Ambulance Quality Indicators Specification Guidance

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Version control

Version	Date issued	Changes made
V0.4	1 April 2011	Original Guidance
V0.5	28 April 2011	Clinical Outcomes definitions greyed out until definitions fully completed
V0.6	21 June 2011	Changes to definitions following clarification from the National Ambulance Information Group
V0.7	8 July 2011	Added definition for emergency patient journeys data.
V0.8	10 August 2011	Amended clinical outcomes definitions based on advice from ambulance Directors of Clinical Care group.
V0.9	22 August 2011	Amended clinical outcomes definitions for survival to discharge to make it clear that patients should be excluded from the indicator if no outcome data are available.
V0.10	12 January 2012	Inserted Annex A – Technical Annex for the Clinical Outcomes. Added row 7 to Table 1 in the SQU03_05 and SQU03_06 sections.
V1.0	5 March 2012	Amended the different call types to be one of 'emergency', 'urgent' or 'Category A'. Updated Annex A to include v1.0 of the Technical Annex for the Clinical Outcomes
V1.1 & V1.2	7 June 2012, 11 June 2012	Category A8 lines discontinued and replaced by Category A8 (Red 1), Category A8 (Red 2) and 95th centile time for responding to Category A8 (Red 1).
V1.3	May 2013	Information to explain how NHS 111 affects data collection added to all Systems Indicators descriptions.

References to KA34 data removed.

Category A defined as encompassing Red 1 and Red 2 calls and their respective clock starts differentiated.

Sentence removed: 'A first responder is not a substitute for an ambulance response and an ambulance response should be dispatched to all calls attended by an approved first responder'.

SQU03_1_1_2: Sentence removed – 'Include non-urgent transport requests, which, after interrogation and the agreement of the caller, are treated as either Category A or C calls'.

Time to Treatment – Explanation of the healthcare professionals exclusion deleted.

SQU03_02: Re-Contact Rate Following Discharge of Care: Rewording of SQU03_2_1_1.

Emergency Calls Closed with Telephone Advice – Improved wording for SQU03_10_1_2 and SQU03_10_2_2.

'Major A&E departments' defined instead as Type 1 and Type 2 A&E departments.

Number of Emergency Patient Journeys renamed as 'Number of Transported Incidents.' Definition altered to reflect this change.

Outcome from acute STEMI – Component (a), regarding thrombolysis removed. Components of care bundle updated: 'no chest pain' added to Notes 1(b); the words 'appropriate' and 'paracetamol' added to 1(d). |

		Outcome from Stroke for Ambulance Patients – further references to 'unresolved transient ischaemic attack patients' added at (b), SQU03_6_2_1 and SQU03_6_2_2. Annex A technical guidance updated.
V1.31	August 2013	V1.2 Clinical Outcomes definitions removed in line with move to collection of 2013-14 data.
V1.4	December 2015	o HQU03_01a (8 minute Red 1 response), o HQU03_1_1_5 (Red 1 95th centile response time), o HQU03_01b (8 minute Red 2 response), o HQU03_01c (19 minute Red transportation response), o SQU03_9_1_1 (Time to arrival): Clock start and clock stop redefined, including use of defibrillators, geo-fence and rapid response vehicles. Call connect capture recommended. o HQU03_01b (8 minute Red 2 response): Running calls defined. o SQU03_01 (Call Abandonment Rate): Abandonments excluded if less than 5 seconds. o SQU03_2_3_1 (Frequent callers): Specified as aged 18 and over, and making five calls in one month or twelve calls in three months. o SQU03_8_1_1 (Time to answer calls): Define answer time as T1; answerphones should not be used. o SQU03_10a (Calls resolved with telephone advice): Named as "Hear and Treat". Include ambulances stood down without certain stop codes. o Systems Indicators in general: Additional guidance added on events, change of priority and cross-border calls, with definitions for static site and CPAD. Paragraphs numbered.

1   Introduction

1.1   Ambulance Quality Indicators (AQI) were introduced in April 2011 to indicate the quality delivered by an Ambulance Service, and to assess on-going service improvement.

1.2   The data for the Ambulance Quality Indicators will be collected on two separate forms:

- Part 1 – System Indicators (AmbSYS)
- Part 2 – Clinical Outcomes (AmbCO)

1.3   Data for Systems Indicators should be available from Ambulance Services' own information system and relate to the initial call. Therefore, data should be readily available.

1.4   Data for Clinical Outcomes will need information passed back from other organisations (for example, Acute Trusts), for the outcome to be determined. To allow for this, data for the same period as that for Part 1 will be collected on a second form to a slower timetable.

1.5   For all of the lines on these forms, AmbSYS and AmbCO, the basis for collection are set out below.

Collection Information

1.6   Level: Ambulance Trusts

1.7   Basis: Provider

1.8   Returns: Monthly Actual

1.9   All data will be submitted centrally via Unify2.

Part 1 – Systems Indicators

2   HQU03_01a: 8 minute Red 1 response

Detailed Descriptor

2.1   Improved health outcomes from ensuring a defibrillator and timely response to immediately life-threatening ambulance calls.

Data Definition

2.2   **HQU03_1_1_3:** The number of Red 1 calls resulting in an emergency response arriving at the scene of the incident within 8 minutes: A response within eight minutes means eight minutes zero seconds or less.

2.3   **HQU03_1_1_4:** The number of Red 1 calls resulting in an emergency response arriving at the scene of the incident: If there have been multiple calls to a single incident, only one incident should be recorded.

2.4   Red 1 incidents: presenting conditions which may be immediately life-threatening and should receive an emergency response within 8 minutes irrespective of location in 75% of cases.

Clock start

2.5   For Red 1 calls (the most seriously ill patients, those in a cardiac arrest or a state of peri-arrest), the clock will start at T0, the point the call is connected to the Emergency Operations Centre (EOC) telephony switch. This will be the case for all calls received on control room telephone lines; from dedicated emergency lines, or otherwise. For all calls that are connected electronically, including NHS 111 calls through Interoperability Toolkit (ITK), and calls electronically transferred from another Trust's Computer-Aided Dispatch (CAD) system, the clock will start immediately at the point that the call presents to the Trust's EOC CAD.

Clock stop

2.6   The clock stops when the first ambulance service-dispatched emergency responder arrives at the scene of the incident.

2.7   A legitimate clock stop position can include the response arriving at a pre-arrival rendezvous point when one has been determined as appropriate for the safety of ambulance staff in agreement with the control room. For example, a rendezvous point could be agreed for the following situations:

- Information has been received relating to the given location that a patient or bystander is violent, and police or other further assistance is required;
- Information has been received that the operational incident, because of its nature, is unsafe for ambulance staff to enter.

