utstein** patients</td>
<td>54.7%</td>
<td>62.4%</td>
<td>22.2%</td>
</tr>
<tr>
<td>Survival to Discharge – All patients</td>
<td>10.3%</td>
<td>14.4%</td>
<td>7.6%</td>
</tr>
<tr>
<td>Survival to discharge – Utstein** patients</td>
<td>30.6%</td>
<td>40.8%</td>
<td>20.8%</td>
</tr>
</tbody>
</table>

As a result of the high levels achieved in 2018/10, the CCGs have increased the thresholds for all Cardiac Arrest Indicators for 2019/20:
- Return of Spontaneous Circulation (pulse) – All patients from 27% to 30%
- Return of Spontaneous Circulation (pulse) – Utstein patients from 52% to 58%
- Survival to Discharge – All patients from 7% to 11%
- Survival to discharge – Utstein patients from 25% to 36%

Case study – CARDIAC ARREST 1

A 999 call was made to the service for a 44-year old man who was in cardiac arrest witnessed by his wife on scene. an ambulance was deployed immediately arriving in less than four minutes.

The 999 call handler guided the wife to start CPR straight away, which is a proven element in the Chain of Survival of patients in cardiac arrest, and this was performed effectively until the crew took over care. Recognising that the patient was in Pulseless Electrical Activity (PEA), a non-shockable rhythm, the crew commenced Advanced Life Support (ALS); continuing with chest compressions, inserting an airway for oxygen therapy, establishing IV access and administering cardiac drugs.

The patient regained a pulse achieving a normal sinus heart rhythm 10 minutes after the crew arrived and started treatment – the patient was conveyed with ongoing treatment to the nearest hospital where the pre-alerted staff were waiting to take over the patient’s treatment from the ambulance crew.
In 2018/19, NHS England introduced two new ACQIs, one of which was the care bundle of a patient who has had a Return of Spontaneous Circulation (ROSC). To give Ambulance Services time to develop new measures, for 2018/19 ambulance trusts were asked to collect and submit data for cases identified within April, July October and January. The conditions for patient inclusion are:

The patient had resuscitation (Advanced or Basic Life Support) commenced / continued by Ambulance Service following an out-of-hospital cardiac arrest, and had a Return of Spontaneous Circulation.

Patients who had suffered a traumatic cardiac arrest, were successfully resuscitated before the arrival of ambulance staff or were aged less than 18 years were not included.

The care bundle consists of six post-ROSC requirements for these patients:

- 12 Lead ECG taken
- Blood glucose recorded
- End-tidal CO2 (ETCO2) reading / waveform recorded
- Systolic blood pressure reading recorded or, if unobtainable, presence of radial pulse documented
- Administration started of a 250ml bolus of saline fluids

Although not directed as a reporting requirement, we feel it appropriate to report it here alongside our mandated requirements relating to patients who have suffered a cardiac arrest. Due to this benchmarking period, there is no locally agreed target set for EEAST.

The main gap in compliance identified appears to be regarding the recording of an end-tidal CO2 (ETCO2) reading / waveform. We are currently reviewing our paramedic core competency framework and will be re-emphasising the need to complete our Airways Log for all patients who are intubated with an endotracheal airway.

With the emphasis on supporting and educating staff through a supervisory model within our soon to be launched Clinical Strategy, we have made a commitment to improve on this ACQI during the year.

Progress will be monitored through our internal governance process and by our commissioners.

### Cardiac arrest care

<table>
<thead>
<tr>
<th></th>
<th>Average</th>
<th>Highest score</th>
<th>Lowest score</th>
<th>EEAST Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Post-ROSC care bundle</td>
<td>60.2%</td>
<td>85.5%</td>
<td>38.8%</td>
<td>39.2%</td>
</tr>
</tbody>
</table>

The main gap in compliance identified appears to be regarding the recording of an end-tidal CO2 (ETCO2) reading / waveform. We are currently reviewing our paramedic core competency framework and will be re-emphasising the need to complete our Airways Log for all patients who are intubated with an endotracheal airway.

With the emphasis on supporting and educating staff through a supervisory model within our soon to be launched Clinical Strategy, we have made a commitment to improve on this ACQI during the year.

Progress will be monitored through our internal governance process and by our commissioners.

### Case Study – CARDIAC ARREST 2

The Trust was called to a 57-year old lady who had woken with breathing difficulties and went into cardiac arrest. This was witnessed by her son who commenced and continued CPR under instruction from the 999 call handler. An ambulance was dispatched and arrived within seven minutes of the call.

The patient was assessed and found to be in Pulseless Electrical Activity (PEA). Basic life support (BLS) was performed and the patient gained a pulse 4-5 minutes after this commenced, the patient then began breathing and was rapidly transported to the nearest hospital where a pre-alert had been given to ensure a medical team was waiting upon arrival.

The lady went on to make a full recovery and was discharged home to her family a few days later.
**Priority 1: Patient Safety**
In 2017/18 we set two priorities within the overarching priority for patient safety and, for the first time within the Quality Account, specific PTS priorities were identified demonstrating that this area of service delivery, and that the safety of and overall experience for all patients, is recognised as an integral part of the organisation. As both of these priorities were new, with support from our commissioners, we continued these priorities into 2018/19 to build and improve on the benchmarking achievements in the previous year.

**Infection Prevention and Control – Improvements within the Patient Transport Service (PTS) vehicle deep cleaning target for all operational areas**
The aim for this priority was to improve the deep cleaning scheduling of PTS vehicles specifically. Although an aspirational target of 95% of vehicle cleans was set for 2017/18, a compliance level of only 52.8% was reached by the end of March 2018.

In October 2018, new cleaning schedules were introduced; a 12 week service clean and a recorded 48 hour interim clean for all patient facing vehicles, which results in the vehicles receiving more frequent cleaning and facilitates maintaining a high standard of cleanliness.

We refocused the work of our ambulance fleet assistants (AFA) and the emergency and urgent care and PTS management teams are using staff and facilities on shared sites to continue to improve these figures.

Although some PTS areas did not meet the schedule requirements, they have all improved compliance overall resulting in 95% compliance for the service clean and 77% for the interim clean by the end of March 2019.

**Looking forwards**
We are working towards a trust vision of a fully integrated standardised ‘Make Ready’ system which will increase the number of AFAs and the good progress made so far should become consistent.

It should also be noted that there is not a national guideline for the frequency of cleaning ambulances and many trusts are conducting different frequencies for this, however we believe that the schedule we have created is the most stringent and the very high levels of cleanliness compliance reported month on month provide us with the assurance that our schedules are effective.

Our progress will continue to be monitored through our own governance framework to Board level and also to our Clinical Commissioning Groups.

A full review of IPC can be found within our Director for Infection Prevention and Control (DIPC) Annual Report which will be published on [www.eastamb.nhs.uk](http://www.eastamb.nhs.uk) in the summer.
Introduction of a quarterly Safety Walkabout Audit tool within Patient Transport Services (PTS)

It was recognised that the safety walkabout audits, already completed by both the emergency and urgent service and the emergency operations centres, were not capturing any routine completion in PTS. It was decided to amend this omission and include PTS within this routine monitoring process.

A bespoke audit tool was designed in consultation with PTS staff which contains a number of questions to directly ask staff, such as; when they last had an appraisal, did they know how to access policies and procedures, how safely they felt they had cared for their patients in the previous week, if there was anything they felt the Trust could do to improve safety and quality. It also contains other more specific metrics ie cleanliness of children’s care seats, safe storage of patient information on the vehicles and general questions around vehicle and premises cleanliness, equipment storage etc.

Although a number of sites are shared with emergency and urgency care staff, it is of high importance that these are being completed by the PTS managers on a quarterly basis to provide ongoing monitoring and assurance that high standards of patient and staff safety are being achieved and maintained, as well as to provide an opportunity for staff to talk to a manager who they may not see on a day-to-day basis due to capacity of work.

The audits began in Q2 which has enable a 9-month review of compliance across the six contracts currently in place across Essex, Bedfordshire, Hertfordshire and Cambridgeshire.

The majority of indicators, detailed in the table, achieved very high levels of compliance, however indicators relating to; staff receiving feedback from reported incidents, knowing when their vehicle was last deep cleaned and notice boards being up to date achieved lower levels.

Operational management teams have put actions in place to improve compliance in these areas moving forwards.

The quarterly audit is now part of ongoing business with quarterly outcomes reported through our governance processes.
Priority 2: Clinical effectiveness

End of Life Care

End of life care and support is provided to a person who is thought to be in the final months of life and aims to help people live well until they die. Good end of life care allows a person to die with dignity when the time arrives, and also ensures appropriate support is provided to families and carers before and after death.

End of life care is not just for cancer sufferers but for any condition from which a person will not recover, like dementia or chronic obstructive pulmonary disease (COPD), and those who are nearing the end of their life as a result of age and frailty. It also includes children and young people with a terminal or life limiting illness.

In England, approximately half a million people die each year, with these numbers expected to rise steadily over the coming years. It is thought that nearly three quarters of all deaths are ‘expected’, and it is believed that high quality end of life care for all these people can be delivered by non-specialist health and care staff as part of their core work. The delivery of this high quality care relies on staff having adequate time, education, training and support.

The ambulance service is frequently called when there is a sudden deterioration or crisis in a dying person’s condition and ambulance clinicians are often the first or only health professionals present at or soon after a death. Therefore the ambulance service has an integral role to play in delivering high-quality care at the end of life.

End of life care needs to be a priority for health and social care organisations. It is a topic that will affect us all at some point, at any age; we are committed to deliver person centred care that supports patients their families /carers to have a dignified death and in line with their wishes.

We recognise that our actions we take in treating and providing comfort for those that are dying has a profound effect on the people around them, we need to have the ability to provide care whatever the circumstances of dying are and where possible allow a natural death.

We published our End of Life Care Strategy in 2017 and completed year 1 objectives within ‘Our 5 Aims’.

Our priority for 2018/19 was to continue our implementation of our End of Life Care Strategy with the completion of the year 2 objectives as described below;

- End of Life patient/family satisfaction surveys have been developed and are being sent to targeted patients that have been identified through our attendance via ePCR. EEAST is the first ambulance service in the country to pioneer this type of targeted survey in order better understand the care we deliver and how we can improve upon patient centred care at the end of life.

- A bespoke ‘end of life’ training package has been developed and rolled out to our community first responders (CFRs). This includes our new starters and existing CFR members. The training allows CFR to have a better understanding of the role they have in attending patients that are nearing their end of life.
• Analysis of complaints and concerns relating to end of life care continues to be a focus of the local management teams

• Using ePCR to better understand how many end of life care patients we attend and what care and referrals we are able to provide for them; this has also been an integral part of and links in with identifying patients for end of life survey.

• We have continued to work closely with the community providers and hospices attending meetings and focus groups across the STP areas.

• A standardised training package for end of life has been developed and delivered by hospices through collaborative work for EEAST clinicians across two Sustainability and Transformation Plan footprints.

