





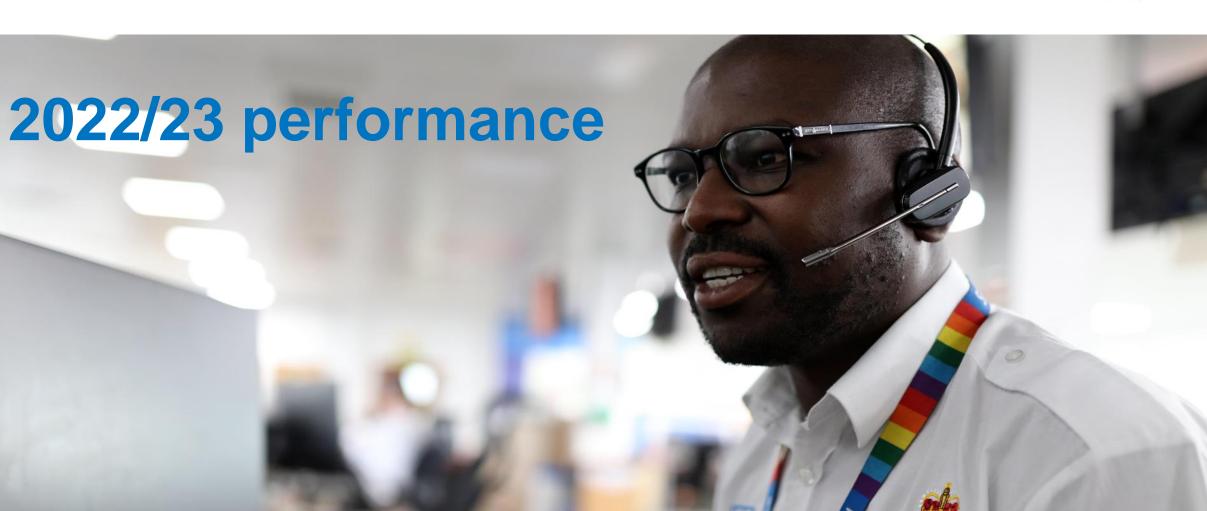
**Mission:** Safe, effective, responsive care for all

Vision: Unmatched quality of care

## Introduction

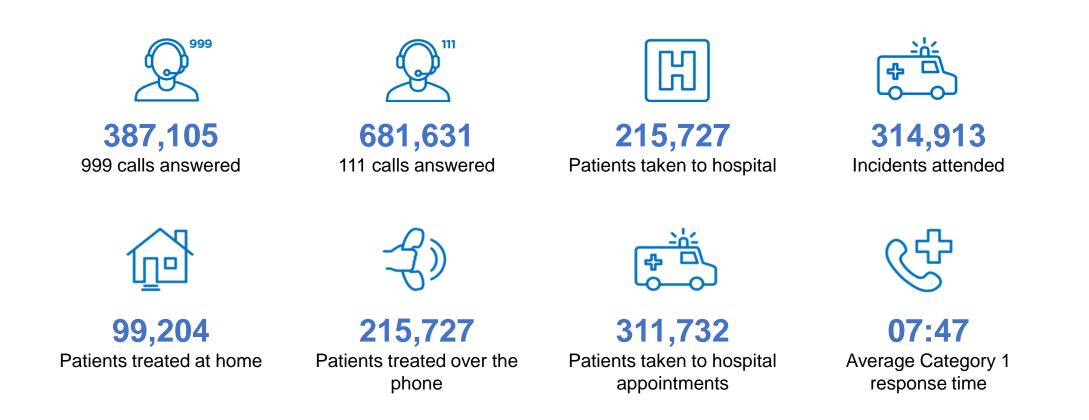
- Overview of Quality Report requirements
- Current position and performance
- Update on 2022/23 quality priorities
- Proposed 2023/24 quality priorities





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# **2022/23 demand on services April 2022- January 2023\*** (\*please note this data is subject to change at the end of the financial year)



# 2022/23 performance April 2022- January 2023\*

(\*please note this data is subject to change at the end of the financial year)

Safety		Clinical Effectiveness	Patient Experience		
		Ambulance Clinical Quality Indicators	Patient Satisfaction Survey		
Q				Very good / good	Very poor / poor
<b>2,825</b> patient safety incidents	<b>31</b> serious incidents	<b>30.7%</b> of patients achieved a return of spontaneous circulation (ROSC)	Patient Transport Service	94.4%	4%
		<b>98.6%</b> stroke care bundles delivered		81.2%	13.1%
		<b>84.2%</b> sepsis care bundles delivered	see & convey	89.1%	7.4%
		86.4% STEMI care bundles delivered	see & treat	96.8%	1.4%

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# Quality priorities

2022/23 quality priority update2023/24 proposed quality priorities

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# Update 2022/23 quality priorities

