

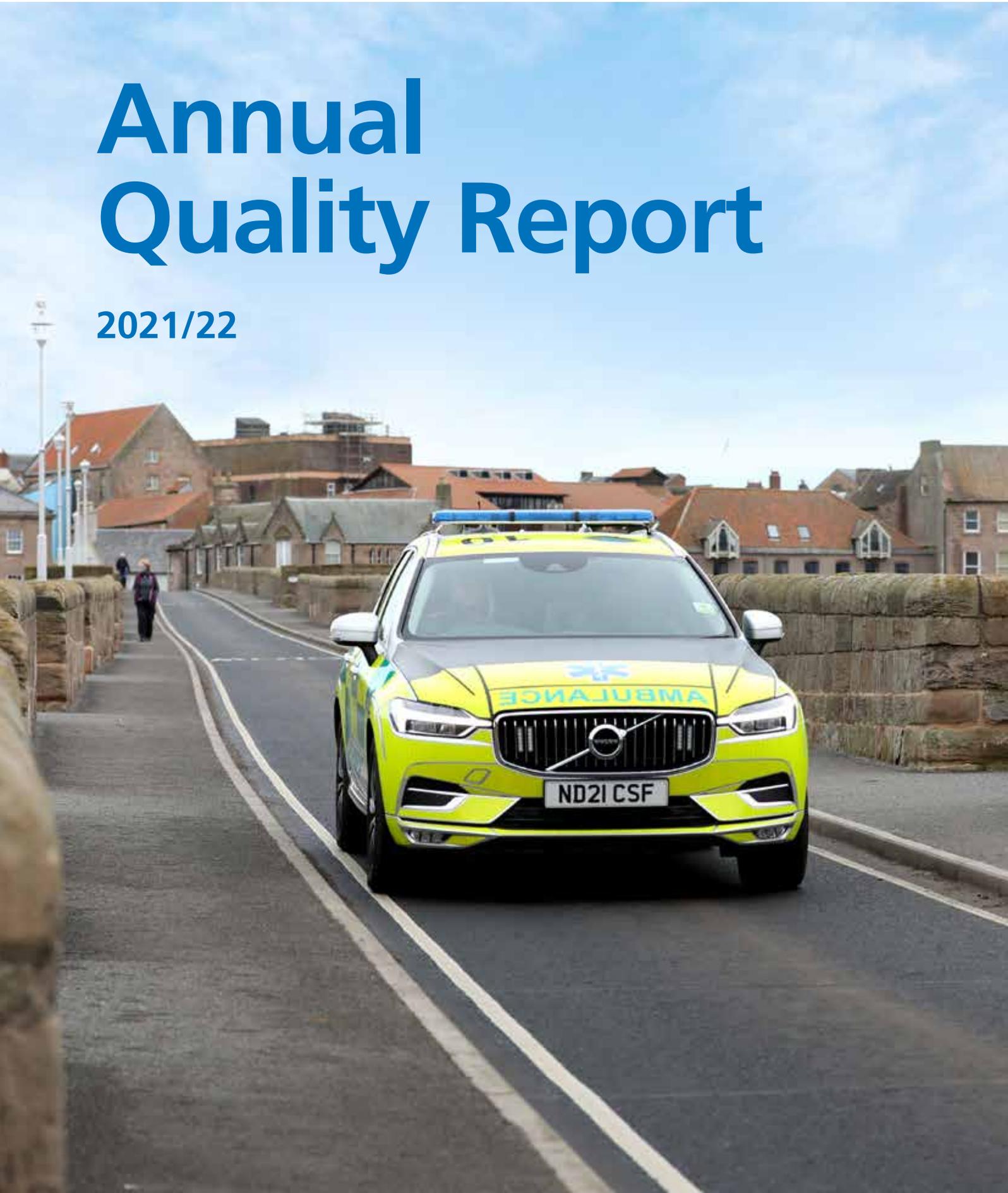
NHS

North East
Ambulance Service
NHS Foundation Trust



Annual Quality Report

2021/22



About us

At NEAS we provide an unscheduled care service to respond to 999 calls and a scheduled care service which offers pre-planned non-emergency patient transport in the region.

We operate NHS111 for our region which is supported by a clinical assessment service, providing clinical support to health advisors and patients ringing 111 and 999. These services are supported by our operations centres based in Newburn, Hebburn and Billingham, managing

more than 1.5 million calls per year. We also deliver specialist response services through our Hazardous Area Response Team (HART) who deal with hazardous untoward incidents

Our Mission:
Safe, effective, responsive care for all

Our Vision:
Unmatched quality of care

Our 2022/23 Quality Priorities

Safety	Clinical Effectiveness	Patient Experience
Working with system partners to reduce handover delays	Learn from incidents and prepare for PSIRF	Use our resources as efficiently as possible
		Involve our patients and communities to improve care

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Statement from the Chief Executive

I am delighted to introduce the North East Ambulance Service (NEAS) 2021/22 Quality Report which demonstrates our commitment to the continued delivery of high quality patient focused care over the past year.

It's hard to believe in my statement last year that I wrote about the challenges being faced by the COVID-19 pandemic and at that time we were starting to see some positive recovery. However, as we all know the Omicron variant of COVID-19 arrived and we saw another difficult and challenging year. Like all our health and social care colleagues across the country, NEAS had to continue to manage the impact of this new variant. In spite of this our staff continued to provide amazing services to our patients and I am so grateful to each and every one of the NEAS family.

Despite the commitment of our staff, the ongoing impact of the pandemic meant we had to make some difficult decisions about pausing some non-critical work and focus on our priority of ensuring we provided safe and effective care for our patients and a safe working environment for our staff.

As we now emerge from the pandemic our focus must move to the recovery of services, supporting our workforce and preparing for the changes in our external environment. 2022/23 will bring major changes which will impact on the way we deliver our services and the lessons we have learnt throughout the pandemic.

As ever our staff continue to go above and beyond our expectations and amongst all the challenges they faced last year, they supported us to develop our new five year trust strategy which we launched in July 2021. The strategy sets out a clear direction for NEAS to deliver our vision of unmatched quality of care, whilst keeping the patient at the centre of all we do. Within the strategy we have identified four ambitions which we fondly call our Ps and Qs: -

- **People** - a great place to work and grow
- **Performance** - deliver outstanding performance, every time
- **Partner** - collaborate and innovate with other partners
- **Quality and safety** - safe, compassionate and inclusive care

These form the cornerstones for our strategy and are supported by nine underpinning plans, which will provide the foundations for the delivery of the priorities we will work on over the next five years.

Our quality report outlines the progress against our 2020/21 quality priorities but, also recognises where we were not able to achieve all the key actions as planned due to prioritising patient care and the unprecedented demands we experienced on our services. However, we will ensure the outstanding actions will be completed during the year ahead.

With the easing of COVID-19 restrictions we were able to undertake a period of consultation with our internal and external stakeholders throughout April and May 2022 which enabled us to ensure our 2022/23 priorities fully addresses the needs of patients, our staff, partner NHS organisations and other business partners across our region.

This Quality Report can only provide a glimpse of what we have achieved in 2021/22 and what we hope to achieve in 2022/23.

Finally, I would like to say I continue to be immeasurably proud of our staff, NEASUS colleagues and our valued volunteers for their hard-work, dedication, compassion and care which has never wavered during an unimaginable time both personally and professionally for everyone. You really do make a difference and we CARE about you. My sincere thanks also go to our partners and the people in the communities who have supported us throughout and who we are extremely proud to serve.

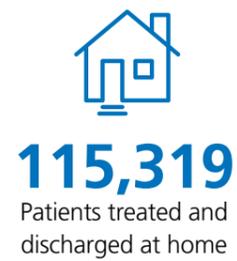


Helen Ray
Helen Ray
Chief Executive



Peter Strachan
Peter Strachan
Chairman

2021/22 At a glance



Ambulance response times



○ Ranked out of 10 ambulance trusts

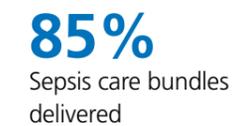
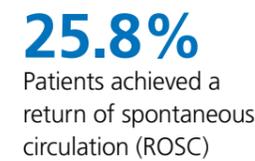
Safety



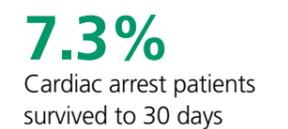
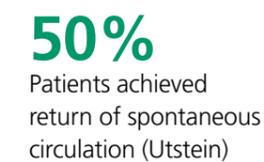
Clinical Effectiveness



Ambulance Care Quality Indicators



TOP PERFORMERS



Patient Experience



Looking Forward

All NHS Trusts are required to produce a Quality Report to provide information on the quality of the services they provide to patients, their families and carers. The report allows NEAS to demonstrate how we are performing and identify areas for improvement considering the views our service users, carers, staff and the public.

NEAS strives continuously to improve patient safety, patient experience and clinical effectiveness. As we emerge from the pandemic our focus is shifting to the recovery of services, supporting our workforce and preparing for the changes in our external environment. 2022/23 will bring major changes which will impact on the way we deliver our services.

Our quality priorities have been chosen to align with NHS England and NHS Improvement's 2022/23 operational planning guidance and priorities for the National Health Service, the Care Quality Commission Domains and our Trust five-year strategy 2021-2026. We have outlined four quality priority options for 2022/23.

We are pleased to report COVID-19 restrictions are easing and we are able to undertake a period of consultation with our internal and external stakeholders throughout April and May 2022. This will enable us to ensure our 2022/23 priorities fully address the needs of patients, our staff, partner NHS organisations and other business partners across our region.



Proposed Priorities for 2022/23

Safety

Why is this important to us?

We want to reduce risks, errors and harm for our patients and improve our services by learning from things that go wrong.

Priority 1: Working with system partners to reduce handover delays

Lead: Stephen Segasby, Chief Operating Officer

Why did we choose this priority?

To reduce the risk of harm to our patients, improve outcomes and patient experience.

We know there is a risk to patients waiting outside in ambulances for admission to the Emergency Department (ED). Delays can result in poor patient outcomes, poor patient experience and impact negatively on ambulance crews.

The national handover target for hospitals is 15 minutes with no ambulances waiting more than 30 minutes.

The average handover time for NEAS during 2021/22 was 22 minutes 16 seconds (7 minutes over the target).

Hospitals are clinically responsible for patients as soon as the ambulance arrives at ED but we all have a role in managing demand pressures and reducing risks to patient safety.

Our aim?

To handover over patients to ED safely within 15 minutes, effectively reducing the risk to our patients, improving patient outcomes and patient and staff experience.

How will we do this?

- Undertake a thematic analysis of handover delays
- Review the procedures in place between NEAS and each acute hospital Emergency Department (ED)
- Understand the impact on the overall patient experience of patients waiting in ambulances
- Understand the impact of handover delays on our staff
- Work with our partners to consider ways to improve effectiveness across all parts of our system
- Review and refine our risk management and escalation arrangements during times of demand

Indicators of success

- Increased understanding of the patient harm caused by delayed handovers and improved learning
- Reduction of harm to patients
- Improved patient experience
- Improved staff experience
- Collaborative working with our partners and a system wide approach to finding a solution
- Achievement of waiting time targets
- Clinically effective escalation processes to keep patients safe in periods of high pressure
- Improved governance arrangements including an increase in incident reporting to promote learning and improvements

Priority 2: Learn from incidents and prepare for the Patient Safety Incident Response Framework (PSIRF)

Lead: Sarah Rushbrooke, Director of Quality, Patient Safety, Innovation & Improvement

Why did we choose this priority? To improve our services by learning from things that go wrong.

The PSIRF calls for a new approach to incident management; doing fewer “investigations” but doing them better and by people that have been trained to do them.

The new framework will be introduced during 2022 and we will need to ensure we have support structures in place for staff and patients involved in patient safety incidents.

Our aim?

To develop the cultures, systems and behaviours necessary to respond to patient safety incidents (PSIs) in a way that ensures we learn from mistakes and improve.

How will we do this?

- Development of robust governance and oversight procedures to support an effective organisational response to incidents
- We will review the feedback from PSIRF early adopters and draw on good practice from healthcare and other sectors to promote learning and continuous improvement
- We will complete a thematic analysis of incidents
- We will continue to learn from when things go well as well as when they go wrong, ensuring that learning is shared both internally and externally to improve the quality of care we provide to our patients
- We will work closely with partners to identify and mitigate risks across the system and implement the Patient Safety Incident Response Framework once published
- Establish a PSIRF implementation oversight group

Indicators of success

- Completion of thematic analysis to identify patient safety priorities including development of a dynamic reporting dashboard
- Improved triangulation of incidents and feedback to understand themes
- Improved quality, timeliness of investigations and learning from PSI investigations
- Reduction in the number of patient safety incidents
- Reduce the numbers of Never Events and/ or PSIs involving death, severe harm and moderate harm
- Establish and provide training for all staff undertaking investigations
- Effective use of investigation process outcomes to inform Trust wide improvements
- Improved working environment for staff in relation to their experiences of patient safety incidents and investigations

Clinical effectiveness:

Priority 3: Use our resources as efficiently as possible by making better use of our clinical model

Lead: Mathew Beattie, Medical Director

Why did we choose this priority? To create a culture of continuous improvement and learning so our patients receive the best care.

As we emerge from the COVID-19 pandemic and enter systemwide partnership working we need to establish our role as providers of urgent and emergency care by ensuring our patients are treated in the right place at the right time by a skilled workforce.

Our aim?

To release the pressure that is being placed on hospital Emergency Departments (EDs) by managing some patients in different ways such as providing more treatment and care on scene, in their own home, or referring them to alternative pathways.