• Further work has been developed by our ECAT team that provides staff with support and access to electronic patient records from scene.

• **Looking forwards**

There is still a lot of work to do as we look forward to the next year to continue with the great work already being undertaken. The strategy aims focus on the following for the next 12 months:

• The introduction of end of life champions across the Trust

• A focus on end of life care for children and develop training packages to support staff

• The electronic MiDOS will be ‘business as usual across’ the trust

• Patient Satisfaction surveys will become a core part of the annual survey programme

• Patient and carer feedback related to end of life care will be critically analysed to determine effectiveness and identify areas for improvement

• All eligible, clinical and patient facing staff will have received training in all aspects of end of life care (target of 100%).

• An end of life and palliative care lead will be recruited.
Recognition and management of Acute Coronary Syndrome patients

Acute Coronary Syndrome (ACS) is a manageable condition which, if treated in a timely manner, can limit the damage to the heart caused by a reduction in blood flow. It can be identified by our staff through thorough history taking and assessment prior to administering a consistently high level of treatments.

Anyone with cardiac chest pain that lasts for more than 15 minutes which is not relieved by Glycerol Trinitrate (GTN) or rest, with or without ECG changes - unstable angina, both ST (STEMI) and non-ST myocardial infarction (NSTEMI) are the three conditions commonly associated with ACS.

We had included this as a priority for the previous year, of which one of the aims was for no SIs to be reported for non-conveyed patients who were subsequently confirmed with ACS. Unfortunately, within 2017/18 there were four such SIs reported, as a result of this we continued the priority into 2018/19 to improve on the previous year along with the completion of a clinical audit of ACS patients.

Regrettably there was one occasion when a patient who presented with chest pain and was discharged, died later due to congestive heart failure – although not a missed STEMI, this was subsequently reported as an SI.

Acute Coronary Syndromes – clinical audit

An audit of Patient Care Records (PCRs) was undertaken of patients presenting with chest pain, excluding patients with ST elevation who were conveyed to a Primary Percutaneous Coronary Intervention Centre (PPCI). Audit findings identified for the audit undertaken in 2018/19 identified that 62% were true ACS cases and eligible for the ACS treatment pathway. Of these, 16% had ACS recorded on the PCR as the relevant clinical impression code, which although an improvement of 7% on the previous year, has demonstrated that the work on educating staff during the year will need to continue in 2019/20.

Unfortunately, pain relief compliance for this group of patients decreased to 68% from 72% in the previous year.

Next steps

The Trust’s Clinical Strategy, which is aligned to the NHS Long Term Plan, includes a section on cardiac care, this along with ongoing training for staff, should improve these outcomes further.

An audit of pain relief, including those suffering from chest pain, is contained within the clinical audit programme for 2019/20.
Emergency care practitioner usage of antimicrobial drugs

Acknowledging the global concern in the occurrence of antimicrobial resistance to infections, the Trust adopted the quality standard for antimicrobial stewardship, introduced by the National Institute of Clinical Excellence (NICE) in 2017/18 to ensure that these drugs are administered appropriately.

A continuing priority from 2017/18, the aim was to demonstrate good practice in relation to when and how we are using antimicrobial drugs and to identify a baseline on which to improve in the following year; however we again failed to complete this audit due to a lack of data. The Trust is still heavily dependent on paper PCRs which, combined with the reduction in emergency care practitioners (ECP) and the Trust’s withdrawal of Chloramphenicol eye ointment and Co-Amoxiclav tablets to reduce resistance, resulted in problems in identifying cases where antimicrobial drugs were administered.

Next steps

With the re-launch and subsequent updates of ePCR and the revision and re-introduction of the ECP role, with new Specialist Paramedic Urgent Care Practitioners, plans have been put in place to enable us to capture this data throughout the year and this will be included as a clinical audit topic for 2019/20 through a designated Trust Lead.
Priority 3: Patient Experience

Within this priority we set two main objectives for 2017/18 around the subject of dementia, the implementation of objectives from our Dementia Strategy and the completion of a bespoke patient survey to gain an understanding of results on which to build in the next year. Dementia affects a large number of people with one in three people over 65 likely to develop dementia, however, currently only 42% of people with dementia in England have a formal diagnosis. We recognise that patients living with dementia account for a large number of our population and we are committed to understanding and supporting their needs.

A number of objectives were completed in year 1 such as focused training for our clinicians and signing up with Dementia Action Alliance to enable a dedicated action plan to be created and to ensure contact and joined up working with agencies such as the Alzheimer’s Society and local groups. This joint working enabled us to develop a bespoke patient survey in the year with input from families and carers.

Building on this topic as a continuing priority for 2018/19, and in line with the timelines of our strategy for year 2, we have continued to look to utilise the bespoke patient survey to gain an insight into our care delivery. Having identified that the traditional postal survey is of limited value, we have continued to develop the “pop up focus group” concept. Opportunities are being actively sought, an example being the Suffolk show where we hosted a stand and our dementia lead, along with our Suffolk based dementia ambassadors, continue to look to gain feedback in a more informal setting.

Next steps

The continued roll out of the training package to staff and volunteers identified within the strategy gathered pace in the year with over 2,000 front line and EOC staff completing the training package to date. The training will continue going forwards and include delivery to our volunteers and non-clinical staff.

Further development of our existing dementia ambassadors is planned to enhance capacity and support a more localised link to patient groups. This coupled with a further dementia ambassador training course being delivered by the University of Hertfordshire to increase the numbers across the Trust, continues to demonstrate our commitment to provide and deliver holistic care to all living with or affected by dementia.
Clinical Audit

Clinical audit is a crucial part of the Trust’s strategy to improve health care to service users. The evaluation of clinical performance against standards or through comparative analysis, with the aim of informing the management of services, is an essential component of modern healthcare provision. It forms part of the Trust’s clinical governance arrangements helping to ensure safe and effective clinical practices.

During 2018/19, EEAST participated in 100% of all required national audits which for ambulances are those defined within the Ambulance Clinical Quality Indicator (ACQI) programme, three of which; stroke, cardiac arrest and STEMI were included earlier in this section. The fourth ACQI which was introduced within the year relates to the care of Sepsis patients.

Sepsis

Sepsis is a life-threatening condition that arises when the body’s response to an infection injures its own tissues and organs. Sepsis leads to shock, multiple organ failure and death especially if not recognised early and treated promptly. Sepsis claims the lives of more than 44,000 people in the UK per year, which is more than lung cancer and more than breast and bowel cancer combined.

Previously a priority for us, we were keen to understand how we would comply with the newly set care bundle for this condition which is made up of:

- Observations assessed: (level of consciousness, blood pressure, oxygen saturation and respiratory rate)
- Hospital pre-alert recorded
- Oxygen administered
- Administration of IV fluids

This ACQI is reported on a quarterly basis, and at the time of this report, the months of September and December have been completed demonstrating compliance levels of 75.4% and 87.6% respectively. Outcome data for this audit shows that although we are accurately assessing and treating sepsis patients, we are failing to recognise the severity of the condition and pre-alerting the receiving hospital.

In response to this, we have begun to introduce the new screening tool, NEWS2, across the Trust and are delivering education and support to staff through a number of means such as; pod casts, bulletins, aide memoire cards etc, as well as through the traditional training route.

The compliance levels will continue to be monitored on a quarterly basis through the ACQI programme and outcomes presented through our internal governance structure and shared with our commissioners.
Submission of patient care records (PCRs)
The submission of patient care records continues to be an integral part of our annual clinical audit programme and involves the tracking of all records against incidents attended by our crews for a defined eight hours within the year. As well as providing a snapshot of the completion and timely submission of PCRs, it also provides us with information relating to the usage of our electronic patient care record system (ePCR).

In line with the Patient Care Record Policy, staff and others acting on behalf EEAST such as private ambulance service providers, are required to submit any completed paper PCRs to their local ambulance station as soon as possible, it is then the responsibility of the operational management teams to ensure all PCRs are sent to one of the three locality offices (Norwich, Chelmsford or Bedford) within 14 days of creation, in a secure manner using the stipulated transfer method, which is usually the Trust’s courier.

An eight hour period, from 1400 to 2200 hours on the 25 July 2018, was selected for the audit period to ensure that both day and night shifts were included and all Emergency 999 and GP urgent calls occurring across the Trust for this period excluding those dealt with via ‘Hear and Treat’, where the vehicle was stood down, or where no patient was found e.g. Hoax calls were included within the audit. A total of 837 Emergency 999 and GP urgent calls attended were identified for the period specified.

The overall compliance for the completion/submission of both paper and electronic PCRs within the 14 day timeframe for the audit period was 93.9%, which was a slight increase of 1.2% when compared to the previous audit (Dec-17: 92.8%).

It should be noted that a further 36 records arrived after the audit cut-off date and if these had arrived within the audit period date, the overall compliance for the Trust would have been 98.2%.

In regards to the completion of electronic patient records, the overall number completed, 72.7% was almost three times the number completed within the previous audit. (December 2017: 23.4%).

It is imperative that the Trust continues to push for the use of ePCR to ensure that Trust can be confident that not only it has all of the records required for audit and investigation purposes, but that it can provide the patient and/or other parties such as HM Coroner with copies of PCRs when required and that the number of lost records is reduced thus lessening the number of information governance breaches being reported.

A number of actions were recommended including;
- Clinical Audit team to promote results
- Operational Management Teams to ensure staff use electronic records and maintain or improve compliance
- Raise awareness at Trust quality governance committees and groups
- Further audits to be included in future audit programmes.

Further points to note
The audit department continues to support a number of Trust and University students with their quality improvement projects and clinical audit projects each year and is working with our partners the Air Ambulance Charities to provide them with cardiac arrest data to enable them to further understand the demography of our region and identify any future developments such as night flying.

We are currently working with our IT department to facilitate the transfer of data from ePCRs to our auditing software to provide a more timely, efficient audit process which will make best use of resources and enable us to expand our audit programme moving forwards.
Participation in research

Research is an important function within the NHS, bringing benefits to patients, clinicians and NHS trusts. Most patients want to take part in clinical research, the findings from research result in better treatment for patients, involvement in research helps clinicians to understand evidence and use this in their clinical practice, and research-active trusts tend to attract more forward-looking clinical staff. Research is essential in successfully promoting health, and plays a major part in continuing to improve services and supporting safe and effective care. High quality research activity identifies and evidences new ways of delivering care, as well as preventing, diagnosing and treating conditions.

During 2018/19 EEAST recruited 172 participants (patients and Trust staff) into three high quality research studies approved by a Research Ethics Committee, all of which were National Institute for Health Research (NIHR) Portfolio pieces of work as follows:

- Rapid intervention with glyceryl trinitrate in hypertensive stroke trial (RIGHT-2)
- Resuscitation with prehospital blood products (RePHILL), and
- Paramedics’ experiences of taking part in the AIRWAYS-2 trial.