2.8   For the purposes of the 8 minute Red 1 standard, an emergency response that will stop the clock occurs when:

- A fully equipped Trust Ambulance (Land or Air), with ambulance staff trained to delivered clinical care to patient(s) at the scene of an incident, arrives within a 200 metre geo-fence of the patient (if tracked); or such an ambulance confirms arrival at scene through an updated status message via the Mobile

Data Terminal (MDT) in the vehicle, or a clinician confirming verbally to the EOC that they are on scene;

- A fully equipped Rapid Response Vehicle (RRV), motorbike or cycle, or Blue Light Response Officer, if tracked, arrives within a 200 metre geo-fence of the patient; or the RRV confirms arrival at scene through an updated status message via the MDT in the vehicle, or a clinician confirming verbally to the EOC that they are on scene;

- An approved Community First Responder (CFR) or an approved Co-Responder (for example, Fire Service Responder, Mountain Rescue) equipped with a defibrillator arrives within a 200 metre geo-fence (if tracked) of the patient; or the CFR confirms arrival at scene through an updated status message via the MDT in the vehicle, or a CFR confirming verbally to the EOC that they are on scene;

- An ambulance resource commissioned to work on behalf of the Trust, who is deployed by the Trust, working to the Trust Policies and Procedures, on a fully equipped ambulance with qualified staff on board (for example, Private Ambulance Service (PAS) or Voluntary Ambulance Service (VAS)), arrives within a 200 metre geo-fence (if tracked) of the patient; or the clinician confirms arrival at scene through an updated status message via the MDT in the vehicle, or a clinician confirming verbally to the EOC that they are on scene;

- A static site defibrillator (formerly known as static Public Access Defibrillator, PAD), located at the address of the Red 1 incident, is confirmed as being on site, at the patient's side, with someone there who is willing to use it, where both questions are confirmed by an EOC Call Assessor;

- A Community Public Access Defibrillator (CPAD) is confirmed as having been brought to the patient's side with someone there who is willing to use it, with both questions confirmed by an EOC Call Assessor (if only a single rescuer is with the patient, they must stay with the patient, and not leave the patient unattended to collect the defibrillator);

- An approved first responder such as a Doctor or other healthcare professional (HCP) is with the patient, and is equipped with a defibrillator, where the question is confirmed by the EOC Call Assessor.

2.9   Once a category (Red or Green) is determined, reporting must remain against the code that was in place within the CAD record prior to the arrival of a first response on scene. It must not be changed after a resource has arrived at scene.

2.10   There will be no re-triage or enhanced clinical triage undertaken on any Red 1 call which originates from 999 or NHS 111.

2.11   All calls that have been passed from NHS 111 as requiring a Red 1 ambulance response, either electronically or manually, should be included in this indicator.

2.12   No CPAD or static site defibrillator can automatically stop the clock (that is, no auto assign / geofenced allocation functions).

2.13   Where no call connect time is recorded, the earliest available time should be used for the clock start, such as the first key stroke of the keyboard.

2.14   It is recommended that all Trusts achieve a minimum call connect capture of 85% on public 999 calls.

3   HQU03_1_1_5: Red 1 95th centile response time

3.1   The time to respond to Red 1 calls.

Data Definition

3.2   The 95th centile of time from Call Connect of a Red 1 call to an emergency response arriving at the scene of the incident.

3.3   The Red 1 definition, and clock start and stop times, are the same as for HQU03_01a above.

4   HQU03_01b: 8 minute Red 2 response

Detailed Descriptor

4.1   Improved health outcomes from ensuring a defibrillator and timely response to immediately life-threatening ambulance calls.

Data Definition

4.2   **HQU03_1_1_6:** The number of Red 2 calls resulting in an emergency response arriving at the scene of the incident within 8 minutes: A response within eight minutes means eight minutes zero seconds or less.

4.3   **HQU03_1_1_7:** The number of Red 2 calls resulting in an emergency response arriving at the scene of the incident: If there have been multiple calls to a single incident, only one incident should be recorded.

4.4   Incidents involving patients with life-threatening conditions that are less time-critical than those categorised as a Red 1, are categorised as Red 2 incidents. They require an emergency response arriving at the scene of the incident within 8 minutes and zero seconds of clock start. The 8 minute response standard should be achieved in a minimum of 75% of the total Red 2 incident volume.

Clock start

4.5   For Red 2 calls, the clock starts the earliest of:

- The call is coded as a Red 2 incident (following establishment of chief complaint or disposition) or;
- The first resource is assigned or;
- 60 seconds from the point that the call is connected to the Emergency Operations Centre (EOC) telephony switch (T0). For Trusts participating in the Ambulance Response Programme (ARP) that started in 2015, this time will vary as authorised by the NHS England ARP Expert Clinical Advisory Group.

4.6   For Red 2 calls connected electronically, including NHS 111 calls through Interoperability Toolkit (ITK), and calls electronically transferred from another Trust's Computer-Aided Dispatch (CAD) system, the clock will start immediately at the point that the call presents to the Trust's EOC CAD.

Clock stop

4.7 The clock stops when the first Ambulance Service-dispatched emergency responder arrives at the scene of the incident.

4.8 A legitimate clock stop position can include the response arriving at a pre-arrival rendezvous point when one has been determined as appropriate for the safety of ambulance staff in agreement with the control room. For example, a rendezvous point could be agreed for the following situations:

- Information has been received relating to the given location that a patient or bystander is violent, and police or other further assistance is required;
- Information has been received that the operational incident, because of its nature, is unsafe for ambulance staff to enter.

4.9 For the purposes of the 8 minute Red 2 standard, an emergency response that will achieve clock stop occurs when:

- A fully equipped Trust Ambulance (Land or Air), with ambulance staff trained to delivered clinical care to patient(s) at the scene of an incident, arrives within a 200 metre geo-fence of the patient (if tracked); or such an ambulance confirms arrival at scene through an updated status message via the MDT in the vehicle, or a clinician confirming verbally to the EOC that they are on scene;
- A fully equipped RRV, motorbike or cycle, or Blue Light Response Officer, if tracked, arrives within a 200 metre geo-fence of the patient; or the RRV confirms arrival at scene through an updated status message via the MDT in the vehicle, or a clinician confirming verbally to the EOC that they are on scene;
- An approved CFR or an approved Co-Responder (for example, Fire Service Responder, Mountain Rescue) equipped with a defibrillator arrives within a 200 metre geo-fence (if tracked) of the patient; or the CFR confirms arrival at scene through an updated status message via the MDT in the vehicle, or a CFR confirming verbally to the EOC that they are on scene;
- An ambulance resource commissioned to work on behalf of the Trust, who is deployed by the Trust, working to the Trust Policies and Procedures, on a fully equipped ambulance with qualified staff on board (for example, PAS or VAS), arrives within a 200 metre geo-fence (if tracked) of the patient; or the clinician confirms arrival at scene through an updated status message via the MDT in the vehicle, or a clinician confirming verbally to the EOC that they are on scene;
- A static site defibrillator (formerly known as static PAD), located at the address of the Red 2 incident, is confirmed as being on site, at the patient's side, with someone there who is willing to use it, where both questions are confirmed by an EOC Call Assessor;
- A CPAD is confirmed as having been brought to the patient's side with someone there who is willing to use it, with both questions confirmed by an EOC Call Assessor (if only a single rescuer is with the patient, they must stay with the patient, and not leave the patient unattended to collect the defibrillator);

- An approved first responder such as a Doctor or other HCP is with the patient, and is equipped with a defibrillator, where the question is confirmed by the EOC Call Assessor.

