NORTH YORKSHIRE COUNTY COUNCIL

SCRUTINY OF HEALTH COMMITTEE

8 April 2011

Yorkshire Ambulance Service - Quality Account 2010/11

Purpose of Report

1. The purpose of this report is to provide an opportunity for Members to offer comments on the Quality Account (QA) for the Yorkshire Ambulance Service.

What is a Quality Account?

2. QAs are annual reports to the public, from NHS providers of healthcare, reporting on the quality of healthcare services they provide. The aim of the QA is to:

   - ❖ demonstrate a commitment to improving the quality of care
   - ❖ let people know where services have been improved
   - ❖ share information on where it is planned to improve services in the coming year.

3. 2010/11 is the second year of QAs.

4. Overview and Scrutiny Committees are part of the formal assurance process set out by the Department of Health. A Department of Health guide to QAs specifically for Scrutiny Committees is attached as APPENDIX 1.

Yorkshire Ambulance Service's QA 2010/11

5. Strictly speaking YAS are only required to share their draft QA with the OSC for the area in which their head office lies, which is Wakefield. In the spirit of wider engagement YAS is giving all Yorkshire OSCs the opportunity to comment.

6. The draft QA is attached as APPENDIX 2. Members are asked to note that this is a working draft. Some data is currently reported to February 2010 and we will be completing the full-year picture by adding March data. Page number references are also marked as 'x' as these will change when we get to the final lay-out stage.

7. A glossary of terms will be completed.

8. It should be noted that in order to meet requirements set out by the Department of Health, Trusts have to work within a defined structure and include some mandatory statements - some of which may include technical terms and need to include a certain level of data which, again, may be difficult for some readers to understand. Where this is the case (for example with the results of Clinical Performance Indicators) YAS has provided a summary alongside the full results.

9. In addition to the full document, YAS plans to publish a summary version of the 2010-11 QA in an easy-to-read style which will set out the key points. As with all of their documents, both the summary and full versions will be available in alternative languages and formats on request.

10. YAS is inviting two types of comment:

    - ❖ comments about individual points of clarity or formatting which OSCs would like YAS to consider in developing the final draft for publication

    - ❖ formal statements on the content and accuracy of the QAs which OSCs wish YAS to publish in full in the final document.

11. Your Scrutiny Officer received YAS' QA on 23 March 2011. In line with the guidelines, YAS are inviting this Committee to provide a response within 30 working days, ie. by Wednesday 4 May 2011.

12. Helen Hugill, Service and Quality Improvement Manager, YAS, will be attending the meeting to guide Members through the draft QA.

Comments from the Scrutiny of Health Committee on YAS' QA for 2009/10

13. The Committee's comments on the YAS' QA for last year are attached as APPENDIX 3.

Recommendations

14. That Members offer comment and advice on YAS's QA for 2010/11.

15. That taking into account discussion at the meeting, Chairman be given delegated powers to respond on behalf of the Committee.

Bryon Hunter
Scrutiny Team Leader
County Hall
NORTHALLERTON

BH/29 March 2011

Background Documents: None

Quality Accounts: a guide for Overview and Scrutiny Committees

DH INFORMATION READER BOX

Policy	Estates
HR / Workforce	Commissioning
Management	IM & T
Planning /	Finance
Clinical	Social Care / Partnership Working

Document Purpose	Best Practice Guidance
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Target Audience	Local Authority CEs
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Cross Ref	Quality Accounts Toolkit 2010/11
Superseded Docs	
Action Required	N/A
Timing	
Contact Details	Richard Owen NHS Medical Directorate Skipton House 80 London Road London SE1 6LH
For Recipient's Use	

Quality Accounts: a guide for Overview and Scrutiny Committees (OSCs).

Healthcare providers publishing Quality Accounts have a legal duty to send their Quality Account to the OSC in the local authority area in which the provider has its registered office, inviting comments on the report from the OSC prior to publication.

This gives OSCs the opportunity to review the information contained in the report and provide a statement on their view of what is reported.

Providers are legally obliged to publish this statement (of less than 1000 words) as part of their Quality Account.

Providers must send their Quality Account to the appropriate OSC by the 30 April each year. This gives the provider up to 30 days following the end of the financial year to finalise its Quality Account, ready for review by its stakeholders.

This mini-guide has been produced specifically for OSCs and draws on relevant information already published in the Quality Accounts toolkit :

http://www.dh.gov.uk/en/Healthcare/Qualityandproductivity/Makingqualityhappen/qualityaccounts/index.htm

What is a Quality Account?

Quality Accounts are annual reports to the public from providers of NHS healthcare services about the quality of services they provide. This publication mirrors providers' publication of their financial accounts.

In the second year of Quality Accounts, providers will report on activities in the financial year 2010/11 and publish their Quality Account by the end of June 2011.

Who has to provide one?

All providers of NHS healthcare services in England, whether they are NHS bodies, private or third sector organisations must publish an annual Quality

Account. For the first year of Quality Accounts, providers were exempt from reporting on any primary care or community healthcare services. This year the community healthcare service exemption has been removed.

What is the purpose of a Quality Account?

The primary purpose of Quality Accounts is to encourage boards and leaders of healthcare organisations to assess quality across all of the healthcare services they offer, and encourage them to engage in the wider processes of continuous quality improvement. Providers are asked to consider three aspects of quality – patient experience, safety and clinical effectiveness. The visible product of this process – the Quality Account – is a document aimed at a local, public readership. This both reinforces transparency and helps persuade stakeholders that the organisation is committed to quality and improvement. Quality accounts therefore go above and beyond regulatory requirements, which focus on essential standards.

If designed well, the Accounts should assure commissioners, patients and the public that healthcare providers are regularly scrutinising each and every one of their services, concentrating on those that need the most attention.

Quality Accounts aim to enhance accountability to the public and engage the leaders of an organisation in their quality improvement agenda.

How will they be used?

Quality Accounts will be published on the NHS Choices website and providers will also have a duty to:

• display a notice at their premises with information on how to obtain the latest Quality Account; and

• provide hard copies of the latest Quality Account to those who request one.

The public, patients and others with an interest in their local provider will use a Quality Account to understand:

• where an organisation is doing well and where improvements in service quality are required;

• what an organisation's priorities for improvement are for the coming year; and

• how an organisation has involved service users, staff and others with an interest in the organisation to help them evaluate the quality of their services and determine their priorities for improvement.

Commissioners and healthcare regulators, such as the Care Quality Commission, will use quality accounts to provide useful local information about how a provider is engaged in quality and tackles the need for improvement.

Quality Accounts will be public-facing documents, published on NHS Choices

How will the process of producing a Quality Account benefit the provider?

The process of producing a Quality Accounts is an opportunity for organisations and clinicians to collect, review and analyse information relating to quality, so that they can decide where improvement is needed in such a way that it becomes part of the core business of the organisation.

It can also help with benchmarking against other organisations.

The process of producing a Quality Account also provides an opportunity for providers to engage their stakeholders, including PCTs, LINKs and the public, in the review of information relating to quality and decisions about priorities for improvement.

This sort of quality monitoring and improvement activity can have many purposes for the provider. For example it will help them to assess their risks and monitor the effectiveness of the services they provide; the information could also inform their internal monitoring of compliance with CQC registration requirements.

Why are OSCs being asked to get involved with Quality Accounts?

The Department of Health engaged widely with healthcare providers, commissioners, patient groups and third sector organisations in the development of Quality Accounts.

A key message from our stakeholder engagement activity was that confidence in the accuracy of data and conclusions drawn on the quality of healthcare provided from these figures is key to maximising confidence in those reading Quality Accounts. Without some form of scrutiny, service users and members of the public may have no trust in what they are reading.

OSCs, along with LINks and commissioning PCTs , have been given the opportunity to comment on a provider's Quality Account before it is published as it is recognised that they have an existing role in the scrutiny of local health services, including the ongoing operation of and planning of services.

The powers of overview and scrutiny of the NHS enable committees to review any matter relating to the planning, provision and operation of health services in the area of its local authority. Each local NHS body has a duty to consult the local overview and scrutiny committee(s) on any proposals it may have under consideration for any substantial development of the health service in the area of the committees' local authorities, or on any proposal to make any substantial variation in the provision of such service(s).

How can OSCs get involved in the development of Quality Accounts?

OSCs are ideally placed to ensure that a provider's Quality Account reflects the local priorities and concerns voiced by their constituents.

If an important local healthcare issue is missing from a provider's Quality Account then the OSC can use the opportunity in the form of a statement to be included in a provider's Quality Account to highlight this omission. Some of these issues might not directly relate to healthcare quality, so their omission by the provider might be unavoidable (given their legal obligation to report on healthcare only) and your commentary should acknowledge that.

Quality Accounts aim to encourage local quality improvements, OSCs can add to the process and provide further assurance by providing comments on the issues they are involved in locally.

OSCs may also wish to comment on how well providers have engaged patients and the public, and how well they have promoted the Quality Account.

OSCs should not feel that they have to comment on areas of the Quality Account where they do not have relevant knowledge. However, conversations between providers and OSCs should start at the beginning of the planning process for the production of a Quality Account so both the provider and the OSC are aware each others expectations in the process.

OSCs could therefore comment on the following:

- does a providers priorities match those of the public;
- whether the provider has omitted any major issues; and
- has the provider demonstrated they have involved patients and the public in the production of the Quality Account;
- any comment on issues the OSC is involved in locally

What must providers do to give OSCs the opportunity to comment on their Quality Account?

A provider must send their Quality Account to the OSC in the local authority area in which the provider has its registered or principal office located.

They must send it to the appropriate OSC by the 30 April each year. This gives the provider up to 30 days following the end of the financial year to finalise its Quality Account, ready for review by its stakeholders.

The OSC then has the opportunity to provide a statement of no more than 1000 words indicating whether they believe, based on the knowledge they have of the provider, that the report is a fair reflection of the healthcare services provided.

The OSC should return the statement to the provider within 30 days of receipt of the Quality Account to allow time for the provider to prepare the report, which will include the statement, for publication.

If the provider makes changes to the final published version of their Quality Account after having received the statement (possibly as a result of the statement), they are required to include a statement outlining what these changes are.

How does the review of Quality Accounts in April fit in with the other activities carried out by OSCs?

Quality Accounts do not replace any of the information sent to CQC by OSCs as part of CQC's regulatory activities.

Quality Accounts and statements made by commissioners, LINks and OSCs will be an additional source of information for the CQC that may be of use operationally in helping to inform their local dialogues with providers and commissioners.

It is recommended that discussions around the proposed content of a Quality Account and review of early drafts of the report is conducted during the reporting year in question so that by April each year OSCs will already have a good idea of what they expect to see in a provider's Quality Account and may have commented on earlier versions.

Where local elections are being held in April and OSCs will not have the opportunity to review Quality Accounts for 2009/10, it is advised that where possible, OSCs discuss plans and suggest content for 2010/11 Quality Accounts with providers when they reconvene in the summer.

Stakeholder engagement in the development of a Quality Account should be a year-long process – ideally starting at the beginning of the reporting year.

Which OSC should a provider send its Quality Account to?

A provider must send their Quality Account to the OSC in the local authority area in which the provider has its registered or principal office located. This may be different from the geographical area of the lead commissioner. In these cases, liaison and co-operation will be the key to achieving a rounded view on the organisation for whose Quality Account you are providing feedback.

Does an OSC have to supply a statement for every Quality Account it is sent?