Why is this important to us?

We want to do the right thing, at the right time, for the right patient and demonstrate improvements in the quality and performance of our services.

How will we do this?

- We will work with colleagues from the performance team and operational directorates to undertake initial analysis of hear and treat and see and treat rates and scope options for improvement
- We will develop a blended workforce model with the right sills to be responsive to the needs of our patients in our communities reducing the reliance on EDs
- We will improve access to additional clinical advice for our staff
- We will review and increase the non-medical prescribing capability
- We will evaluate a mental health car pilot and explore other pathways to provide mental health support
- We will evaluate end of life service provision and look to explore ways to improve working
- We will look to introduce technology for remote consultation in EOC
- We will work with our partners in the region to develop urgent care 2-hour community pathways

Indicators of success

- Reduction in conveyance to hospital
- Increased hear and treat rates
- Increased see and treat rates
- Improved patient experience and outcomes
- First cohort of rotational paramedics to support primary care networks
- Increased staff training
- Non- medical prescriber workforce capacity increased
- Real time data alerts to identify issues and trends to support redistribution of resources
- Access to additional clinical advice for frontline staff
- Improved workforce skill mix

Patient experience:

Why is this important to us?

What matters to our service users matters to us. We want to ensure our patients, their families and carers have the best possible experience of care when they use our services.

Priority 4: Involve our patients & communities to improve care

Lead: Sarah Rushbrooke, Director of Quality, Patient Safety, Innovation & Improvement

Why did we choose this priority?

Our patients are at the heart of everything we do and are paramount to helping us shape the care we deliver.

We strive to deliver the highest possible quality of care that is accessible to all. We want to shape our services on what matters to our patients, their carers and our communities.

Our aim?

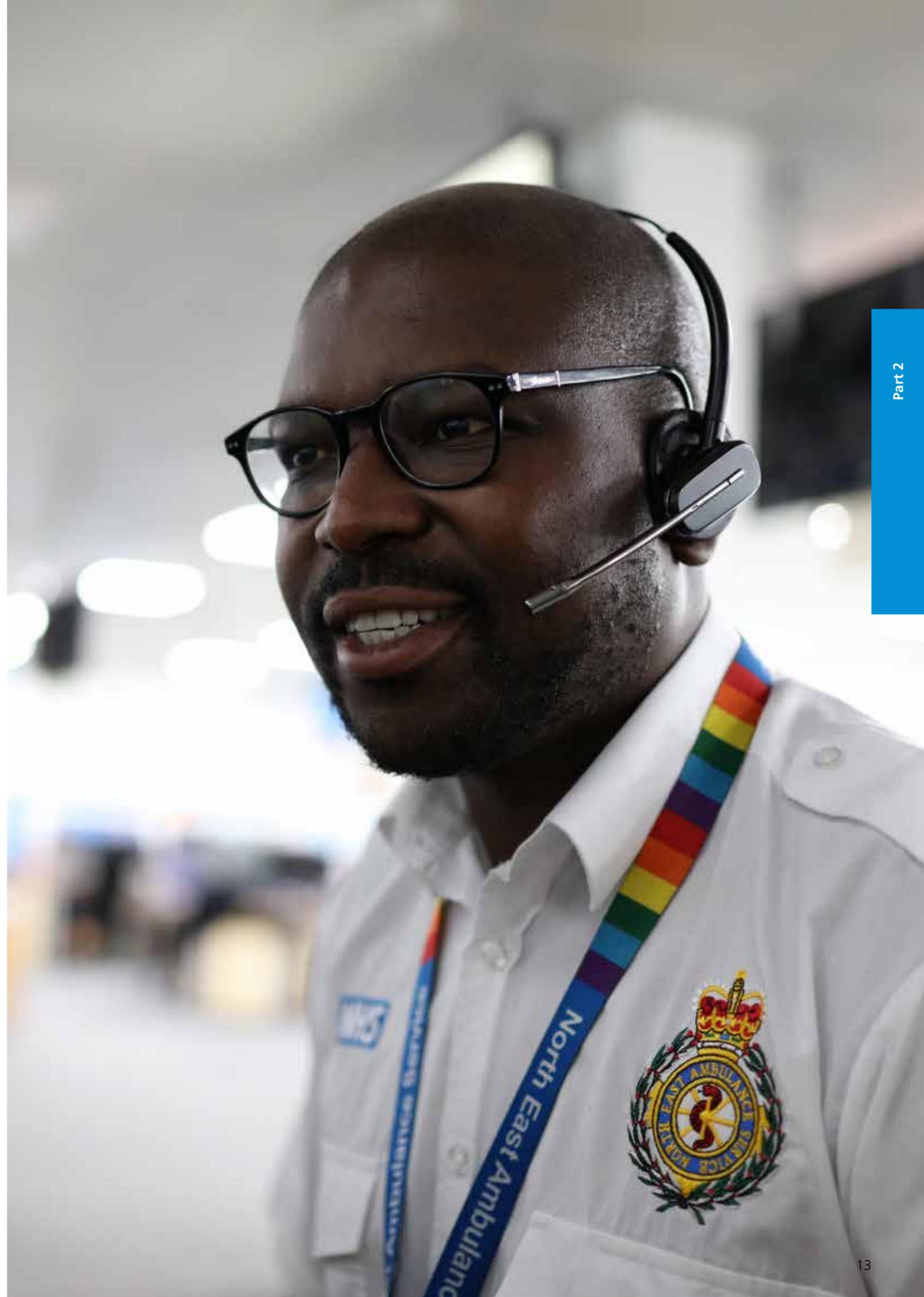
We want to create a positive experience for our patients/service users and their families/carers by delivering excellent services. We recognise that some patients do not participate in our survey and we will look to new ways to improve how we listen to and use feedback from patients' carers and families to improve our services.

How will we do this?

- We increase our engagement events in person and virtual including through joint engagement opportunities with local health providers, Healthwatch organisations, local authorities and commissioners
- We will explore opportunities to develop volunteers (e.g. community responders) as ambassadors in their areas
- We will listen to patients to understand their priorities
- We will seek patient feedback and involvement in service change, service delivery, design and redesign
- We will look for opportunities to include patient representatives on assurance committees
- We need to widen and increase our public involvement in both the development of these new services and monitoring of their success
- We need to listen to our patients, their families and carers, and respond to their feedback

Indicators of success

- Improved patient experience shown by reduced complaints
- Increase in positive feedback from patients via Friends and Family Test, compliments, National Patient Surveys and other social media platforms, indicating that patients feel involved in planning our services
- Increased capacity to engage with local communities
- Improved patient outcomes for selected patient groups
- Improved working relationships with stakeholders and partners
- Projects and developments will benefit from patient engagement and statutory requirements will be met



2021/22 Review

Quality Priority Performance 2021/22

Monitoring of the progress against our quality priorities was reported to our Clinical Quality Committee.

We were not able to achieve all of the key actions as planned due to prioritising patient care in response to the COVID-19 pandemic and unprecedented demands on our services but we will ensure the outstanding actions will be completed during the year ahead. We are pleased to outline the progress we have made so far in delivering the 2021/22 quality priorities.



Priority 1 Managing the deteriorating patient in the Emergency Operations Centre (EOC)

Our aim was to ensure we have robust processes to manage the identification of deteriorating patients in the care of the EOC efficiently and effectively.

We planned to reduce the number of patients who suffer harm or deterioration in their condition while they wait for an ambulance by identifying 'at risk' patients at the earliest opportunity and escalating them to the most appropriate service for treatment.

How did we do?

Our updated Clinical Safety Plan helped to identify and allocate resources safely and efficiently to the sickest patients during unprecedented periods of demand.

What do we need to do now?

We recognise that there are still further improvements to be made and we continue to review and adapt our processes including the use of digital systems to support our EOC teams to achieve this priority.

What we wanted to achieve

Did we achieve this?

Further review and survey of clinicians regarding upgrading of patients in a peri arrest situation	✗
Review our research findings to determine if the timing and frequency of call backs can be linked to determining if patients are clinically deteriorating and any learning that can be used to improve the systems we use	✓
We will look at the role of clinicians based in the dispatch area to understand the impact of this on the deteriorating patient	✓
We will look at the data linking learning from deaths reviews and patient safety incidents with any delays in responding to the patient to determine learning from this	✓
We will continue to review the impact of the 'No send' policy when we are in times of escalation	✓
We will further review patient safety incidents relating to scheduled care services and how we may learn from these.	✓

What did we do?

Multiple call backs study

The study was led by our consultant paramedics and aimed to identify the link between frequent call backs, conditions of concern and patient deterioration. The team met weekly with operational colleagues to review patient outcome and mortality data, and as a result, significant improvements have been made to recognise and manage the deteriorating patient. The study identified a shift in the clinical profile of patients who were likely to deteriorate whilst waiting for an ambulance resulting in new cohorts of patients that should be prioritised. New actions were introduced to support dispatchers and EOC clinicians to review clinical need and respond to the clinical risk safely by allocating ambulances based on clinical need.

Dispatchers - conditions for review:

- Marked by a clinician as a priority
- Resource on scene requiring back up
- Uncontrolled haemorrhage
- Inter-facility transfers (IFT) level 2
- Stroke
- Declared hypoxia (<85%) or National Early Warning Score (NEWS) >7
- Paediatric patients

Clinicians - patients prioritised for validation:

- Clinical concern identified by the shift coordinator
- Unconscious
- Bleeding
- Stroke
- Breathing problems
- Paediatrics
- Chest pains

If validation confirms the case does not require prioritisation the priority code will be removed, and an ambulance will be dispatched under as per normal procedures. This is to ensure only the sickest patients are being prioritised.

We continue to evaluate our findings to determine if there is a statistically significant correlation between calls and deterioration and will continue to use this work to inform future changes.

Safety in times of demand

Challenges with staffing resource levels and peaks in demand resulted in pressures which affected our performance against the ambulance response and clinical performance standards. Our Clinical Safety Plan (CSP) allowed us to respond quickly in times of pressure whilst maintaining patient safety.

We used the findings from the 'multiple call backs' study data from the multiple call backs study, patient safety incidents and learning from deaths to develop our dispatch clinical risk assessment procedure for EOC and update our clinical safety plan.

We implemented these actions to improve the early recognition of deteriorating patients leading to a reduction in the expected number of incidents associated with failure to recognise and address patient deterioration. Early findings suggest a reduction in the number of Inter Facility Transfer (IFT) call upgrades, improvements in stroke performance and a decrease in the patient pre-alerted following long waits category.

Dispatch Clinicians

We undertook a study to understand clinicians' rationale when considering upgrades to Category 1 ambulance response targets and found clinicians appeared to upgrade to a priority 1 due to individual patient risk and were not aware of the priorities of patients outside their area already waiting for a response. We initiated a pilot allocating clinicians to a designated dispatch desk working with individual dispatch teams to inform decision making and found this reduced deaths and pre-alerts and allowed the early recognition of deteriorating patients. However, this was resource intensive, and we were unable to sustain this approach due to staffing levels and periods of high demand.

We recognise clinically led prioritisation so that the most urgent cases are scheduled first, improves the safety and outcomes for patients and plans to increase EOC clinician capacity are on-going including recruitment to core clinical advisor vacancies, and additional sessional GP activity and Vocare sub-contracted support from external providers.

Review of no send policy

We follow our internal Demand Management Plan in times of pressure this which includes asking patients who can safely make their own way to hospital to do so. This frees up an ambulance resource to respond to those patients in greater clinical need. We evaluate every ambulance re-attendance to a patient within 24 hours to review whether the initial non-conveyance was clinically safe or whether

there was potential for patient harm. We formally report our no send activity to the Trust's Executive Management Group and Quality Committee on a quarterly basis. Introduction of the no send policy has not resulted in any serious patient safety incidents or complaints.

We introduced a 'no send' patient survey in 2021 to allow us to review the number of people re-contacting the service, their reason for doing so and also monitor their satisfaction with the service. The latest data shows despite the continued high levels of Category 1 and Category 2 incident volumes the number of patients re-contacting the service within 24 hours was 7.1%, and 61.9% patients rated the service as good or very good compared to 21.4% poor or very poor. We will continue to collect survey data until September 2022.

We explored the possibility of accessing data for patients who may have presented at any Emergency Department (ED) after calling NEAS but however, under the General Data Protection Regulation (GDPR) we are unable to access personal data within from a separate part of the NHS system.

Learning from deaths and patient safety incidents. There have been marginal improvements in the number of patients who died in care (which still correlates to operational performance) but, the profile of the patients that now die in care has changed since the full implementation of the updated Clinical Safety Plan.