4.10   Once a category (Red or Green) is determined, reporting must remain against the code that was in place within the CAD record prior to the arrival of a first response on scene. It must not be changed after a resource has arrived at scene.

4.11   It may be appropriate for some 999 calls to receive additional clinical assessment that may result in an alternative category, prior to the arrival of the responding resource. This additional assessment must be undertaken by a registered HCP (paramedic, specialist paramedic, Nurse Practitioner or Doctor) within the clinical Hub or EOC.

4.12   All calls that have been passed from NHS 111 as requiring a Red 2 ambulance response, either electronically or manually, should be included in this indicator, and must not be re-triaged.

4.13   No CPAD or static site defibrillator can automatically stop the clock through auto assign or geofenced allocation functions.

4.14   If a responding resource is asked to head towards the location of an incident, it must be allocated to the incident on the CAD, therefore registering the correct clock start point.

4.15   Where no call connect time is recorded, the earliest available time should be used in the calculation of the clock start, such as the first key stroke of the keyboard.

4.16   It is recommended that all Trusts achieve a minimum call connect capture of 85% on public 999 calls.

4.17   A running call is defined as when at the point of first contact with a patient, there is limited or no information from which to derive a code.

4.18   Running calls can be in two forms:

- The Trust resources or clinicians come across an incident and are immediately on scene with that patient;
- Where a Trust resource arrives on scene before triage is complete and the call is not coded.

4.19   All running calls are categorised as Red 2 and have the same parameters that start and stop the clock as for Red 2 incidents detailed above.

5   HQU03_01c: 19 minute Red transportation response

Detailed Descriptor

5.1   Patient outcomes can be improved by ensuring patients with immediately life-threatening conditions receive a response at the scene, which is able to transport the patient, in a clinically safe manner, if they require such a response.

Data Definition

5.2   **HQU03_1_2_1**: The number of Red calls resulting in an ambulance arriving at the scene of the incident within 19 minutes: The total number of Red 1 and

Red 2 incidents that resulted in a fully equipped ambulance vehicle (car or ambulance) able to transport a patient, in a clinically safe manner, arriving at the scene of the incident, within 19 minutes of the request being made. A response within 19 minutes means 19 minutes 0 seconds or less.

5.3   **HQU03_1_2_2:** The number of Red calls resulting in an ambulance arriving at the scene of the incident: The total number of Red 1 and Red 2 incidents which resulted in a fully equipped ambulance vehicle (car or ambulance) able to transport a patient, in a clinically safe manner, arriving at the scene of the incident.

5.4   The 19 minute Red transportation standard should be achieved, irrespective of location, in 95% of cases.

Clock start

5.5   If a non-conveying vehicle arrives on the scene and requests backup from a fully equipped ambulance vehicle (car or ambulance) able to transport the patient, in a clinically safe manner, when none has yet been assigned, the clock starts at the point of this request.

5.6   Otherwise, the clock start is according to the appropriate Red 1 (HQU03_01a) or Red 2 (HQU03_01b) rules above.

Clock stop

5.7   The clock stops when any one of the following resource types arrive:

- A fully equipped Trust Ambulance (Land or Air) with clinical staff on board arrives within a 200 metre geo-fence of a patient (if tracked), or the ambulance confirms arrival at scene through an updated status message via the MDT in the vehicle, or the clinician confirms verbally to the EOC that they are on scene;
- A fully equipped RRV with a clinician on board, capable of transporting a patient, arrives within a 200 metre geo-fence (if tracked) of the patient, or the RRV confirms arrival at scene through an updated status message via the MDT in the vehicle, or the clinician confirms verbally to the EOC that they are on scene;
- An ambulance resource commissioned to work on behalf of the Trust, who is deployed by the Trust, working to the Trust Policies and Procedures, on a fully equipped ambulance with qualified staff on board (for example, PAS or VAS), arrives within a 200 metre geo-fence (if tracked) of the patient; or the clinician confirms arrival at scene through an updated status message via the MDT in the vehicle, or a clinician confirming verbally to the EOC that they are on scene.

5.8   A legitimate clock stop position can include one of the above resource types arriving at a pre-arrival rendezvous point when one has been determined as appropriate for the safety of ambulance staff in agreement with the control room. For example, a rendezvous point could be agreed for the following situations:

- Information has been received relating to the given location that a patient or bystander is violent, and police or other further assistance is required;

- Information has been received that the operational incident, because of its nature, is unsafe for ambulance staff to enter.

5.9 Only the first ambulance response to arrive at the scene of the incident should be included, where more than one ambulance response has been despatched.

5.10 Once the category Red is determined, reporting must remain against the code that was in place within the CAD record prior to the arrival of a first response on scene. It must not be changed after a resource has arrived at scene.

5.11 All calls that have been passed from NHS 111 as requiring a Red ambulance response either electronically or manually should be included in this indicator and must not be re-triaged.

5.12 It is recommended that all Trusts achieve a minimum call connect capture of 85% on public 999 calls.

5.13 Where no call connect time is recorded, the earliest available time should be used for the clock start, such as the first key stroke of the keyboard.

Monitoring Data Source

5.14 Ambulance CAD system.

6 SQU03_01: Call Abandonment Rate

Detailed Descriptor

6.1 The percentage of emergency and urgent calls abandoned before the call was answered and rings for more than 5 seconds. This will ensure that abandonment before automatic call distribution does not distort the reporting of patient experience.

Data Definition

6.2 **SQU03_1_1_1:** Number of emergency calls abandoned before the call was answered and rings for more than 5 seconds.

6.3 **SQU03_1_1_2:** Total number of emergency and urgent calls presented to switchboard.

6.4 If there have been multiple calls to an incident, all calls should be recorded in this line.

6.5 From 01 April 2007, all "urgent" calls have been prioritised and categorised in the same way as emergency calls. These "urgent" calls should be included in both the numerator and denominator for this indicator.

6.6 Calls that have been passed electronically from NHS 111 as requiring an ambulance response should not be included in this indicator.

6.7 Calls that have been passed manually via telephone from NHS 111 as requiring an ambulance response should be included in this indicator.

Monitoring Data Source

6.8 Ambulance telephony system.

7   SQU03_02: Re-Contact Rate Following Discharge of Care

Detailed Descriptor

7.1   Unplanned re-contact with the ambulance service within 24 hours of discharge of care (discharge by clinical telephone advice, or following treatment at the scene).

Data Definition

SQU03_2a: Re-contact rate following discharge of care by telephone

7.2   **SQU03_2_1_1**: Emergency calls closed with telephone advice where re-contact occurs within 24 hours: Emergency calls closed with telephone advice where re-contact with the ambulance service via 999 occurs from the same location and patient gender within 24 hours of time of discharge of the initial call.