No. The role of OSCs in providing assurance over a provider's Quality Account is a voluntary one. Depending on the capacity and health scrutiny interests of the OSC, the committee may decide to prioritise and comment on those

providers where members and the constituents they represent have a particular interest.

It would be helpful to let the provider know that you do not intend to supply a statement so that this does not hold up their publication.

Does the statement have to be 1000 words longs?

No, this is a maximum set in the Regulations. We have increased the maximum limit for situations where LINks and OSC wish to produce joint comments.

Working with commissioning PCTs, LINks and other stakeholders

Existing DH guidance recommends that scrutiny of services provided, commissioned or planned by a single NHS body covering more than one local authority area, is undertaken by a joint committee.

Joint committees may therefore wish to work together when considering Quality Accounts for organisations that provide services across multiple authority areas such as ambulance trusts. For instance, joint arrangements may already be in place for providing third party comments on providers to the CQC (for instance, to provide comments to CQC about a provider's compliance with registration requirements) and it would be appropriate to use these existing arrangements to discuss provider's Quality Accounts.

It should be noted however that the legal requirement is for a provider to send their Quality Account to the OSC in the local authority area in which the provider has its registered or principal office located and to publish within their final Quality Account any statement that they have provided. It is important therefore that when OSCs jointly consider a provider's Quality Account that it is the OSCs residing in the local authority area that sends the statement back to the provider. If the statement has been jointly written, it would be appropriate to state who has contributed to it.

How OSCs and other stakeholders work together is left for local discretion as there is variation across authority areas.

When OSCs jointly consider a provider's Quality Account, the OSC residing in the local authority area for the provider should send the statement back to the provider.

What should OSCs do if they receive a Quality Account from a provider with a national presence?

Some OSCs may receive Quality Accounts from multi-site providers. We do not expect an OSC to assure the quality of a national provider. Instead, we ask that the provider demonstrates how they nationally engage stakeholders day-to-day and in the production of the Quality Account.

How does Quality Accounts fit with the wider quality improvement agenda?

The objectives for Quality Accounts remain the same as last year, to encourage boards and leaders of healthcare organisations to assess quality across all of the healthcare services they offer, and encourage them to engage in the wider processes of continuous quality improvement, holding them accountable to stakeholders.

We will explore how Quality Accounts align with an NHS described in '*Equity and excellence: Liberating the NHS'*.

How do Quality Accounts relate to the work of regulators such as CQC and Monitor?

Quality Accounts do not replace any of the information sent to CQC as part of their regulatory activities. Quality Accounts and statements made by commissioners, LINks and OSCs will be an additional source of information for the CQC that may be of use operationally in helping to inform their local dialogues with providers and commissioners.

When providing comments on a Quality Accounts, LINks should consider whether their reflections on the quality of healthcare provided should also be submitted to CQC.

Monitor's annual reporting guidance requires NHS foundation trusts to include a report on the quality of care they provide within their annual report. NHS foundation trusts also have to publish a separate Quality Account each year, as required by the NHS Act 2009, and in the terms set out in the Regulations. This Quality Account will then be uploaded onto NHS Choices.

Monitor's annual reporting guidance for the Quality Report incorporates the requirements set out in the Department of Health's Quality Accounts Regulations, as well as additional reporting requirements set by Monitor. This is available from Monitor's website.

Quality Accounts for OSCs - Getting started

Before you receive a draft Quality Account:

- Identify which providers will be sending their Quality Account to you and start discussions on proposed content early on in the reporting year.

- Providers have been encouraged in guidance to share early drafts of their Quality Account and useful background information on the content with stakeholders .

- Discuss the provider's proposed content of their Quality Account at an early stage to ensure that it includes areas that have been identified as being local priorities.

Once you have received a draft Quality Account (between 1 – 30 April):

- Before providing a statement on a provider's Quality Account, OCSs may wish to consult with other OSCs where substantial activity (for instance specialised services) is provided to patients outside their area.

- Write a statement (no more that 1000 words in length) for publication in a provider's Quality Account on whether or not they consider, based on the knowledge they have of the provider, that the report is a fair reflection of the healthcare services provided. The statement could include comment on for instance, whether it is a representative account of the full range of services provided.

Sending the written statement back to the provider:

- Send the statement back to the provider within 30 days of the draft Quality Account being received. Your statement will be published in the provider's Quality Account.

- If the provider makes changes to the final published version of their Quality Account after having received the statement (possibly as a result of the statement), they are required to include a statement outlining what these changes are.

Yorkshire Ambulance Service NHS
NHS Trust

Yorkshire Ambulance Service Quality Account 2010-11

DRAFT 3
For Stakeholder Consultation

23 March 2011

CONTENTS

STATEMENT ON QUALITY FROM THE CHIEF EXECUTIVE

For everyone at Yorkshire Ambulance Service (YAS), providing high quality patient care is our highest priority. This applies to our ambulance clinicians responding to emergency calls, to our Patient Transport Service (PTS) crews taking patients to and from their planned hospital appointments, to our managers developing new care pathways or ways of working, and to our Trust Board making decisions about the future of our Trust.

The progress we have made has been acknowledged by the Care Quality Commission (CQC) who agreed in September that we had met the full requirements for registration with them. This means that we are achieving all of the essential standards of quality and safety.

The Board has been leading our focus on quality and has given significant time to developing our Quality Governance Framework. This will ensure that quality is at the centre of all our systems and structures, and enable the investment in our staff, managers and leaders to build a culture of quality. Demonstrating strong quality governance will be essential as we work towards achieving foundation trust status, our systems and structures will be subject to close scrutiny as we progress our application. We welcome this process as it will provide us with additional challenge in setting ambitious objectives and supporting innovation.

In 2010-11 we have made improvements in important areas of quality including incident reporting, management of serious untoward incidents (SUIs), safeguarding vulnerable adults and children, and the development of new care pathways. We have continued to measure the quality of our clinical care using the national Clinical Performance Indicators (CPIs). CPI results are regularly shared with front-line clinicians and local teams. This empowers clinical leaders to take responsibility for driving up achievement in their areas, and identifying where they can learn from colleagues in other areas.

2011-12 will be a challenging year for all healthcare providers as the health care reforms are implemented. We will be exploring and implementing new and more efficient ways of working which will enable us to improve the quality of our care, whilst also reducing the cost to the taxpayer. To achieve this we will work in partnership with our healthcare partners, our patients and local communities to listen and agree local priorities and concerns if we are to ensure our services are responsive to their needs.

We know from the thank you letters and telephone calls we received from patients and their families that many people receive an outstanding service thanks to the skill, care and dedication of all our staff. We want this to be the experience of every patient and will continue to strive towards this goal.

STATEMENT OF ACCOUNTABILITY

The Trust Board is accountable for quality. It oversees the development and delivery of the Trust's strategy which puts quality of patient care at the heart of all the Trust's activities.

As Accountable Officer and Chief Executive of this Board I have responsibility for maintaining the standard of the Trust's services and creating an environment of continuous improvement.

This report is in the format required by the Health Act 2009. It contains the sections mandated by the Act and also measures that are specific to YAS that demonstrate our work to drive up standards. We have chosen these measures based on feedback from our patients, members of the public, health overview and scrutiny committees, staff and commissioners.

As Accountable Officer I confirm that, to the best of my knowledge, all the information in this Quality Account is accurate. I can provide this assurance based on our internal data quality systems and [add opinion of internal/external audit once complete]

Dave Whiting
Chief Executive

PRIORITIES FOR IMPROVEMENT 2011-12

Recording Performance Against Clinical Outcome Measures

We know that for patients with certain life-threatening conditions, getting to them quickly saves lives and is vital to achieving the best possible clinical outcomes.

The nationally-set targets for 2010-11 were to reach:

- 75% of Category A patients (immediately life-threatening) within eight minutes
- 95% of Category A patients within 19 minutes
- 95% of Category B patients (serious but not life-threatening) within 19 minutes

Although it is important to get there quickly, it is not the only factor in providing a high quality service.

Based on Lord Darzi's definition, quality means providing a service that is safe, clinically effective and results in a positive patient experience.

For ambulance services this means measuring the outcomes of our clinical care in addition to our response time. This is why 11 new ambulance clinical quality indicators have been set by the Department of Health for 2011-12. The new indicators were developed by the National Ambulance Director, working with colleagues from across the ambulance service, including people from YAS.

The 11 new indicators keep the same requirements to reach Category A patients, but replace the Category B target. This has been agreed by the medical directors for the 11 English ambulance services because the Category B target was not based on clinical evidence. It is recognised that the most important factor for patients requiring ambulance assistance is the time it takes for them to get the right treatment for their condition. Often attending the nearest hospital emergency is not the fastest way to get this treatment and, increasingly, ambulance clinicians are able to refer patients to alternative sources of care or to take them directly to specialist treatment centres. These new ways of working also help us to ensure that we have ambulances available to respond immediately to patients with conditions, such as cardiac arrest, where fast response is proven to be life-saving.

To understand how well our care improves the health of our patients we need to record the clinical outcomes for those patients. Using the new indicators we will start to do this from April 2011 for patients suffering from cardiac arrest, heart attack (ST-Elevation Myocardial Infarction) and stroke.

We will also be reporting the number of patients whose calls we are able to resolve with telephone advice or whose conditions we can manage without transport to a hospital emergency department. To check how these decisions affect safety and patient experience we will be monitoring the numbers of patients who then need to call 999 again and surveying patients' opinions.

In 2010-11 we will set up the systems that will enable us to report against the 11 new clinical outcome measures for 2011-12:

1. Service experience (feedback from service-users)
2. Outcome from ST-elevation myocardial infarction (STEMI)
3. Outcome from cardiac arrest: return of spontaneous circulation
4. Outcome from cardiac arrest: recovery to discharge from hospital
5. Outcome following stroke for ambulance patients
6. Proportion of calls closed with telephone advice or managed without transport to A&E
7. Re-contact rate following discharge of care
8. Call abandonment rate
9. Time to answer calls
10. Time to treatment by an ambulance-dispatched health professional
11. Category A eight minute response time

Ambulance Response Times

Getting to patients with life-threatening conditions as quickly as possible saves lives and is a vital part of achieving the best possible clinical outcomes. In 2010-11 we made improving our response times our highest priority. We took every opportunity to learn from good practices in other services and we developed a detailed A&E Operational Improvement Plan to ensure we reached and continued to maintain the required standards. In September 2010 the Care Quality Commission (CQC) agreed that our performance in responding to patients with life-threatening (Category A) conditions had improved significantly and was now in line with national targets. We are now fully registered with the CQC without conditions. More details of this work are included in our Annual Report (pX). Our ambulance response times for 2010-11 measured against national targets are reported on pX. This shows that we met our national targets up to November 2010 when our performance was significantly affected by the extended period of adverse weather. With the milder weather in February and March 2011 we were able to improve our response times again.

In 2011-12 we will:

1. Maintain our response times to patients with life-threatening (Category A) conditions in line with the nationally-agreed indicator to reach 75% of patients within eight minutes

Developing Patient Pathways

We know that the best care for patients is not always provided by transporting them to hospital and that people with some conditions can be better supported be referral to specialist teams. Our progress in 2010-11 to develop pathways for diabetes, falls and patients at the end of their lives is reported on pX.

In 2011-12 we will:

1. Work with healthcare partners to develop our referral processes and establish pathways that meet patient needs and link effectively with local services.