In addition, data on more than 3,000 cardiac arrest patients was uploaded to the epidemiology and Outcome from out-of-Hospital Cardiac Arrest (OHCA) registry study. Research Support Services (RSS) also supported an increasing number of smaller-scale student level projects being undertaken by Trust staff and external parties.

After more than ten years of high quality study delivery, research is considered business as usual within the Trust. Such continued participation in clinical research has demonstrated the Trust’s on-going commitment to improving the quality of care offered, and to making a contribution to wider health improvement.

In terms of research capacity building, RSS continued to make relevant emerging research evidence available to all staff on a regular basis through dissemination on the Trust intranet. In addition, all new clinical staff were offered Good Clinical Practice (GCP) training in readiness for undertaking research activity.
Patient safety incidents

All NHS organisations have a responsibility to report any safety incidents relating to patients through the National Reporting and Learning Service (NRLS). A patient safety incident, defined by the National Patient Safety Agency (NPSA), is any unintended or unexpected incident which could have or did lead to harm for one or more patients receiving NHS care. This includes:

- incidents that caused no harm or minimal harm
- incidents with a more serious outcome
- prevented patient safety incidents (known as ‘near misses’).

The table below shows the latest published data of the number of incidents reported by EEAST vs the national average and the highest and lowest ambulance trust scores.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>1 April 2018 to 30 September 2018 - latest comparable data published</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>EEAST</td>
</tr>
<tr>
<td>Number of reported patient safety incidents that resulted in severe harm or death</td>
<td>4</td>
</tr>
<tr>
<td>Number of patient safety incidents reported within the trust</td>
<td>837</td>
</tr>
<tr>
<td>Percentage severe harm or death incidents of total</td>
<td>0.48%</td>
</tr>
</tbody>
</table>

NB. High and low data does not always relate to the same organisation.
## What went wrong and what we did

It remains important to us to act in a timely manner when something goes wrong. This part of the report shows the response we made in acting on some of these things and what we did about it.

<table>
<thead>
<tr>
<th>WHAT WENT WRONG</th>
<th>WHAT WE DID</th>
<th>WHAT THIS MEANS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 A 999 call was logged in a disused section of the computer aided dispatch system. This meant that there was a delay in responding to the call.</td>
<td>We removed the ability for control room staff to access the disused section of the system and also improved the support available for staff members.</td>
<td>It is now not possible for this error to occur again and staff receive better support and guidance in their roles.</td>
</tr>
<tr>
<td>2 A patient was discharged from our care without an adequate head injury assessment. The patient was later found to have suffered multiple injuries following their fall.</td>
<td>We developed a session to be included on the Trust’s Learning from Incidents event and improved the training package available to staff prior to them commencing lone-working shifts on a rapid response vehicle.</td>
<td>All staff attending Learning from Incidents events will benefit from the learning achieved in this investigation. This is discussed in an open and safe environment. Additionally, staff will be more familiarised with working alone on an RRV rather than as part of an ambulance crew.</td>
</tr>
<tr>
<td>3 A patient’s bag containing personal belongings was left behind at the hospital, in a public place, following their discharge. The bag was later returned to the patient following readmission.</td>
<td>The patient transport service discharge checklist was reviewed and re-released to all staff. A focus on completion of mandatory information governance training amongst all staff members was implemented.</td>
<td>It is now clearer for all patient transport staff on their responsibilities when discharging patients from hospitals. The workforce completed training in the key principles of good data management.</td>
</tr>
<tr>
<td>WHAT WENT WRONG</td>
<td>WE DID</td>
<td>WHAT THIS MEANS</td>
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<tr>
<td>-----------------</td>
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</tr>
<tr>
<td><strong>4</strong> During an attendance to a patient in cardiac arrest, the defibrillator failed to deliver a shock to the patient when required.</td>
<td>The defibrillator was removed from service following the call and the incident referred to the Medicines and Healthcare products Regulatory Agency (MHRA). The clinical engineering team completed a trend analysis of equipment failures and instigated appropriate actions.</td>
<td>The faulty equipment was assessed and appropriate action taken to rectify the fault. The issue was also raised to a national agency so that any known trends of fault are collated and any learning disseminated widely across the NHS.</td>
</tr>
<tr>
<td><strong>5</strong> Following a resuscitation, it was found that an unrecognised oesophageal intubation had occurred.</td>
<td>The clinicians involved were debriefed following the incident. The Trust’s introduced a mandatory ‘airway log’ to ensure that airway management competence is maintained.</td>
<td>The individuals involved learned from the incident. It was also possible to enhance the governance of advanced airway management and organisational assurance around the practice.</td>
</tr>
<tr>
<td><strong>6</strong> A crew attended a patient suffering with chest pain and ECG changes. The crew recognised these changes but did not recognise that they were indicative that the patient required treatment at a specialist hospital. The patient was conveyed to the nearest emergency department.</td>
<td>We ensured that the crew were supportively debriefed following the incident and completed reflective practice in order to learn. The Trust reviewed and re-released its supportive material used for ECG recognition to all clinical staff. The Trust continued to promote its supportive decision making options, such as clinical advice line and clinical manual (including the mobile app).</td>
<td>All Trust clinicians are now furnished with up to date decision making tools and knowledge of the advice which is remotely available to them, should they require it. As always, we ensured that the crew involved were supported and learned from the incident.</td>
</tr>
</tbody>
</table>
Duty of Candour Policy

The Trust has in place a Duty of Candour Policy, which replaced the previous ‘Being Open’ Policy.

Duty of Candour is managed by the Safety and Risk Team. Cases are identified through the daily review and coding of any incident reported and where applicable, contact is made with the patient or their family via telephone in the first instance. Following this telephone call, follow up arrangements are made according to the patient or family’s wishes, and these are documented via letter.

The conversations held under Duty of Candour all include:
- introduction
- explanation of the incident identified
- an apology and condolences if required
- explanation of the investigation process
- discussion of terms of reference and identification of any issues the patient or family wishes to be investigated
- establishment of preferred methods of involvement and communication moving forwards.

As 999 calls do not document patient’s names, there are a number of instances for the Trust where significant work is required to identify the individual most appropriate for the Duty of Candour discussions. Approaches include:
- communication with GPs
- liaison with the admitting hospital
- close working relationships with Her Majesty’s Coroner
- physical visits to location of 999 calls to identify next of kin.

In previous years, the Trust has embedded the Duty of Candour into its serious incident reports. The main focus for the 2018/19 financial year was to improve awareness of the Duty of Candour amongst all staff within the organisation and maintain organisational compliance with the statutory timeframe. Approaches to achieving this aim included:
- inclusion of Duty of Candour familiarisation in the Trust induction process for all staff
- delivery of patient safety training and the importance of the Duty of Candour through university programmes.
- Duty of Candour posters circulated to all Trust ambulance stations and emergency operations centres.
- a designated section of the Trust’s patient safety intranet page has been developed to give information on the Duty of Candour.
- regular externally facing communication via social media.

Regulation relating to the timeframe for Duty of Candour is ten working days or as reasonably practicable.

Analysis of data demonstrates the following compliance with Duty of Candour in the 2018/19 financial year:

| Number of cases initially requiring Duty of Candour | 80 |
| Duty of Candour discharged | 77 |
| Duty of Candour not discharged | 3 Unknown patients. |
| Average timeframe for DoC to occur | 7.9 working days |
| Longest timeframe for DoC | 37 working days Prolonged period of time to ascertain patients details in a sensitive case. Liaised through safeguarding networks. |
| Followed up with a letter | 76 (95%) 3 x unknown patients. 1 x patient refused further contact following phone call. |
| Average timeframe for letter follow up | 2.5 working days |
| Longest timeframe for letter follow up | 14 working days Delayed due to safeguarding concerns. |
Workforce Planning, Recruitment and Retention

We have made significant advancements in our recruitment this year, reflected in the increased performance of the team. We processed 9,332 applications and recruited 773.58 whole time equivalent staff. 584 of these recruits were front line members of staff, recruited to support the growth of the clinical workforce and ensure we provide a timely, high quality response to our patients.

We have made significant changes to the recruitment process during quarter 4 including additional training courses, the offering of the C1 driving costs as an incentive to new recruits and the implementation of the local recruitment model, partnering an operational and recruitment team lead. These changes have also enabled an increased EEAST presence at recruitment events across the region. The team have recently implemented TRAC and will continue with a process transformation plan to enhance the customer service, performance and efficiency of the service offered. However, in spite of this high level of recruitment, our course fill rate did not hit target and our turnover rate has been higher than anticipated at over 9% against a planned 7% and as a result, our workforce growth has not met the in-year target required.

The establishment of the retention steering group in December 2018 has brought together workstreams aimed at supporting the retention of the workforce, to ensure integration and the maximisation of benefits. The workstreams represented include Health and Wellbeing, Employee Engagement, Equality and Diversity and Dignity and Respect alongside the wider People and Culture Retention Strategy.

There are a number of key activities to support the retention of staff including the implementation of a robust exit interview process, to ensure we are aware of the reasons for staff leaving so that we can address them. The wellbeing team have also worked to deliver a number of key initiatives which is expected to help reduce the numbers of staff leaving us.

Recruitment of new, and retention of existing staff, remains our most important objective for 2019/20 to ensure we have enough resources to cope with the increasing demand on our services.

Our plans and attainment for projected staff numbers will be monitored by our commissioners in line with our contracts.
Organisational development

Leadership
A new Leadership Programme has been developed and rolled out. It has been tailor made to suit all level of Managers and these have been structured around a Leadership Pipeline. The learning available has a blended approach and includes face to face training, ILM Awards, On-line e-learning, Scenario Based Training, Coaching, Mentoring and Action Learning Sets.

Compassionate Conversations
The Trust’s new approach to appraisals, Compassionate Conversations, has been designed to support leaders to engage with their people in a way that leads to them feeling valued, supported, empowered and accountable for what they do and how they do it.

Based around the four pillars (Performance, Talent, Value, Wellbeing), Compassionate Conversations takes a holistic approach to the individual staff member, providing the opportunity to engage by discussing performance and values and their talent and wellbeing needs and empowering our staff to identify what development needs they require to support them meeting and achieving their role objectives, linking to future career aspirations and ultimately talent and succession planning.

Access to Compassionate Conversations information and training is being delivered face to face across the Trust to our Managers as well as e-learning packages, toolkit and information resources available.

Apprenticeships
We are continuing work on matching our frontline training roles to apprenticeship standards and the Apprentice Emergency Medical Technician programme is now up and running, and our Level 3 apprenticeship opportunity is now available for the role of Apprentice Emergency Care Support Worker.

EVOLVE
At the end of March we implemented our new learning management system, Evolve. This new system is more user-friendly for staff, enabling them to access their own bespoke identified training courses and assessments and also providing the Trust with a robust monitoring system of completion.

The Trust is using NHS Skills for Health National Standards for Core Statutory/Mandatory content and frequency and is aligned to job roles where appropriate. Some topics are trust specific and training will be developed by the trusts subject matter experts. This means a core set of competencies will be allocated to individuals depending on their role and training will, in the future, be completed on a 12-month rolling basis.

