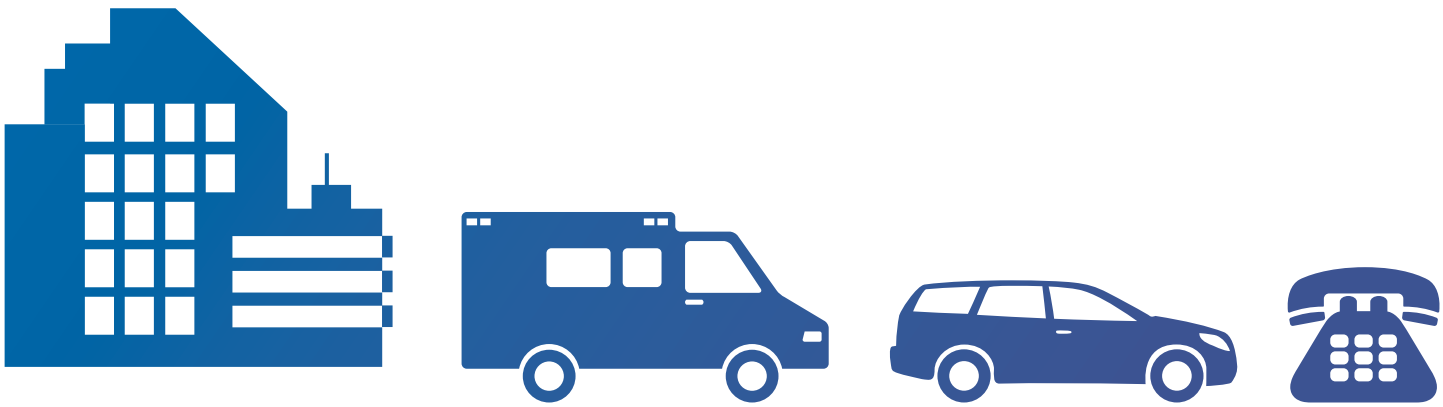
North East Ambulance Service NHS
NHS Foundation Trust

North East Ambulance Service NHS Foundation Trust



Quality Report

for the year ending 31st March 2013

Welcome to the North East Ambulance Service NHS Foundation Trust Quality Report for the year ending 31st March 2013

Note:
Where the source of data is not stated, the source is internal Trust data systems. Where it is not stated that a national definition has been applied, then the definition has been agreed locally.

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PART 1

PART 1

Introduction to NEAS and the services we provide

The North East Ambulance Service NHS Foundation Trust (NEAS) covers the counties of Northumberland, Tyne and Wear, Durham and Teesside – an area of around 3,230 square miles. We employ over 2,200 people and serve a population of 2.6 million.

We provide emergency ambulance services and non-emergency transport and respond to 999 calls for people in the north east of England. From April 2013 we also started to respond to NHS 111 calls for all those people living in the North East.

Our headquarters is based at Newburn Riverside business park, to the west of Newcastle upon Tyne city centre. These headquarters house the Patient Transport Service (PTS) contact centre and a large number of our support services staff. We split our 999 and NHS 111 contact centre between our headquarters site and our site at Russell House in South Tyneside. We can also take calls at Scotswood House, where our training department is based.

We currently have 64 locations, including 56 emergency-care ambulance stations. A number of these stations also house non-emergency Patient Transport Service (PTS) employees and vehicles and, to save public money, we share some of our sites with fire and rescue services.

We have a fleet of various vehicles to cover the different areas we serve in terms of population and geography. We can adapt to road conditions in urban and rural areas and can respond in all weather situations. Our fleet of emergency-care vehicles is made up of over 195 vehicles and we have 232 non-emergency vehicles within the PTS.

Our performance during 2012/2013 has remained strong. We have met all the targets in the service-performance areas, including achieving both category-A8 and -A19 performance targets. We also met our financial obligations in 2012/ 2013.