2. Work with healthcare partners to develop processes for referring patients to alternative care pathways that are the same in all areas of Yorkshire. Having consistent procedures will promote the high standards in all geographic areas and allow comparisons to be made across the region and with other regions.

3. Introduce a monitoring process for the care provided to patients referred via the diabetes and end-of-life care pathways throughout the full patient journey.

Working with Partners to Ensure Appropriate Care and Management of 'Frequent Callers'

Some of the people who most frequently call our 999 service require help – but not necessarily the attendance of A&E ambulance clinicians. Since 2009 we have worked with local PCTs to identify frequent callers (either individuals or care homes) and review their care needs via multi-agency case conferences. This helps identify potential gaps in the care they are receiving in their communities and how this care could be improved. By putting in place alternative sources of care which better meet individuals' needs, this reduces the number of times they call 999 for an ambulance, leaving resources free for others who need them. This work earned Clinical Hub Team Leader Annette Strickland, our YAS lead for the programme, a Success in Partnership Working Award at the 2010 Yorkshire and the Humber Health and Social Care Awards.

In 2011-12 we will:

1. Continue to identify the top ten most frequent individual callers and care home callers by commissioned area

2. Work with other healthcare providers to review cases, agree action plans and monitor the impact of these plans

3. Analyse past cases to identify early warning indicators for potential frequent callers and work with healthcare partners to develop procedures for early action so at-risk individuals can get the care they need before resorting to the 999 service.

Improving Patient Transport Service (PTS) Performance

Our PTS provides transport for people who are unable to use public or other transport because of their medical condition and includes those:

- attending hospital outpatient clinics
- being admitted to or discharged from hospital wards
- needing life-saving treatments such as chemotherapy or renal dialysis.

The measures we use to monitor PTS service quality and our performance in 2010-11 are set out on pX. Some of our patients have been telling us that, in the past year, they have too often experienced extended waiting times for transport home after their appointments. We are working to improve this and in 2011-12 we will:

1. Agree a target with each of the three PTS commissioning consortia for the percentage of patients who should be collected for their return journeys within 60 minutes of the hospital/clinic advising that they are ready to travel.

2. Measure our performance against these quality targets and work towards reducing waiting times for all patients.

In order to reduce waiting times for home-ward journeys and improve patients' overall experience of our service we need to have better knowledge of the timings of individual clinics. At the moment we plan our journeys based on an appointment time of one-and-a-half hours for every clinic. In 2011-12 we will:

3. Map the timings of individual clinics and use this to plan return journeys that better match patients' appointment times.

Developing Clinical Leadership and Assessment Skills

In order to improve the quality of our care in line with the new ambulance outcome measures we need to ensure that our clinical staff have the skills and confidence to make good, clinically sound, decisions about treatment and referral. By supporting our staff to develop their clinical assessment and decision-making skills we aim to increase the numbers of appropriate referrals to appropriate alternative care pathways.

In 2011-12 we will:

1. Develop and deliver a clinical leadership and skills-development project.

2. Monitor the numbers of staff who have increased their clinical skills through the clinical leadership and skills-development project.

Providing Ambulance Clinicians with 24/7 Access to Clinical Advice

Our ambulance clinicians work 24 hours a day, seven days a week, 365 days a year. The nature of their jobs mean that they deliver care in peoples' homes and in public places where they do not have the same access to reference sources or advice from colleagues as people who work in hospitals or clinics. We want to provide our clinicians with better access to clinical advice and guidance on the available alternative care pathways. To do this we will be developing our 'Clinical Hub'.

The Clinical Hub is staffed by clinical advisors (specially-trained nurses and paramedics). Currently their role is to take calls from patients with non-life-threatening conditions (Category C) and assess their needs using a clinical triage system. The clinical adviser may then be able to provide advice about self-care, arrange a home visit by a healthcare professional such as a district nurse, GP or emergency care practitioner or refer the patient to an appropriate care pathway.

In 2011-12 we will:

1. Develop our Clinical Hub to provide a new clinical advice and guidance service for ambulance clinicians.

2. Monitor the number of incidents where clinicians working in ambulances and rapid response vehicles access the Clinical Hub.

3. Increase the satisfaction of clinicians with the service provided by the Clinical Hub. We will monitor this through surveys of staff opinions.

Measuring and Improving Patient Experience

Listening to and acting on feedback from patients is a vital part of providing a high quality service. By listening to what our patients are saying we can reduce the risk of missing the warning signs of poor care.

In 2010-11 we developed new ways to measure the experience of our patients and started to record our level of achievement. Details of this work and some early results are reported in section X.

In 2011-12 we will:

1. Increase the overall level of feedback given by patients and other service-users as a proportion of those using our services.

2. Review the diversity of those providing feedback on our services compared to the diversity of our services users and use this information to increase the opportunities for key groups to make their views known.

3. Develop mechanisms through which patient feedback influences and improves our services eg recruitment, induction, mandatory training and clinical leadership.

4. Keep records of work showing how feedback from patients has been used to develop and improve our services.

STATEMENTS OF ASSURANCE FROM THE BOARD

The National Health Service (Quality Accounts) Regulations 2010 require the Trust Board to make a number of Statements of Assurance. These are common to all providers, which makes our accounts comparable with those of other organisations. The statements confirm the total number of services we provide, that we have participated in research and national audits and that we are registered with the Care Quality Commission.

REVIEW OF SERVICES

During 2010-11 YAS provided five NHS services:

- Accident and Emergency (including Emergency Preparedness) response
- Patient Transport Service
- GP Out-of-hours call handling service
- Private and Events service.
- Vehicles and drivers for the Embrace neonatal transport service.

YAS has reviewed all the data available on the quality of care in all five of these services.

The income generated by the NHS services reviewed in 2011-12 represents 100% of the total income generated from the provision of NHS services by YAS for 2011-12.

In addition to Board reports and scrutiny at the Integrated Governance and Business Delivery committees directors also participate in 'Listening Watch' visits. Listening Watch is an annual programme of which covers all geographic areas, front-line services and support services. It gives directors the opportunity to hear from staff about a wide range of issues and to discuss safety and quality-related issues. After every visit directors record their learning from Listening Watch and a regular report is presented to the Executive Team. Key issues discussed and actions agreed. Wherever possible feedback is provided to staff on actions taken by the Executive Team as a result of their visits.

PARTICIPATION IN CLINICAL AUDITS

During 2010 -2011 two national clinical audits and one national confidential enquiry covered NHS services that YAS provides.

During that period YAS participated in 100% of national clinical audits and 100% of national confidential enquiries of the national clinical audits and national confidential enquiries which we were eligible to participate in.

The national clinical audits and national confidential enquiries that YAS was eligible to participate in during 2010-11 are as follows:

National Clinical Audits:

- Myocardial Ischemia National Audit Project (MINAP) - this is a national database gathering information on all patients who have had a heart attack or who have acute coronary syndromes.

- National Infarct Angioplasty Project (NIAP) – this is an audit of patients referred for an angioplasty surgical procedure.

National Confidential Enquiries

- Centre for Maternal and Child Enquiries (CMACE) - Confidential Enquiry into Head Injury in Children (completion of required data submission)

The national clinical audits and national confidential enquiries that YAS participated in, and for which data collection was completed during 2010 - 2011, are listed below.

National Clinical Audit/National Confidential Enquiry	**Number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry**
MINAP and NIAP	The MINAP process requires ambulance trusts to validate data submitted to this national audit by acute trusts. There is no direct submission of data by YAS. At the moment we are able to validate the data submitted by one out of the 15 trusts who submit data on YAS patients.
CMACE - Head Injury in Children	Rather than submitting a required number of cases to this audit, CMACE requests information about specific patients. YAS provided information to CMACE about 130 patients.

We also submitted data to the national ambulance services' audit of Clinical Performance Indicators. The results of these audits are reported on pX.

YAS participated in the trial of the National Patient Safety Agency Community Suicide Prevention Toolkit Ambulance Audit Tool. The comments we submitted will be used to develop the toolkit in 2011.

The reports of two national clinical audits (MINAP and NIAP) were reviewed by the provider in 2010-11 and YAS intends to take the following actions to improve the quality of healthcare provided:

- enhance data collection, sharing and validation with acute trusts
- continue with staff education and awareness regarding Acute Coronary Syndrome management
- develop links with Primary Percutaneous Coronary Intervention (PPCI) centres, audit local pathways and improve awareness of best practice amongst YAS clinicians.

The above initiatives will build on our work as part of the Ambulance Service Cardiovascular Quality Initiative, which aims to improve the delivery of pre-hospital care for cardiovascular disease, acute myocardial infarction and stroke. In 2010-11 we received funding from this initiative for a quality improvement fellow to support teams of clinicians to work together to develop proposals for improving care for patients suffering from a heart attack or stroke.

As well as participating on national clinical audits, we undertake our own, local audits to measure our clinical practice against best practice standards. The results from these audits are provided to local teams every month to help them improve the quality of their service. They are also reported to the Trust Board.

Our local audits include:

- monthly audits of compliance with the five national Clinical Performance Indicators (see pX)
- audit of care provided to patients suffering neck of femur fracture.

The reports of 15 local audits were reviewed by the provider in 2010-11.

YAS intends to take the following actions to improve the quality of healthcare provided:

- Continue to undertake local audit (including peer review) of completed patient report forms (PRFs)
- Continue with staff education and awareness of clinical audit and engagement of front-line clinicians in reviewing the results
- Build on the best practice and learning from the Ambulance Service Cardiovascular Quality Initiative.

RESEARCH

Commitment to research as a driver for improving the quality of care and patient experience

Participating in clinical research demonstrates that an organisation is committed to improving the quality of care it provides and to making a contribution to wider health improvement.

YAS is committed to participating in clinical research that leads to better care for patients. Like all ambulance services, we are relatively new to the field of research. We continue to build our skills, experience and partnerships and look forward to developing our research programme further in the year ahead.

In 2010-11 we took part in three observational research studies approved by a research ethics committee. Two of these studies were related to our staff where researchers invited them to provide information about the barriers and benefits when treating certain groups of patients:

- Understanding how ambulance services achieve effective engagement from ambulance clinicians to improve the delivery of pre-hospital care for cardiovascular disease; primarily acute myocardial infarction and stroke
- Understanding to what extent the Mental Capacity Act (MCA) and its guidance are effective in providing a clear framework for the protection and empowerment of those who are judged to lack capacity.

The third research study was the final phase of a multi-national [CHECK] study that aims to identify variables that might act as predictors of survival in emergency medical patients:

- Development And Validation of Risk-adjusted Outcomes for Systems of Emergency Medical Care (The DAVROS Project)

The number of patients receiving NHS services provided or sub-contracted by YAS in 2010-2011 that were recruited during that period to participate in research approved by a research ethics committee was 1423. [Number to be confirmed at end of March]

In 2010-2011 we also:

- supported 20 ambulance clinicians to become research champions to promote and encourage the principles and benefits of research.

- Worked with three Comprehensive Local Research Networks (CLRNs) and two Higher Education Institutes to develop and carry out clinical research. These were:
    - West Yorkshire CRLN
    - South Yorkshire CRLN
    - North East Yorkshire and North Lincolnshire CRLN
    - University of Sheffield School of Health and Related Research
    - University of Bradford.