7.3   **SQU03_2_1_2:** Emergency calls closed with telephone advice: Number of successfully completed emergency calls that have been resolved (that is, where advice has been given with any appropriate action agreed with the patient), with no resource arrived at the scene of the incident, by:

- a designated HCP accountable to the Trust providing telephone advice only, or;
- calls dealt with by an HCP accountable to the Trust, or;
- call dealt with through decisions supported by clinical decision support software, or;
- calls passed to another organisation working with the Trust through an agreed contract or Service Level Agreement, or Directory of Services.

7.4   Only count one re-contact per 24 hours. This indicator should capture the number of individual patients (identified by same location and patient gender) who re-contact 999 within 24 hours of their initial call.

7.5   All locations should be captured within this indicator. There should be no exclusions for non-residential addresses or events.

7.6   If the patient's gender is unknown on the re-contact, it should be included, to ensure no patients are missed.

7.7   The second call from the patient (the re-contact) cannot count as the primary contact for a further call.

7.8   All calls that have been passed from NHS 111 as requiring an ambulance response either electronically or manually should not be included in this indicator.

7.9   From 01 April 2007, all "urgent" calls have been prioritised and categorised in the same way as emergency calls. However, these "urgent" calls should not be included with data for emergency calls for this indicator.

Exclusions for SQU03_2a

7.10   This indicator measures patients re-contacting 999 within 24 hours of original emergency call; the following calls should be excluded from the numerator:

- Re-contact for different patient

- Patients transported after first attendance on scene

7.11 Re-contact rates are based on address and gender information, rather than patient level information. Therefore it should be noted that data may not be available for:

- patients calling from public places;
- patients calling from locations not in their own home for first contact.

SQU03_2b: Re-contact, following discharge of care from treatment at the scene

7.12 **SQU03_2_2_1:** Patients treated and discharged on scene where re-contact occurs within 24 hours: Patients treated and discharged on scene where re-contact with the ambulance service via 999 occurs from the same location and patient gender within 24 hours of time of their initial call.

7.13 **SQU03_2_2_2:** Patients treated and discharged on scene: Number of patients treated at the scene only.

7.14 Only count one re-contact per 24 hours. This indicator should capture the number of individual patients (identified by same location and patient gender) who re-contact 999 within 24 hours of their initial call.

7.15 All addresses should be captured within this indicator. There should be no exclusions for non-residential addresses or events.

7.16 If the patient's gender is unknown on the re-contact, it should be included, to ensure no patients are missed.

7.17 The second call from the patient (the re-contact) cannot count as the primary contact for a further call.

7.18 All calls that have been passed from NHS 111 as requiring an ambulance response either electronically or manually should not be included in this indicator.

7.19 From 01 April 2007, all "urgent" calls have been prioritised and categorised in the same way as emergency calls. However, these "urgent" calls should not be included with data for emergency calls for this indicator.

Exclusions for SQU03_2b

7.20 This indicator measures patients re-contacting 999 within 24 hours of original emergency call; the following calls should be excluded from the numerator:

- Re-contact for different patient
- Patients transported after first contact

7.21 Re-contact rates are based on address and gender information, rather than patient level information. Therefore it should be noted that data may not be available for:

- patients calling from public places;
- patients calling from locations not in their own home for first contact.

SQU03_2c: Proportion of emergency calls from patients for whom a locally agreed frequent caller procedure is in place

7.22 **SQU03_2_3_1:** Emergency calls from patients for whom a locally agreed frequent caller procedure is in place.

7.23 Emergency calls from patients for whom a frequent caller procedure is in place should be reported, and the narrative explanation of performance for this component of the indicator should refer to what actions the trust is taking to manage and provide an appropriate clinical service to these frequent callers.

7.24 Frequent caller procedures should be locally determined; these procedures should relate to individual patients, and be agreed with that individual and the main care provider (for example, GP, Mental Health Service).

7.25 A frequent caller is defined as someone aged 18 or over who makes five or more emergency calls related to individual episodes of care in one month, or 12 or more emergency calls related to individual episodes of care in three months.

7.26 Individuals aged 17 or under are not included because they should be managed by the relevant safeguarding team. Where services identify a frequent caller who is 17 or under, they should be referred to safeguarding and excluded from this indicator because they are likely to require a different risk assessment and management plan.

7.27 **SQU03_2_3_2:** Total number of emergency calls: Number of emergency calls presented to switchboard.

7.28 The following calls should be excluded from the numerator and denominator of this indicator:

- Duplicate or multiple calls to an incident where a response has already been activated;
- Hang-ups before coding is complete;
- Caller not with patient and unable to give details;
- Caller refuses to give details;
- Hoax calls where response not activated;
- Response cancelled before coding is complete (for example, patient recovers).

7.29 This line is identical to SQU03_1_1_2.

Monitoring Data Source

7.30 Ambulance CAD system.

8 SQU03_08: Time to Answer Call

Detailed Descriptor

8.1 The time to answer calls (emergency and urgent) in seconds.

Data Definition

8.2 **SQU03_8_1_1:** Time to call answer, measured by median, 95th centile and 99th centile:

- median time spent between Call Connect and call answer (that is, the time below which 50% of calls were answered);
- 95th centile of times from Call Connect and call answer (that is, the time below which 95% of calls were answered);
- 99th centile of times from Call Connect and call answer (that is, the time below which 99% of calls were answered).

8.3   Call Connect refers to the time at which the call is presented to the control room telephone switch.

8.4   From 01 April 2007, all "urgent" calls have been prioritised and categorised in the same way as emergency calls. These "urgent" calls should be included with data for emergency calls for this indicator.

8.5   Exclude calls that are abandoned before being answered.

8.6   The call answer time is T1, that is, when an operator begins communicating with a caller. Answerphones should not be used on 999 calls.

8.7   Where no call connect time is recorded, the call should be treated as having a time-to-call-answer of zero seconds.

8.8   Calls that have been passed electronically from NHS 111 as requiring an ambulance response should not be included in this indicator.

8.9   Calls that have been passed manually via telephone from NHS 111 as requiring an ambulance response should be included in this indicator.

Monitoring Data Source

8.10   Ambulance telephony system.

9   SQU03_09: Time to Treatment

Data Definition

9.1   **SQU03_9_1_1:** Time to arrival of ambulance-dispatched health professional, for immediately life-threatening Red 1 and Red 2 calls, measured by median, 95th centile and 99th centile:

- median time to arrival of an ambulance-dispatched health professional (that is, the time below which 50% of incidents reported the arrival of an ambulance-dispatched health professional);
- 95th centile of times to arrival of an ambulance-dispatched health professional (that is, the time below which 95% of incidents reported the arrival of an ambulance-dispatched health professional; so "95% of incidents reported the arrival of an ambulance-dispatched health professional within [x] minutes");
- 99th centile of times to arrival of an ambulance-dispatched health professional (that is, the time below which 99% of incidents reported the arrival of an ambulance-dispatched health professional, so "99% of incidents reported the arrival of an ambulance-dispatched health professional within [x] minutes").