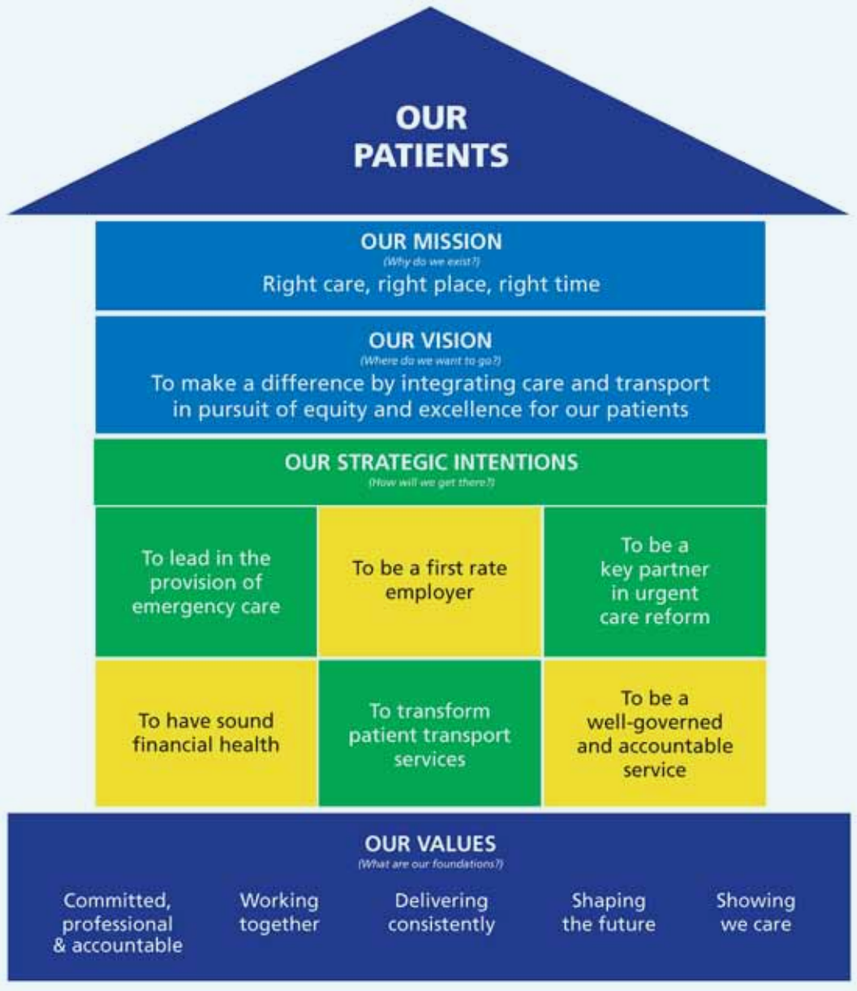
We became a foundation trust in November 2011 and have received feedback from Monitor, the healthcare regulator, on how we are performing. Monitor rated us as 'Green' for compliance (meeting the relevant standards) and we received a financial risk rating of 4 (where 1 represents the highest risk and 5 the lowest) for 2012/2013.

Our vision, shown below in our 'house diagram', is: "To make a difference by integrating care and transport in pursuit of equity and excellence for our patients". To make sure we achieve our vision, we have set ourselves priorities. These are:

- to take the lead in providing emergency care
- The quality of our care
- to be a key partner in changing the face of urgent care; and
- to transform our patient transport services.

We are continuing to take significant steps towards achieving our vision with the NHS 111 service for the North East. NHS 111 is a 24-hour helpline for the public when they urgently need medical help or advice but the situation is not life-threatening. Our governors, directors and staff see this as a ground-breaking opportunity to change the way urgent care is provided and build reliable ways of providing care, working with others who also provide urgent and community care. So far we have been successful in putting the 111 service into practice, doing better than the national targets. We want our NHS 111 service to not only be the first choice for patients but also for other professionals and carers, to make sure our patients get the 'right care at the right place at the right time'.

Over the next two years, we will be strengthening and improving our emergency response service, introducing an 'intermediate tier' to our transport services (to take patients, on a GP's advice, to hospital) and developing better ways of providing urgent care which will give us alternatives to hospital. We are still fully committed to continuing to improve the quality of services to our patients and we hope that we can continue this through our yearly corporate strategy and the priorities identified in this quality report.