- had three peer-reviewed articles published related to research, audit and innovation activity:
    - J Taylor: *The role of ambulance clinicians in management and leadership.* Journal of Paramedic Practice, January 2011, vol/is 3/1 34-37
    - N Roberts, S Curran, V Minogue, J Shewan, R Spencer, J Wattis: *A pilot of the Impact of NHS Patient Transportation on Older People with Dementia*. International Journal of Alzheimer's Disease, Volume 2010 (2010), Article ID 348065, 9 pages
    - JT Gray, K Challen, L Oughton: *Does the pandemic medical early warning score system correlate with disposition decisions made at patient contact by emergency care practitioners?* Emergency Medical Journal, December 2010, vol/is 27/12 943-947

GOALS AGREED WITH COMMISSIONERS

X% of YAS's income in 2010-11 was conditional on achieving quality improvement and innovation goals agreed between YAS and our PCT commissioners through the Commissioning for Quality and Innovation (CQUIN) payment framework.

We achieved all our CQUIN targets for 2010-11 which related to our performance against clinical performance indicators, increasing referrals to alternative care

pathways, developing new alternative care pathways and increasing referrals to specialist services for safeguarding children and vulnerable adults.

Our CQUIN goals for 2011-12 are closely aligned to the new ambulance outcome measures and the priorities for improvement in these Quality Accounts.

Full details of our CQUIN goals are available electronically at www.XXXX [exact web address TBC]

WHAT OTHERS SAY ABOUT US

Care Quality Commission

YAS is required to register with the Care Quality Commission (CQC) and our current registration status is 'full registration'. The CQC has not taken enforcement action against YAS during 2010-11.

In April 2009 YAS was registered with the CQC with one condition: to ensure that by 31 October 2010 it is responding to emergencies defined as immediately life-threatening promptly in line with national requirements in order that people who use the services receive safe and appropriate care, treatment and support. This condition was lifted by the CQC on 3 September 2010 on the basis of our improved ambulance response times.

YAS has not participated in any periodic or special review or investigations by the CQC during 2010-11.

NHS Litigation Authority

On 11 November 2010 the Trust was assessed for compliance with the NHSLA Risk Management Standards for Ambulance Trusts at Level 1. The assessors looked at 50 key policies and all 50 were accepted as meeting the required standard. This shows a significant improvement since our last assessment in 2008 when 40 out of 50 policies met the required standard.

DATA QUALITY

Good quality information helps the effective delivery of patient care and is essential to our work to improve the quality of our care.

We place a high priority on maintaining effective, secure data management systems. This means that both ourselves and our partners can have confidence that the information that we use to measure the quality of our services is reliable and accurate.

In 2010-11 we took the following actions to maintain and improve our data quality:

- Delivered training workshops on to ensure that managers and staff in key data-processing roles understand their responsibilities and have the necessary skills

- Our Management Information team developed a monthly [CHECK] data quality report to help PTS managers to monitor and improve reporting and data quality in their teams
- Our managers responsible for our 'KA34' performance report to the Department of Health work together to ensure that any changes to our information technology are assessed for their impact on reporting systems.

In 2011-12 we will be taking the following actions to improve data quality:

- We will develop a data quality report for managers in our Access and Response communications centres to help them monitor and improve data quality in their teams
- [Add section here about data quality around outcome indicator reporting – work under development]

Our attainment against the NHS Information Governance (IG) Toolkit assessment provides an overall measure of the quality of our data systems, standards and processes.

Our Information Governance Assessment Report score for 2010-11 was 67% [awaiting final results – this is a minimum level and may be higher] and we were graded [colour - TBC]. Each year the standards within the IG Toolkit are strengthened, challenging NHS organisations to improve their systems and processes. This means that the standards are higher than in 2009-10 when we achieved a score of 72%.

The Health Act 2009 requires us to make the following statements:

YAS did not submit records during 2010-11 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

YAS was not subject to the Payment by Results clinical coding audit during 2010-11 by the Audit Commission.

REVIEW OF QUALITY PERFORMANCE IN 2010-11

How we selected our indicators

In our 2010-11 Quality Accounts we set ourselves six priorities for improvement. As these were our first Quality Accounts we chose these priorities ourselves based on the quality elements of our 2010-11 Business Plan and the CQUIN targets we agreed with our commissioners.

We report a summary of our performance against each of our 2010-11 priorities in the table on pX.

During the past year we have engaged our staff and stakeholders in discussions about service quality and their views on the content of our Quality Accounts. These activities included:

Staff Engagement

- Presentations and workshops at our October management time out event. Our time outs are held twice a year and are an opportunity for all our managers to meet each other in a single location, hear from the chief executive and the executive team about progress over the past year and plans for the year ahead. Workshops focus on key priorities and allow managers to share best practice and learn from each others' experience.
- To build awareness of YAS's responsibilities to maintain high quality services and the role of the Care Quality Commission the Director of Standards and Compliance visited managers and teams from front-line and support services. Staff were able to discuss what quality meant to them in their roles, put forward their views and ask questions.

Engagement with Partners

- We have a monthly Clinical Review Group attended by the YAS Medical Director, Director of Standards and Compliance and PCT commissioners to review service quality and performance against CQUINs.
- We work closely with the Yorkshire-wide Local Involvement Network (LINk) Ambulance Group. All LINks are invited to participate in this group which is a forum for members to raise concerns to their local LINks, identify common experiences across areas and receive responses from YAS managers.
- When issues are specific to an individual LINk we also engage directly with them to provide detailed information and, where possible, resolve problems.
- We acknowledge the important feedback provided via our 14 Yorkshire Health Overview and Scrutiny Committees (HOSCs). Our directors and assistant directors have attended meetings of most committees over the course of the year to report on performance and receive feedback on local issues.
- All LINks and HOSCs were given the opportunity to provide input on the content of our 2010-11 Quality Accounts through a questionnaire and, where possible, meetings with councillors or presentations to committee meetings.

Engagement with Patients and the Public

- We have a Critical Friends Network made up of patients and members of the public who have said they are willing to work with us on different aspects of our service provision and development. We asked all Critical Friends to give us their views on the content of our 2010-11 Quality Accounts by filling in a questionnaire.

From the results of this engagement we learned that while some of the indicators we had chosen in 2009-10 were important to our patients and stakeholders, others that were not included last year were considered more important. We have chosen our indicators for the Review of Quality Performance based on this feedback from stakeholders. All performance against all 2010-11 priorities is included in the table on page X. Other indicators, including our performance against national response time targets and the performance of our PTS are included this year in response to the feedback we received.

Context

When looking at the information presented in this section, it is important to remember the numbers of patients who use our services each year. In summary we:

- Received XXX,XXX urgent and emergency calls
- Responded to a total of XXX,XXX incidents of which XXX,XXX were immediately life-threatening.
- Made X,XXX,XXX journeys transporting patients to and from their planned hospital appointments.

Performance Against 2010-11 Priorities for Improvement

		Achieved	Summary of achievement	Reference for further detail
Patient Safety				
1a	To increase the number of referrals made to specialist services for safeguarding children and vulnerable adults.	✓	965 adult referrals were made in 2010-11 compared to 783 in 2009-10. This is an increase of x%. 797 adult referrals were made in 2010-11 compared to 610 in 2009-10. This is an increase of x%.	
1b	To ensure the Trust works closely with other agencies to respond effectively to all Serious Case Reviews (SCRs).	✓	Contributed to X SCRs, working with other organisations through the SCR panels.	
1c	To ensure all Independent Management Reports (IMRs) required as part of Serious Case Reviews are completed on time, to the necessary standard and all relevant recommendations are implemented.	✓	We completed X reports. All reports were submitted on time.	
2a	For every emergency patient's patient report form (PRF) to be fully completed.		In 2010-11 we started two pieces of work to improve PRF completion rates. We now monitor the percentage of records for which the boxes for date, vehicle and staff details and geographical area are correctly completed. This is the information needed to ensure all PRFs can be found from the archives if needed. Local systems are now in place to review the quality of clinical information recorded on PRFs and report the results back to teams and to individuals.	
2b	For no investigation following a Serious Untoward Incident to identify inadequate clinical assessment as a root cause.	✗	Two SUI investigations have identified issues with clinical assessment. These relate to spinal immobilisation and misinterpretation of ECG results. Actions have been taken as a result of these incidents and our plans to develop clinical assessment skills in 2011-12 will also help reduce the risk of future incidents.	
Clinical Effectiveness				
3a	To maintain the current level of achievement of greater than 90% for recording of clinical observations for patients with stroke	✓	All CPIs for stroke achieved above 90%	Full CPI performance: pX

3b	To maintain the current level of achievement of greater than 95% for management of patients with hypoglycaemia and 95% for management of patients suffering ST-elevation myocardial infarction (STEMI) heart attacks.	✓	All CPIs for hypoglycaemia achieved above 95%. All CPIs for STEMI improved compared to 2009 scores.	Full CPI performance: pX
3c	To achieve performance that is no worse than 1.8 standard deviations below the average score for all English ambulance services for response to patients with cardiac arrest and treatment of patients with asthma.	✓	Response to cardiac arrest: z score = -0.29 Treatment of patients with asthma: z score = 0.66	Full CPI performance: pX
3d	To make improvement against the clinical performance indicators for patients suffering STEMI heart attacks: recording of two pain scores and administration of analgesia	✓	May 2009 results: recording of pain scores = 60.34, analgesia given = 38.14 May 2010 results: recording of pain scores = 85.40, analgesia given = 75.2	Full CPI performance: pX
3e	To make improvements in the recording of peak flow readings for patients with asthma.	✓	Sept 2009 result: peak flow recording = 45.34 March 2010 result: peal flow recording = 54.50	Full CPI performance: pX
4a	To increase the percentage of eligible patients referred to the hypoglycaemia care pathway by 5%.	✓	To achieve a 5% increase 1500 referrals were required during the year. XX referrals were made in 2010-11.	
4b	To increase the percentage of eligible patients over the age of 65 referred to the falls care pathways.	✓	173 referrals were made in April 2010 and a target of 210 referrals per month was set. The target was met every month from July 2010 onwards. The average number of referrals per month was xx.	
Patient Experience				
5	To identify new ways to measure the experience of our patients and start recording our level of achievement.	✓	Satisfaction surveys carried out with users of Patient Transport Service. New patient experience survey for A&E patient developed. Experience survey of users of diabetes care pathway completed.	
6	To increase the number of patients requiring palliative care being referred to a district nursing service following assessment by our crews	✓	Trial of end of life pathway completed in Wakefield and results assessed. Agreement from PCTs to roll-out Yorkshire-wide.	

Indicator 1: Ambulance Response

In 2010-11 our nationally set targets were to respond to:

- 75% of Category A patients (immediately life-threatening) within eight minutes
- 95% of Category A patients within 19 minutes
- 95% of Category B patients (serious but not life-threatening) within 19 minutes.

The funding for our services is provided by PCTs and we work with our PCT commissioners to negotiate a level of funding that will allow us to achieve the national Category A response time indicator, on average, over the PCT area.