Reporting will be aligned to subject and frequency and produced on a monthly basis and will also be reported on a 12-month rolling basis rather than having a defined start and finish date to correlate with the financial year.
Raising concerns

The independent review of the patient deaths at Gosport War Memorial hospital is a tragic reminder of the responsibilities we shoulder every day as we work to deliver the very best patient care. The review has found that between 1988 and 2000 up to 450 patients at Gosport War Memorial hospital had their lives shortened as a result of being prescribed powerful opioids without any medical justification.

Over the past months much has been said about NHS culture particularly around the lack of confidence of staff to raise patient safety concerns. No one need be reminded about the findings following the public enquiry into the practices at Stafford Hospital where it has been suggested that between 400 and 1,200 patients died as a result of poor care over the 50 months between January 2005 and March 2009. It was the Mid Staffordshire public enquiry and the subsequent Freedom to Speak Up (FTSU) Review that prompted the recommendation that every NHS trust in England should have:

“as a minimum, someone to whom staff can go, who is recognised as independent and impartial, has the authority to speak to anyone within or outside the trust, is expert in all aspects of raising and handling concerns, has the tenacity to ensure safety issues are addressed and has dedicated time to perform this role” (Freedom to Speak Up Review : 2015)

We have two Freedom to Speak Up Guardians who have been in post since its launch in March 2017. During the past two years, the Guardians have taken on cases and continue to support staff from which feedback has demonstrated that all of have felt supported by the process in raising their concerns.

The Trust adopted the National NHS Whistleblowing Policy, which explains the process and how feedback will be given, and actively encourages staff to engage with FTSU guardians to raise any concern.

Our Guardians play an active role in our regional network and National Ambulance Network where EEAST co-chair.

Freedom to speak up works as one method of raising concerns within the Trust and both Guardians are fully supported by the Trust Board and CEO in promoting and respectfully dealing with any concerns raised through the Freedom to Speak up process, which have also been externally reviewed and gained positive feedback.

The Deloitte Review (2018) highlighted that “The Trust is an early adopter of the Freedom to Speak up Guardian programme within the ambulance sector, and we observed a highly proactive approach to raising awareness of this across the organisation.”

The latest CQC report (2018) also provided positive approach in saying “The trust had Freedom to Speak up Guardians who were passionate about giving staff any support they needed to raise concerns and have them addressed. They told us that they were supported by the board in their work and have developed excellent links with other guardians and the national guardian’s office.”

In addition to the external reviews, the Guardians have undertaken a number of audits and regulator interviews with our internal auditors and NHS Improvement whereby both the process and case management were scrutinised. Within these reviews, no concerns were raised about the independent and respected process the Guardians in the Trust have adopted and follow - in fact the Trust Guardians have been providing support to the national guardian group and the regulators in helping them understand the way Freedom to Speak Up is completed within the ambulance sector.

In March 2019, one of the Guardians from the Trust presented at the Ambulance Leadership Forum to help further embed the importance of Freedom to Speak Up and what it offers in improving the culture within the wider NHS.
Results from the NHS Staff Survey question

The National Staff Survey was undertaken by Quality Health between September and December 2018 for 114 organisations (five within the ambulance sector). Questionnaires were sent to 4,649 staff. The response rate was 38.6% (1,794 questionnaires were returned).

As part of Quality Account 2018/19 requirements, trusts are asked to consider including information against two indicators within the staff survey:

- KF 21 - percentage believing that trust provides equal opportunities for career progression or promotion
- KF 26 - percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months.

The charts show our score for these questions in 2018 against the national average for ambulance services and our score/comparison.

Although the percentage of staff experiencing harassment, bullying or abuse from staff increased, there has been a significant improvement in the number of staff who said that the last time they experienced violence at work they or a colleague reported it, 71% compared to 65% in 2017, which was better than the average for ambulance services.
In relation to staff believing that we provide equal opportunities for career progression or promotion this year, this is lower than 2017 and significantly lower than the national average for ambulance trusts.

The Trust recognises that is a continuing need to improve the culture of the organisation and has implemented a number of actions within the year:

- A number of groups have been established to ensure all members of staff know that we are an inclusive organisation: (BAME, LBGT, AWE and disability support groups).
- Compassionate Conversation training for managers has been established and rolled out, with a significant proportion of managers having undergone the training.
- The freedom to speak up (FTSU) activity is an important way of raising and addressing issues.
- The Trust established a Raising Concerns Forum which meets regularly to consider themes and identify appropriate action which has included cross referencing of themes and trends or concerns raised via Trust channels (such as FTSU, Wellbeing Service, Patient Safety, Equality & Diversity) to implement collaborative working and meaningful interventions across the Trust.
- Dignity at work e-learning is planned for roll out April/May 2019
- Enhanced additional learning needs support has been included within the occupational health tender specification to ensure greater support for progression
- The Trust has embraced the use of assessment centres for recruitment to ensure fairness and good practice in promotion opportunities.
Commissioning for Quality and Innovation (CQuIN)
The CQuIN scheme is intended to deliver clinical quality improvements and drive transformational change and will impact on reducing inequalities in access to services, the experiences of using them and the outcomes achieved.

Sustainability and Transformation Partnership (STP) CQuIN
This CQuIN was in response to the increased focus on demand management and the on-going development of increased referrals into Alternate Care Pathways (ACPs) as a major factor to alleviate pressures in local health systems, most notably to ensure that there is assurance that patients are being appropriately referred into ACPs by crews and EEAST’s ECAT team. There is also a focus on frequent calling institutions and people to help manage demand from individuals or institutions that often call 999 when an alternative intervention to the emergency 999 ambulance service is more appropriate to their needs. People and institutions can become frequent callers for a variety of reasons that can include physical health factors, mental health factors and social factors (social isolation, inadequate housing, lack of a care package at home or inadequate care provision, etc). The rationale was therefore to establish a dedicated DoS Management and Frequent Caller team to increase quality of care, improve patient outcomes and service provision by:

- Maximising referrals to Alternative Care Pathways (ACPs) signposting them to the most appropriate help utilising the systems available across the EoE and in-turn reducing EEAST sending a physical resource and potential conveyance to A&E
- Lead and Co-ordinate the EEAST DoS related activities across the region through a regional lead within EEAST
- Engagement with Clinical Commissioning Groups related to frequent callers, especially around high-risk care homes, leading to effective management of both individuals and homes and improve learning around patient needs; CCG DoS leads to improve DoS profiling and engagement - this engagement includes attendance on a quarterly based Locality Meetings to report on the DoS activity locally
- Dedicated focus on larger service user groups such as care homes, and prison services that place disproportionate strain on the 999 service and increase blue light collaboration

Emergency Department Avoidance CQuIN
Our scheme for ED avoidance supports the ambitions of the Long-Term for Urgent and Emergency Care by helping people with urgent care needs to get the right advice or treatment in the right place, first time and bring care closer to home. This CQuIN was aimed at:

- Identifying high intensity service users, individual and organisational, (resulting in a high use of emergency and urgent care services where there is potential for an alternative pathway or self-management)
- Reducing conveyances of patients to ED where an appropriate alternate pathway is available and able to accept a referral
- supporting the work of the Sustainability and Transformation Plans (STPs) in producing system efficiencies by utilising alternate pathways in the community
- supporting the A&E delivery boards in identifying opportunities to deliver urgent and emergency care in the community.
To build on the success of Year-One of this CQuIN, a full audit was undertaken of Type 1 and Type 2 A&E Departments along with other conveyance destinations (Midwifery, Acute Medical Unit (AMU), PPCI, etc). This audit has improved the accuracy of EEAST’s conveyance reporting and has demonstrated EEAST’s positive work to improve See and Treat rates to reduce unnecessary conveyance to Emergency Departments.

Local CQuINs
As part of EEAST’s commitment to work with system partners, a series of local CQuINs were developed within each STP footprint to improve service delivery quality and performance for patients. The key objectives are therefore:

- To support the delivery of a clinically safe and effective service for higher acuity patients by freeing up higher skill mix Double Staffed Ambulance (DSAs) to deliver C1/C2 as efficiently as possible
- To provide a service which can rapidly respond to people experiencing a mental health crisis through delivering rapid treatment and intervention as well as ensuring any ongoing needs or support takes place in the most appropriate environment

The schemes included:

**Mental Health Street Triage**
This pilot model comprised of a tripartite team of a mental health professional, police officer and a paramedic working together, across the system in response to mental health crisis calls from the police and ambulance control rooms.

If someone experiencing a mental health crisis calls 999, their call is diverted to the Mental Health Street Triage (MHST) team who can offer advice over the phone, or attend incidents in the MHST vehicle.

The key objectives of the MHST team are to:

- Improve the experience and outcomes of people in mental health crisis
- Ensure any detentions under Section 136 of the Mental Health Act are appropriate
- Reduce the amount of duplicated time spent by emergency services responding to and managing mental health crises
- Ensure attendance at Emergency Departments in our hospitals are appropriate
- Improve awareness, confidence, training and joint working relationships between professionals involved in mental health crisis work
- Reduce demand on EEAST core service
- Responding to crew requests for assistance with Mental Health crises
Early Intervention Vehicles (EIV)
The EIV generally incorporates a (Occupational or Physio) therapist from the local Community Health or Social Care provider, working alongside EEAST staff. Please note that this bid is only to provide the EEAST resource here i.e. ambulance clinician and car. The community element could however be provided through the community service contract CQUIN available within their contracts also?

The objective is a joint assessment at the initial point of contact to provide safe admission avoidance solutions, and / or referral to appropriate care pathways. A typical assessment process would be holistic and include medical, functional, environmental and personal care assessments with recommendations for current or future requirements. The patient’s own GP would also be involved in any treatment decisions where the patient is expected to be managed in the community.

Services provided include (but not limited to):
- Community based activities of daily living assessments including medical, social and functional needs
- Supply and provision of mobility equipment and minor aids, with direct referral for major home adaptations, i.e. wet rooms, stair lifts, etc
- Implementation of new or increased social care provision
- Sign-posting to statutory and voluntary organisations
- Support and advice to service users, and their carers, to prevent or minimise the risk of an avoidable future crisis

The EIV can also be deployed to Category 1 calls where it is the closest resource to identified life-threatening emergencies, thus providing an additional response to those most critically ill and specifically in cardiac arrest.

Urgent Care Desk
We have developed a dedicated resource within our Ambulance Operations Centre (AOC) to rotate Specialist Paramedic cover alongside an AOC Dispatcher. The initial phase of the UCD has concentrated the Specialist Paramedics: ECPs and EIVs on appropriate calls by interrogating the stack of 999 ongoing calls, identifying appropriate patients, discussing care needs with the patient and dispatching accordingly. This targeted response is utilising skill sets more effectively and is releasing DSAs from lengthy calls. The desk also offers advice to crews on scene and can offer a follow up contact if necessary. The ambition for the UCD is that it will encompass more specialist resources across the region and will, by project end, be coordinating all of those 24 hours per day, 7 days per week.