9.2   The clock start is according to the appropriate Red 1 (HQU03_01a) or Red 2 (HQU03_01b) rules above.

9.3   This clock start position reflects this indicator's aim to:

- Ensure the appropriate resource is dispatched to meet the clinical needs of the patient (that is, chief complaint information is obtained);
- Avoid perverse incentives to dispatch HCPs to all calls regardless of the clinical need of the patient (that is, clock start of chief complaint, rather than Call Connect / call presented to ambulance control room telephone switch);
- Maintain best practice in timely handling and answering of ambulance calls (that is, clock start is capped at 60 seconds following presentation of the call to the ambulance control room telephone switch).

9.4 Only Red 1 and Red 2 (immediately life-threatening) calls should be used for analysis. Any "urgent" calls from an HCP which are categorised as Red 1 or Red 2 should be included with data for emergency calls for this indicator.

9.5 HCPs include Doctors, Paramedics, Nurse or Ambulance Technicians accountable to, and / or dispatched by, the Ambulance Trust.

9.6 This definition of HCP excludes Emergency Care Support Workers, Emergency Care Assistants, Community First Responders, and static defibrillator sites. Therefore calls that are not closed by HCPs (as defined above) attending the scene should be excluded from this indicator.

9.7 This is to be reported in minutes, so 4 minutes 30 seconds would be reported as 4.5 minutes.

9.8 All calls that have been passed from NHS 111 as requiring a Red 1 or Red 2 ambulance response either electronically or manually must be included in this indicator.

9.9 Where no call connect time is recorded, the earliest available time should be used in the calculation of the clock start, such as the first stroke of the keyboard, as in HQU03_01a and HQU03_01b above.

Monitoring Data Source

9.10 Ambulance CAD system.

10 SQU03_10: Ambulance calls closed with telephone advice or managed without transport to A&E (where clinically appropriate)

Detailed Descriptor

10.1 Measure the proportion of patients managed appropriately without the need for an ambulance response at the scene, or onward transport to Type 1 and Type 2 A&E departments (www.datadictionary.nhs.uk/data_dictionary/attributes/a/acc/accident_and_emergency_department_type_de.asp).

Data Definition

SQU03_10a: Hear and Treat

10.2 **SQU03_10_1_1:** Number of emergency calls that have been resolved by providing telephone advice: Number of successfully completed emergency calls that have been resolved (that is, where advice has been given with any appropriate action agreed with the patient), with no face-to-face resource, by

- a designated HCP accountable to the Trust providing telephone advice only, or;

- calls dealt with by an HCP accountable to the Trust, or;
- call dealt with through decisions supported by clinical decision support software, or;
- calls passed to another organisation working with the Trust through an agreed contract or Service Level Agreement, or Directory of Services.

10.3 Include emergency incidents resolved by one of the above options where a vehicle is dispatched but stood down before arrival, **and not** with a stop code of:

- Duplicate;
- Cancelled;
- Abandoned; or
- Information only (no clinical information).

10.4 **SQU03_10_1_2:** All emergency calls that receive a telephone or face-to-face response from the ambulance service at the scene of the incident

Exclusions

10.5 The following calls should be excluded from the numerator and denominator of this indicator:

- Calls where a face-to-face contact and likely transport has been pre-determined, from HCP calls, whether urgent or immediate (because no such calls can currently be re-triaged for an alternative outcome such as hear and treat);
- Duplicate or multiple calls to an incident where a response has already been activated;
- Hang-ups before coding is complete;
- Caller not with patient and unable to give details;
- Caller refuses to give details;
- Hoax calls where response not activated;
- Response cancelled before coding is complete (for example, patient recovers).

10.6 All calls that have been passed from NHS 111 as requiring an ambulance response either electronically or manually should not be included in this indicator.

10.7 From 01 April 2007, all "urgent" calls have been prioritised and categorised in the same way as emergency calls. However, these "urgent" calls should not be included with data for emergency calls for this indicator.

SQU03_10b

10.8 **SQU03_10_2_1:** Patient journeys to a destination other than Type 1 and Type 2 A&E, plus number of patients discharged after treatment at the scene or onward referral to an alternative care pathway: Emergency only.

10.9 **SQU03_10_2_2:** All emergency calls that receive a face-to-face response from the ambulance service.

10.10 Each incident conveyed is counted as an individual transport. Number of incidents without requiring onward conveyance is counted as an individual

treated at the scene. Trusts should include only those patients conveyed as a result of an emergency call made by a member of the public or organisation.

10.11 It should be noted that the activity currency is a single incident even though it may result in more than one patient journey.

10.12 Emergency patient journeys to a destination other than Type 1 and Type 2 A&E: Include those incidents which result in an emergency patient journey to all other destinations other than Type 1 or Type 2 A&E departments. An example of this could be conveying a patient to a minor injuries unit or a Walk-in Centre, a specialist stroke or cardiac centre, GP service or any other health or social care service.

10.13 Treatment at the scene:

10.14 Include those incidents where patients were treated at the scene by the ambulance service and as a result of that treatment no patients required onward transportation for further treatment. If, as part of that treatment, the Ambulance Service staff arranged, for example, an appointment for the patient at a GP surgery or a follow-up home visit from a health professional, that should also be counted as treatment at the scene. Responses where ambulance trust staff attended an incident and advice was given, but no clinical intervention was necessary with no onward transportation required, should also be included as treatment at the scene.

10.15 From 01 April 2007, all "urgent" calls have been prioritised and categorised in the same way as emergency calls. However, these "urgent" calls should not be included with data for emergency calls for this indicator.

10.16 Calls from an HCP should be excluded from this indicator because a likely transport and destination has been pre-determined, whether urgent or immediate, as none of these calls can be transported to an alternative destination or treated at scene.

10.17 All calls that have been passed from NHS 111 as requiring an ambulance response either electronically or manually should be included in this indicator

Monitoring Data Source

10.18 Ambulance CAD system.

11 SRS17_1_1_1: Number of Transported Incidents

Detailed Descriptor

11.1 The number of emergency and urgent incidents resulting in a patient being transported to Type 1 & Type 2 A&Es.

Data Definition

11.2 Include only those incidents which resulted in a patient being conveyed as a result of an emergency call made by a member of the public or organisation, or as a result of being categorised as requiring an emergency response following a referral by an HCP or electronically transferred to the CAD system from another CAD system.

11.3 Journeys without patients should be excluded.

11.4 All calls that have been passed from NHS 111 as requiring an ambulance response either electronically or manually should be included in this indicator.

11.5 From 01 April 2007, all "urgent" calls have been prioritised and categorised in the same way as emergency calls. These "urgent" calls should be included with data for emergency journeys for this indicator.