[Figures at 28 February 2011]

	Demand (Number of Incidents)				Demand (Number of Incidents)			
AREA	Category A				Category B			
	COMMISSIONED	ACTUAL	Diff	% Var	COMMISSIONED	ACTUAL	Diff	% Var
NHS NORTH YORKSHIRE AND YORK	28049	30598	2549	9.1%	25813	26483	670	2.6%
NHS EAST RIDING OF YORKSHIRE	13637	14588	951	7.0%	11449	11347	-102	-0.9%
NHS HULL	13935	14314	379	2.7%	13594	13794	200	1.5%
NHS BRADFORD AND AIREDALE	24362	25463	1101	4.5%	22711	22210	-501	-2.2%
NHS CALDERDALE	8112	8595	483	6.0%	8239	8568	329	4.0%
NHS KIRKLEES	15582	16283	701	4.5%	16433	16611	178	1.1%
NHS WAKEFIELD DISTRICT	14887	15858	971	6.5%	14960	15661	701	4.7%
NHS LEEDS	33302	34649	1347	4.0%	34906	35082	176	0.5%
NHS BARNSLEY	9960	10483	523	5.3%	9094	9315	221	2.4%
NHS DONCASTER	13255	13949	694	5.2%	12971	13068	97	0.7%
NHS ROTHERHAM	10883	11088	205	1.9%	10357	10134	-223	-2.2%
NHS SHEFFIELD	21837	23083	1246	5.7%	23284	22986	-298	-1.3%
OTHER AREA (Not Yorkshire)		1314						
TOTAL	207801	218951	11150	5.4%	203811	205259	1448	0.7%

	Performance					
AREA	Category A 8 Minute		Category A 19 Minute		Category B 19 Minute	
	ACTUAL	% Var	ACTUAL	% Var	ACTUAL	% Var
NHS NORTH YORKSHIRE AND YORK	68.0%	-7.0%	93.5%	-1.5%	90.8%	-4.2%
NHS EAST RIDING OF YORKSHIRE	68.2%	-6.8%	93.1%	-1.9%	89.5%	-5.5%
NHS HULL	87.1%	2.1%	99.5%	-0.5%	97.8%	2.8%
NHS BRADFORD AND AIREDALE	70.7%	-4.3%	97.1%	2.1%	91.3%	-3.7%
NHS CALDERDALE	75.6%	0.6%	97.5%	2.5%	91.8%	-3.2%
NHS KIRKLEES	71.9%	-3.1%	98.0%	3.0%	92.5%	-2.5%
NHS WAKEFIELD DISTRICT	76.1%	1.1%	98.5%	3.5%	93.7%	-1.3%
NHS LEEDS	72.7%	-2.3%	98.5%	3.5%	94.4%	-0.6%
NHS BARNSLEY	75.5%	0.5%	98.7%	3.7%	96.4%	1.4%
NHS DONCASTER	73.5%	-1.5%	98.5%	3.5%	95.7%	0.7%
NHS ROTHERHAM	75.0%	0.0%	98.7%	3.7%	95.8%	0.8%
NHS SHEFFIELD	77.4%	2.4%	99.0%	4.0%	95.7%	0.7%
OTHER AREA (Not Yorkshire)	56.9%		90.9%		85.3%	
YAS TOTAL	73.5%	-2.4%	97.3%	1.9%	93.6%	-1.4%

In 2010-11 we made significant progress in improving our response times to patients requiring emergency ambulance attention. This was recognised by the CQC and the condition on our registration, which related to our ability to meet our Category A targets, was removed in September 2010.

However between November and January our performance was significantly affected by the snow and freezing conditions which increased demand for our services and extended the journey times for our ambulances. This affected our

response times in this period and our overall achievement in 2010-11. More information about our response to the adverse weather is included in our Annual Report on pX.

We continue work with our primary care trust (PCT) commissioners to ensure we reach patients in all areas of Yorkshire – both urban and rural – as quickly as possible. This means looking carefully at the numbers and types of staff and vehicles we have in each area, and the way they operate, to best meet the needs of local communities.

In outlying rural areas where it is not always possible to get an emergency vehicle to a patient with a life-threatening condition within the first few vital minutes we support many local Community First Responder (CFR) schemes. CFRs are trained in basic life support skills, the use of an automated external defibrillator and to administer oxygen. They can provide treatment in the first few vital minutes before an ambulance arrives. We are also developing partnerships with other organisations, such as the Coastguard and Mountain Rescue services.

Our patients and stakeholders also asked us to state in our Quality Accounts the time it took us to answer 999 calls. This is the time between the call being connected to our 999 communications centre by BT and the call being answered by one of our trained call-takers.

Time from Call Connect to Call Answer (seconds)	Apr	May	Jun	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Target	**4**	**4**	**4**	**4**	**4**	**4**	**4**	**4**	**4**	**4**	**4**	
Actual	4	4	3	3	2	2	3	3	7	4	3	

Indicator 2: Patient Transport Service Performance

Our PTS is provided by trained staff working to high standards of quality, safety and professionalism.

In addition to trust-wide indicators of quality, we measure the standard of our PTS operational performance using three measures:

- Punctuality: whether patients arrive in time for their appointments. We aim to get patients to their clinic between 0 and 60 minutes before their appointment time.

- Waiting time: how long patients have to wait for their return transport after the clinic tells us that the patient is ready to travel. We aim to pick up patients for their return journey within 60 minutes of being told by the clinic that they are ready to travel.

- Journey times: how long patients spend on the vehicle. We aim for journey times to be below 60 minutes.

For each of the above measures we have agreed performance targets. Our achievement against these targets is reported below.

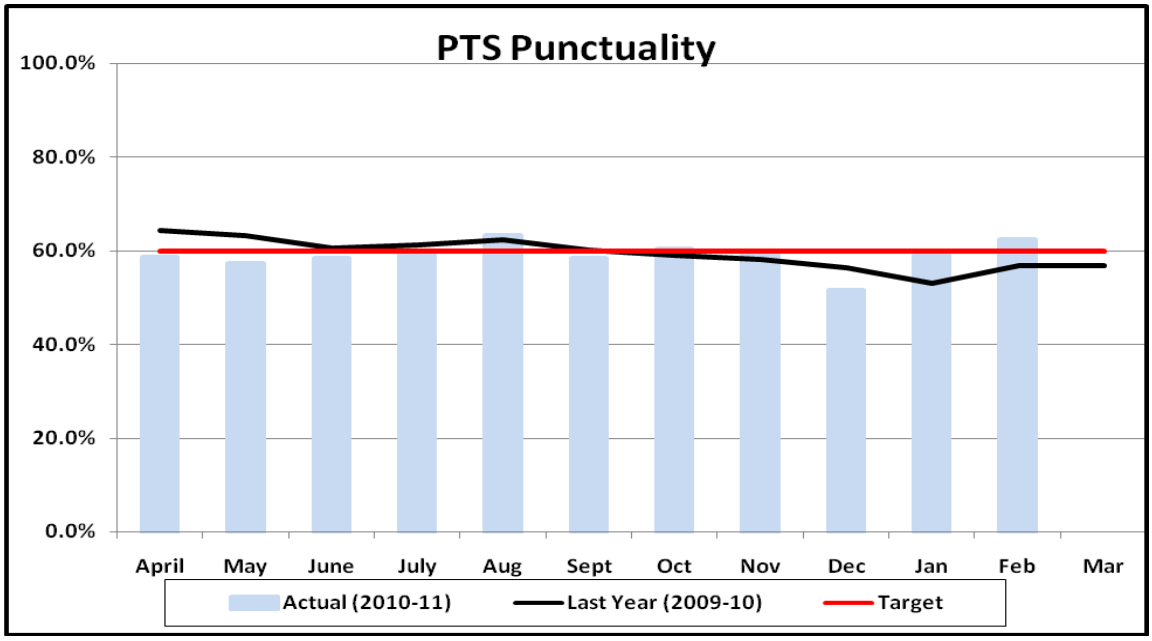


Table X: Percentage of patients arriving at their clinic up to 60 minutes before their appointment time.

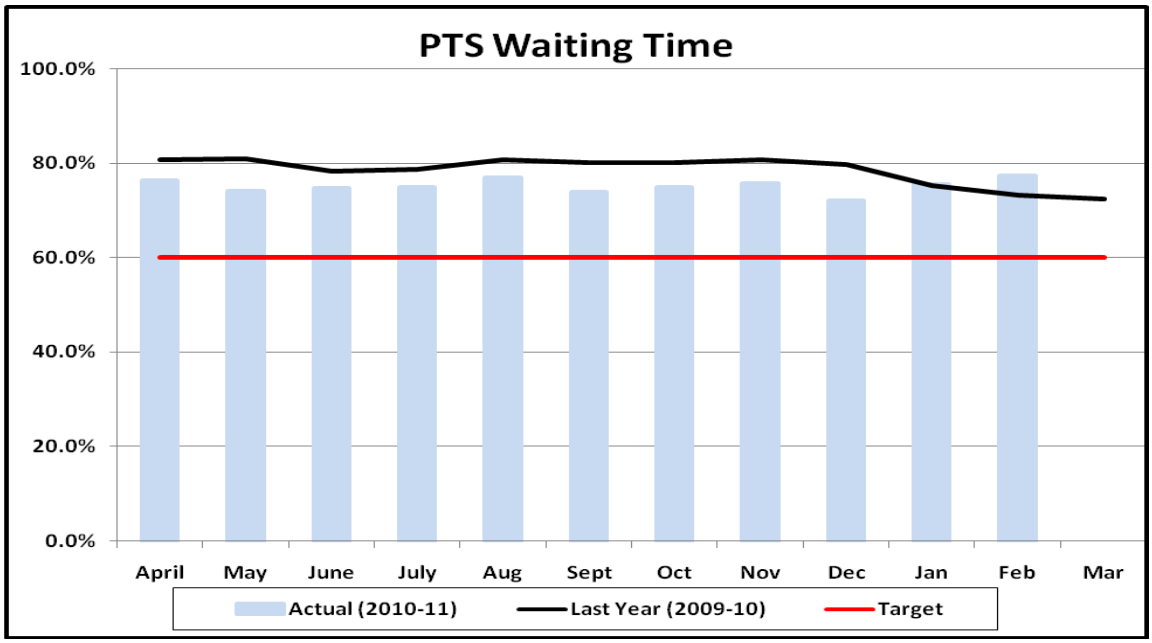


Table X: Percentage of patients waiting less than 60 minutes for transport home after they have been identified by the clinic as ready to travel.

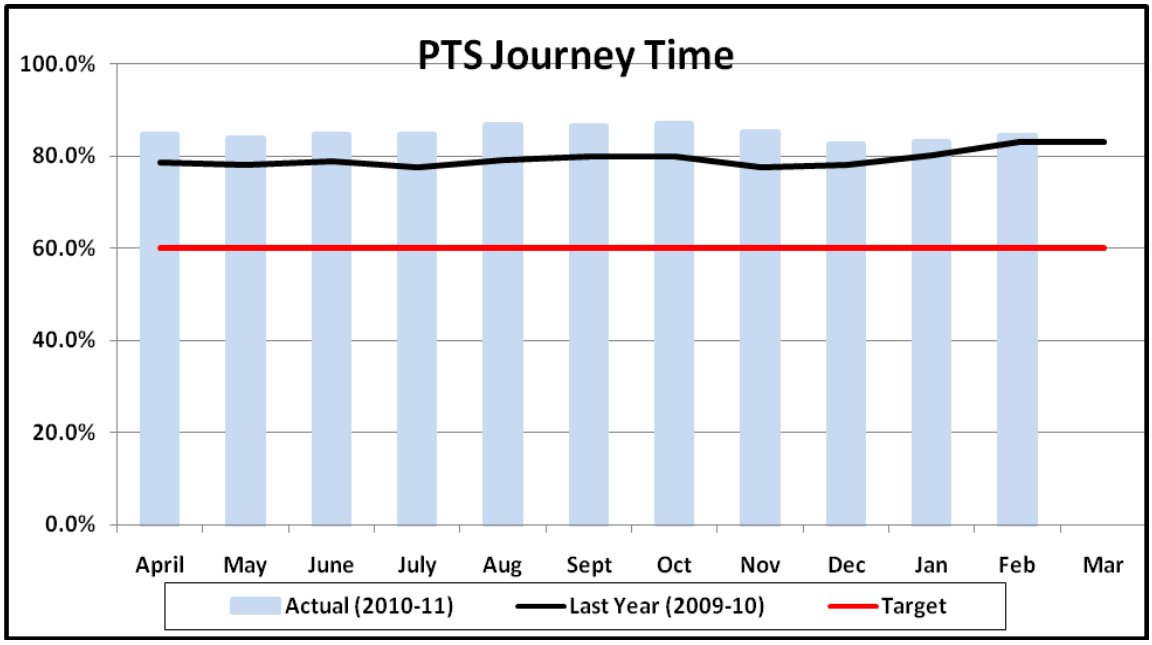


Table X: Percentage of patients who spend less than 60 minutes on the PTS vehicle on their journey to hospital.