The potential for reducing the 999 ‘stack’ and responding to patients quickly is significant. Ensuring the most appropriate resource is deployed, looking for a diversity of models available to respond is the right answer for future proofing our service under the enormous pressure of increased elderly population with more acute needs. The use of UCDs across the country has proven very effective with, in some areas, the introduction of virtual support systems to care homes, frequent callers and suitable patients. This again is a key enabler to support Long Term Plan objectives.
**Hospital Ambulance Liaison Officer**

HALOs are a valuable resource in relevant acute sites to minimise handover delays and help improve patient flow through Emergency Departments to improve patient experience and outcomes, underpinned by patient safety measures.

The HALO resource:
- A resource to improve patient care by supporting the development of improved operational practices for effective ambulance turnaround through the implementation of HALOs
- Liaise with other community / local resilience schemes to facilitate providing the best outcome for the patient
- Effectively signpost crews to alternate pathways
- Give EEAST the flexibility to maintain a high standard of service in response to extra pressures on front line services
- Assist with streamlining the handover process to improve patient safety and experience
- Improve EEAST’s ability to respond to patients in the community to reduce avoidable harm through delays
Other quality successes in 2018/19

The Trust has implemented a number of new ways of working and improving care and experience for both patients and staff over the past year, here are just a few of the many things we have achieved....

New lightweight double staffed ambulance
EEAST has been working collaboratively with staff side representative, frontline staff and external stakeholders to develop a new ambulance.

We have sought to improve the safety of staff, enhance their ability to deliver their clinical care and ergonomic working environment whilst trying to increase where possible the patients experience.

We were able to have nearly 500 staff use the different concept vehicles as part of the evaluation process.

The new vehicle complies with the requirements nationally for a more cost efficient, sustainable and environmentally friendly vehicle whilst seeking simultaneously to improve upon the working experience of our staff. 56 of these new vehicles will be introduced from June with just over 170 due by the end of April 2020.

‘Restart a Heart Day’
As part of this national scheme, staff and volunteers from EEAST visited secondary schools across the east of England and taught more than 7,300 children cardiopulmonary resuscitation (CPR).

The training involved showing students how to perform this crucial lifesaving skill if someone was in cardiac arrest and how to use a defibrillator.

Gold award for supporting the armed forces
In August, The Ministry of Defence granted EEAST with the Employer Recognition Scheme (ERS) Gold Award for showing outstanding support for its Armed Forces staff.

We were one of 50 winners within the year to receive this prestigious award, given to organisations who have signed the Armed Forces Covenant and have demonstrated outstanding support for those who serve and have served in the Armed Forces and only the third ambulance trust to receive this award since it was created in 2014.
Mobile stroke unit

In the summer of 2018, we undertook a feasibility audit of a mobile stroke unit (MSU) in the south east Essex area.

The MSU is a fully-equipped, custom-built specialist Ambulance that comes equipped with a built-in CT scanner and laboratory. It operates in a similar way to a normal ambulance responding under emergency conditions to suspected stroke and other related time critical emergencies but with a significant number of enhancements. It can perform hospital grade brain scans in a pre-hospital or community-based setting enabling diagnosis and treatment to take place 'on scene', during the earliest phase of stroke, where treatment success rate is highest (as opposed to awaiting the patient's arrival at hospital for treatment).

It is staffed with a paramedic, a radiologist and a stroke physician with telemedicine support from a consultant radiologist, and carries a full range of stroke treatment drugs, including blood clot-dissolving medications and drugs designed to halt bleeding into the brain.

A full range of assessments are undertaken by the MSU team including blood analysis and, where appropriate, a CT scan and analysis is performed and supported by the radiologist.

Patients who fulfil the inclusion criteria will immediately receive thrombolytic (clot busting) therapy treatment and then be transported under emergency conditions to the most suitable hospital for further care, in most cases bypassing the emergency department and going directly to a specialist ward or admissions unit.

Although 14.3% of stroke patients in the UK are eligible for thrombolysis, 28% of them do not receive it, mainly due to inadequacies in services. With the potential to more than double the number of patients that can receive stroke treatment, and the potential to treat 57% instead of 4% of patients within the golden hour, the MSU can create significant value for the health economy, but most importantly for patients themselves - for the patient, every half hour gained results in a 10% higher chance of a good (independent) outcome.

The MSU can also be used to triage patients to the appropriate hospital e.g. patients with an intracranial bleed can be transported to a neurosurgical unit and patients with major vessel occlusion can be taken directly to a stroke centre that can perform thrombectomy.

Other benefits of the unit include:

- A reduction in the number of EEAST resources required to manage the patient
- A reduction in pressure on emergency services and hospital handover delays
- An improvement in compliance for both ambulance services and hospitals with current national and international guidelines and recommendations in relation to stroke patients.

The aim of the audit was to establish if the MSU could effectively be integrated into the health system. This audit was successful and is currently in the process of being written up for publication, however it also identified that the MSU concept in the UK requires further study before a recommendation can be made with regards to outcomes for patients and importantly the cost effectiveness of such a scheme that requires investment of tax payers money to deliver such a service in the longer terms. As a result, EEAST in collaboration with partners is proposing to undertake a more detailed and larger scale research project. This is will be delivered as a prospective randomised control trial with the aim to answer the questions that first audit identified as requiring further study. The trial is proposed to commence in the autumn of 2019 within the Norwich and Ipswich areas subject to ethical approval and organisational sign off.
Community Engagement

We have a number of staff who work tirelessly within their local communities; visiting schools, Scout and Girl Guide groups and career events to name but a few.

One of our Emergency Medical Technicians has recently completed his 100th event at the same primary school where he started his engagement programme seven years ago.

Our volunteers!

We have a large number of volunteers who work with us to provide services to patients across the region.

Our 802 Community First Responders (CFRs), is the biggest volunteer group within the Trust. These volunteers are trained by us to attend certain types of emergency calls in their local area. Their aim is to reach a potential life-threatening emergency in the first vital minutes before the ambulance arrives and we currently have 243 CFR groups covering all six of the counties covered in our area – Bedfordshire, Cambridgeshire, Essex, Hertfordshire, Norfolk and Suffolk.

In 2018/19, they volunteered a total of 455,345 hours – that’s the equivalent of just over 18,972 days or 51 years!

We’re also lucky to have partnership arrangements with British Association for Immediate Care Schemes (BASICS) across our region, including in:

- Essex - BASICS Essex Accident Rescue Service (BEARS)
- Norfolk – Norfolk Accident Rescue Service (NARS)
- Suffolk - Suffolk Accident Rescue Service (SARS)
- Cambridge - (MAGPAS)
- Hertfordshire – (BASICS)

These schemes include both volunteer doctors and paramedics who are trained in emergency medicine including anaesthesia. Working with us, they deliver life-saving care in the community to patients who are in cardiac arrest or where other critical care is needed.

Our volunteer car drivers are also an essential part of our service, giving up their time to take patients to out-patient appointments at hospitals across the East of England.

Our Community Engagement Group (CEG), made up of 18 keen and enthusiastic volunteers, have their own work plan and members of the group sit on many of the Trust’s groups and committees to ensure patient and public representation is integral to how we plan and deliver our services.

We’re grateful to all of the incredible volunteers who devote their time to help patients in our region!
Infection Prevention and Control
Infection control within EEAST is well established and forms an essential part of patient safety. The Trust has a dedicated Infection Control team who provide specialist advice and support to operational staff. They produce all the staff training materials to ensure that staff are kept up to date with the latest infection control best practice.

It is important to ensure that our vehicles and stations are maintained to the highest possible standards of cleanliness to minimise the risk of infection, this is monitored through the Trusts comprehensive audit schedule which is reported on monthly. The Trust IPC team also produce an annual Director of Infection Prevention and Control report which covers all aspects of infection control throughout the previous year and plans for the coming year.

This report is available at www.eastamb.nhs.uk
Statements from the Commissioners, HealthWatch and Overview and Scrutiny Committees

The following section contains statements and comments received from stakeholders following the 30-day consultation period. These comments were reviewed prior to formal approval by the Trust Board. Some of the feedback received will also be used to formulate next year’s Quality Account.
NHS Ipswich and East Suffolk Clinical Commissioning Group (CCG), as the lead commissioner* for East of England Ambulance Service NHS Trust, confirm that the Trust has consulted and invited comment regarding the Annual Quality Report for 2018/2019. This has occurred within the agreed timeframe, and the CCG is satisfied that the Quality Report incorporates all of the mandated elements.

NHS Ipswich and East Suffolk CCG have reviewed the Quality Report data to assess reliability and validity and to the best of our knowledge consider that the data is accurate. The information contained within the Quality Report is reflective of both the challenges and achievements within the Trust over the previous 12 month period. The priorities identified within the account for the year ahead reflect and support agreed priorities.

NHS Ipswich and East Suffolk CCG with the other Clinical Commissioning Groups* are working with clinicians and managers from the Trust and with local service users to continue to improve services; ensuring quality, safety, clinical effectiveness and good patient experience is delivered across the organisation.

This Quality Report demonstrates the Trust’s commitment to improving services. In particular, the work undertaken with NHS Improvement around patient experience and the plans to focus on receiving feedback from hard to reach groups and those with learning disabilities to improve the service.

At the time of writing the Care Quality Commission are preparing their report following a series of recent inspections of the Trust. NHS Ipswich and East Suffolk CCG with the other Clinical Commissioning Groups* await the publication of the report and will work with the Trust to ensure services continue to improve.

NHS Ipswich and East Suffolk CCG endorse the publication of this Annual Quality Report.

Lisa Nobes
Chief Nursing Officer - NHS Ipswich and East Suffolk Clinical Commissioning Group

4 June 2019

* NHS Ipswich and East Suffolk CCG, as the lead commissioner, working with NHS Bedfordshire CCG; NHS East and North Hertfordshire CCG; NHS Herts Valleys CCG; NHS Luton CCG; NHS Cambridgeshire and Peterborough CCG; NHS Great Yarmouth and Waveney CCG; NHS North Norfolk CCG; NHS Norwich CCG; NHS South Norfolk CCG; NHS West Norfolk CCG; NHS West Suffolk CCG; NHS Basildon and Brentwood CCG; NHS Castle Point and Rochford CCG; NHS Mid Essex CCG; NHS North East Essex CCG; NHS Southend CCG; NHS Thurrock CCG; NHS West Essex CCG.
Dear Dorothy,

6th June 2019

EEAST - Quality Report/Account (QA) 2018/19
Comments from Healthwatch Bedford Borough (HBB)

HBB are pleased to have been asked to peruse your Quality Report and mandatory Quality Account.

As we know, the NHS has continued to face huge national scrutiny and media coverage, not least due to current political uncertainty. We recognise that you have seen a large call demand and are aware that this is, in part, due to uncertainty in relation to service provision in some areas, but also because EEAST are a product of their own success due to your perceived reliability to the public.