Priority 2
Improving cardiac arrest care

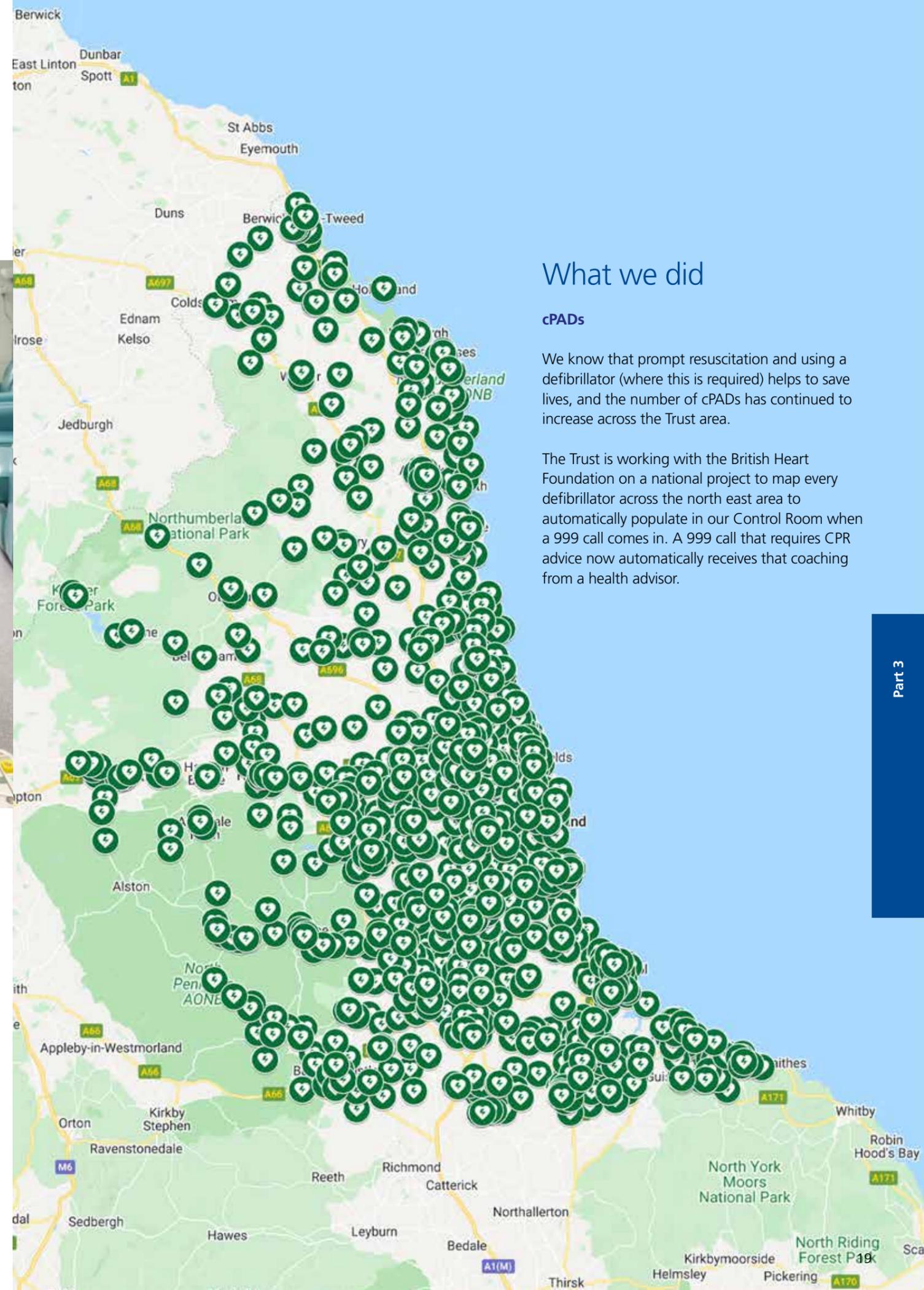
Our aim was to improve cardiac arrest outcomes for our communities. It is well known that survival for patients experiencing a cardiac arrest is dependent on receiving treatment within a very short timeframe. Early recognition and access to treatment, early cardiopulmonary resuscitation (CPR) and early defibrillation are all key to survival.

How did we do?

We have increased the number of Community Public Access Defibrillators (cPADs) throughout the north east and we are working with the British Heart Foundation to map the location of all defibrillators

What do we need to do now?

We will look to reduce inequalities in our region through our research projects. We will increase life-saving skills training events as COVID-19 restrictions ease.



What we did

cPADs

We know that prompt resuscitation and using a defibrillator (where this is required) helps to save lives, and the number of cPADs has continued to increase across the Trust area.

The Trust is working with the British Heart Foundation on a national project to map every defibrillator across the north east area to automatically populate in our Control Room when a 999 call comes in. A 999 call that requires CPR advice now automatically receives that coaching from a health advisor.

What we wanted to achieve

Did we achieve this?

Continue to support the purchasing of community public access defibrillators (cPADs), through our NEAS Trust Fund to place in areas we feel would benefit most, based on our local intelligence



Review the impact of the specialist paramedics in emergency care dispatch desk in deploying dedicated resource to patients who have had a cardiac arrest.



Use smart technologies to activate the public and clinical staff to a nearby cardiac arrest to enable early intervention



Contribute to research regarding cardiac arrest in the out of hospital setting



Bystander CPR

Despite the North East and Cumbria having a higher number of cardiac arrests in the community compared to other parts of the country, statistics show that if you have a cardiac arrest outside of hospital in our region, you are less likely to receive CPR and therefore less likely to survive.

We launched a targeted communications strategy to improve cardiac awareness via social media Facebook and Twitter and we have continued to work with the local community to provide education and training at face to face events where permitted.

Whilst NEAS remains in the lowest 25% of all Ambulance Trusts for bystander CPR our position has improved from last year and we have seen an improvement in our cardiac outcomes.

Specialist Paramedic Emergency Care (SPEC) deployment

Following changes to our operating model specialist paramedics no longer work within EOC. We have worked with informatics colleagues to develop a specialist paramedic utilisation report. Using the dispatch deployment criteria for our specialists we have determined by hour of the day and geographical area where these incidents most frequently occur. Our intention now is to use this to trial dynamic stand by bases with a view to assessing if this improves the utilisation and appropriateness of tasking for specialist paramedics.

Research

The research team at North East Ambulance Service has secured £50,000 in funding from the National Institute of Health Research Applied Research Collaboration to undertake a 12-month project, to better understand the reasons why people are less likely to perform CPR in the north east, and to begin to address these inequalities. The research includes a regionwide face to face survey with the public on their understanding of CPR.

There is also a multi centred research project ongoing looking at the different routes to give medication to a patient in cardiac arrest.

NEAS contribute to the national out-of-hospital cardiac arrest outcomes study which is facilitated by Warwick University. This national registry is used to inform policy and practice changes.

All findings and action plans are monitored regularly through the Trust's Clinical Quality Governance Group and Quality Committee. In addition to this NEAS has a well embedded learning from deaths process, with a continuous commitment to reviewing and improving care provided to patients.



3.1.3 Priority 3 Improving End of Life Care

Our aim was to ensure patients receive end of life care and a calm and peaceful death, in their preferred place of care, wherever possible.

We want to allow our patients with a life limiting illness to die with dignity enabling them to achieve what they would consider 'a good death' whilst supporting their families and carers. Our aim for every patient is to provide treatment and support in line with their wishes, to the best of our ability, to ensure the alleviation of pain and suffering.

In order to fulfil this priority, we need to have skilled staff within our EOC and throughout the operations department to support high quality assessment and care when caring for a patient at the end of their life and providing support to their loved ones by having access to information to support clinical decision making.

How did we do?

- We reviewed our service delivery to ensure it is consistent with the Association of Ambulance Chief Executives guidance 'the route to success in end life care – achieving quality in ambulance services'
- We are working closely with our regional palliative care stakeholders to continually improve our services
- We have updated and improved our training content

What do we need to do now?

- We will continue to work with our stakeholders to develop efficient integrated systems to improve information sharing
- We will continue working with our commissioners to secure funding to provide a 7-day end of life transport service
- We will implement our patient and carer feedback survey to determine effectiveness and identify areas for improvement



Patient Frank Kelly reunited with Nissan workers who delivered bystander CPR and the 999 call handler and ambulance crew who attended

What we wanted to achieve

Did we achieve this?

Embed the process to triangulate learning from patient safety incidents, feedback from carers, feedback from acute providers and themes identified from the learning from deaths process to better understand what we need to do within NEAS and across the system to support end of life care



Continue to collect data on Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) information shared with NEAS, broken down to Clinical Commissioning Group level and report the findings to identify where information sharing gaps occur



Review the data for non-conveyance of patients where we know there is a DNACPR in place, by CCG area and work with key partners to determine reasons for this



Identify and work within a locality to review conveyance rates to hospital of patients in the care home sector who die within 24 hours to determine learning from this



Develop the business case for commissioners to consider so that we can provide a 7-day end of life transport service



What did we do?

Learning from patient safety incidents, deaths and feedback from our service users

The end of life team received 76 incidents from 2018 to date via complaint form submissions or the patient experience team. The incidents and feedback have identified trends relating to ambulance delays and issues regarding 'do not attempt cardiopulmonary resuscitation' (DNACPR) forms.

NEAS has three dedicated ambulances provided by St John Ambulance Service, one for each operational division. The vehicles are equipped to transport patients at the end of life comfortably and efficiently and are staffed by an emergency care technician-led crew who have undergone palliative care training.

We aim to provide a vehicle within one hour of booking where possible but if this response is not met, a NEAS call handler will contact the person who placed the booking with an explanation and an updated expected time of collection. Our performance against this target in 2021/22 was 1 hour 27 minutes on average and we are working with St John Ambulance and our Operations Centre to protect the service to improve response times.

DNACPR issues included inconsistencies with documentation, concerns regarding the validity of the document and out of date documents. The end of life team has provided training, issued medical alerts and released DNACPR Frequently Asked Questions (FAQ) information to help staff understand the principles and implications of DNACPR.



DNACPR data

Sharing information across services eg plans and stated preferences such as DNACPR is essential to allow our clinicians to make appropriate decisions. We have collected DNACPR data at Clinical Commissioning Group (CCG) level since April 2019. We have not identified any reportable gaps or inconsistencies with the data, although it is highly likely DNACPR data is underreported to NEAS.

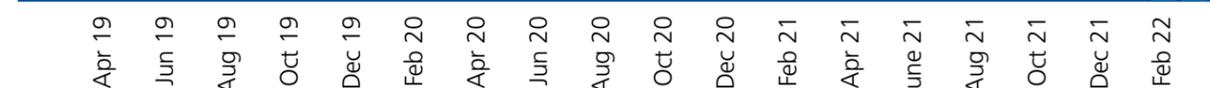
DNACPR Data April 2019-January 2022

15000

10000

5000

0



It is estimated around 1% of the population will be in the last year of their life and on the palliative care register (with a vast proportion having a DNACPR in place), although we have seen an increase in the number of DNACPRs reported to NEAS this only equates to between 0.3%-0.7% across the various CCGs.

We are working with our partners and palliative care network to improve information sharing information across all services.

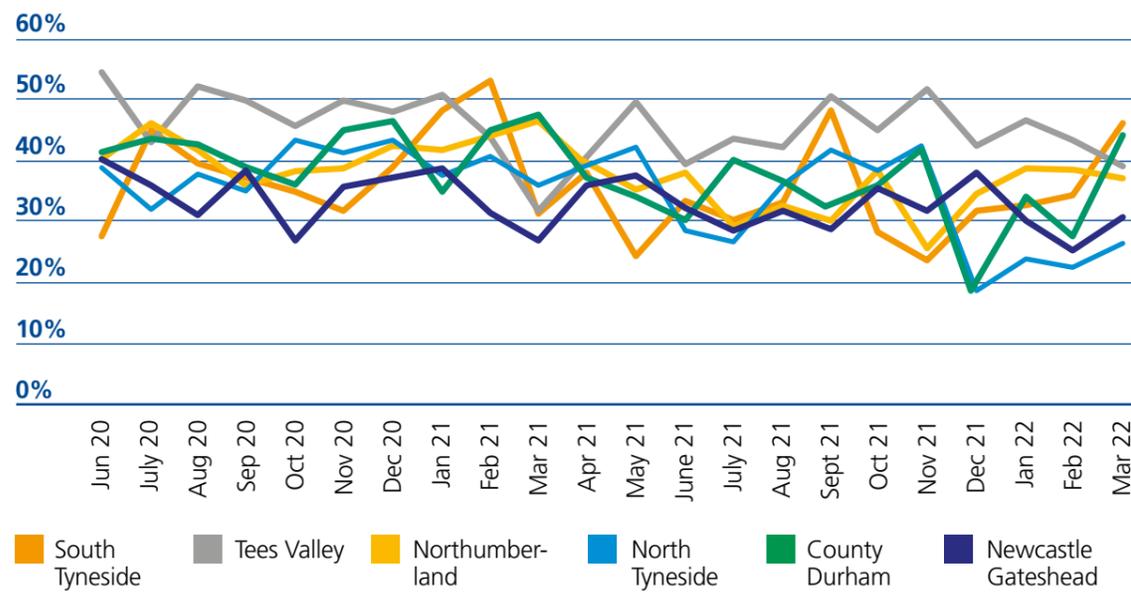
There is a clear link between increased information sharing and a reduction in palliative and end of life care patients being conveyed to hospital after an ambulance has arrived on scene. This is reported monthly to the Palliative and End of Life Care regional clinical network and to CCG representatives.

Review of conveyance rates

It is vital that ambulance services are made aware when care plans and DNACPRs are in place to prevent unnecessary conveyances for people nearing the end of life.

Non-conveyance rates have fluctuated throughout the year but continue to demonstrate the correlation between increased information sharing and fewer palliative patients being conveyed to emergency departments. We are currently working with South of Tyne partners to review non-conveyance rates.

Non-conveyance rates June 2020- January 2022



7- day end of life (EOL) transport

There is sufficient evidence to support a 7-day transport service. 12.6% of all transport requests are received over a weekend and all weekend requests are responded to by core emergency vehicles. Introducing a 7-day service would allow appropriately skilled crews to attend to our EOL patients, reduce waiting time delays, release A&E resources to respond to emergency calls, reduce bed pressures in hospitals and align our service with the national ambition for 7-day palliative and EOL services. We have developed the business case to provide a 7-day EOL transport service and will be working with our commissioners to support our request.