Monitoring Data Source

11.6 Ambulance CAD system.

12 Additional Guidance on Systems Indicators

12.1 The AQI's apply equally to calls originating via 999 and originating from 112.

12.2 Ambulance attendance at an event, whereby the activity can be included in the AQI, requires:

- A partner organisation, in attendance at a planned event at which an incident occurs, with whom the Service has an overarching agreement (such as a Service Level Agreement (SLA), Memorandum of Understanding (MOU) or Event Plan);
- **Or** a partner organisation, in attendance at an incident where the plan for the planned event (for example, a sporting event), has been signed off by the Ambulance Service, and the Ambulance Service have the normal command input in place;
- **Or** an emergency vehicle, belonging to the Trust, or the organisation a SLA / MOU is held with, attends a patient.

12.3 Reporting on subsequent calls with a different priority from the original call:

- If a further call is received from any source (HCP or public 999) and is triaged to a higher category than the original call, then the clock start should be from the upgrading call. If a Green call is subsequently upgraded to Red, the clock start from the upgrading call will apply, as stated in HQU03_01a (Red 1) or HQU03_01b (Red 2) as appropriate.
- If a further call is received from any source (HCP or public 999) and is triaged to a lower category than the original call, then the new incident should be the time of start for the downgraded call. If a Red call is subsequently downgraded to Green, the clock start from the downgrading call will apply. Only a registered HCP is able to agree a downgrade of call, through a telephone call to the EOC, and before a resource has arrived on scene.
- In both scenarios above, the original call is then closed as a duplicate call to avoid double counting.

12.4 Cross Border Calls:

- The performance reporting for an incident should sit with the Trust in the area in which the incident occurs, unless there is a reciprocal agreement around certain border areas.

Glossary of Terms

Static Site

12.5   A location which contains an Automated External Defibrillator (AED) and other first responder equipment, and where the staff have been trained by the Ambulance Service. The location is logged in Ambulance Control and these sites are activated by the Ambulance Service for incidents at their location. Some sites can respond outside their main location, depending on the agreement with the Ambulance Service. The Ambulance Service undertakes update training for the staff and manages the governance.

Community Public Access Defibrillator (CPAD)

12.6   An AED at a location which is accessible by the general public, such as a train station platform, in unlocked or locked cabinet. These are designed for untrained members of the public to access in the event of an arrest at or near the location.

Part 2 – Clinical Indicators

13 SQU03_03: Outcome from Cardiac Arrest – Return of Spontaneous Circulation

Detailed Descriptor

13.1 Outcome from cardiac arrest, measured by return of spontaneous circulation (ROSC) at point of arrival of the patient at hospital. Recording of ROSC at hospital indicates the outcome of the pre-hospital response and intervention.

Data Definition

SQU03_03a: ROSC at time of arrival at hospital (Overall)

13.2 **SQU03_3_1_1:** Of the patients included in the denominator, the number of patients who had return of spontaneous circulation on arrival at hospital.

13.3 Time of arrival refers to point of arrival of the patient at the receiving hospital.

13.4 **SQU03_3_1_2:** All patients who had resuscitation (Advanced or Basic Life Support) commenced / continued by ambulance service following an out-of-hospital cardiac arrest.

SQU03_03b: ROSC at time of arrival at hospital (Utstein Comparator Group)

13.5 **SQU03_3_2_1:** Of the patients included in the denominator, the number of patients who had return of spontaneous circulation on arrival at hospital.

13.6 Time of arrival refers to point of arrival of the patient at the receiving hospital.

13.7 **SQU03_3_2_2:** All patients who had resuscitation (Advanced or Basic Life Support) commenced / continued by ambulance service following an out-of-hospital cardiac arrest of presumed cardiac origin, where the arrest was bystander witnessed and the initial rhythm was Ventricular Fibrillation (VF) or Ventricular Tachycardia (VT).

Monitoring Data Source

13.8 Ambulance Trust data (including clinical and CAD data) collected as per National Ambulance Service Clinical Quality Group guidance and definitions (see Annex A).

14 SQU03_05: Outcome from acute ST-elevation myocardial infarction (STEMI)

Data Definition

SQU03_05b: The percentage of patients suffering a STEMI and who, following direct transfer to a centre capable of delivering primary percutaneous coronary intervention (PPCI), receive primary angioplasty within 150 minutes of emergency call

14.1 **SQU03_5_2_1:** Patients with initial diagnosis of 'definite myocardial infarction' for whom primary angioplasty balloon inflation occurs within 150 minutes of emergency call connected to ambulance service, where first diagnostic Electrocardiogram (ECG) performed is by ambulance personnel and patient was directly transferred to a designated PPCI centre as locally agreed.

14.2 **SQU03_5_2_2:** Patients with initial diagnosis of 'definite myocardial infarction' who received primary angioplasty, where first diagnostic ECG performed is by ambulance personnel and patient was directly transferred to a designated PPCI centre as locally agreed.

Exceptions to SQU03_05b

14.3 Secondary transfers to PPCI from non-PPCI capable hospitals;

14.4 Delay obtaining consent;

14.5 Cardiac arrest;

14.6 Ambulance procedural delay (This includes any pre-hospital delay outside the control of the ambulance service, such as incorrect address, difficulty finding address, unable to gain entry to patient's house, patient reasons (for example initial refusal to go to hospital, or extended domestic arrangements), adverse weather conditions, stabilising the patient, crew had to wait for boat, helicopter delay, wait for police to gain entry, failure to cannulate);

14.7 Sustained hypertension;

14.8 Clinical concern about recent cerebro-vascular event or recent surgery;

14.9 Other exclusions on clinical grounds which have been formally approved in discussions with MINAP.

SQU03_05c: The percentage of patients suffering a STEMI who receive an appropriate care bundle

14.10 **SQU03_5_3_1:** Patients with a pre-hospital diagnosis of suspected STEMI confirmed on ECG who received the STEMI care bundle.

14.11 **SQU03_5_3_2:** Patients with a pre-hospital diagnosis of suspected STEMI confirmed on ECG.

Notes

14.12 Components of the care bundle for STEMI patients, in line with National Ambulance Service Clinical Quality Group guidance, are presented below, with their exceptions in parentheses:

   a. Aspirin given (Patient refusal, contraindication to drug);
   b. Glyceryl trinitrate (GTN) given (Patient refusal, contraindication to drug, no chest pain);
   c. Two pain scores recorded (Patient refusal / Patient unable / Patient unconscious);
   d. Appropriate Analgesia given – Options available are Morphine, Entonox and paracetamol (Patient refusal / Patient not in pain / Contraindication to drug(s)).

Exceptions to SQU03_05c

14.13 An exception to the care bundle can only be counted where there is an exception to the delivery of one or more elements and each of the remaining elements have been delivered.

14.14 The table below sets out examples to illustrate whether a care bundle has been completed, not completed, or whether there is an exception from administering the care bundle.

14.15 Where there is a valid exception to the care bundle, this case should be recorded in both the numerator and the denominator for this indicator.

14.16 The number of such exceptions may be monitored separately and referred to in the narrative for the indicator to share learning (for example, where there are high numbers of exceptions due to patient refusal of an element in the care bundle).