Introduction to quality within NEAS

We have a strong track record for delivering high-quality, good-value patient care and we plan to build on that in 2013/2014 by taking forward every opportunity to continue to improve patient care.

Like all NHS organisations we have closely reviewed the recommendations of the second Francis Inquiry into Mid-Staffordshire hospitals. We will continue to put the patients at the heart of everything we do, delivering effective clinical care as well as excellent patient experience. In line with the Francis Inquiry recommendations, our quality report provides full and accurate information about how we are keeping to the fundamental standards of quality and safety and our aim to deliver quality to patients in everything that we do.

To help us develop the priorities, we hold a Quality Report Task and Finish Group made up of governors and staff who shared their views and those of the people they represent. We consulted the local involvement networks (LINks), the regional Overview and Scrutiny Committee (OSC) and our commissioners when deciding on the final list.

We felt it was important to make sure that the priorities were in line with our business plans so that we could support real improvements. It was also important, where possible, to be able to measure the priorities and to compare our performance against past results and against the performance of other ambulance trusts.

This year has seen us further develop our arrangements for governing the way we work through the Quality Committee. They will monitor the progress of our plans to deliver our clinical governance, quality and patient safety strategy. The purpose of the Quality Committee is to give the Board an independent review of, and reassurance about, the following:

- All aspects of the quality of services, particularly clinical effectiveness and how we will maintain this over the long term, patient experience and patient safety, and monitoring whether we meet essential standards of quality and safety set by the Care Quality Commission (CQC).
- Improvements in quality and patient safety – making sure these are central to all our activities.
- How we encourage and monitor high-quality, clinically safe patient care.
- Whether we are meeting our own and other quality and clinical improvement targets, and the action management should take if we are not meeting these targets.
- Whether we are meeting the committee's legal, mandatory and regulatory requirements.

Making sure that the clinical governance, quality and patient safety strategy covers:

- the experience of patients and the public, including how a patient's care is planned and the situation in which care is given;
- how information is used in terms of patient experience, resources, process and outcomes;
- improvements in quality, including the clinical audit programme, decisions made based on research studies (evidence-based practices), the way we manage risk, and learning from incidents and complaints;
- staffing and staff management, education, training and continuing professional development.
- the leadership strategy and planning, including involving the community and patients and clinical leadership.
- leadership strategy and planning, including involving the community and patients and clinical leadership.

The Quality Committee is attended by the Director of Clinical Care and Patient Safety and is chaired by a non-executive director. Towards the end of 2012/2013, we formed a quality review group with our commissioners to provide assurance of joined-up working and quality across the region.

Statement of quality from Chief Executive: our senior employee

This is our fourth quality report and our second as a foundation trust. We have prepared it under the National Health Service (Quality Reports) Regulations 2010.

We have reviewed all the information available on the quality of care in all core services and, as far as we know, the information in this report is accurate. This quality report for 2012/2013 includes a quality review which tells you how we did in 2012/2013. It sets out how we will continue to deliver high-quality healthcare services in 2013/2014.

The report gives details of some of the progress we are making in achieving our vision. Last year we identified a number of areas where we would make improvements and this report describes the progress we have made. Also, we identify new priorities for the coming year, which we have chosen after careful discussion with those with an interest in our work. We will report on our progress in next year's quality report.

The report describes a number of successes. However, we are not going to just sit back. We recognise that we can always make further improvements. Part of this is about maintaining and improving our response times and improving our performance with the national ambulance quality indicators (AQI). These are measures of performance which will help us to show the quality of care that we provide and to focus on improving the quality of our services. This will help us to improve the care we provide for our patients by making sure that our staff have the right skills and training to properly care for and treat patients.

Simon Featherstone
Chief Executive

PART 2

PART 2

An Introduction to our Quality Report

‘This Quality Report reviews our performance for 2012/2013 and sets out our main priorities for 2013/2014.’