#### **Patient safety**

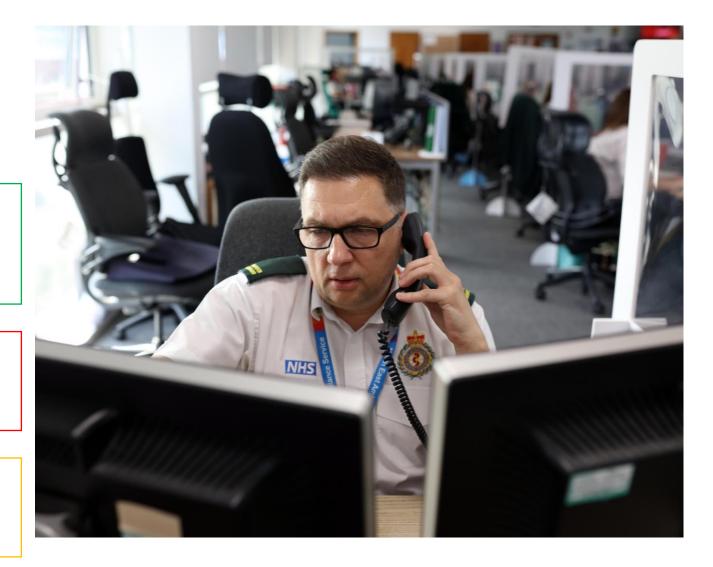
- Working with system partners to reduce handover delays
- Learn from incidents and prepare for the Patient Safety Incident Response Framework (PSIRF)

#### **Clinical effectiveness**

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

#### **Patient experience**

Involve our patients & communities to improve care



## Working with system partners to reduce handover delays

# What we achieved

- We have completed a thematic review of handover delays and developed a comprehensive handover report to share with Acute Trusts
- Worked with the system to develop a handover Standard Operating Procedure and agree a regional commitment to a zero-tolerance approach to handovers over 60 minutes
- Updated clinical safety plan- safe allocation of resources in time of demand

# What we need to do

• Continue working with our system partners to consider ways to improve effectiveness across all parts of our system to reduce handover delays

## Learn from incidents and prepare for the Patient Safety Incident Response Framework (PSIRF)

### What we achieved

- We employed a PSIRF Implementation Programme Lead to provide expert programme leadership and to ensure we meet the transition deadline
- We have completed a gap analysis against the framework to inform our implementation action plan

### What we need to do

• We need to develop our Patient Safety Incident Response Plan and Policy based on our incident profile

# Use our resources as efficiently as possible by making better use of our clinical model

## What we achieved

- Developed our First Contact Practitioner (FCP) workforce improving their skills for the management of low acuity patients
- Completed a benchmarking exercise to identify gaps in out of hospital provision which has enabled us to work with providers to treat patients away from hospital
- Improved access to clinical advice for our staff by introducing a Clinical Team Leader (CTL) role

## What we need to do

- We need to increase mental health expertise in our Emergency
  Operation Centres
- We need to continue working with providers and commissioners to develop mental health and urgent care 2-hour community pathways

## Involve our patients & communities to improve care

## What we achieved

- We have increased our in-person engagements
- Working with regional partners to improve services
- We involve patients through the Stakeholder Equality group and have worked with this group to inform the development of the Equality Plan 2023-27

## What we need to do

 We need to increase our public involvement in service change, service delivery, design and redesign and include our patient representatives on assurance committees.

# Proposed 2023/24 quality priorities

#### **Patient safety**

- To continue working with system partners to reduce handover delays
- Respond to patient safety incidents in a way that leads to service improvements and safer care for all our patients

#### **Clinical effectiveness**

• To be confirmed however it is anticipated it focus on improving see and treat rates or reducing C2 delays or improving mental health care access

#### Patient experience

• To increase service user involvement in our patient safety and patient satisfaction activities



# To continue working with system partners to reduce handover delays

### **Executive Director Lead: Stephen Segasby**

#### Why?

 To handover over patients to Emergency Departments safely within national target timeframe to effectively reduce the risk to our patients, improve patient outcomes and patient and staff experience

#### How?

- Collaborative working with our partners and a system wide approach to finding a solution, improve data sharing, standardise reporting to drive improvements
- 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 moral injury impact of handover delays on our staff
- Review and refine our risk management and escalation arrangements during times of demand
- Review the impact and effectiveness of our clinical procedures to reduce the impact on ED

# Respond to patient safety incidents in a way that leads to service improvements and safer care for all our patients

### **Executive Director Lead: Julia Young**

### Why?

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

#### How?

- Develop robust governance and oversight procedures
- Understanding of our incident profile and local safety priorities
- Ensure investigators have received appropriate training in communication of patient safety incidents including 'being open' and Duty of Candour
- Improve system wide learning to improve the quality of care we provide to our patients.
- Work closely with partners to identify and mitigate risks across the system and implement the Patient Safety Incident Response Framework
- Include staff health and wellbeing as a critical component of patient safety

## **Clinical effectiveness to be confirmed**

**Executive Director Lead: Dr Kat Noble** 

### Why?

• To create a culture of continuous improvement and learning so our patients receive the best care

### Potential areas of focus

- Safely reducing avoidable conveyance/ improvement of see and treat rates
- Initiatives to improve Category 2 response rates
- Work with providers and commissioners to develop mental health and urgent care 2-hour community pathways
- Clinical supervision of operational workforce

# To increase service user involvement in our patient safety and patient satisfaction activities

**Executive Director Lead: Julia Young** 

#### Why?

• To reinforce the patient voice at all levels in an organisation by strengthening service user/family/ staff involvement in the shaping and delivery of our patient safety priorities

#### How?

- We will seek patient and staff feedback and involvement in service change, service delivery, design and redesign
- We will adopt the procedures produced by NHS England and NHS Improvement for regular review of Patient Safety Partner (PSP) involvement
- We will identify a lead on the board for PSPs
- We will encourage patient membership of safety and quality committees whose responsibilities include the review and analysis of safety data
- We will encourage patient participation in patient safety improvement projects
- Understanding of the moral injury impact of patient safety incidents on our workforce



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