Calculation of care bundle delivery and valid exceptions

Patient ID	Care bundle criterion 1	Care bundle criterion 2	Care bundle criterion 3	Care bundle delivered?
1	✓	✓	✓	Yes
2	✓	✓	x	No
3	✓	Exception	x	No
4	Exception	Exception	x	No
5	✓	✓	Exception	Yes
6	Exception	Exception	✓	Yes
7	Exception	Exception	Exception	Yes

Monitoring Data Source

14.17 SQU03_05b: The percentage of patients suffering a STEMI who are directly transferred to a centre capable of delivering primary percutaneous coronary intervention (PPCI) and receive angioplasty within 150 minutes of emergency call:

14.18 Myocardial Ischaemia National Audit Project (MINAP) data. Acute trusts are required to work and support ambulance trusts in the provision and timely linking of data to ensure that outcome information is captured as accurately, and for as many patients as possible.

14.19 SQU03_05c: The percentage of patients suffering a STEMI who receive an appropriate care bundle:

14.20 Ambulance Trust data collected as per National Ambulance Service Clinical Quality Group guidance and definitions (see Annex A).

15 SQU03_06: Outcome from stroke for ambulance patients

Detailed Descriptor

15.1 SQU03_06a: The percentage of Face Arm Speech Test (FAST) positive stroke patients (assessed face to face) potentially eligible for stroke thrombolysis, who arrive at a hyperacute stroke centre within 60 minutes of emergency call.

15.2 SQU03_06b: The number of patients with symptoms of suspected stroke, or unresolved transient ischaemic attack, assessed face to face who received an appropriate care bundle.

Data Definition

SQU03_06a: The percentage of Face Arm Speech Test (FAST) positive stroke patients (assessed face to face) potentially eligible for stroke thrombolysis, who arrive at a hyperacute stroke centre within 60 minutes of emergency call.

15.3 **SQU03_6_1_1:** FAST positive patients (assessed face to face) potentially eligible for stroke thrombolysis within agreed local guidelines arriving at hospitals with a hyperacute stroke centre within 60 minutes of emergency call connecting to the ambulance service.

15.4 **SQU03_6_1_2:** FAST positive patients (assessed face to face) potentially eligible for stroke thrombolysis within agreed local guidelines.

15.5 Exclusions that may be considered for inclusion in local guidelines:

a. Patient refusal;
b. Complete resolution of symptoms before arrival at stroke centre (transient ischaemic attack, TIA);
c. Advance Directive for refusal of treatment (ADRT);
d. Patients who are not clinically safe for bypass to hyperacute stroke centre (that is, patients with seizures / agitation; Glasgow Coma Scale score below 8; time critical features (airway problem, reduced consciousness).

SQU03_06b: The number of suspected stroke, or unresolved transient ischaemic attack, patients assessed face to face who received an appropriate care bundle.

15.6 **SQU03_6_2_1:** The number of suspected stroke or unresolved transient ischaemic attack patients assessed face to face who received an appropriate care bundle. This refers to patients with a new onset / presentation of suspected stroke symptoms, or unresolved transient ischaemic attack. It does not exclude patients with previous stroke or transient ischaemic attack who have a new onset of symptoms.

15.7 **SQU03_6_2_2:** The number of suspected stroke or unresolved transient ischaemic attack patients assessed face to face. This refers to patients with a new onset / presentation of suspected stroke symptoms, or unresolved transient ischaemic attack. It does not exclude patients with previous stroke or transient ischaemic attack who have a new onset of symptoms.

Notes

15.8 Components of the care bundle for suspected stroke or unresolved transient ischaemic attack patients, in line with National Ambulance Service Clinical Quality Group guidance, are presented below, with their exceptions in parentheses:

a. FAST assessment recorded (Patient unable / patient declined);
b. Blood glucose recorded (Patient refusal);
c. Systolic and diastolic blood pressure recorded (Patient refusal / Time critical features (airway problem, reduced consciousness)).

Exceptions to SQU03_06b

15.9 An exception to the care bundle can only be counted where there is an exception to the delivery of one or more elements and each of the remaining elements have been delivered.

15.10 The table below sets out examples to illustrate whether a care bundle has been completed, not completed, or whether there is an exception from administering the care bundle.

15.11 Where there is a valid exception to the care bundle, this case should be recorded in both the numerator and the denominator for this indicator.

15.12 The number of such exceptions may be monitored separately and referred to in the narrative for the indicator to share learning (for example, where there are high numbers of exceptions due to patient refusal of an element in the care bundle).

Calculation of care bundle delivery and valid exceptions

Patient ID	Care bundle criterion 1	Care bundle criterion 2	Care bundle criterion 3	Care bundle delivered?
1	✓	✓	✓	Yes
2	✓	✓	x	No
3	✓	Exception	x	No
4	Exception	Exception	x	No
5	✓	✓	Exception	Yes
6	Exception	Exception	✓	Yes
7	Exception	Exception	Exception	Yes

Potential eligibility for thrombolysis

15.13 Trusts are encouraged to clearly define their local criteria for determining eligibility for thrombolysis (including local exclusions), and this information may be referred to in the narrative for this indicator.

Monitoring Data Source

15.14 SQU03_06a: The percentage of Face Arm Speech Test (FAST) positive stroke patients (assessed face to face) potentially eligible for stroke thrombolysis, who arrive at a hyperacute stroke centre within 60 minutes of emergency call:

15.15 Ambulance Trust data (including clinical and CAD data) collected as per National Ambulance Service Clinical Quality Group guidance and definitions (see Annex A).

15.16 SQU03_06b: The percentage of suspected stroke or unresolved transient ischaemic attack patients (assessed face to face) who receive an appropriate care bundle:

15.17 Ambulance Trust data collected as per National Ambulance Service Clinical Quality Group guidance and definitions (see Annex A).