HBB recognises that this past year has not been without its considerable challenges for the Trust, not least the loss of Robert Morton, who HBB held in the highest esteem for both his honesty and transparency.

We are still aware of your capacity gap, its intrinsic link to workforce and understanding that performance improvements are still required. We are hopeful that by improving future time based targets, this will support better outcomes however. HBB are grateful for your brutal honesty around this issue. Testament once again to the Trust adhering to its core values. We are in addition very pleased to see that despite an average of 3,200 emergency 999 calls coming in to the Trust on a daily basis, patient safety incidents - by harm, and SI’s have shown a decrease since quarter 1 of 2018. This is to be highly commended and we look forward to the implementation of EEASTs Learning from Incidents policy and methodology in the future. We feel this will add a further robust layer to your impressive safety culture for incident reporting at EEAST.

We look forward to seeing a continuation of your sterling work with sepsis and dementia. It is testament again to the QI team’s dedication that there are high levels of compliance for the new sepsis care bundle. Having seen first-hand how passionate Tracy Nichols is at ensuring all staff have an embedded culture of the need for early sepsis recognition, HBB awaits the next level of this work.
Having sat down with the QI team and discussed your quality improvement initiatives, we are grateful to see learning disability and autism as well as your collaboration with PHE on health inequalities featuring on the local priorities. Whilst there is quite a way to go yet, HBB looks forward to continuing to work with you around these two vital topics including the possibility of some multi-disciplinary partnership focus groups with the afore mentioned seldom heard groups.

In summary, HBB thank you for allowing us the opportunity to be able to comment and wish you all well with the year ahead.

Yours Sincerely,

A. Bustin

Chair, Healthwatch Bedford Borough

“A strong voice for local people”
Dear Tracy,

Quality Accounts 2018/19

Healthwatch Suffolk and all the other local Healthwatch organisations involved thank the East of England Ambulance Service Trust for the opportunity to comment on its Quality Account for the year 2018/19.

We have considered your draft document and produced a response statement (enclosed) for inclusion in the appendix of the published report.

If you have any questions regarding this response, please do not hesitate to contact Michael Ogden on 01449 703 949 or by email to michael.ogden@healthwatchsuffolk.co.uk.

We all look forward to working with the East of England Ambulance Service Trust in the year ahead and to hearing of progress made to improve services and outcomes for patients and service users in Suffolk.

Yours sincerely,

Andy Yacoub  
Chief Executive  
Healthwatch Suffolk

Healthwatch Suffolk has coordinated a full response from other Healthwatch branches from across the region. Additional written commentary from other Healthwatch is also included below.

Healthwatch Suffolk’s overall assessment is as follows:

- We still hold concerns relating to excessive waiting times people are experiencing throughout the east of the country, particularly including cases involving the elderly or those located in more rural areas.
- The fact that the number of reported patient safety incidents resulting in severe harm or death is substantially lower than the national average should be commended.
- Paramedic respondents and telephone operator attitudes are often praised, with users citing their calming and reassuring manner. However, communication between the telephone operator and the service user can be a mixed experience when managing expectations in regard to ambulance availability. While the disposal of resource is often in a state of flux, members of the public often negatively mentioned the disparity between promised and actual arrival times.

Local Healthwatch have identified the following:

- Staff morale is low according to the staff survey, although we acknowledge that EEAST is working to improve morale and communication through a variety of methods, such as the Freedom to Speak Up guardians.
- Priorities have yet to be achieved in respect to key response time indicators at hospitals, while the Trust is slightly below target regarding conveying patients to coronary intervention treatment centres.
- The challenges surrounding the recruitment and retention of staff are often difficult to address. Local Healthwatch recognise the innovative approaches EEAST are enacting to improve staff retention, and the Trust must continue its work in retaining experienced paramedics and helping them feel valued.
Response from Healthwatch Cambridgeshire and Peterborough

Healthwatch Cambridgeshire and Peterborough continue to hear positive experiences from people using the service stating that the standard of care they have received from ambulance staff has been excellent. However, we are still hearing that people are having to wait a long time, particularly in rural areas, for an ambulance to attend.

Healthwatch Cambridgeshire and Peterborough have been concerned by the number of experiences people have shared with us about the time taken to respond to people who have suffered falls. We would welcome a system-wide response in improving the way this is managed to ensure a consistent approach. It is acknowledged that there are ongoing challenges with recruitment and retention of staff. We welcome that initiatives have been introduced to improve staff retention in particular, including the establishment of a retention steering group. It is important for EEAST to maintain momentum in this area of work. An innovative approach needs to be adopted in designing new initiatives, with other areas of the health system redesigning professional responsibilities, creating opportunities for experienced paramedics and therefore placing them in high demand.

In response to last year’s Quality Account, Healthwatch Cambridgeshire and Peterborough stated that we welcomed the steps taken by the Trust in reviewing the reporting of Serious Incidents and that we looked forward to seeing evidence that the improvements were being consolidated in the coming year. It is pleasing to see that momentum has been maintained in this area. Although the number of incidents reported within the Trust are still above the national average, the number of reported patient safety incidents resulting in severe harm or death is considerably below the national average.
Response from Healthwatch Hertfordshire

Notes for inclusion in a joint local Healthwatch response:

Healthwatch Hertfordshire welcomes the opportunity to comment on EEAST’s Quality Account. In addition we would like to make the following comments:

- The Quality Account provides a clear picture of the actions taken to improve quality across the organisation. We support the quality priorities for 2019/20 and welcome the additional focus on learning disabilities and autism.

- Since EEAST took over the contract for the Non-Emergency Patient Transport Service (NEPTS), patient satisfaction with this service has improved though we recognise that the Trust still has challenges in relation to recruitment and meeting targets. However Carers in Hertfordshire raised some issues about the way carers were being assessed by the service as ‘escorts’. This was communicated to the Contract Manager for Hertfordshire at Herts Valleys Clinical Commissioning Group who arranged a meeting with EEAST in January 2019 to explore how things could be improved. This was a very positive meeting that resulted in a number of actions to take forward including a closer working relationship between East of England Ambulance Trust and Carers in Hertfordshire. We will be expecting an improvement in feedback from Carers in Hertfordshire going forward.

- The Trust should be congratulated for being the first ambulance service to introduce a targeted survey of patients/carers at end of life. It is also good that they are introducing an end of life training package for CFRs (Community First Responders).

- EEAST has shown a commitment to improving the training of staff to better support patients and their families living with dementia and has been proactive in promoting dementia awareness. The novel concept of a ‘pop up focus group’ at a fair sounds promising. The aim to become a dementia friendly organisation is welcomed.

- Staff morale is poor as shown by the staff survey. It is good to see EEAST trying to improve communication and staff morale by a number of mechanisms including the Freedom to Speak Up guardians - two very active
and effective members of staff act as these guardians and are very visible and well supported by the Board and EEAST senior management.

- The Chief Executive comments that she is leading on projects with acute trusts to improve and increase the alternative care pathways. While there are specific examples, such as the Early Intervention Vehicle, it might be useful to hear more about these projects in the Quality Accounts.

- It is very pleasing that EEAST is the first ambulance service to work with NHSI on a framework that helps to assess how efficient and effective the trust is regarding the Patient Experience. This involved a workshop attended by patients and EEAST staff working through the framework and scoring how well EEAST responds to patient’s concerns. The exercise provided some good reflection on what happens/or doesn’t happen now and what could be improved.

- Generally when the public contacts us, it is to raise an issue or to find a service but we did have someone recently telephone to actively compliment EEAST’s emergency service, both the prompt response and the care received from the paramedics.

- The HwH Chair and CEO had a very productive meeting with EEAST last summer and look forward to continuing this dialogue in the near future to improve patient experience and outcomes.

Steve Palmer, Chair Healthwatch Hertfordshire, May 2019
Essex County Council - Health Overview Policy and Scrutiny Committee

The Trust has directly supported the Essex HOSC in a review of A&E and seasonal pressures held with the hospital trusts and a further follow-up discussion is planned. The Essex HOSC expects to continue working closely with the Trust in the coming year on this and other issues.

In relation to your report it is encouraging to see the number of patient safety incidents (PSI’s) continuing to improve. The HOSC is pleased to see the clear list of priorities, in particular the reference to understanding the needs of people with learning disabilities and autism – this is a patient group which the HOSC will also be looking at in the near future.

It is pleasing to see the establishment of a new control centre in Bedfordshire, thereby taking the strain off the Essex control centre. This can only be of benefit to the patients.

We welcome the 24% decrease in complaints and would expect this to be reflected in improved staff morale.

The disclosure on turnaround times is welcome but we find it disappointing that the EEAST continues to experience delays between arrival/handover/departure from hospitals.

The “What went wrong and what we did” is an excellent illustration to the reader into the daily work of the ambulance service and we encourage similar disclosure in future reports to help make your work and challenges clearer to the public.

The Committee is aware that local Healthwatch also reviews Quality Accounts and is content that they can represent the patient and public voice and comment accordingly.

On behalf of the HOPSC, may I thank you for the opportunity to comment on these draft accounts.

Suffolk County Council – Health Scrutiny Committee

As has been the case in previous years, the Suffolk Health Scrutiny Committee does not intend to comment individually on NHS Quality Accounts for 2018/19. This should in no way be taken as a negative response. The Committee has, in the main, been content with the engagement of local healthcare providers in its work over the past year. The Committee has taken the view that it would be appropriate for Healthwatch Suffolk to consider the content of the Quality Accounts for this year, and comment accordingly.

