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North East Ambulance Service
NHS Foundation Trust

2022/23 Quality Report

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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 performance

2022/23 demand on services April 2022- January 2023*

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

387,105

999 calls answered

681,631

111 calls answered

215,727

Patients taken to hospital

314,913

Incidents attended

99,204

Patients treated at home

215,727

Patients treated over the phone

311,732

Patients taken to hospital appointments

07:47

Average Category 1 response time

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**		
				Very good / good	**Very poor / poor**
2,825 patient safety incidents	**31** serious incidents	**30.7%** of patients achieved a return of spontaneous circulation (ROSC)	Patient Transport Service	94.4%	4%
		98.6% stroke care bundles delivered	111	81.2%	13.1%
		84.2% sepsis care bundles delivered	999 see & convey	89.1%	7.4%
		86.4% STEMI care bundles delivered	999 see & treat	96.8%	1.4%

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Quality priorities

2022/23 quality priority update

2023/24 proposed quality priorities

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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