In 2009, the Department of Health (DoH) ruled that all NHS provider trusts must publish a quality report every year. The purpose of the report is to show our commitment to quality and for others to hold us to account. Quality is broken down into three areas:

The purpose of the Quality Report is to show our commitment to quality and for others to hold us to account. Quality is broken down into three areas:

- Patient safety
- Clinical effectiveness
- Patient experience

This report reviews our performance for 2012/2013 and sets out our main priorities for 2013/2014

We are yet to agree targets and associated payments with commissioners for the 2013/2014 Commissioning for Quality and Innovation (CQUIN) scheme.

Review of the 2011/2012 Quality Report priorities: our performance in 2012/2013

Patient Safety			
Priority 1	**2010/2011**	**2011/2012**	**2012/2013**
To develop better methods of collecting patients’ views and use a ‘net promoter score’	We measured patient experience using postal surveys each year for users of PTS as well as other postal surveys for specific services such as renal dialysis. A combination of work with North East Quality Observatory and the publication of the NHS Operating Framework for 2011/12 prompted us to focus our attention on improving the way we measure patient experience and make this a priority for future quality reports.	We used a number of methods to get patients’ views of our services, doing so shortly after their care: • Telephone survey for NHS 111 • Postal surveys for PTS • Focus Groups for PTS • Questionnaires for those who use emergency services	We developed a new way of measuring patient experience. We set up a pilot in 2012-2013 with North of Tyne Patient Advice and Liaison Service (PALS) at Newcastle’s Royal Victoria Infirmary to test this new method. PALS volunteers and staff were trained to survey ambulance patients arriving by emergency and PTS ambulances.

Priority 2	**2010/2011**	**2011/2012**	**2012/2013**
Percentage of patients treated by appropriate healthcare professionals: Hear and treat	3.8%	3.3%	4.0%
Percentage of patients treated using appropriate healthcare professionals see and treat	35.2%	32.7%	30.7%

Effectiveness			
Priority 3	**2010/2011**	**2011/2012**	**2012/2013**
Redcar rural perform ance	73.01%	77.53%	71.46%
County Durham rural performance	63.38%	66.95%	65.63%
Northumberland rural performance	67.18%	67.79%	68.22%

Effectiveness			
Priority 4	**2010/2011**	**2011/2012**	**2012/2013**
To effectively use the new emergency-care trauma pathways within the North East (number of patients transferred to urgent care centres)	Does not apply	Does not apply	1673 patients

Priorities for the year ending 31st March 2014

To make our quality report useful to, and include, all readers, we asked a wide range of organisations and others with an interest, including our Board of directors, our staff, the local involvement networks (LINks), the regional Overview and Scrutiny Committee and our commissioners, how we could make the three areas of quality, patient safety, clinical effectiveness and patient experience, meaningful to them.

Our aim was to develop a report which was shaped by patients, the public and our staff so that they had an opportunity to understand, contribute to and promote quality within NEAS. We considered their feedback and agreed on seven local priority areas for 2013/2014.

Patient Safety		
Priority 1	**Baseline 2012/2013**	**Target 2013/2014**
Demonstrate ways to gather and measure the patient experience across our region and learn about patient experiences by recording patient stories in emergency care, PTS and from our contact centre.		
	Developed new ways of measuring patient experience. Test out methodology at Royal Victoria Infirmary (RVI) to see if it is effective before rolling it out across the North East Region in 2013/2014. Built a relationship with PALS in putting the survey into practice. We worked with other ambulance trusts to develop national agreement to use the 'friends and family test' as a benchmark.	We will roll out a survey across the North East region. We will develop and put into practice a text-message service and website-based questionnaire. We will set up a baseline measure for 2014/2015 for PTS and emergency care. We will develop and test telephone and postal surveys to measure callers' experience of our contact centre. We will hold a postal survey of emergency-care and PTS patients. We will report patient stories back to commissioners for each of the three service lines.
Reason for doing this	Patients' experience of our service can be very different from what we plan or assume it to be and they can tell us what works, what does not work and what could be done better. As a result, this priority builds on the work carried out previously and aims to roll out the survey of our patients across the region after the success of the pilot developed by working with the Royal Victoria Infirmary (RVI).	
	We used the framework in 2012/2013 to develop a way of working. We then refined this using feedback from PALS and patient groups and it is now ready to be put into practice across our service area. We will also introduce new methods this year, such as text messaging and website surveys, for patients to give us their experiences. Patient stories can also help build understanding that is based on actual experience. Stories can stimulate reflection and lead to us developing new ideas. Stories can have three important qualities. 1. They are memorable and can be powerful incentives for change. 2. Because stories describe direct experience, they can change a listener's understanding by offering fresh insights that the listener may associate with due to their own experience and knowledge. 3. Stories can cross boundaries and appeal to a broad range of audiences. From this point of view, stories appear particularly helpful for multi-disciplinary teams (MDT) with members from a wide variety of personal and professional backgrounds. After reviewing the findings of the second Francis Inquiry into Mid-Staffordshire hospitals, these stories are still as important as ever. This priority will aim to help ordinary people tell their stories so that those who create and put plans into action in NEAS, as well as the professionals and clinicians directly involved in care, may carry out their duties in a more informed and compassionate way.