Education and training

We have updated and improved our education and training resources to ensure our staff understand the issues and implications around caring for people nearing the end of life. The training includes communication and listening skills, tackling difficult conversations, understanding other organisations' roles and relevant guidance. We have delivered training to 241 front line staff and health advisors this year and plan to develop bespoke training packages for Associate Practitioners and GPs, bitesize training videos for front line staff, and to release a frequently asked questions factsheet.



Case Study

We were asked to transfer a patient who wanted to visit home prior to their transfer to St Oswald's Hospice. The patient wanted to see his home and his friend one last time as his friend was unable to visit the patient at hospital or hospice due to their own limiting health conditions. Our Dispatch Manager and St John Ambulance team worked together to ensure the patient's wishes were fulfilled.

Thanks to NEAS and St John Ambulance team's responsiveness and compassion the patient was able to spend precious time with his wife and friend one last time prior to arriving safely at the hospice where he died peacefully.

Statement of Assurance from the Board of Directors

During 2021/22 the North East Ambulance Service NHS Foundation Trust (NEAS) provided and/or sub-contracted three relevant health services. For NEAS relevant health services are defined as Emergency Care (Unscheduled care), Patient Transport Services (Scheduled care), NHS111, including our Clinical Assessment Service and GP Out of Hours services.

NEAS has reviewed all the data available to them on the quality of care in all three of these relevant health services.

Financial and reporting arrangements including CQUIN

This section of the report is common to all healthcare providers and ensures that all quality accounts are comparable.

High level indicators of quality and safety are routinely reported to the Board and Council of Governors and our quality report gives information under the headings of patient safety, clinical effectiveness and patient experience, measuring areas of compliance, progress and improvement throughout the financial year. Performance is also compared to local and national standards where these are available.

All members of the Board would usually undertake regular quality walkarounds and report issues and concerns into individual directorates as and when necessary. However due to COVID-19 this has not been possible. The Board has therefore received assurance from Executive colleagues at Board and received reports focussed on responding to COVID-19 and how quality and safety has been maintained.

The income generated by the relevant health services reviewed in 2021/22 represents X% of the total income generated from the provision of relevant health services by NEAS for 2021/22. This represents a minimal change with just over £Xk of reported £X million coming from non-NHS partners, mainly around event cover and local authority funding.

The Commissioning for Quality and Innovation (CQUIN) payment framework is designed to support the cultural shift to put quality at the heart of the NHS. Local CQUIN schemes contain goals for quality and innovation that have been agreed between the Trust and our Commissioners across the region. NHS England continued the block payments approach for arrangements between NHS commissioners and NHS providers in England for the first half of the 2021/22 financial year. Block payments to NHS providers are deemed to include CQUIN, and there will be no 2021/22 CQUIN scheme (either CCG or specialised) published at this stage.

NEAS did not submit (and is not required to submit) records during 2021/22 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

NEAS's Data Security and Protection Toolkit status for 2020/21 is "Approaching Standards".

NEAS was not subject to the Payment by Results clinical coding audit during 2021/22 by the Audit Commission.

Clinical Audit

During 2021/22, 25 national clinical audit projects and 8 clinical outcome quality indicators covered the relevant health services that NEAS provides. There were no national confidential enquiries that NEAS was eligible to take part in this financial year. NEAS submitted 100% eligible cases for the national ambulance clinical quality indicators and two eligible national clinical audit projects; myocardial ischaemia national audit project and sentinel stroke national audit project.

National Clinical Audits the Trust was eligible to participate in	Did the Trust participate	Number of cases submitted
Data presented represents nationally published performance between April – September 2021. This is subject to change due to the bi-annual re-submission period.		
Cardiac arrest: return of spontaneous circulation	Yes	100% (1017)
Cardiac arrest: return of spontaneous circulation (Utstein)	Yes	100% (168)
Cardiac arrest: survival to 30 days	Yes	100% (992)
Cardiac arrest: survival to 30 days (Utstein)	Yes	100% (158)
Post-ROSC	Yes	100% (135)
STEMI	Yes	100% (147)
Stroke	Yes	100% (852)
Sepsis	Yes	100% (642)
Myocardial Ischaemia National Audit Project (MINAP)*	Yes	*Annual data returns not available
Sentinel Stroke National Audit Project (SSNAP)*	Yes	*Annual data returns not available

*Ambulance Clinical Quality Indicators are reported quarterly to NHS England 4 months in arrears, except for cardiac arrest data which is reported monthly.



25 local clinical audit projects were completed by NEAS in 2021/22 and we intend to take the following actions to improve the quality of healthcare provided:

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

- Implement the locally developed clinical performance indicators
- Implement a new clinical audit tool
- Implement system developments to electronic patient care records (ePCR) and replace the current devices
- Explore automated referrals direct from ePCR
- Explore embedding clinical governance at an operational level

- Work with informatics colleagues to expand the use of the application and develop a suite of reports to support individual and service development
- Provide training to clinical team leaders so they have the skills, knowledge and resource to undertake audits and reviews to support their team's development

Local clinical audits completed	Number of cases reviewed	Summary and actions to improve practice
Pre-alert	100	Overall good assurance in the appropriateness of patients being pre-alerted. <ul style="list-style-type: none"> • Reminder to use Age, Time of onset, Medical complaint/injury, Investigation, Signs and Treatment (ATMIST) to structure handovers and ensure all pertinent information is passed concisely.
Post-partum haemorrhage	4	Thankfully a small sample due to rare incidence. <ul style="list-style-type: none"> • Ensure all treatments are delivered and documented.
COVID	235	Care bundle developed to support the assessment and management of COVIDoid patients.
PGD compliance x6	284	Overall good assurance provided in the use of Patient Group Directions (PGDs) by paramedics. <ul style="list-style-type: none"> • ePCR developments requested to improve data quality. • Communication regarding appropriate use of PGD indications.
Adult seizures	418	There is scope to improve the care provided to adult seizure patients. <ul style="list-style-type: none"> • Ensure early oxygenation, assessment of injuries and ECG are recorded.
COPD	221	Further work is required to clarify the NEWS2 scales and education to improve the recognition of COPD exacerbations.
Delayed hospital handover	71	Performance consistent with previous year. <ul style="list-style-type: none"> • Communication reissued to staff. • Checklist to support managers providing hospital situation reports.
Hyperventilation	177	Good compliance with history taking. <ul style="list-style-type: none"> • Communication to staff to ensure alternative diagnosis are considered and early assessments to exclude life-threatening presentations.
Paediatric cardiac arrest	45	Sustained improvement for fourth consecutive year. <ul style="list-style-type: none"> • Ensure Recognition of Life Extinct (ROLE) forms are completed for all paediatric patients not resuscitated. • All deceased paediatric patients should be conveyed to emergency department.
Drug overdose cardiac arrest	56	Re-audit demonstrated improvements in airway and ventilation. <ul style="list-style-type: none"> • Communication with staff to increase naloxone administration. • Local guideline to be reviewed.
Conveyed with Advanced Life Support (ALS) ongoing	65	Sustained improvement during re-audit. <ul style="list-style-type: none"> • Communications regarding public place arrests and the early use of specialist resources.
Co-amoxiclav for open fractures	-	Deferred audit at time of the report
Febrile convulsions	250	Ongoing

Re-contact within 24 hours	69	To understand if Non-conveyance was safe and appropriate and to determine if there were earlier opportunities to refer to alternative services and avoid subsequent contact.
Discharge by non-qualified clinicians	374	Ongoing
Discharge by Newly Qualified Paramedics (NQPs)	374	Ongoing
Category1 calls	141	Focused work exploring the C1 case mix. <ul style="list-style-type: none"> Targeted work for Healthcare Professional (HCP)/Inter Facility Transfers (IFT) calls. Recommendations for managing seizures.
HCP calls	462	Disproportionate number of HCP calls requesting high dispositions. <ul style="list-style-type: none"> Review and update of external communication tools. EOC to review requests from primary care.
IFT calls	358	Disproportionate number of IFT calls requesting high dispositions. <ul style="list-style-type: none"> Recommendation for updating internal processes. Dispatch clinical risk assessment procedure to prioritise IFT level 2.
EOLC End of Life Care: DNACPR	98	Only 20% of patients with a DNACR were recorded on the NEAS system. <ul style="list-style-type: none"> Internal education to support appropriate resuscitation. External engagement to improve the special patient notes.
NHS Pathways: Health Advisors	10444	81% call pass rate with an average score of 88%. 96% of the 411 performance improvement plans have been completed. To support EOC with service improvement initiatives, the following groups of calls were targeted for audit: Category 2 dispositions, urgent dispositions and Directory of Services (DoS) first choice. Next year an annual cycle of business has been developed to target call and competencies to support continuous improvement within EOC.
NHS Pathways: Clinicians	3719	79% call pass rate with an average score of 94%. 96% of the 76 performance improvement plans have been completed. Work is ongoing to increase establishment of clinical call auditors to achieve license compliance with the NHS Pathways end-user license agreement.
Head injury with tranexamic acid administration	156	58% of our patients received this treatment. We are working with the Northern Trauma Network to improve this.

We replaced the previous data quality and correct use of ePCR audits with automated reports that can be used by service lines to drill down into the data to monitor compliance and improve performance for their area.

NICE guidance

The National Institute of Health and Care Excellence (NICE) produces evidence-based recommendations developed by independent committees, including professional and lay people for health and social care organisations in England. Whilst many of the guidance documents produced are not applicable for the ambulance sector there are some which are relevant.

NEAS reviewed 373 NICE guidelines and identified 104 as relevant to our services. Baseline assessments have been completed and NEAS is compliant with 73 (71%) of the relevant guidance. Action plans are in place to address the non-compliance guidelines and will be reviewed April-June 2022.

Clinical research

The NHS Constitution states that research is a core part of the NHS's role, enabling the NHS to improve the current and future health of the population. The Trust's commitment to research as a driver for improving the quality of care and patient experience remains strong despite the challenges presented by the ongoing pandemic.

Participation in clinical research is important for both our patients and staff as it enables our clinical teams to stay up to date with the latest possible treatments, and network with other research teams across the world. The Research Department strives to increase opportunities for patients and staff to engage in research studies and this is the fourth year in a row the team have increased patient recruitment into research studies. During 2021/22, our research team have continued to work on internationally recognised studies, recruiting 1,384 patients to participate in research approved by the Health Research Authority or a research ethics committee.



We are currently conducting 12 clinical research studies, 11 of which were adopted onto the National Institute for Health Research portfolio, and successfully sponsored 4 National Institute for Health Research (NIHR) portfolio studies, as where the organisation that takes on overall responsibility for proportionate, effective arrangements being in place to set up, run and report a research project.

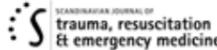
The Network analyses trends over the year to understand research performance, in particular;

- How quickly participants are recruited once a study is set up-time between date site selected and date of the first participant recruited?
- How many clinical trial participants are recruited to time and target?

The NIHR publish a comparison table showing the performance of all NHS organisations that submit to the Performance in Delivering exercise, and trends analysing performance across the country.

As a result on the number of patients we were able to recruit (accruals) we were ranked 2nd out of all of the UK Ambulance services.

The Research and Development team published five papers in peer reviewed journals during 2021/22.

Publication Title	Journal	Author/s	Link
'Incidence of emergency calls and out-of-hospital cardiac arrest deaths during the COVID-19 pandemic: findings from a cross-sectional study in a UK ambulance service' (2021)		Karl Charlton, Matt Limmer, Hayley Moore	https://emj.bmj.com/content/early/2021/04/07/emered-2020-210291.full?ijkeyG7rkvwzXOnZOriW&keytype=ref
'Defining major trauma: a Delphi study' (2021)		Lee Thompson, Gary Shaw, Michael Hill, Fiona Lecky	https://sjtrem.biomedcentral.com/track/pdf/10.1186/s13049-021-00870-w.pdf
'Do methods of hospital pre-alerts influence the on-scene times for acute pre-hospital stroke patients? A retrospective observational study' (2021)		Jacob Gunn	
'Ambulance service call handler and clinician identification of stroke in North East Ambulance Service' (2021)		Graham McClelland, Emma Burrow	
'Hangings attended by ambulance clinicians in the North East of England' (2021)		Graham McClelland, Lee Thompson, Gary Shaw	https://www.ingentaconnect.com/contentone/tcop/bpj/2021/00000006/00000003/art00007



What others say about us as a Provider

Care Quality Commission (CQC)

NEAS is required to register with the Care Quality Committee and its current registration is 'Registered Without Conditions'.

NEAS has not participated in any special reviews or investigations by the Care Quality Commission during the reporting period. The Care Quality Commission has not taken enforcement action against the Trust during 2021/22.

	Safe	Effective	Caring	Responsive	Well-led	Overall
Emergency & urgent care	Good Nov 2016	Requires improvement 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016
Patient transport services	Good Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016
Emergency operations centre	Requires improvement ↔ 2019	Good ↔ Jan 2019	Good ↔ Jan 2019	Good ↔ Jan 2019	Good ↑ Jan 2019	Good ↑ Jan 2019
Resilience	Good Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016
Overall	Good ↔ Jan 2019	Good ↔ Jan 2019	Good ↔ Jan 2019	Good ↔ Jan 2019	Good ↔ Jan 2019	Good ↔ Jan 2019

2018 Unannounced Inspection CQC rating. Core services inspected; Emergency Operations Centre and NHS111 Service NB. all inspections are currently paused due to the COVID-19 pandemic

Audit One

Governance, risk management and control arrangements should provide a good level of assurance that the risks identified are managed effectively. Audit One provides external auditing of our services on an annual basis.

Three services were reviewed during 2021/22:

- Infection Prevention Control: High level of compliance with the control framework. Good compliance with some minor updates to policies required.
- Coroners and Claims: Audit commenced: results expected April 2022.
- Board Assurance Framework and Risk Management: planning stages.