Indicator 3: Clinical Performance Indicators

There are five nationally-agreed clinical performance indicators (CPIs) which relate to conditions where the care of ambulance clinicians can make a significant difference to patient outcomes. For each indicator there are a number of agreed actions that should be completed for every patient with that conditions and we audit our PRFs to identify whether these were carried out. Our performance is reported as the percentage of cases for which our ambulance clinicians carried out these actions compared to the total number of cases.

Our scores are also compared with those of other English ambulance services and a measure calculated for how close we are to the national average score. The z-score describes how many standard deviations above or below the mean score a trust is positioned. The standard agreed by national ambulance directors of clinical care is that a z-score of -2 or above indicates that a trust is performing within acceptable limits in comparison with other trusts, whereas a score of below -2 indicates underperformance in relation to other trusts.

In 2011-12 these CPIs will be included in the nationally agreed ambulance clinical outcome measures (see pX for more information about outcome indicators).

Summary of CPI Results 2010-11

Condition	Number of CPIs relating to the management of patients with this condition	National standard
Heart Attack (STEMI)	5	Met in 5 areas
Cardiac Arrest	3	Met in 3 areas
Stroke	3	Met in 3 areas
Hypoglycaemia	3	Met in 3 areas
Asthma	5	Met in 5 areas

Full CPI Results 2010-11

ST Elevation Myocardial Infarction (STEMI)	**Nov 2009 Results %**	**National Average**	**z-score**	**May 2010 Results %**	**National Average**	**z-score**
M1 – Aspirin administered	95.65	93.99	0.26	98.5	96.9	0.57
M2 – GTN administered	79.35	90.04	-1.56	93.0	92.2	0.13
M3 - Two pain scores recorded	80	77.56	0.72	85.4	79.9	0.79
M4 - Morphine alone given	58.44	64.94	0.47	67.6	72.1	0.59
M5 - Analgesia given	67.11	66.36	0.57	75.2	73.3	0.67
Cardiac Arrest	**Dec 2009 Results %**	**National Average**	**z-score**	**June 2010 Results %**	**National Average**	**z-score**
C1 – Return of spontaneous circulation on arrival at hospital	16.16	18.92	-0.34	15.3	21.1	-0.55
C2 - Advanced life support provider in attendance	92.61	95.55	-0.65	99.4	97.8	0.77
C3 - Response to cardiac arrest < 4 minutes	19.21	24.39	-0.60	21.1	23.4	-0.29
Stroke	**Jan 2010 Results %**	**National Average**	**z-score**	**July 2010 Results %**	**National Average**	**z-score**
S1 - Face, Arm, Speech Test (FAST) recorded	96.74	95.12	0.35	95.2	95.6	-0.07
S2 - Blood glucose recorded	96.60	90.89	0.92	94.6	92.5	0.50
S3 - Blood pressure recorded	98.98	98.45	0.25	100	98.6	0.59
Hypoglycaemia	**Feb 2010 Results %**	**National Average**	**z-score**	**Aug 2010 Results %**	**National Average**	**z-score**
H1 - Blood glucose recorded before treatment	99.3	98.9	0.22	98.0	98.8	-0.57
H2 - Blood glucose recorded after treatment	97.7	97.0	0.35	96.9	93.3	0.39
H3 - Treatment for hypoglycaemia recorded	99.3	96.92	0.48	99.0	95.3	0.40
Asthma	**Mar 2010 Results %**	**National Average**	**z-score**	**Sept 2010 Results %**	**National Average**	**z-score**
A1 - Respiratory rate recorded	98.8	98.49	0.29	100	97.4	0.82
A2 – Peak flow recorded before treatment	54.50	41.74	0.86	56.3	50.0	0.39
A3 – Oxygen saturation recorded before treatment	84.60	90.80	-0.65	92.8	92.8	0.00
A4 - Beta 2 agonist recorded	99.20	96.12	0.73	98.3	96.0	0.53
A5 - Oxygen administered	99.2	92.90	0.56	99.0	93.6	0.47

In 2010-11 we improved our performance against all five of the CPI areas. This shows that more patients than ever are getting the best possible care for their conditions.

As well as submitting information to the national CPI audits we now also carry out local audits every month. The results of the local audits are sent to local teams so that our clinicians can see where they are doing well, where they may be able to improve and where they may be able to learn from teams in other areas. The results are also reported every month to the Trust Board.

Indicator 4: Developing Alternative Care Pathways

Our priorities for improvement in 2010-11included making increasing the number of patients referred by our ambulance clinicians to care pathways for stroke and falls and end-of-life care.

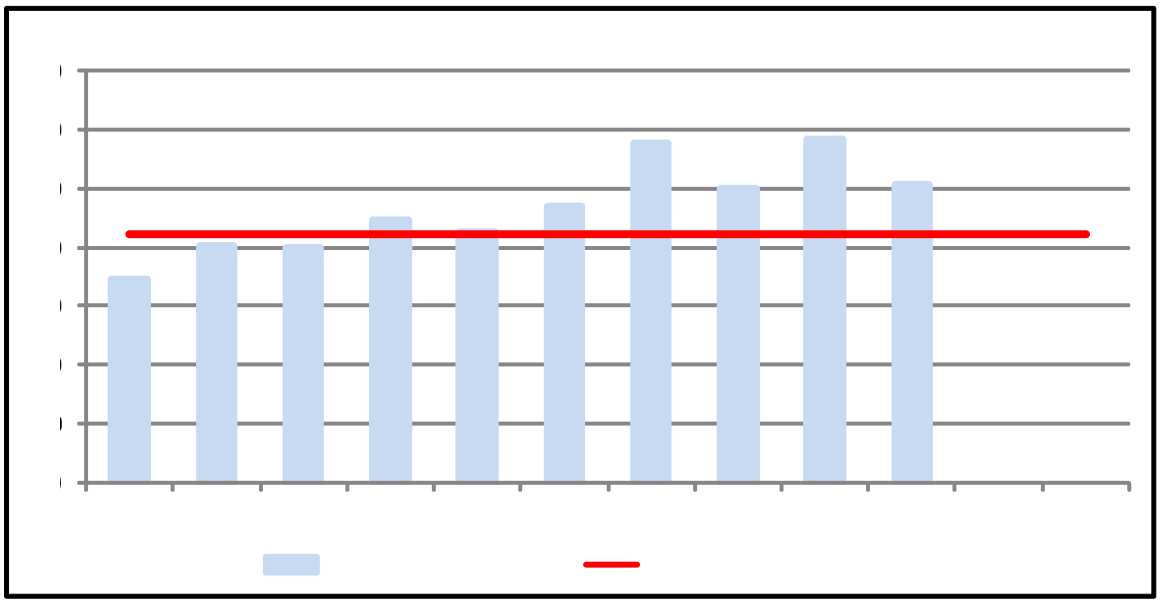


Table X: Numbers of patients over the age of 65 suffering falls who are referred to a falls care pathway. Target = 210 referrals per month.

Quite often patients who have fallen do not need to be transported to hospital for treatment. However it is important that they receive follow-up assessment to try to prevent them falling again in future. In 11 out of 12 of the Yorkshire PCT areas falls pathways are in place where ambulance clinicians can arrange for the patient to be visited by a member of a community falls team. We are in discussions with NHS Sheffield, the remaining PCT, about developing a pathway in this area.

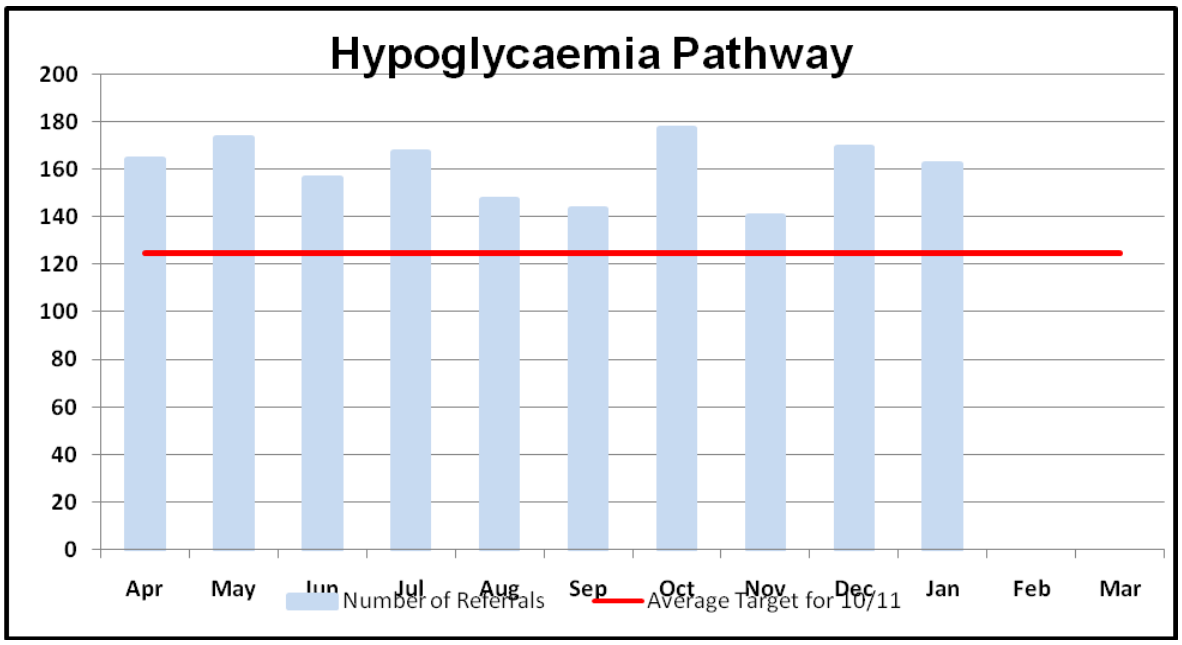


Table X: Numbers of patients with hypoglycaemia attended by YAS crews who were referred to hypoglycaemia pathways. Target = 125 referrals per month.

Following a 999 call for a hypoglycaemic episode (where blood sugar has fallen very low), patients across much of Yorkshire are referred to diabetes specialist nurses who provide follow-up care. Referral may not be appropriate for all patients attended, but those referred in this way have reported that it helped them understand the importance of monitoring their blood sugar and how to prevent problems in the future.