Hertfordshire County Council – Health Scrutiny Committee

The Trust has supported the scrutiny process when approached and the Committee look forward to working with the Trust in the future.
<table>
<thead>
<tr>
<th>Term</th>
<th>Acronym</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accident and emergency</td>
<td>A&amp;E</td>
<td>A medical treatment facility specialising in acute care of patients who present without prior appointment, either by their own means or by ambulance. The emergency department is usually found in a hospital or other primary care centre.</td>
</tr>
<tr>
<td>Acute Coronary Syndrome</td>
<td>ACS</td>
<td>Acute coronary syndrome happens when the heart is not getting enough blood and includes conditions such as unstable angina and a heart attack.</td>
</tr>
<tr>
<td>Advanced life support</td>
<td>ALS</td>
<td>A set of life-saving protocols and skills that extend basic life support to further support the circulation and provide an open airway and adequate ventilation (breathing).</td>
</tr>
<tr>
<td>Airways2</td>
<td></td>
<td>A randomised controlled trial research project to determine the cost effectiveness of differing airway management tools in pre-hospital cardiac arrest</td>
</tr>
<tr>
<td>Alzheimers Society</td>
<td></td>
<td>A UK care and research charity for people with dementia and their carers.</td>
</tr>
<tr>
<td>Ambulance (clinical) quality indicators</td>
<td>ACQIs</td>
<td>A set of national measures to benchmark clinical quality against eleven indicators to improve quality and safety of patient care.</td>
</tr>
<tr>
<td>Ambulance Operations Centre</td>
<td>AOC</td>
<td>Control centre for managing call receipt, triage and dispatch functions.</td>
</tr>
<tr>
<td>Ambulance Response Programme</td>
<td>ARP</td>
<td>This aims to improve response times to critically ill patients, making sure that the best, high quality, most appropriate response is provided for each patient first time.</td>
</tr>
<tr>
<td>Antimicrobial</td>
<td></td>
<td>An agent that kills microorganisms or stops their growth for example an antibiotic used against bacteria / infection.</td>
</tr>
<tr>
<td>Basic life support</td>
<td>BLS</td>
<td>The level of medical care used for victims of life-threatening illnesses or injuries until they can be given full medical care at a hospital.</td>
</tr>
<tr>
<td>Blood pressure</td>
<td>BP</td>
<td>The pressure exerted by circulating blood upon the walls of blood vessels and is one of the principal vital signs.</td>
</tr>
<tr>
<td>Cardiopulmonary resuscitation</td>
<td>CPR</td>
<td>An emergency procedure, performed in an effort to manually preserve intact brain function until further measures are taken to restore spontaneous blood circulation and breathing in a person in cardiac arrest.</td>
</tr>
<tr>
<td>Care Quality Commission</td>
<td>CQC</td>
<td>The independent watchdog for healthcare in England. It assesses and reports on the quality and safety of services provided by the NHS and the independent healthcare sector, and works to improve services for patients and the public.</td>
</tr>
<tr>
<td>Category 1</td>
<td>Cat 1</td>
<td>National response time standard for 999 immediately life-threatening injuries and illnesses.</td>
</tr>
<tr>
<td>Term</td>
<td>Acronym</td>
<td>Definition</td>
</tr>
<tr>
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</tr>
<tr>
<td>Category 1T</td>
<td>Cat 1T</td>
<td>National response time standard for 999 immediately life threatening injuries and illnesses where the patient is transported</td>
</tr>
<tr>
<td>Category 2</td>
<td>Cat 2</td>
<td>National response time standard for 999 emergency calls</td>
</tr>
<tr>
<td>Category 3</td>
<td>Cat 3</td>
<td>National response time standard for urgent calls and in some instances where patients may be treated in situ (e.g. their own home) or referred to a different pathway of care.</td>
</tr>
<tr>
<td>Category 4</td>
<td>Cat 4T</td>
<td>National response time standard for less urgent calls. In some instances patients may be given advice over the phone or referred to another service such as a GP or pharmacist</td>
</tr>
<tr>
<td>Chief Executive Officer</td>
<td>CEO</td>
<td>The position of the most senior officer, executive, or administrator in charge of managing an organisation.</td>
</tr>
<tr>
<td>Chloramphenicol</td>
<td></td>
<td>An antibiotic used for the treatment of a number of bacterial infections</td>
</tr>
<tr>
<td>Chronic obstructive pulmonary disease</td>
<td>COPD</td>
<td>A chronic inflammatory lung disease that causes obstructed airflow from the lungs.</td>
</tr>
<tr>
<td>Clinical Advice Line</td>
<td>CAL</td>
<td>Telephone support service within EEAST manned by senior clinicians</td>
</tr>
<tr>
<td>Clinical commissioning group</td>
<td>CCG</td>
<td>NHS organisations set up as a result of the Health and Social Care Act 2012 to organise the delivery of NHS services in England.</td>
</tr>
<tr>
<td>Co-amoxiclav</td>
<td></td>
<td>An antibiotic used for the treatment of a number of bacterial infections</td>
</tr>
<tr>
<td>Commissioning</td>
<td></td>
<td>The processes which local authorities and clinical commissioning groups undertake to make sure that services funded by them meet the needs of the patient</td>
</tr>
<tr>
<td>Commissioning for Quality and Innovation programme</td>
<td>CQuIN</td>
<td>The incorporation of quality metrics within quality and innovation three-year contracts. Full reimbursement of activity is made upon delivery of quality initiatives.</td>
</tr>
<tr>
<td>Community Engagement Group</td>
<td>CEG</td>
<td>Volunteers who participate and support the Trust wherever they can, but are also a critical friend where necessary.</td>
</tr>
<tr>
<td>Community first responders</td>
<td>CFR</td>
<td>Teams of volunteers who are trained by the ambulance service to a nationally recognised level and provide lifesaving treatment to people in their communities.</td>
</tr>
<tr>
<td>Compassionate Conversation</td>
<td>EADR</td>
<td>EEAST’s appraisal process for staff</td>
</tr>
<tr>
<td>Computer Aided Dispatch</td>
<td>CAD</td>
<td>Computer software used to record all patient system calls and patient activity.</td>
</tr>
<tr>
<td>Data Protection Act</td>
<td>DPA</td>
<td>United Kingdom Act of Parliament which updates data protection laws in the UK</td>
</tr>
<tr>
<td>Data Security Protection Toolkit</td>
<td>DSPT</td>
<td>An online system which allows NHS organisations and partners to assess themselves against NHS Digital information standards.</td>
</tr>
<tr>
<td>Term</td>
<td>Acronym</td>
<td>Definition</td>
</tr>
<tr>
<td>-------------------------------------------------------------</td>
<td>---------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Datix</td>
<td></td>
<td>Datix Ltd is a patient safety organisation that produces web-based incident reporting and risk management software for health and social care organisations.</td>
</tr>
<tr>
<td>Deep clean(ing)</td>
<td></td>
<td>A rigorous intensive clean of the ambulance and all equipment contained therein. This is in addition to routine cleaning undertaken after each patient contact.</td>
</tr>
<tr>
<td>Dementia Action Alliance</td>
<td>DAA</td>
<td>An easy and proven structure for creating a dementia friendly community (DFC)</td>
</tr>
<tr>
<td>Department of Health and Social Care</td>
<td>DHSC</td>
<td>A department of the Government with responsibility for government policy for health and social care matters and for the NHS in England along with a few elements of the same matters which are not otherwise devolved to the Scottish, Welsh or Northern Irish governments.</td>
</tr>
<tr>
<td>Duty of Candour</td>
<td>DoC</td>
<td>Regulation 20 of the Health and Social Care Act 20012 (Regulated Activities) Regulations 2014 to ensure that providers are open and transparent with people who use services or their representatives.</td>
</tr>
<tr>
<td>Early Intervention Vehicle</td>
<td>EIV</td>
<td>An ambulance response dedicated to patients who have fallen but are not unwell</td>
</tr>
<tr>
<td>Eastern Academic Health Science Network</td>
<td>EAHSN</td>
<td>An organisation that works across the East of England to promote health service innovation and improvement</td>
</tr>
<tr>
<td>EasyRead</td>
<td></td>
<td>An accessible format which can be used by people with learning difficulties</td>
</tr>
<tr>
<td>Electrocardiography</td>
<td>ECG</td>
<td>An ECG is a test used to measure the electrical activity of the heart.</td>
</tr>
<tr>
<td>Electronic patient care record</td>
<td>ePCR</td>
<td>A patient care record which is in electronic format.</td>
</tr>
<tr>
<td>Emergency care practitioner</td>
<td>ECP</td>
<td>A paramedic who has additional academic qualifications and enhanced skills in medical assessment and treatment predominantly for primary care conditions</td>
</tr>
<tr>
<td>Emergency Clinical Advice and Triage centre</td>
<td>ECAT</td>
<td>This service accepts lower acuity and clinically appropriate 999 calls for ‘hear and treat’. Staffed by clinicians who can provide advice and arrange safe and appropriate care pathways</td>
</tr>
<tr>
<td>Emergency Medical Technician</td>
<td>EMT</td>
<td>A clinician who works either autonomously, making their own clinical decisions within their training and remit, or as an assistant to a higher skilled paramedic</td>
</tr>
<tr>
<td>Face arm speech time</td>
<td>FAST</td>
<td>A national campaign highlighting the most common tell-tail signs indicating a person is having a stroke.</td>
</tr>
<tr>
<td>Freedom to Speak Up</td>
<td>FTSU</td>
<td>A national initiative to apply measures to enable staff to speak out about patient safety.</td>
</tr>
<tr>
<td>Friends and family test</td>
<td>FTT</td>
<td>A single question survey which asks patients whether they would recommend the NHS service they have received to friends and family who need similar treatment or care.</td>
</tr>
<tr>
<td>General Data Protection Regulation</td>
<td>GDPR</td>
<td>A regulation in EU law on data protection and privacy for all individuals within the European Union (EU) and the European Economic Area (EEA).</td>
</tr>
<tr>
<td>Term</td>
<td>Acronym</td>
<td>Definition</td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>---------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>General practitioner</td>
<td>GP</td>
<td>A medical practitioner who treats acute and chronic illnesses and provides preventive care and health education to patients.</td>
</tr>
<tr>
<td>Glasgow Coma Scale</td>
<td>GCS</td>
<td>A neurological scale that aims to give a reliable, objective way of recording the conscious state of a person for initial as well as subsequent assessment.</td>
</tr>
<tr>
<td>Glyceryl trinitrate</td>
<td>GTN</td>
<td>Drug for heart disease patients to dilate the blood vessels. Delivered as a spray or in tablet form.</td>
</tr>
<tr>
<td>Hazardous Area Response Team</td>
<td>HART</td>
<td>Specialist ambulance unit that provides medical care to patients in hazardous or ‘hot’ environments. They utilise special vehicles and equipment.</td>
</tr>
<tr>
<td>Health and Social Care Act 2012</td>
<td></td>
<td>An Act of the Parliament of the United Kingdom. It provides for the most extensive reorganisation of the structure of the National Health Service in England to date. It removed responsibility for the health of citizens from the Secretary of State for Health, which the post had carried since the inception of the NHS in 1948.</td>
</tr>
<tr>
<td>Health overview and scrutiny committee</td>
<td>HOSC</td>
<td>Provides external assessment of any NHS consultation process giving local assurance that the business cases for any future NHS developments are robust.</td>
</tr>
<tr>
<td>Healthwatch</td>
<td></td>
<td>An independent national body with the power to monitor the NHS and to refer patients’ concerns to a wide range of authorities. It represents the interests of patients as consumers, strategic commissioning, pursues and refers patient complaints and contributes to national public debate on the NHS.</td>