Review of 2021/22 Performance

NHS Foundation Trusts are required to report performance against a core set of indicators using data available through NHS Digital. Trusts are required to report only on the indicators that are relevant to the services they provide or subcontract. For ambulance services these include the speed of response, performance, and clinical indicators.

We know that the last 18 months have arguably been the hardest ever for NEAS. This financial year has continued to be dominated by efforts to respond to the pandemic. Despite the significant challenges seen during 2020/21, national response standards for C1 and C4 have both been achieved, with improvements across all categories compared to 2019/20. NEAS continues to be one of the best performing Trusts nationally for responding to those patients who are most seriously ill (category 1 response).



Ambulance Response Programme Indicators

Target (minutes)	Mean response time	National response time	Response 90th Percentile	National response 90th percentile	Benchmark Ambulance trusts	Better or worse than previous year	Previous performance	Mean	National	90th %	National
Category 1 - Life threatening (eg resuscitation needed)							Previous performance	Mean	National	90th %	National
07 90% within 15	06:56	08:51	12:13	16:08	1st	↑	2018/19	06:10	07:21	10:36	12:48
							2019/20	06:39	07:19	11:22	12:51
							2020/21	06:26	07:07	11:01	12:33
Category 2 - Emergency (eg stroke, chest pain)							Previous performance	Mean	National	90th %	National
18 90% within 40	36:39	18:00	01:17:13	40:00	4th	↑	2018/19	21:33	21:50	45:18	00:44:59
							2019/20	29:29	23:53	01:03:32	00:49:16
							2020/21	25:38	20:57	00:53:37	00:42:43
Category 3 - Urgent (eg conditions needing treatment and transfer to hospital)							Previous performance	90th %	National		
90% within 120	01:52:48	02:00:00	04:50:58		3rd	↑	2018/19	02:55:50	02:26:00		
							2019/20	03:47:41	02:50:20		
							2020/21	02:54:57	02:07:53		
Category 4 - Non-Urgent (eg transportation to ward or clinic)							Previous performance	90th %	National		
90% within 180	01:32:33	03:00:00	03:37:55		1st	↑	2018/19	02:54:23	03:09:04		
							2019/20	03:09:18	03:19:42		
							2020/21	02:36:59	02:57:20		

Ambulance Quality Indicators (AQIs)

All UK ambulance services participate in the national ambulance clinical quality indicators. These measures benchmark the clinical care provided by ambulance services for patients who have had a cardiac arrest including post-Return of Spontaneous Circulation (ROSC), stroke, ST Elevation Myocardial Infarction (STEMI), which is a heart attack where there are changes seen on an ECG heart tracing, and sepsis patients.

Each indicator is calculated based on clinically relevant times, delivery of relevant clinical care criteria which can include patient outcomes. They are routinely reported four months in arrears so current data is complete until September 2021.



NEAS considers that this data is as described for the following reasons:

- National guidance and definitions for Ambulance Quality Indicators (AQI) submissions to NHS Digital when producing category-performance information.
- This information is published every month on the NHS England statistics web pages as part of the AQIs.
- Ambulance trusts peer review AQI definitions interpretations and calculations as part of the annual workload of the NAIG (National Ambulance Information Group) to make sure that all are measured consistently.
- We are aware through peer review audits that are some variances in the way other Trusts are reporting.
- This information is reported to the Board of Directors monthly in the Integrated Quality and Performance Report

The reports of the national audits and clinical outcomes programmes were reviewed by NEAS in 2020/21. NEAS attended 2,565 cardiac arrests in the six months period published, which is the highest number ever recorded and despite this increase we saw improvements in our cardiac arrest outcomes, with performance above the national average in all measures.

ACQI	2020/21	2021/22	Peer	Comments
Return of spontaneous circulation*	21.38% Mar 21	25.8% Sep 21	34.20%	NEAS performs in the highest 25% of all Ambulance Trusts
Return of spontaneous circulation (Utstein)**	50.0% Mar 21	50.0% Sep 21	77.80%	NEAS performs in the highest 25% of all Ambulance Trusts
Survival to 30 days*	-	7.3%	9.40%	Using survival to 30 days allows us to identify the outcome for 99% of cardiac arrest patients which is significantly higher than the survival to discharge
Survival to 30 days (Utstein)*	-	26.9%	43.50%	Using survival to 30 days allows us to identify the outcome for 99% of cardiac arrest patients which is significantly higher than the survival to discharge
Sepsis care bundle	76.0% April 21	85.05%	83.7%	Assessment and care provided to patients for suspected sepsis and the pre alert call we make to the receiving hospital, so that they are prepared for the patients arriving. Performance against the sepsis care bundle has remained relatively consistent. It should be noted that within the North East there is a regionally agreed sepsis process which differs slightly to the national indicator.
Stroke care bundle**	99.0% Apr 21	98.50%	98.5% Aug 21	Assessment and care provided for suspected stroke patients by our staff on scene, with onward transfer to an appropriate hospital site providing acute stroke care. NEAS perform consistently well against the stroke care bundle metric and is one of the highest performing ambulance trusts.
STEMI care bundle**	94% April 21	83.70%	77.1% Aug 21	Patients with symptoms a heart attack and visible changes on their ECG (heart tracing), indicating a heart attack is occurring, this is known as a ST Elevation Myocardial Infarction (STEMI). NEAS perform consistently well against the station STEMI care bundle.

* (metric introduced 2021/22)

**Data taken from Model Hospital and NHS England and NHS Improvement website: Statistics » Ambulance Quality Indicators (england.nhs.uk)

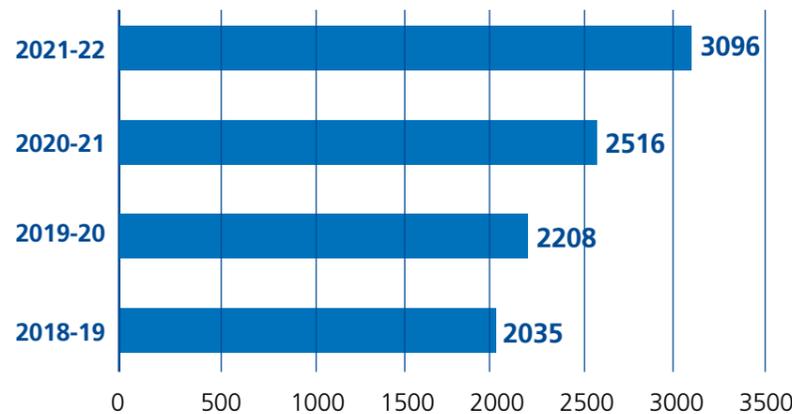
Patient safety data

Patient safety incidents

The Trust aims to provide safe, effective and high-quality care for all patients and service users. One of our priorities is to ensure that lessons are learned wherever possible from patient safety incident investigations, serious incidents (SIs) and Never Events.

The team actively promoted Patient Safety week 2021 emphasising that we want our staff to feel safe so they openly talk about and report incidents, knowing they will be supported throughout investigations with the purpose of reducing the risk of harm and improving patient safety.

We aim to foster a strong patient safety culture and a commitment to improving patient safety. The Patient Safety team promotes a just and restorative culture by providing a psychologically safe space in which staff can openly discuss patient safety incidents and learn from what went well, and what didn't.



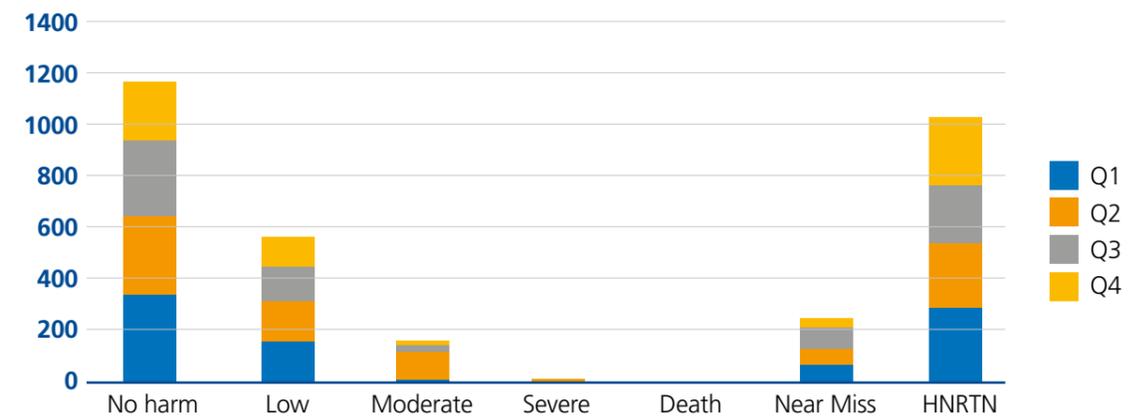
Patient safety incident reporting continues to improve with the available reporting data to date suggesting 2021/22 reporting will surpass 2020/21.

During April 2021 - March 2022 the Trust recorded 3,096 patient safety incidents. This equates to a rate of 1.7% per 1,000 calls answered.

High incident reporting rates with low levels of harm is an indicator of a good safety culture. NEAS continue to be one of the highest reporters of patient safety incidents in the ambulance service in England. NEAS like all Ambulance services faced extraordinary pressure over the past 18 months and demand for 999 and 111 services was unprecedented.

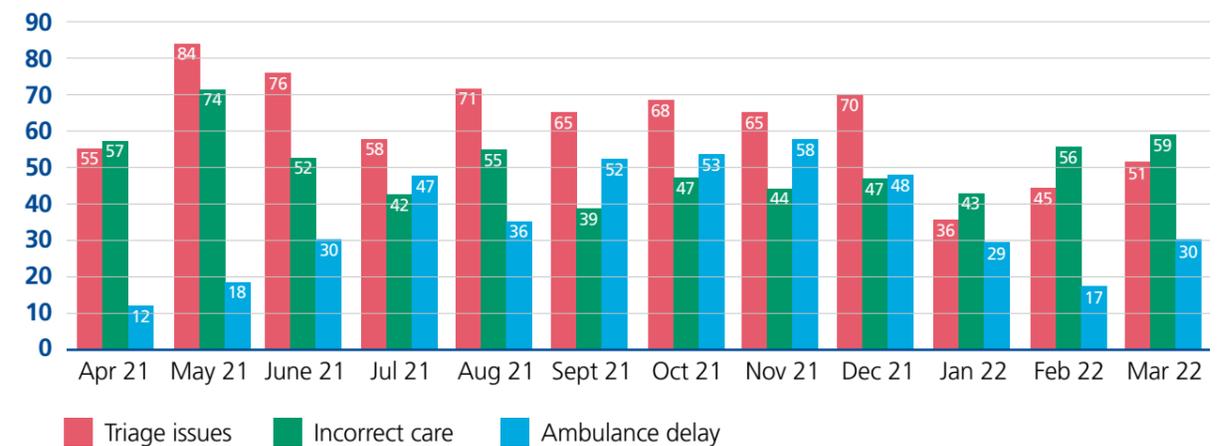
Calls for the most serious conditions, such as cardiac arrests, rose significantly during this period, placing significant pressures on our services and the wider system. Whilst we experienced an increase in incident reporting during 2021/22 to date 96.5% of all incidents have resulted in a low level of harm to our patients.

Patient Safety Incidents Levels of Harm



2020/21 highlighted '111 triage', 'third party provider issues' and 'access, admission, delay, transfer, discharge' as the top three causes for patient safety incidents whilst the top three causes of patient safety incidents for 2021/22 are triage issues, incorrect care and ambulance delays.

PSI Themes: Top 3 Cause Groups



We updated the Ulysses system on 1st April 2021 to include two sub causes of the incident to enable better analysis of incidents being reported. This has enabled the Patient Safety Team to undertake a thematic analysis of the top 3 three patient safety incident cause groups highlighting:

- The majority of incidents in triage are related to a 'delay in assistance' which is mainly due to problems with accessing a translator.
 - We identified this was due to requests for specific languages where UK based interpreters were limited so we negotiated with the current provider to increase capacity by expanding access to their translators in America.
- Ambulance delays in category 2 ambulances accounted for 50% of the overall ambulance delays with 13% resulting in moderate harm or above to patients.
 - We identified our ambulance disposition rate was increasing and was high when compared to other providers. We acknowledged that this would have been influenced by initiating the no-send policy but introduced a work group to gain a better understanding. We have chosen reducing ambulance delays as a quality priority for 2022/23.
- Inadequate assessment/ monitoring and inappropriate treatment were the dominant themes relating to incorrect care.
 - We introduced a number of initiatives to reduce the number of incidents in relation to sub-optimal care and recognising deteriorating patients.
 - We have chosen to look at using our resources as efficiently as possible by making better use of our clinical model to improve patient care as a quality priority for 2022/23.

We have continued to develop our understanding and insights of patient safety incidents and recurrent themes over the past year, and we have communicated our findings via regular discussions and engagement through our committees,

Executive Safety Panel group and a weekly Patient Safety and Patient Experience Bulletin.

We have reviewed and will continue the following initiatives introduced in 2020/21:

Daily Rapid Review: daily oversight and timely review of all patient safety incidents received within a 24-hour period and determine the next steps for investigation.

Clinical Review Panel: twice weekly review of moderate harm and over incidents. Membership has been reviewed and streamlined to ensure appropriate attendance. The group determines the harm level and level of investigation required and whether Duty of Candour Coronial Notification is applicable.

Executive Safety Panel: weekly review of moderate harm and over incidents with executive oversight and measurement against the serious incident framework. In addition, a thematic review of all incidents discussed to aid the early identification of themes/trends.