16 SQU03_07: Outcome from cardiac arrest – Survival to discharge

Detailed Descriptor

16.1 SQU03_07a: Survival to discharge – Overall survival rate.

16.2 SQU03_07b: Survival to discharge – Utstein Comparator Group survival rate.

16.3 This survival to discharge measure reflects the effectiveness of the whole urgent and emergency care system in managing out of hospital cardiac arrest.
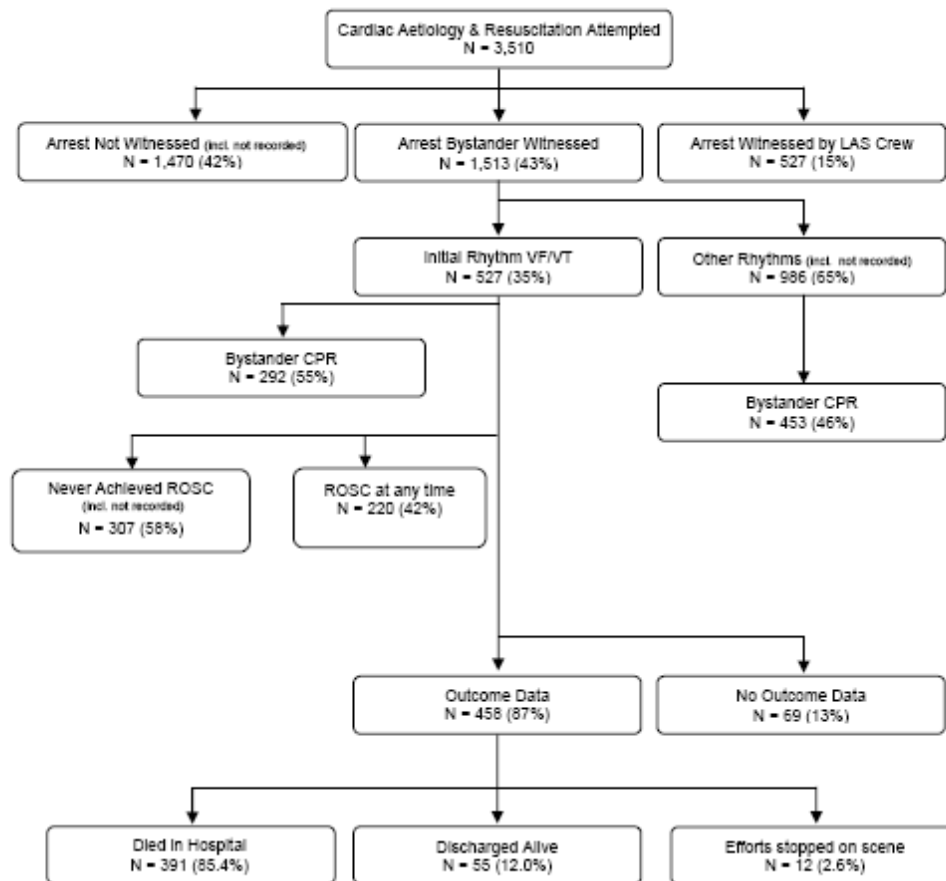
Data Definition

SQU03_07a: Survival to discharge – Overall survival rate

16.4 **SQU03_7_1_1:** Of the patients included in SQU03_7_1_2, the number of patients discharged from hospital alive.

16.5 **SQU03_7_1_2:** All patients who had resuscitation (Advanced or Basic Life Support) commenced / continued by ambulance service following an out-of-hospital cardiac arrest.

SQU03_07b Survival to discharge – Utstein Comparator Group survival rate

16.6 **SQU03_7_2_1:** Of the patients included in SQU03_7_2_2, the number of patients discharged from hospital alive

16.7 **SQU03_7_2_2:** All patients who had resuscitation (Advanced or Basic Life Support) commenced / continued by ambulance service following an out-of-hospital cardiac arrest of presumed cardiac origin, where the arrest was bystander witnessed and the initial rhythm was VF or VT.

16.8 The denominator and numerator for this indicator should exclude patients for whom outcome data was not available. For example, the diagram below sets out that the value for lines SQU03_7_2_1 should be 55 patients and the value for line SQU03_7_2_2 would be 458 rather than 527, as no outcome data was available for 69 patients who otherwise should have been included in the denominator.

```
                    ┌──────────────────────────────────────┐
                    │  Cardiac Aetiology & Resuscitation    │
                    │           Attempted                   │
                    │           N = 3,510                   │
                    └──────────────────────────────────────┘
```

| Arrest Not Witnessed (incl. not recorded) N = 1,470 (42%) | Arrest Bystander Witnessed N = 1,513 (43%) | Arrest Witnessed by LAS Crew N = 527 (15%) |

Initial Rhythm VF/VT N = 527 (35%) — Other Rhythms (incl. not recorded) N = 986 (65%)

Bystander CPR N = 292 (55%)

Bystander CPR N = 453 (46%)

Never Achieved ROSC (incl. not recorded) N = 307 (58%) — ROSC at any time N = 220 (42%)

Outcome Data N = 458 (87%) — No Outcome Data N = 69 (13%)

| Died In Hospital N = 391 (85.4%) | Discharged Alive N = 55 (12.0%) | Efforts stopped on scene N = 12 (2.6%) |

Utstein Survival Rate: (55/458) = 12.0%

Reproduced from London Ambulance Service: Cardiac Arrest Annual Report: 2007/08

Monitoring Data Source

16.9   Survival to discharge information will be obtained from clinical and operational information from ambulance trust records, and data obtained from national databases and hospital sources as per National Ambulance Service Clinical Quality Group guidance and definitions (see Annex A).

16.10 Although the denominators for the survival to discharge indicator (that is, lines SQU03_7_1_2 and SQU03_7_2_2) have the same definition as the denominators in the SQU03_03 Return of Spontaneous Circulation indicator (that is, SQU03_3_1_2 and SQU03_3_2_2) it should be noted that the values of the denominators in the survival to discharge indicator may be lower as outcome data may not be obtained from acute trusts for all patients. Acute trusts are required to work and support ambulance trusts in the provision and timely linking of data to ensure that outcome information is captured as accurately, and for as many patients as possible.

16.11 Trusts are encouraged to use the narrative section for this indicator to set out the number of patients for whom full outcome data were not obtained, and to provide information on why these data could not be obtained.

17 SQU03_04: Service Experience (Not collected in Unify2)

Detailed Descriptor

17.1 Narrative on how the experience of users of the ambulance service is captured, what the results were, and what has been done to improve the design and delivery of services in light of the results.

Data Definition

17.2 There is no one definitive data source or method for understanding the experience of service users. Ambulance services have therefore been given the flexibility to develop and commission the methods they feel are most appropriate for understanding and assessing the experience of their users.

17.3 However this indicator should include a qualitative understanding and description of user experience, and should not be restricted to reporting quantitative measures of user satisfaction from questionnaires. This indicator aims to ensure that the health needs and issues which matter most to patients (in all call categories), such as timeliness and being treated with dignity, are being effectively met.

17.4 Providers are expected to provide a narrative which sets out:

a. What work they have undertaken to understand and assess the experience of a wide and representative range of patients, carers and staff, reflecting the 24 hour nature of the service, over the whole of the previous quarter;
b. What the results of these assessments were;
c. What has been done to improve services in light of these results;
d. What the outcome has been in terms of improved user experience.

17.5 It is important that all four components of the narrative are completed. For example, it is not enough to note that user have been asked "Were you treated with dignity and respect?" or that discovery interviews have been conducted (Component 1); or to report the percentage of users reporting dissatisfaction on this measure, or anonymised narrative information summarising the interviews (Component 2); providers should also say what they have done to improve services (Component 3), and what the outcome was in terms of users reporting an improvement on this particular aspect of their care (Component 4).

Basis for Accountability

17.6 This data will be reported for all Ambulance Trusts at a Trust-wide level.

Collection Information

17.7 Level: Ambulance Trusts

17.8 Basis: Provider

17.9 Returns:

Monitoring Data Source

17.10 Please see data definitions section.

Annex A

The technical guidance for the Ambulance Clinical Outcomes indicators is linked below.

ACQI Technical Guidance