We set a target to increase the number of referrals made by our ambulance clinicians by 5% compared to 2009-10. This required us to make 1500 referrals during the year. In 2010-11 we made XX referrals.

Working with our PCT colleagues we carried out a survey to ask patients about their experience of the hypoglycaemia care pathway. The results are reported in section X.

Indicator 5: Complaints, Concerns, Comments and Compliments

Our staff work very hard to get the job right first time but, with a busy service, mistakes can happen and problems occur. When people tell us about their experiences we listen, if necessary put things right, and learn for the future.

As well as telling us when things go wrong, we are very pleased when people tell us about a good experience of our services. When this happens the member of our staff will receive a personal letter from their director acknowledging their good service. That director will also write back to the person who sent in the compliment to thank them for taking the time to contact our service.

	2010-11											
Complaints, Concerns and Comments	April	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Attitude - negative	21	11	13	19	13	19	16	15	17	16		
Delayed, inappropriate, no response	125	89	127	113	91	144	122	73	78	110		
Patient care	26	19	25	20	17	17	12	28	20	24		
Driving Issues	6	4	8	9	12	9	5	6	13	4		
Administrative	12	10	10	9	6	25	8	9	5	6		
Other (procedural issues)	3	2	1	2	2	2	0	0	0	1		
TOTAL negative	193	135	184	172	141	216	163	131	133	161		
Compliments	49	49	68	88	56	49	66	49	71	66		

	2009-10											
Complaints, Concerns and Comments	April	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Attitude - negative	13	15	12	17	16	8	22	20	13	19	11	14
Delayed, inappropriate, no response	43	55	61	59	43	62	75	61	58	42	99	131
Procedural deviation	14	19	18	31	21	29	34	39	42	40	29	50
Road Traffic Collisions	1	0	0	0	0	0	1	0	0	3	0	0
Equipment Failure	0	2	0	0	0	0	2	1	1	1	0	0
TOTAL negative	71	91	91	107	80	99	134	121	114	105	139	195
Compliments	20	44	37	38	13	18	49	58	25	40	46	53

When people contact us to tell us about a problem we understand that they want us to respond to their concerns as soon as possible. In 2010-11 we received XX concerns and XX formal complaints. Of these we responded to XX (XX%) within five working days.

Learning lessons from complaints, concerns and comments is very important to us. Every two months we report key issues, themes and trends to our Integrated Governance Committee (a sub-committee of the Trust Board) and how we are learning from these to improve our services in the future. Some of the improvements we made in 2010-11 as a result of issues highlighted through complaints, concerns and compliments were:

Patient Transport Service

- In April, September and October 2010 we received high numbers of concerns and complaints from patients calling our PTS patient booking line. This service is provided for patients in North and East Yorkshire where patients are required to book their transport directly with us rather than having it done for them by their GP surgery or hospital clinic. As a result of the feedback we recruited and trained additional call-takers in the PTS communications centre.

- A number of patients told us that they had found that their transport home from hospital had been cancelled without their knowledge. This happened where the patients had made their own way to hospital after their booked transport had been late to collect them. As the journey to hospital was logged on our system as cancelled, this then meant that the return journey was

automatically cancelled as well. As a result we changed our system so return journeys were not automatically cancelled in these circumstances. We also contact the clinic or surgery who are responsible for making the transport booking to ask them to check that the patient is still eligible for the service.

- A number of patients complained after receiving injuries whilst being transported in wheelchairs by PTS staff. As a result we developed new training and assessment to refresh staffs' skills. We are also improving the content of the statutory and mandatory training programme for PTS staff.

Accident and Emergency Service

- We received several complaints from patients which highlighted cases where clinicians had mistakenly diagnosed patients as suffering from panic attacks. To improve awareness of the potential clinical causes of hyperventilation (over-breathing) reminders about best practice were published in our weekly staff bulletin, *Operational Update*, and in the monthly *Clinical Catch-up* briefing.

- Following a complaint, we reviewed the case of an elderly patient who had fallen outdoors and had waited close to three hours for ambulance assistance. This had happened at a time when YAS had called a major incident due to the exceptional number of calls we were receiving as a result of adverse weather. As a result we developed a new system in our 999 communications centres where, during major incidents, a member of staff is responsible for checking the waiting times and clinical conditions of patients who have been waiting longer than usual for an ambulance.

Indicator 6: Adverse Incidents and Serious Untoward Incidents

If errors are made which put patients at risk, or if patients are harmed, we report and thoroughly investigate the incident to ensure lessons are learned for the future. The majority of incidents are reported internally according to Trust processes, but in addition, the most serious are reported to our commissioners as Serious Untoward Incidents (SUIs).

Incident Reporting

In 2010-11 we did a lot of work to develop and improve the way we record and report incidents and how we use this information to identify issues, themes and trends requiring action. Every month we report the numbers new incidents recorded and also, separately, report the numbers of incidents relating to patient care, medication and staff.

The numbers of incidents reported in 2010-11 are shown in the table below. In the future we will be able to compare the figures with those of the previous year.

The figures show that increased numbers of incidents reported between November 2010 and January 2011. This was due to the period of sustained adverse weather

when we received exceptionally high numbers of 999 calls and road and pavement conditions were treacherous for staff and vehicles. Front-line staff also reported that some clinical equipment did not work effectively in very cold conditions. Advice was quickly provided and, where necessary, new equipment sourced to address these issues.

Directorate	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Accident and Emergency	81	154	111	185	119	133	165	224	293	243		
Access and Response Communications Centres	32	82	56	60	39	52	43	110	235	220		
Patient Transport Service	12	32	30	31	28	38	38	25	55	50		
Other (includes fleet, equipment and estates)	88	210	250	257	229	221	244	366	293	278		
TOTALS	213	478	447	533	415	444	490	725	876	791		

Table X: Numbers of incidents reported by department

In our consultation with patients, public and our stakeholders, people said that they thought it was important for us to publish the numbers of medication-related incidents reported each month.

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
TOTALS	24	17	17	25	9	28	35	37	26	24		

Table X: Numbers of medication-related incidents

This year we have rolled out morphine for use by qualified clinicians in all areas of Yorkshire. We have very strict procedures for managing this controlled drug and any errors in recording stock levels or breaches of security procedures have to be reported. We have also changed the systems for managing drugs in West Yorkshire and some incidents have been reported as a result of the transition to the new procedures. All medication-related incidents are reviewed by our Medicines Management Committee which is chaired by an Assistant Medical Director.

Serious Untoward Incidents

In 2010-11 we reported 19 SUIs. This compares to 23 in 2009-10.

Incident Category	2009-10
Delayed dispatch/response	8
Road traffic collision	1
Clinical care	2
Equipment failure	4
Inappropriate response	1
Incidents involving other organisations	2
Medication related	1
Procedural deviation	1
Other	3
TOTAL	23

Incident Category	2010-11
Delayed dispatch/response	7
Road traffic collision	3
Clinical care	2
Inadequate clinical assessment	2
Alleged assault	2
Data protection breach	1
Adverse media attention	1
Workplace safety	1
TOTAL	19

This year we have developed our procedures for managing SUIs to ensure that all incidents are reported and investigated in a thorough and timely manner, that action plans are agreed and monitored and that lessons are learned for the future. To support this we have provided training for managers in root cause analysis techniques and the management of incidents and SUIs.

Actions we have taken as a result of learning from SUIs include:

- Developing a Trust-wide driving policy and a process for periodic assessment of individual drivers
- Developing new routes for communicating essential clinical information and reminders to ambulance clinicians
- Completing a review of replacement and maintenance programmes for all essential clinical equipment.

Indicator 7: Referrals to Services for Safeguarding Vulnerable Adults and Children

The welfare of children and vulnerable adults is an ongoing priority and we aim to ensure that patients in our care are safe and protected by effective intervention if they are thought to be suffering, or likely to suffer significant harm.

The numbers of referrals our staff make to specialist services show how vigilant they are being for signs of neglect and abuse and their confidence in the training they have received.

YAS is leading the way in developing best practice for safeguarding in ambulance services and we chair the National Ambulance Safeguarding Group. This group allows safeguarding managers to work together on common issues, share knowledge and experience and compare information between ambulance trusts.

In 2011-12 our staff made the following numbers of referrals:

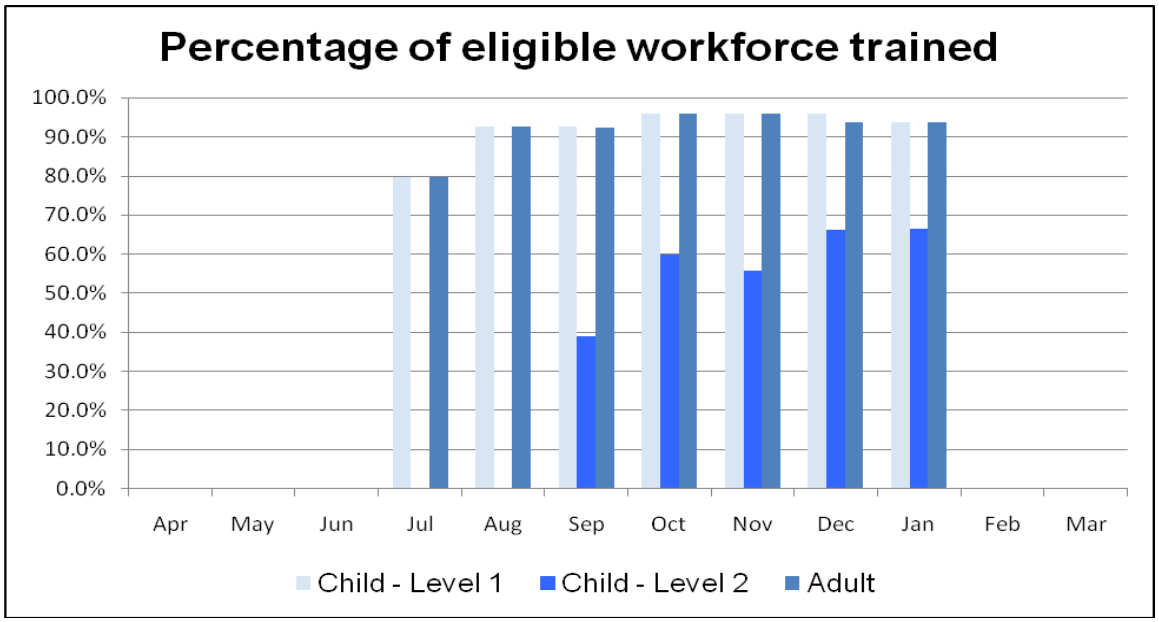
Referrals	09-10	10-11*
CHILDREN		
Referrals	783	965
ADULTS		
Referrals	610	797

* Figures at January 2011

We achieved this increase of X% on 2009-10 due to the significant effort we have put into our staff training programme.

Safeguarding Children level-one is basic-level training which is required by all YAS staff.

Safeguarding Children level-two is more in-depth training and is required by staff who have direct contact with children and vulnerable adults as part of their jobs.