In addition, the following groups have been introduced:

Scheduled Care Task and Finish Group: Scheduled Care (patient transport) staff highlighted there was a lack of appropriate feedback following incident reporting. The group was introduced to address concerns and formulate plans to improve feedback and disseminate learning post incident reporting.

Third Party Provider Task and Finish Group: the meeting was introduced to understand the underlying themes arising from patient safety incidents within this category. The number of reported incidents for Third Party Providers reduced as a result of the findings of this group which identified the requirement to reshare NEAS policies and procedures to ensure each Third-Party Provider had access to the most up to date information.

Serious incidents

When things go wrong, we want the investigation process to be as timely as possible so that we do not cause additional harm to service users or their families. We have focussed on responding to serious incidents throughout 2021/22 with 100% of serious incident investigations completed within the 60-day timeframe.

Six cases were reported as a serious incident in 2021/22. Three of the six serious incidents declared are associated with missed opportunities during the call triage aspect of patient care. This theme has continued from 2020/21 where 50% of serious incidents declared were associated with call triage. No recurrent themes were identified for the remaining 3 three serious incidents.

Work continues to refine the management and analysis of patient safety incidents, particularly in the form of thematic analysis, and senior oversight at Director level is in place where there are patient safety incidents which meet the moderate harm or over threshold.

The Serious Incident Review Group is chaired by the Director of Quality, Patient Safety, Innovation and Improvement (Executive Nurse), and membership includes the Medical Director and Chief Operating Officer, other executives and senior clinical managers. The group reviews all patient safety investigation reports including Serious Incident (SI) reports.

The Clinical Commissioning Groups formally review our SI reports and progress against action plans, and we share investigation reports and action plans for SIs and other patient safety incident investigations for oversight and challenge, with our regulators, the Care Quality Commission. NEAS considers that this data we reported is as described for the following reasons:

- We use the Ulysses Safeguard system for reporting and managing all patient safety incidents;

- We use the system to create reports and add data to the National Risk Learning System (NRLS) and have been a contributor to the DPSIMS beta testing project. We also share information with other external agencies such as NHS Protect and the Health and Safety Executive (HSE);
- We conduct weekly/monthly data quality checks to ensure reporting is as accurate as possible.

Learning from deaths

We review the care given by our service for every admitted patient that we find out dies in the 24-hour period after the 999 or 111 call. This allows us to identify any lessons which need to be learned and to make improvements in patient care.

All NHS Trusts and Foundation Trusts use the Structured Judgement Review (SJR) approach for mortality reviews. The process involves a critical review of the healthcare record by trained assessors who comment on specific phases of clinical care reporting on lessons learned and areas for improvement. Between April 2021 - December 2022 NEAS completed 100 SJR level 1 first stage reviews, with 1 case being passed to SJR second stage review.

NEAS changed the way that delayed ambulance responses were reported and investigated. These are now handled via the patient safety process instead of Learning from Deaths. NEAS also changed the way that patients that die in care are monitored and reported. We have developed a suite of reports to understand mortality which specifically explores the impact of delayed ambulance handover, responses and outcomes following contact with NEAS services.

We have developed real time alerts to contribute to public health work with the aim of reducing avoidable drug overdose related deaths and this initial project is currently being evaluated.

NEAS has not received any Regulation 28 prevention of future deaths notices during 2021/22.



Preparing for Patient Safety Incident Response Framework (PSIRF)

The PSIRF calls for a new approach to incident management, one which facilitates learning and improvement with the emphasis placed on the system and culture. The aim is to support continuous improvement in patient safety through how we respond to patient safety incidents. One of the underpinning principles of PSIRF is to do fewer investigations but to do them better by ensuring systems-based investigations are undertaken by people that have been trained to do them.

PSIRF will be introduced during 2022 and we will need to ensure we have support structures for staff and patients involved in patient safety incidents, part of which is the fostering of a psychologically safe culture shown in our leaders, our trust-wide strategy and our reporting systems. We have identified preparing for PSIRF as a Quality Priority for 2022/23 as we recognise there is a significant amount of work to be completed to achieve this ambition.

Infection Prevention and control (IPC)

The pandemic response for ambulance services across the UK continues to be managed centrally for IPC. The National Ambulance Service IPC Group (NASIPCG) consists of the Heads of IPC from all UK Ambulance Services and represents the Ambulance sector within the National IPC Cell, led by NHS England, which is responsible for the development and review of the National IPC Guidance. The NEAS IPC Manager is an active member of this group and currently meets with specialists from the four UK nations weekly to review the latest IPC evidence and guidance and to assist with the development and implementation of new national ambulance service policy.

The last year has continued to present a number of challenges to the Ambulance Service but however we have mitigated the risk to our patients and staff by following national IPC guidance for the management of COVID-19 including the Association of Ambulance Chief Executives (AACE) 'Hierarchy of Controls', Working Safely in UK Ambulance Services during Winter 2021-22 and IPC precautions during hospital handover delays guidance.

All areas of the service have been risk assessed against the 'Working Safely' guidance to ensure the environment is COVID-19 secure. All staff are expected to adhere to 1 one metre plus distancing, perform adequate hand hygiene and twice weekly Lateral Flow Tests (LFTs) testing. Patient facing staff have access to appropriate Personal Protective Equipment (PPE) supplies and been fit tested to maintain staff and patient safety. Non-clinical areas are kept COVID-19 secure by perspex screens between desks in the Emergency Operations Centre and agile workspaces and the use of surgical masks when walking around buildings.

It is important that staff maintain high standards of infection prevention and control practice when caring for patients. The number of clinical practice audits to monitor compliance was limited during 2021/22 but the results demonstrated high standards were achieved:

Vehicle Cleanliness scores

	Emergency Vehicles 97.8% 102 audited
	Patient Transport vehicles 99.7% 162 audited
	Ambulance care service vehicles 97% 19 audited

Staff IPC compliance scores

	Hand hygiene 97.2% 107 audited
	Glove use 97.2% 108 audited
	Apron use 97.2% 196 audited
	Bare below the elbow 97.3% 113 audited

Incidents relating to COVID-19 and IPC were reviewed for incident trends, key learning and also levels of harm. All of the incidents reported were no or low harm. Our IPC Team successfully managed outbreaks at a number of our sites including EOC reducing the pressure on our operational delivery during what was an already challenged period due to increased demand and staff absences.

The safety of our patients, communities and staff is paramount and we have taken a strong and proactive approach to staff vaccination throughout the pandemic and as a result the majority of our staff received both doses of the COVID vaccine.

Patient experience

Patient feedback

The Trust recognises that sometimes things do not happen in the way we would wish and there are occasions where our services either fall short of the required standards or do not meet the expectations of our patients, their families or care providers. NEAS fosters a culture of openness and accountability when dealing with complaints and we will apologise and investigate matters to understand why things went wrong and ensure that appropriate action is taken to reduce the risk of them being repeated.

We have been working in preparation for the new Parliamentary and Health Service Ombudsman (PHSO) Complaints standards. The Complaint Standards should provide a more consistent approach to complaint handling across organisations delivering NHS services promoting a culture that seeks to learn from complaints, treats people fairly, and works to resolve problems in a timely way.

NHS Trusts were invited to pause the management of complaints during the first wave of the COVID-19 pandemic. There was no national pause in the management of complaints during the second wave and, it was accepted that Trusts could extend their timescales for responding in negotiation with complainants.

Throughout 2021/22 the Patient Experience Team streamlined their governance processes and prioritised responding to service user complaints to ensure there is a timely response and action as appropriate.

Research consistently confirms that positive patient experience correlates with better health outcomes.

The Trust continues to receive more appreciations than complaints.

Our service users, their families and care givers expect quick, seamless interactions with us and want to receive a response through their preferred methods of communication. We offer email, Microsoft Teams conference calling technology and face to face meetings where possible to help us understand your concerns and feedback.

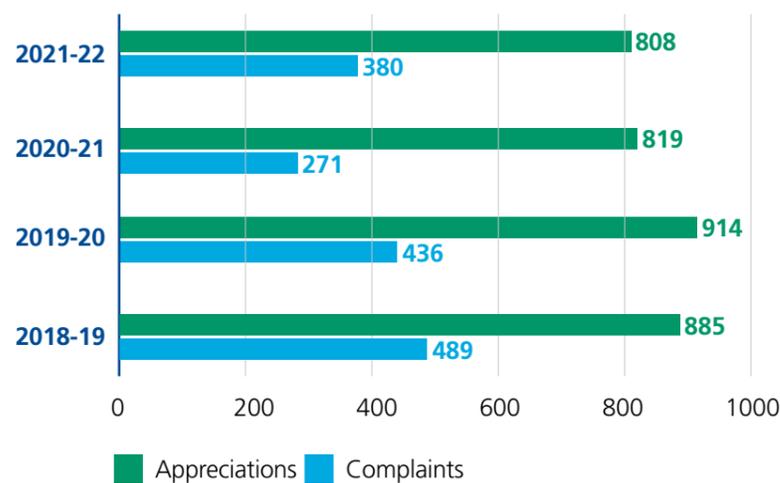
We also provide people with an opportunity to let us know how we have handled a complaint by providing a weblink for feedback in our formal response letter to a complaint.

Understanding patient experience is critical to our recovery from COVID-19 and for our services to be successful going forward. The top 3 themes for patient complaints are quality of care, staff attitude and timeliness of response. Complaints and lessons learned from them are shared at individual, team and divisional meetings and with the Board, Commissioners and CQC via the Quality and Safety Quarterly Report.

Further details and analysis of the Trust Complaints, Concerns and Comments data can be found in the Trust's Annual Patient Experience Report available at [How we are doing - North East Ambulance Service - NHS Foundation Trust \(neas.nhs.uk\)](https://www.nhs.uk/our-services/north-east-ambulance-service).

The Trust recognises it has more work to do to learn from and improve its complaint handling and has identified 'Involve our patients & communities to improve care' as a quality priority for 2022/23.

Patient Feedback Complaints vs Appreciations



You said. We did.

We do consider all feedback about the management of the process and we have ensured that we have made some changes to how we manage complaints to improve the process for complainants as a result of their feedback:

You felt that you wanted a quicker complaint response.

- We explained that, due to demand on our service, there were delays in responding to complaints.
- We made every effort to minimise any delay to responses, and during the first 6 months of 2021/22 we still managed to maintain an average response timeframe of 33 days.



Thinking of the service we provide. Overall how was your experience of the service.

Friends and Family survey and engagement

		Very good / good	Poor/ very poor	Responses
PTS	Percentage	93.2%	2.4%	1,200
	Count	1118	29	
111	Percentage	76.0%	13.5%	1,890
	Count	1436	255	
999 See and Convey	Percentage	90.6%	5.0%	4,234
	See and Convey	3836	211	
999 See and Treat	Percentage	96.8%	1.1%	469
	See and Treat	454	5	

The engagement and inclusion team would usually work closely with community groups, attend public events and host a number of community events across the year but the ongoing pandemic response has posed challenges for patient and community engagement and all physical engagement was paused during this period of time.

Despite the restrictions the team has achieved the following:

- Collected, collated and analysed 7,793 responses to our patient surveys between April 2021 to January 2022
- Delivered a Positive Action Project targeting ethnic minority communities. The project has worked with 96 community organisations to deliver 53 sessions and train 768 individuals. 687 people have been trained in service awareness and 658 people in lifesaving skills including CPR and defibrillators
- Recruited and trained 60 community ambassador volunteers to work in ethnic minority communities and improve awareness of our services and how to access them
- Developed new online engagement spaces on our website www.neas.nhs.uk/patient-info.aspx. This includes areas for adults, young people, people with learning disabilities and British Sign Language users with content tailored to the needs of each group and delivered in accessible communication formats
- Developed 108 individual videos to help patients and the public obtain more information about our services including an interactive ambulance 360 tour and service awareness and information videos
- Liaised with the public to identify key questions they wanted answers for from paramedics and developed an 'ask a paramedic' section of our website with short videos answering each question www.neas.nhs.uk/patient-info/ask-a-paramedic.aspx
- Attended two virtual Pride events in Newcastle and Sunderland and sponsored one of the Sunderland sub events
- Attended four community/school events to promote our services
- Liaised with several schools virtually as part of 'restart a heart' day
- Held a virtual disability and ethnic minority recruitment event in partnership with six regional NHS Trusts
- Continued to hold our Health Watch Ambulance forum virtually each quarter and liaise with them on key decisions and service challenges and receive community feedback
- Continued to hold our Stakeholder Equality group every four months and reviewed key decisions relating to diversity and inclusion, undertaking assessments against the NHS Equality Delivery System and receiving community feedback
- Launched an Engagement Diversity and Inclusion Twitter page and attracted over 150 followers @NEAS-EDI

Clinical Effectiveness

	2020/21	2021/22
999 calls answered	439,940	520,899
111 calls answered	864,050	675,912
Patients taken to hospital	266,013	412,068
Patients treated at home	127,352	115,319
Patients treated over the phone	34,306	48,054
Patients taken to hospital appointments	284,507	272,186
incidents attended by our crews	393,365	387,440
average C1 Ambulance response times for our emergency patients	06:26	06:56

	2018/19	2019/20	2020/21	2021/22
Hear & Treat	20,996	23,958	34,306	48,054
	5.1%	5.7%	8.0%	11.03%
See & Treat	104,697	113,465	127,352	115,319
	25.20%	26.80%	29.78%	26.48%
See, Treat & Convey	289,009	285,846	266,013	272,186
	69.70%	67.50%	62.20%	62.49%
See & Convey to ED	242,112	242,864	229,497	230,687
	58.04%	57.40%	53.66%	9.53%

At the start of the first wave and lock down of the COVID-19 pandemic NEAS worked with private ambulance providers to increase the number of frontline ambulances available to respond to emergencies, and to provide resilience in the event the Trust lost high numbers of our own staff due to sickness or self-isolation. This allowed us to allocate the most appropriate resource to our category 3 and 4 calls so we could ring fence practitioners to respond to patients, treating them in their own home where appropriate. This has led to a safer and better experience for our patients and has relieved the pressure on Emergency Departments throughout the region.