Patient Safety		
Priority 2		
To work with healthcare professionals to improve the way patient transport needs are managed.		
	Baseline 2012/2013	**Target 2013/2014**
Vehicles arriving within 60 minutes of request	52%	To increase
Vehicles arriving within 120 minutes of request	63%	To increase
Vehicles arriving within 240 minutes of request	76%	To increase
	Urgent transport requests are for those patients who are referred by a doctor or other healthcare professional (HCP), usually from the patient's home to a place of treatment such as an acute hospital, or a non-emergency transfer between hospitals. The time period within which transport is needed is agreed with the person making the referral and is usually between one and four hours.	

	We have experienced delays in responding to 'GP urgent requests' due to increased demand in emergency cases. The A&E review, which recognised the need to develop a dedicated urgent service, should tackle this issue when it is put in place in April 2013. We have made a number of other changes to our dispatch services in an effort to reduce these delays. These include: • A new script for those who take calls to find out at the beginning of the call whether the patient can be transported by PTS, NEAS car or taxi; • recruiting someone in the contact centre to work only with urgent patients so that they get the priority of response they need; • better monitoring and recording, and putting in place a system of 'ring backs' to check the patient's condition and where appropriate a clinical triage and an emergency response if there is a delay in the urgent response; and • providing more vehicles with appropriately trained staff, particularly at the weekend, to transport patients.

Priority 3

To introduce an appointment-based patient transport service through 2013/2014, across the entire NEAS area.

	Baseline 2012/2013	Target 2013/2014
To take patients to their clinical appointment so they are no more than 45 minutes early and no more than 15 minutes late	Does not apply	75%

Reason for doing this	A good ambulance service will often carry out surveys about the experiences of users, and act on this feedback. While there is strong positive feedback of the PTS, one common negative response relates to transport times not being linked to appointment times. Currently the PTS service works to banding times except in Tees which works to appointment times. This means that except for Tees, PTS ambulances are scheduled to deliver patients to hospitals twice in the morning and once in the afternoon, and collect patients from hospitals once in the morning and twice in the afternoon. This is at odds with hospital outpatient services where patients have individual appointment times spread through the day. The banding time model of transport can lead to patients waiting unnecessarily long in hospital. The appointment-based PTS model which we operate in the Tees area is more consistent with the trust's vision by having a patient-centred service delivering patients to their destination at the 'right time'. To make sure PTS delivers a high-quality service that meets the needs of its patients, we need to change the way we work to make sure that we can transport patients to hospital on time for their appointments.

Patient Safety

Priority 4

Work with the acute trusts to reduce the effect of hospital turnaround delays to make sure patients have a positive and safe experience.