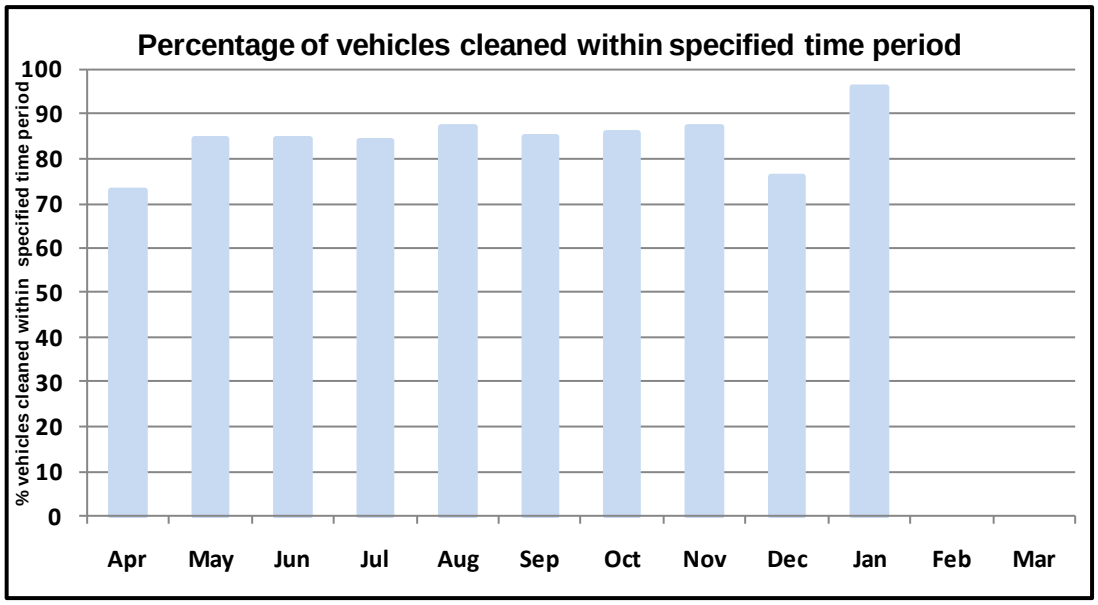
Indicator 8: Vehicle Cleaning and Hand Hygiene

Infection prevention and control is one of the basic elements of providing safe patient care. At YAS we monitor two key indicators:

- compliance with vehicle deep-cleaning schedules
- the compliance of staff with hand hygiene procedures.

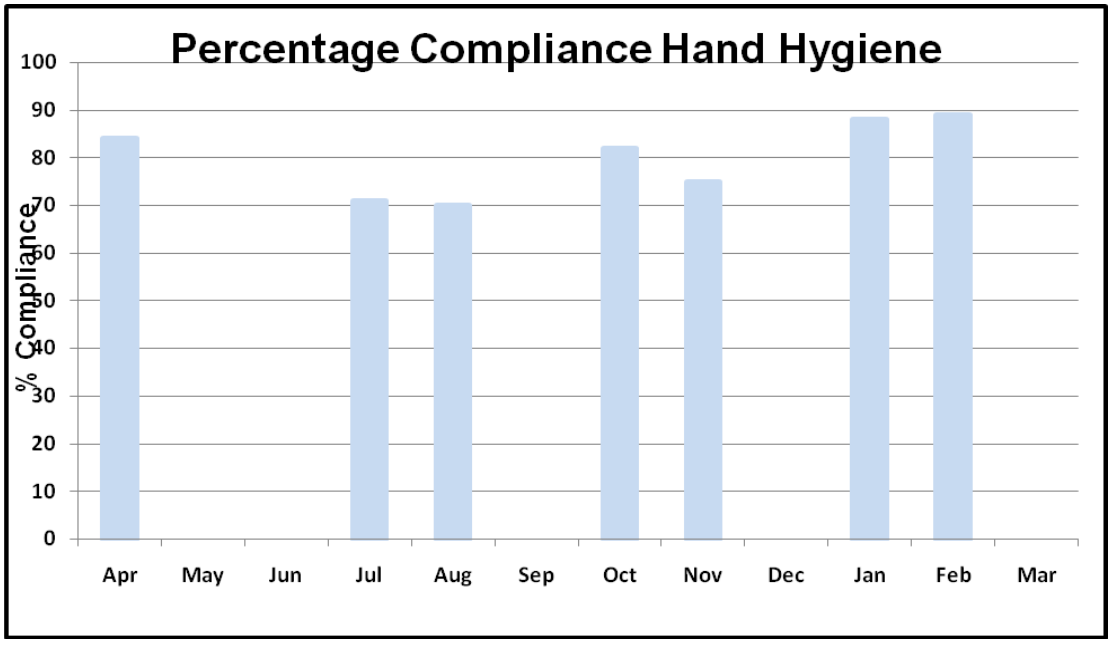
Vehicle Deep-cleaning

We set ourselves very tight targets for vehicle deep-cleans. In 2010-11 we aimed for 95% of ambulance vehicles to receive a deep clean once every 28 days. This was a challenging target to achieve as high demand for our services meant that vehicles were only off the road for relatively short periods. During the year we have recruited additional cleaners and developed our processes to ensure standards are consistently met.



Hand Hygiene Audits

We carried out seven audits (checks) on how well our staff were complying with rules on hand hygiene.



Our work this year to improve our infection prevention and control includes the introduction of our Trust '*Bare Below the Elbows'* policy and an ongoing programme of awareness-raising activities and staff training. From October 2010 hand hygiene audits have been completed every month with the exception of December 2010 when the process was suspended due to the adverse weather.

Indicator 9: Measuring Patient Experience

Unlike in hospital trusts, there is no standard national survey of the experience of ambulance service patients. However, we know that it is vital that the Board has a clear picture of what it feels like to be a patient using our services.

In 2010-11:

- We set up a Patient Experience Group to look at feedback from patients. The Group's role includes developing new ways to obtain feedback to get a balanced view from A&E and PTS patients and recognises the diversity of our communities. The group shares the learning from patient feedback with the staff and managers so they can improve services for the future.

- Our Trust Board started to use patient stories at its public meetings. This includes anonymised case studies and video footage of patients talking about their experiences. By putting the voices and experiences of real patients into our Board room it helps Board members maintain their focus on high quality patient care at all times.

- Launched a Dignity and Respect Campaign with our staff based around a six point Dignity Code:
    1. remembering that many care activities can leave people feeling vulnerable (physically, emotionally or psychologically)
    2. demonstrating respectful verbal and non-verbal communication
    3. having zero tolerance for all forms of abuse
    4. supporting people with the same respect you would want for yourself or a member of your family
    5. respecting people's right to privacy
    6. treating everyone as being of worth, in a way that is respectful of them as valued individuals.

We received feedback from patients via the following routes:

- 439 patients were asked to complete a questionnaire about their experience of the diabetes care pathway. 125 patients sent back their questionnaires

although not all patients answered all the questions. Out of 125 patients who responded to the survey, 114 said that they were very satisfied with the care provided by the ambulance staff. Six patients said they were fairly satisfied, one patient was not sure and four did not answer the question.

- We made comments cards available to all PTS users. 96 cards were returned over the year. 78% of service users rated the helpfulness and friendliness of our staff as excellent and 16% rated it as good. However some patients also told us they sometimes had to wait too long for their transport home. 51% rated their waiting time as good, 20% said it was satisfactory and 26% said it was poor.

- We also called a sample of PTS patients directly to ask them to tell us about their experience of our service. We called 125 patients and 46 gave us their feedback. 100% of patients said they were either satisfied or very satisfied with the attitude and professionalism of our staff. However 41% also said they had to wait longer than two hours for their return journeys after their appointments.

- We commissioned patient experience research to look at the experiences of renal patients using our PTS.

STATEMENTS FROM LOCAL INVOLVEMENT NETWORKS, OVERVIEW AND SCRUTINY COMMITTEES AND PRIMARY CARE TRUSTS

This section will follow the 30 day consultation period

[The regulations of the Health Act 2009 require us to send copies of our Quality Account to our LINks, OSCs and lead commissioning PCT for comment prior to publication. The regulations state that must allow a consultation period of 30 working days. We must publish the comments at the end of the Quality Account.]

GLOSSARY

Patient Report Form
Clinical Performance Indicator
Patient Transport Service
A&E Service
Category A
Category B
Category C
Alternative Care Pathway
Clinical Hub
Hypoglycaemia
Stroke
STEMI
Audit
PPCI
CQC

North Yorkshire County Council
Chief Executive's Group

County Councillor Gareth Dadd
Thirsk Electoral Division

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4 May 2010

Hester Rowell
Executive Officer to Martyn Pritchard, Chief Executive
Yorkshire Ambulance Service
Springhill 2
Wakefield 41 Industrial Estate
Brindley Way
WAKEFIELD WF2 0XQ

Dear Hester

Quality Accounts

Thank you for your e-mail of 18 March 2010. Please include the following comments from the North Yorkshire Scrutiny of Health Committee in your Trust's Quality Account:

> *The North Yorkshire Scrutiny of Health Committee intends to offer commentary on Quality Accounts based on its recent experience with the Yorkshire Ambulance Service (YAS).*
>
> *Last year representatives from YAS attended two Committee meetings and at each ambulance response times were highlighted as a key issue.*
>
> *The Committee was informed that the YAS year to date figure in November 2009 for meeting the Category A call response time of 8 minutes was only 68.9% in North Yorkshire. The national target is 75%. In the Hambleton / Richmondshire area, a particularly rural part of the County, the figure was 59.8%.*

Cont/d ….

The data quoted may actually conceal a more worrying picture of the service in North Yorkshire relative to the more urban communities served by YAS, as it relies heavily here on single paramedics responding to Category A calls. For monitoring response times the clock stops when the paramedic arrives which is sometimes well before the ambulance, if required, actually arrives to take the patient to a hospital. Due to the geography of North Yorkshire and the location of the A&E units, ambulances will take significantly longer to arrive with the patient at an A&E unit than ambulances undertaking the same task in an urban area.

The concern is that the delay in the actual ambulance arriving at the patients address (possibly masked in response time data by the use of single paramedics) is compounded by a longer return journey to the hospital. Currently this total duration time to arrive at hospital is not covered by performance monitoring data. The Committee accepts that this is not an issue solely for ambulance services so it will be considering taking this up with the Department of Health.

However the Committee does feel that improving response times should feature more prominently in the YAS Quality Account.

In part the situation outlined is mitigated by the extensive use of the 2 air ambulances that cover North Yorkshire for urgent transfer of patients to the distant hospitals. However these air ambulances do not operate in poor weather conditions, or generally at night.

In the light of all this the Committee feels that YAS should use the Quality Accounts initiative as an opportunity to develop its existing links with the air ambulance services.

Worryingly the Committee has learned of high levels of sickness absence (in the range of 10% during July to October 2009) amongst the YAS front line staff that serve the County. This has occasionally resulted in ambulance stations being staffed insufficiently, delaying ambulances in being sent on emergency calls that involve a journey to hospital.

If ambulance stations are not properly manned it is impossible for the service to deliver a quality service in terms of safety and patient experience. Data on this aspect of the service could be included in the QA with actions to address the underlying problems.

Finally the Committee would like to commend the YAS on the exemplary way in which its senior staff have engaged with the Committee.

County Councillor Gareth Dadd
Chairman – North Yorkshire Scrutiny of Health Committee

Please send Bryon Hunter (contact details below) a copy of your Quality Account when it is available.

If you need to discuss this matter further or any other issue relating to the work of the Scrutiny of Health Committee, please do not hesitate to contact Bryon or myself.

I hope this is helpful.

Yours sincerely

County Councillor Gareth Dadd
Chairman – North Yorkshire County Council Scrutiny of Health Committee

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