Acute Mental Health

NEAS's Executive Director for Quality and Patient Safety is currently co-sponsor of the ICS Mental Health Crisis Leadership Group alongside the Deputy Chief Operating Officer for Cumbria Northumberland Tyne and Wear (CNTW) NHS Foundation Trust. The aim of the group is to work with our partners to seek alternatives to crisis services and how these can improve patient pathways.

2 Hour Urgent Community Response Teams (100-day challenge)

In line with NHS planning guidance, by 31st March 2022 all Integrated Care Systems (ICSs) in England must deliver the national community two-hour crisis response standard. As part of the standard, crisis response care must be provided to people in their homes or usual place of residence within two hours. The trust is currently working with our partners throughout the ICS to review Urgent Community Response and Community Services to fulfil this challenge.



Quality Improvement (QI)

Why do we do QI?

The overall aim of healthcare QI is simple - to provide high-quality care to patients. For everything we do well there is something else that is not working right or that causes frustration, delay or wasted effort. Sometimes processes and systems can get in the way of delivering the best possible service and that is where the QI team can help.

The QI team works together with many departments across our organisation to consider which approach is best suited and how we can work together to resolve problems. There are always problems to solve, and the team has benefitted from support by operational colleagues posted to alternative duties throughout the COVID-19 pandemic. This support has helped the team undertake more projects and the team has benefited from the knowledge of operational colleagues whilst these colleagues will be able to use the quality improvement skills and techniques they have developed whilst working with the team in their everyday work.

We want all our staff to look continually to improve our services, and understanding QI is an important part of the Trust's induction programme.

New employees are also given a guide on the key principles of the QI approach.

The 'Model for Improvement' guide and Plan, Do, Study, Act cycle (PDSA) is used as part of internal project management training to help support departments throughout the QI process.

The QI team delivered sessions to partners across the higher education sector from Teesside University and Sunderland University and supported a cohort of student nurses from Northumbria University through 2021. This is part of our ongoing work to look at embedding the principles of quality improvement into everything we do.

We are active in and have shared learning with multiple groups including the regional Human Factors group, the National Ambulance Association QI forum, the Academic Health Service Network and Ambulance QI.



What have we done this year?

1 Handover work at James Cook University Hospital



Why? Handovers delays can pose a risk to our patients and have a negative effect on patient and staff experience. Reducing handover delays will free up our crews so they are in the community responding to the patients who need them the most.

How? We worked with staff at James Cook University Hospital and North Tees General Hospital to look at how we can improve the pathways into the ED department and use established referral pathways to reduce waits. We also looked at using technology to improve the effectiveness of the booking processes.

How have we helped? We have seen some improvement at North Tees in the turnaround time for our patients at the ED which means our patients are admitted quickly and our crews are released to see other patients quicker. We are working with South Tees and Tees Valley Commissioners to help improve the flow of patients in their ED. We are already seeing improvements including new IT support, better signage and new systems and we expect to see further improvements in 2022/23.

2 Downtime

Why? We wanted to review our ability to be able to respond safely to our patients and understand our reasons for 'downtime' (the times our crews are not available for patients).

How? We looked at the codes used by our crews to understand why they were not available and if a more appropriate code could be used to provide our operational teams with the best information possible so they could make decisions on how to best manage resource against patient demand.

How have we helped? Understanding where our downtime is and why allows us to safely manage resource against patient demand, so we can respond to patients.



3 Electronic Vehicle Daily Inspection (EVDI)

Why? We must, by law, complete a list of vehicle daily checks to ensure our vehicles are safe to use. We used to complete checks on paper which meant finding and auditing vehicle inspection results and identifying repeated faults was time consuming.

How have we helped? The electronic app and vehicle report are now live and widely used throughout the Trust.

How? We worked with North East Ambulance Service Unified Solutions (NEASUS), Operational colleagues and Informatics to develop an electronic Vehicle Daily Inspection report and supporting app.



What our people tell us?

We engage with and gather feedback from our people in several ways, including: the annual NHS Staff Survey, our Quarterly People Pulse Survey, our recently formed Task Group and we have a number of staff networks. We also gather informal feedback when senior leaders visit hospitals in the welfare car and our internal Workplace social media platform. The executive team have also undertaken live Q and As and roadshows throughout 2021.

NHS Staff Survey 2021

The national annual NHS Staff Survey collates employee views on their experience at work in several key areas and this year the survey has seen significant changes. Many new questions were added, and some removed, to align to the National People Promise and to support the delivery of the NHS People Plan. Due to the significant changes to this year's survey we do not have historical data for all aspects to compare our performance to 2020.

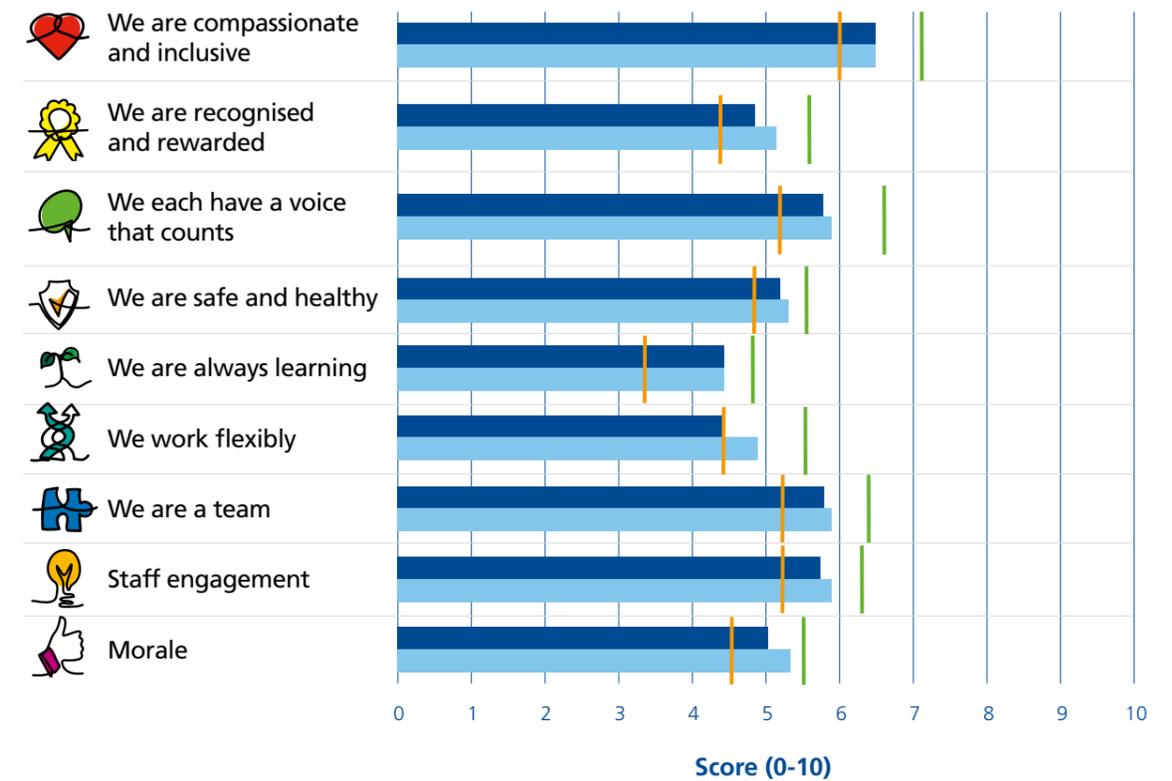
Our response rate however has increased to 50%, recovering the dip we had seen in the last few years. With the size of our workforce, a response rate over 30% indicates that the results are statistically significant.

People Promise Results

The Trust's summary score for each of the seven People Promise elements, and two key themes of morale and staff engagement are shown in Figure 1. It shows the score for NEAS, the average across Ambulance Trusts and the best and worst scores for each Promise and Theme, with 10 being the highest possible positive score. As shown, NEAS scores comparably with the two People Promise elements of 'we are compassionate and inclusive' and 'we are always learning', with all other scores sitting below the average for Ambulance Trusts. We have the lowest score when compared to other Ambulance Trusts for the promise 'we work flexibly'.



Figure 1: NEAS overall scores in relation to the Ambulance Sector average, and the best and worst scores.



	1	2	3	4	5	6	7	8	9	10
Best	7.1	5.6	6.6	5.6	4.9	5.6	6.4	6.3	5.5	
NEAS	6.6	4.8	5.7	5.2	4.4	4.4	5.8	5.7	5.0	
Average	6.6	5.1	5.9	5.3	4.4	4.9	5.9	5.9	5.3	
Worst	6.0	4.4	5.2	4.9	3.3	4.4	5.2	5.2	4.6	
Reponses	1456	1453	1446	1451	1367	1448	1454	1455	1456	

We have studied the feedback from the Staff Survey in conjunction with the data from our January 2022 People Pulse and Task Group which comprises a cross-section of our people. Data shows us that overall performance has declined this year. Some of this data is expected due to the pandemic. However, we are below average when comparing to other Ambulance Trusts in several key areas, where action is needed to improve the experience for our teams and colleagues.

We are doing well around some areas including teams working well together, colleagues supporting each other and over the last 5 years, there has been a positive upward trend in terms of colleagues feeling able to raise concerns around clinical practice and reporting violence and aggression.

Our health and wellbeing score from the staff survey is below average, however positive feedback from the January People Pulse indicates recent actions taken to support wellbeing, from the introduction of a wellbeing task and finish group in Autumn 2021 may be starting to have a positive impact for our people.

Despite this, there is a clear indication that colleagues are feeling burnt out. Colleagues stated they were demotivated with feelings of being overworked most prevalent. Colleagues have also highlighted that they feel they don't always have adequate materials and equipment to do their job properly, which has been on a downward trend over the last 5 years.

Our response to the results

We will continue to review all feedback we receive from our people, triangulate the key findings, and use this to ensure the actions we have outlined in our NEAS 9 People Plan will address any concerns raised. Current activities that are in progress that align to our Trust strategy and focus on recovery of our people, include:

Health and Wellbeing:

- Health and Wellbeing Task and Finish group and two Health and Wellbeing Leads in post on a temporary basis
- We have supported COVID vaccine and flu vaccine delivery
- Redesigned 'Help Hub' on our Intranet, for quick access to wellbeing resources.
- We have recently introduced the TRiM (Trauma Risk Management) support programme to support colleagues with difficult and traumatic experiences
- A mental health practitioner will be joining our occupational health team in April 2022

Engagement:

- We continue to gather feedback from our colleagues through a number of routes, including staff networks, live Q&As and roadshows, informal feedback through Workplace and our welfare cars
- Our recently formed Task Group is made up of colleagues across the organisation and they are in the process of considering over 200 ideas from colleagues, such as key operational issues around equipment and resources

Additional Activities:

- We have redesigned our leadership roles in operational teams to improve visibility and provide dedicated clinical team leadership support
- We are reviewing leadership development to better support our leaders and offer a more flexible approach to training opportunities, including CPD and dedicated time
- Our appraisal approach is under review and will launch later this year
- A refresh of our behaviour framework is underway and due to be launched in the next few months

We will continue to look for new ways to engage with our colleagues to ensure we build a healthy culture across our organisation. We have committed as a Trust to ensure over the coming years we have a set of achievable actions within our People Plan to try and realise our ambition for NEAS to be a great place to work and grow.

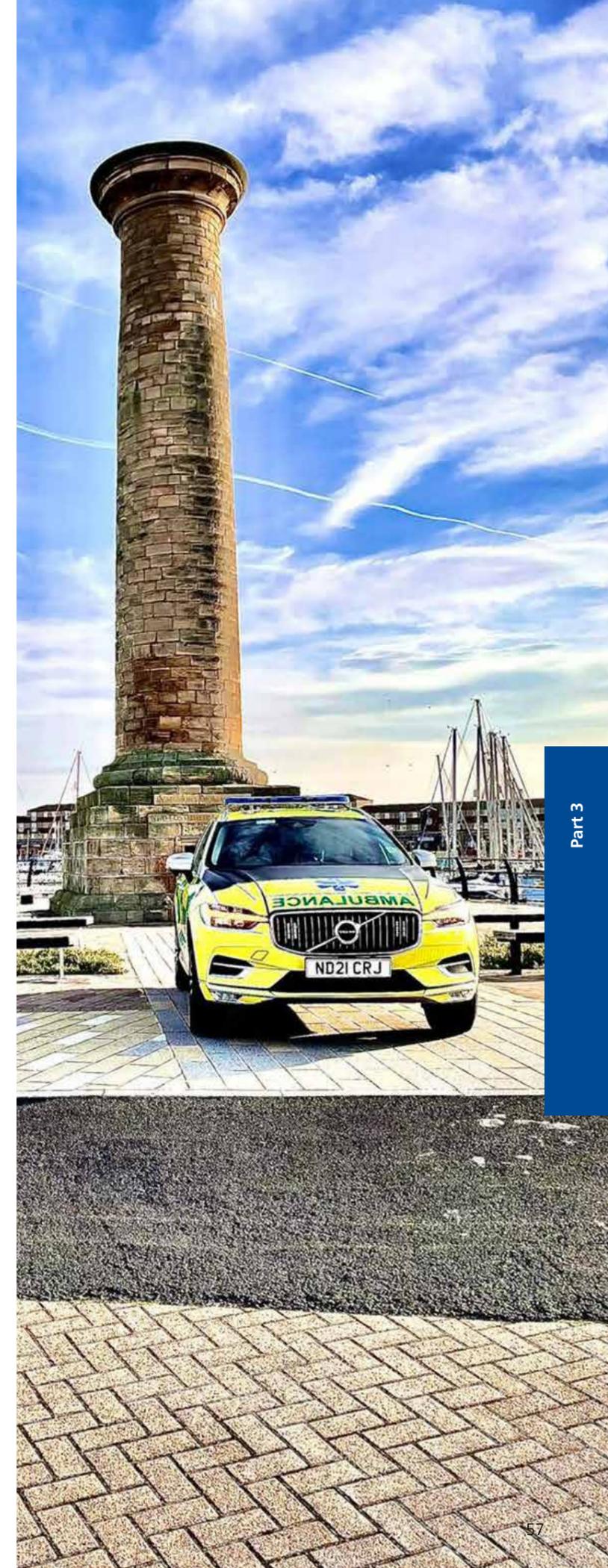
Freedom to Speak Up (FTSU)

FTSU is one component of a wider strategy to develop the Trust as a more open and inclusive place to work. Staff are encouraged to raise concerns about risk, malpractice or wrongdoing with the Trusts Freedom to Speak Up Guardians.