</tr>
<tr>
<td>Hear and treat</td>
<td></td>
<td>Over-the-telephone advice that callers who do not have serious or life-threatening conditions receive from an ambulance service after calling 999.</td>
</tr>
<tr>
<td>Hyper-acute stroke unit</td>
<td>HASU</td>
<td>A specialist centre which provides the initial investigation, treatment and care immediately following a stroke.</td>
</tr>
<tr>
<td>Intravenous</td>
<td>IV</td>
<td>Into the vein.</td>
</tr>
<tr>
<td>Joint Royal College Ambulance Liaison Committee</td>
<td>JRCALC</td>
<td>Committee which provides robust clinical speciality advice to ambulance services in the UK</td>
</tr>
<tr>
<td>Key Line of Enquiry</td>
<td>KLOE</td>
<td>Five key questions, which CQC inspectors use to help establish whether a service is providing the high standard of care expected of them.</td>
</tr>
<tr>
<td>Key performance indicator</td>
<td>KPI</td>
<td>Clear, comparative gauge for CCGs, boards, local authorities, patients and the public to monitor about the quality of health services commissioned by CCGs and the associated health outcomes.</td>
</tr>
<tr>
<td>Mental Capacity Act (2005)</td>
<td>MCA</td>
<td>A law that applies to individuals aged 16 and over designed to protect and empower individuals who may lack the mental capacity to make their own decisions about their care and treatment.</td>
</tr>
<tr>
<td>Metrics</td>
<td></td>
<td>Set of ways of quantitatively and periodically measuring performance.</td>
</tr>
<tr>
<td>Term</td>
<td>Acronym</td>
<td>Definition</td>
</tr>
<tr>
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<tr>
<td>My Directory of Services</td>
<td>MiDos</td>
<td>A national database of all services commissioned within the NHS which provides information on how they can be accessed</td>
</tr>
<tr>
<td>Myocardial infarction</td>
<td>MI</td>
<td>Clinical term for a heart attack.</td>
</tr>
<tr>
<td>National Health Service</td>
<td>NHS</td>
<td>The publicly funded healthcare system of England. It is the largest and the oldest single-payer healthcare system in the world.</td>
</tr>
<tr>
<td>National Institute for Health and Care Excellence</td>
<td>NICE</td>
<td>A non-departmental public body of the Department of Health in the United Kingdom who publish guidelines in three areas; the use of health technologies within the NHS, clinical practice and guidance for public sector workers on health promotion and ill-health avoidance.</td>
</tr>
<tr>
<td>National Institute for Health Research</td>
<td>NIHR</td>
<td>An organisation funded through the Department of Health to improve the health and wealth of the nation through research.</td>
</tr>
<tr>
<td>National Patient Safety Agency</td>
<td>NPSA</td>
<td>An arm’s length body of the Department of Health. It was established in 2001 with a mandate to identify patient safety issues and find appropriate solutions.</td>
</tr>
<tr>
<td>National Reporting and Learning Service</td>
<td>NRLS</td>
<td>A central database of patient safety incident reports.</td>
</tr>
<tr>
<td>National staff survey</td>
<td></td>
<td>A way of ensuring that the views of staff working in the NHS inform local improvements and input into local and national assessments of quality, safety, and delivery of the NHS Constitution.</td>
</tr>
<tr>
<td>National Early Warning Score</td>
<td>NEWS2</td>
<td>A simple aggregate scoring system in which a score is allocated to physiological measurements</td>
</tr>
<tr>
<td>NHS Digital</td>
<td></td>
<td>The national provider of information, data and IT systems for commissioners, analysts and clinicians in health and social care.</td>
</tr>
<tr>
<td>NHS England</td>
<td>NHSE</td>
<td>The lead body for the National Health Service in England.</td>
</tr>
<tr>
<td>NHS Improvement</td>
<td>NHSI</td>
<td>Organisation responsible for overseeing foundation and NHS trusts, as well as independent providers that provide NHS-funded care.</td>
</tr>
<tr>
<td>NHS Long Term Plan</td>
<td></td>
<td>A 10 year plan published by the NHS which provides its commitment to improve the health, levels of care and outcomes those living in the UK and how it will achieve these improvements</td>
</tr>
<tr>
<td>Out-of-hours</td>
<td>OOH</td>
<td>GP services provided outside of normal business hours.</td>
</tr>
<tr>
<td>Oxygen saturation</td>
<td>SpO2</td>
<td>Term referring to the fraction of oxygen within the haemoglobin levels. A normal level would range between 95-97%.</td>
</tr>
<tr>
<td>Term</td>
<td>Acronym</td>
<td>Definition</td>
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<tr>
<td>Paramedic</td>
<td></td>
<td>A registered healthcare professional, working predominantly in the pre-hospital and out-of-hospital environment.</td>
</tr>
<tr>
<td>Parliamentary and Health Service Ombudsmen</td>
<td>PHSO</td>
<td>Investigates complaints that individuals have been treated unfairly or have received poor service from government departments and other public organisations and the NHS in England.</td>
</tr>
<tr>
<td>Patient Advice and Liaisons Service</td>
<td>PALS</td>
<td>PALS queries are processed by the Patient Services team who are the first point of contact for enquiries from the public or other healthcare organisations.</td>
</tr>
<tr>
<td>Patient and Public Involvement</td>
<td>PPI</td>
<td>Involving the public in shaping care system developments and keeping patients well informed of clinical processes and decisions.</td>
</tr>
<tr>
<td>Patient care record</td>
<td>PCR</td>
<td>All NHS providers are required to record the care given to a patient on a patient care record.</td>
</tr>
<tr>
<td>Patient experience framework</td>
<td></td>
<td>NHSI framework which enables organisations to carry out an organisational diagnostic to establish how far patient experience is embedded in its leadership, culture and operational processes</td>
</tr>
<tr>
<td>Patient safety incident</td>
<td>PSI</td>
<td>Any unintended or unexpected incident which could have or did lead to harm for one or more patients receiving NHS care.</td>
</tr>
<tr>
<td>Patient transport service</td>
<td>PTS</td>
<td>Provides transport to and from premises providing NHS healthcare and between NHS healthcare providers. This is also known as scheduled transport or non-emergency service.</td>
</tr>
<tr>
<td>Patient Transport Service Clinical Assessment and Advice Service</td>
<td>PTCAAS</td>
<td>Support service for patients to determine eligibility to patient transport and where eligible to book transport</td>
</tr>
<tr>
<td>Payment by results</td>
<td></td>
<td>The payment system in England under which commissioners pay healthcare providers for each patient seen or treated, taking into account the complexity of the patient’s healthcare needs.</td>
</tr>
<tr>
<td>Peak Expiratory Flow Recording</td>
<td>PEFR</td>
<td>The peak expiratory flow is a person’s maximum speed of expiration, as measured with a peak flow meter.</td>
</tr>
<tr>
<td>Primary care</td>
<td></td>
<td>Out-of-hospital health services that play a central role in the local community.</td>
</tr>
<tr>
<td>Primary percutaneous coronary intervention</td>
<td>PPCI</td>
<td>Commonly known as coronary angioplasty or simply angioplasty, is a therapeutic procedure to treat the narrowed coronary arteries of the heart found in coronary heart disease.</td>
</tr>
<tr>
<td>Quality Governance Committee</td>
<td>QGC</td>
<td>An EEAST committee which has authority from the Trust Board to be assured that progress is being made on the assurance processes for clinical effectiveness, patient safety and patient experience.</td>
</tr>
<tr>
<td>Quarter 1 (2,3,4)</td>
<td>Q1 (2,3,4)</td>
<td>Financial year (1st April – 31st March) quarter indicator.</td>
</tr>
<tr>
<td>Research Ethics Committee</td>
<td>REC</td>
<td>Responsible for the ethical conduct of research studies designed to increase understanding of workplace factors that contribute to ill-health and workplace accidents.</td>
</tr>
<tr>
<td>Term</td>
<td>Acronym</td>
<td>Definition</td>
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<tr>
<td>Return of spontaneous circulation</td>
<td>ROSC</td>
<td>The resumption of sustained perfusing cardiac activity associated with significant respiratory effort after cardiac arrest.</td>
</tr>
<tr>
<td>RIGHT2</td>
<td></td>
<td>A controlled research project for stroke patients in the pre-hospital setting.</td>
</tr>
<tr>
<td>Safety walkabout audit</td>
<td></td>
<td>An internal audit designed to capture and monitor key areas of risk for both patient and staff safety.</td>
</tr>
<tr>
<td>Scheduled transport service</td>
<td>STS</td>
<td>A non-emergency service provided to patients who are unable to convey themselves for outpatients’ appointments. This is also sometimes known as Patient Transport Service or non-emergency service.</td>
</tr>
<tr>
<td>See and treat</td>
<td></td>
<td>Patients who are treated at home by ambulance staff and do not require taking to a hospital or other care centre</td>
</tr>
<tr>
<td>Senior Information Risk Owner</td>
<td>SIRO</td>
<td>An executive who takes ownership of the organisation’s information risk policy and acts as advocate for information risk on the Board.</td>
</tr>
<tr>
<td>Sepsis</td>
<td></td>
<td>A life threatening condition that arises when the body’s response to an infection injures its own tissues and organs. Sepsis leads to shock, multiple organ failure and death especially if not recognized early and treated promptly</td>
</tr>
<tr>
<td>Serious Incident</td>
<td>SI</td>
<td>An event or circumstance that could have resulted, or did result, in unnecessary damage, loss or harm such as physical or mental injury to a patient, staff, visitors or members of the public.</td>
</tr>
<tr>
<td>Service user</td>
<td></td>
<td>Anyone who uses, requests, applies for or benefits from health or local authority services.</td>
</tr>
<tr>
<td>Sign Up to Safety</td>
<td></td>
<td>A national patient safety campaign from NHS England to strengthen patient safety in the NHS</td>
</tr>
<tr>
<td>Stakeholders</td>
<td></td>
<td>Anyone with an interest in the way services are delivered including service users, carers, patients, service providers, staff, health professionals and partner organisations, councils and other community or voluntary groups.</td>
</tr>
<tr>
<td>ST-elevation myocardial infarction</td>
<td>STEMI</td>
<td>A heart attack recognised by characteristics on and ECG.</td>
</tr>
<tr>
<td>STEMI care bundle</td>
<td></td>
<td>A set of interventions that when used together significantly improve patient outcomes for a heart attack.</td>
</tr>
<tr>
<td>Stroke</td>
<td>TIA</td>
<td>A stroke happens when the blood supply to the brain is disturbed.</td>
</tr>
<tr>
<td>Stroke diagnostic bundle</td>
<td>SCB</td>
<td>A set of assessments that when applied provide information indicating as to whether a stroke has occurred.</td>
</tr>
<tr>
<td>Sustainability and Transformation Partnership</td>
<td>STP</td>
<td>Partnership organisations across England involving both NHS organisations and local councils in place to develop proposals to improve health and care at a local level</td>
</tr>
<tr>
<td>Term</td>
<td>Acronym</td>
<td>Definition</td>
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</tr>
<tr>
<td>Transient ischaemic attack</td>
<td>TIA</td>
<td>Transient ischaemic attack (TIA) or ‘mini-stroke’ has similar symptoms to stroke but these symptoms are resolved faster and the person usually will get better within 24-hours. The TIA may be a warning sign of a more serious stroke and always requires further immediate medical attention.</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>UK</td>
<td>The United Kingdom is the official name for the country consisting of Great Britain and Northern Ireland</td>
</tr>
<tr>
<td>Utstein</td>
<td></td>
<td>The Utstein Style is a set of guidelines for uniform reporting of cardiac arrest. The Utstein Style was first proposed for emergency medical services in 1991.</td>
</tr>
</tbody>
</table>