Seven FTSU concerns were raised during 2021/22, none of which related to patient care:

- 2 cases Systems and Process
- 1 case Infrastructure and Environment
- 2 cases Leadership and Management Behaviour
- 2 cases Misuse of NHS Property and Victimisation and Bullying

It is recognised that Freedom to Speak Up is only one mechanism for raising concerns within the Trust. The Trust is also a high reporter of incidents, which again provides assurance that staff feel confident in reporting issues through the formal incident reporting channels; however, further work is required to promote engagement with the staff survey. The People and Development Committee and Board of Directors have been apprised of Freedom to Speak Up activity during the year.



Annexes

Stakeholder Engagement

We have developed our Quality Accounts with, and for, those who have an interest in and influence on our approach to the quality of our services. We recognise the value of listening to patients, public and staff when setting our quality priorities. When producing this report, we have involved everyone who has an interest in our organisation. This has been a continuing process throughout the financial year.

Statement of directors' responsibilities for the Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year. NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report. Guidance used for this quality report was published for 2021/22 reports.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2021/22 and supporting guidance;
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
 - board minutes and papers for the period April 2021 to March 2022;
 - papers relating to quality reported to the board over the period April 2021 to March 2022;
 - feedback from commissioners dated X;
 - feedback from governors X;
 - feedback from local Healthwatch organisations X;
 - feedback from Overview and Scrutiny Committees; Durham County Council Adults

Wellbeing and Health Overview and Scrutiny Committee, . X Newcastle City Council Overview and Scrutiny Committee;

- the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009 dated X;
- the latest national staff survey 2021
- the Head of Internal Audit's annual opinion over the trust's control environment – not applicable for 2021/22 Quality Report;
- CQC inspection report dated 10 January 2019.
- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered; 1st April 2021 to 31st March 2022
- the performance information reported in the Quality Report is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and
- the Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

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

By order of the Board



Peter Strachan Chair



Helen Ray CEO

Abbreviations

AED	Automated External Defibrillator
ARP	Ambulance Response Programme
ACQIs	Ambulance Clinical Quality Indicators
AQIs	Ambulance Quality Indicators
BAME	Black, Asian & Minority Ethnic
CARe	Care and Referral
CQC	Care Quality Commission
CCG	Clinical Commissioning Group
CPR	Cardiopulmonary Resuscitation
CQUIN	The Commissioning for Quality and Innovation payments framework
DBS	The Disclosure and Barring Service
DoS	Directory of Services
CCM	Clinical Care Manager
ED	Emergency Department
EMR	Emergency Medical Responder
EOC	Emergency Operations Centre
EoLC	End of life care
ESR	Electronic Staff Record
EPRF	Electronic Patient Report Form
FOT	Forecast Outturn
FTE	Full Time Equivalent
HENE	Health Education North East.

HSE	Health and Safety Executive
ICaT	Integrated Care and Transport
LGBT	Lesbian, Gay, Bisexual and Transgender
NCA	National Clinical Audit
NEAS	North East Ambulance Service NHS Foundation Trust
NHS	National Health Service
NRLS	National Reporting and Learning System
PALS	Patient Advice and Liaison Service
PbR	Payment by Results
PHKiT	Pre-Hospital Knowledge in Trauma
QGG	Quality Governance Group
RCA	Route Cause Analysis
SPN	Special Patient Note
UEC	Urgent & Emergency Care

Glossary of Terms

Term	Definition
Accessible Information Standard	The Accessible Information Standard aims to make sure that disabled people have access to information that they can understand and have any communication support they might need. All organisations must follow this standard in full by 31st July 2016.
Advanced Practitioner (AP)	An Advanced Practitioner provides advanced primary care skills. May be a paramedic or a nurse with advanced skills.
Ambulance Quality Indicators	These are the Ambulance sector's national quality indicators.
Ambulance Response Programme (ARP)	NHS England is conducting a programme of work that is exploring strategies to help ambulance services reduce operational inefficiencies whilst remaining focused on the need to maintain a very rapid response to the most seriously ill patients and improve the quality of care for patients, their relatives and carers.
Care bundle	A care bundle is a group of between three and five specific procedures that staff must follow for every single patient. The procedures will have a better outcome for the patient if done together within a certain time limit, rather than separately.
Care Quality Commission (CQC)	The independent regulator of all health and social-care services in England. The commission makes sure that the care provided by hospitals, dentists, ambulances, care homes and services in people's own homes and elsewhere meets government standards of quality and safety.
Category 1	For those patients that require an immediate response to a life threatening condition and where this requires resuscitation or emergency intervention from the ambulance service. This requires a 7 minute response, and 90th percentile is measured.
Category 2	For those with symptoms linked to a serious condition, for example stroke or chest pain, that may require rapid assessment and / or urgent transport. This requires an 18 minute response, and 90 percentile is measured.
Category 3	Is for those urgent problems that require treatment and transport to an acute care provider. This requires a 2 hour response (90th percentile)
Category 4	Is for those that are not urgent and require transportation to a hospital ward or clinic within a given time window. This requires a 3 hour response (90th percentile)
Clinical Commissioning Groups (CCGs)	Clinical Commissioning Groups are NHS organisations set up by the Health and Social Care Act 2012 to organise the delivery of NHS services in England.

Clinical audit	A clinical audit mainly involves checking whether best practice is being followed and making improvements if there are problems with the way care is being provided. A good clinical audit will find (or confirm) problems and lead to changes that improve patient care.
Clinical effectiveness	Clinical effectiveness means understanding success rates from different treatments for different conditions. Methods of assessing this will include death or survival rates, complication rates and measures of clinical improvement. This will be supported by giving staff the opportunity to put forward ways of providing better and safer services for patients and their families as well as identifying best practice that can be shared and spread across the organisation. Just as important is the patient's view of how effective their care has been and we will measure this through patient reported outcomes measures (PROMs).
Commissioning for Quality and Innovation (CQUIN) payment framework	The Commissioning for Quality and Innovation payment framework means that a part of our income depends on us meeting goals for improving quality.
Contact centre	The first point of contact for 999, 111 and Patient Transport Services patients who need frontline medical care or transport.
Core services	Our core services are accident and emergency, NHS 111, Community First Responders, the patient transport service and emergency planning.
Disclosure and Barring Service	The Disclosure and Barring Service (DBS) helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups, including children. It replaces the Criminal Records Bureau (CRB) and Independent Safeguarding Authority (ISA)
Directory of Services (DoS)	Once we have decided on the appropriate type of service for the patient – so that we can direct them to a service which is available to treat them – we use a system linked to a directory of services. This directory contains details of the services available, their opening times and what conditions and symptoms they can manage, within an area local to the patient.
End-of-life patients	Patients approaching the end of their life.
Electronic Staff Record (ESR) system	Electronic staff record system used in the Trust to hold personnel related information.
Enforcement action	Action taken against us by the Care Quality Commission if we do not follow regulations or meet defined standards.
Electronic Patient Report Form (EPRF)	The Electronic Patient Report Form uses laptops to replace paper patient report forms. Ambulance staff attending calls can now download information on the way, access patients' medical histories, enter information in 'real time' and send information electronically to the accident and emergency department they are taking the patient to and to the patient's GP practice.

Foundation Trust Boards	These make sure that trusts are effective, run efficiently, manage resources well and answer to the public.
Governors	Foundation Trust members have elected a council of governors. The council is made up of 21 public governors and four staff governors, plus nine appointed governors.
Governor Task and Finish Group	A group set up to identify which priority areas and risks should be included in a specific document, such as the annual plan or quality account.
Handover and turnaround process	Handover is the point when all the patient's details have been passed, face-to-face, from the ambulance staff to staff at the hospital, the patient is moved from the ambulance trolley or chair into the treatment centre trolley or waiting area and responsibility for the patient has transferred from the ambulance service to the hospital. Turnaround is the period of time from an ambulance arriving at hospital to an ambulance leaving hospital.
Health Act 2009	An Act relating to the NHS Constitution, healthcare, controlling the promotion and sale of tobacco products, and the investigation of complaints about privately arranged or funded adult social care.
Hear and Treat	A triage system designed to assess patients over the phone and to provide other options in terms of care, where appropriate, for members of the public who call 999.
Health Education North East	Health Education North East supports Health Education England to ensure local workforce requirements are met and there is a competent, compassionate and caring workforce to provide excellent quality health and patient care.
SIREN	This has is a bespoke Microsoft SharePoint site which has been developed across the trust as a communication tool, sharing information, learning and news updates.
Major trauma	Major trauma means multiple, serious injuries that could result in death or serious disability. These might include serious head injuries, severe gunshot wounds or road-traffic accidents.
Monitor	The independent regulator of NHS Foundation Trusts.
National Ambulance Quality Indicators (AQIs)	Measures of the quality of ambulance services in England, including targets for response times, rates when calls are abandoned, rates for patients contacting us again after initial care, time taken to answer calls, time to patients being treated, calls for ambulances dealt with by advice over the phone or managed without transport to A&E, and ambulance emergency journeys.
National clinical audit	National clinical audit is designed to improve the outcome for patients across a wide range of medical, surgical and mental health conditions. It involves all healthcare professionals across England and Wales in assessing their clinical practice against standards and supporting and encouraging improvement in the quality of treatment and care.

National confidential enquiries	Investigations into the quality of care received by patients to assist in maintaining and improving standards.
NHS (Quality Accounts) Regulations 2010	Set out the detail of how providers of NHS services should publish annual reports – quality accounts – on the quality of their services. In particular, they set out the information that must be included in the accounts, as well as general content, the form the account should take, when the accounts should be published, and arrangements for review and assurance. The regulations also set out exemptions for small providers and primary care and community services.
NHS Foundation Trust Annual Reporting Manual 2014/15	Sets out the guidance on the legal requirements for NHS Foundation Trusts' annual report and accounts.
Pathways	A system developed by the NHS which is used to identify the best service for a patient and how quickly the patient needs to be treated, based on their symptoms. This may mean the patient answering a few more questions than previously. All questions need to be answered as we use them to make sure patients are directed to the right service for their needs. Types of service may include an ambulance response, advice to contact the patient's own GP or an out-of-hours service, visit the local minor injury unit or walk-in centre or self-care at home.
Patient Advice and Liaison Service (PALS)	The Patient Advice and Liaison Service offers confidential advice, support and information on health-related matters. They provide a point of contact for patients, their families and their carers.
Patient experience	This includes the quality of caring. A patient's experience includes how personal care feels, and the compassion, dignity and respect with which they are treated. It can only be improved by analysing and understanding how satisfied patients are, which is assessed by patient reported experience measures (PREMS).
Patient safety	Makes sure the environment the patient is being treated in is safe and clean. This then reduces harm from things that could have been avoided, such as mistakes in giving drugs or rates of infections. Patient safety is supported by the National Patient Safety Agency's 'seven steps to patient safety'.
Quality Committee	This committee gives the Board an independent review of, and assurances about, all aspects of quality, specifically clinical effectiveness, patient experience and patient safety, and monitors whether the Board keeps to the standards of quality and safety set out in the registration requirements of the Care Quality Commission.
Quality dashboard	An easy-to-read, often single-page report showing the current status and historical trends of our quality measures of performance.

Clinical Quality Governance Group	This is a core management group which has the primary purpose of operationalising the Trust's Quality Strategy and managing all aspects of safety, excellence and experience. The CQGG directs the programmes and performance of the quality working groups that report to it.
Quality Strategy	Describes the Trust's responsibilities, approach, governance and systems to enable and promote quality across the Trust whilst carrying out business and planned service improvements.
Relevant Health Services	Services provided by the Trust – Emergency Care, Patient Transport and 111.
Research Ethics Committee	This committee helps to make sure that any risks of taking part in a research project are kept to a minimum and explained in full. Their approval is a major form of reassurance for people who are considering taking part. All research involving NHS patients has to have this approval before it can start.
SharePoint	SharePoint is a software package that can be used to create websites. This can then be used as a secure place to store, organise, share and access information.
See and Treat	A face-to-face assessment by a paramedic that results in a patient being given care somewhere other than an A&E department.
Special reviews or investigations	Special reports on how particular areas of health and social care are regulated.
Ulysses Safeguarding system	The Incident reporting system used by NEAS



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