	Baseline 2012/2013	Target 2013/2014
Number of delays over 60 minutes	6365	To reduce
Number of delays over 120 minutes	465	To reduce

Reason for doing this	Delays in transferring the care of a patient from an ambulance crew to hospital staff can potentially harm patients waiting for an ambulance response in the community and because delays waste valuable NHS resources. In the past, these delays happened only in times of extreme pressure during the winter months as pressure builds in acute settings from increased levels of activity. However, this year we have seen an increase in the number of delays affecting patients. To recognise this increase, we held a summit with people from across the health community. There was a willingness to work together to tackle the issues and a number of actions have been put into practice immediately. This includes appointing two temporary posts to review the systems of care in the region and put improvements into practice. Although we are employing these people, they will be working with all agencies. This indicator is very important to us because we saw the performance against the eight-minute standard for red calls deteriorate significantly during December 2012 when hospital turnaround delays were very high. All organisations in the North East recognise that this is an issue. Our figures show a strong link between delays at hospitals and us not achieving the national target for ambulances to respond to 75% of emergency incidents within eight minutes. It is important for us to spend some time on this priority and work with acute hospitals to sort out the problems, improve service for our patients and reduce the time patients are waiting for an ambulance to respond to their incident. We have written a report that measures the handover time based on staff using information technology in every emergency department across the North East. We are working with the acute hospitals to make sure that the figures are accurate and that we take action to deal with any concerns across the region.

Reason for doing this	Other areas we will focus on to reduce turnaround delays include: • Developing a divert and deflection policy, which ensure that ambulances do not attend to hospitals where there is likely to be a delay in patient handover; • Making sure there are appropriate procedures in place for providing care; • Developing the process of handing patients over and turnaround times with individual acute trust providers; • Developing a system to help keep accurate records of when patients are handed over; • Identifying problematic areas, periods of time, and so on, by analysing information; and • Holding rapid process improvement workshops (RPIW) with hospitals to help improve services.

Priority 5		
Lead the work with those with an interest in our services to deliver support, both medical and social, to high-intensity users (see below) to make sure that they get the most appropriate response in the most appropriate place to meet their needs.		
	Baseline 2012/2013	**Target 2013/2014**
Number of patients flagged on system as high-intensity users	Does not apply	Set baseline
Reason for doing so	We have ongoing work with high-intensity users which are mainly managed by our Customer Care Department. Although there Is currently no recognised definition of what is a frequent caller to 999, callers are identified on an individual basis by crews, call takers or from various multi-agency meetings that are held with a number of other organisations including social services, GPs, acute trusts and the police. High-intensity users rely heavily on resources that could otherwise be delivering an emergency response to those in greater need. They also represent an ineffective use of health resources, particularly where ambulance attendance is linked to hospital attendance. It may also be that they have an unidentified medical need which the wider health and social-care community needs to tackle. Current cases are managed after an MDT meeting depending on the circumstances of the individuals. We have recently begun working with Yorkshire Ambulance Service and York University to look at a way of identifying potential frequent callers and looking at trends and patterns of calls. However, the work is at a very early stage. All ambulance trusts have been invited to a national conference to discuss ideas and look at agreeing a national definition of what is classed as a high-intensity user of 999 services and to share ideas for managing this group of patients.	

	We are also continuing to work with alcohol services in County Durham and Darlington to look at those callers who are frequently admitted to emergency departments with alcohol-related incidents and who already have an alcohol treatment plan in place. The idea is to explore the possibility of crews being able to directly refer the patients into the hospital alcohol service.

Clinical effectiveness		
Priority 6		
Explore with commissioners a system and structure which supports putting individual treatment plans (ITPs) into action and new ways of caring for patients.		
	Baseline 2012/2013	**Target 2013/2014**
Review ITPS every month	Does not apply	10 ITPs each month
Reason for doing so	The Government's approach to delivering a new NHS is based on a set of main principles. Their aim is to create an NHS which responds much better to patients and achieves better outcomes, with more power to act at each level as well as more responsibility. The new CCGs need to have an overview of the commissioning processes as a 'whole system' and what this means in practice so that they can develop plans to achieve successful outcomes. As a result, CCGs need to work together to plan and deliver better local services to make sure that patients enjoy the highest quality, responsive, affordable and personalised services, shaped directly by the patients as service users. Individual treatment plans need a joined-up system with effective arrangements for governing them to make sure that they are of high quality and safe. Some of the intentions for 2013/2014 relate to redesigning signposting to specific care providers which need involvement from the wider NHS, and local-authority and voluntary-sector organisations. We have said to commissioners that we are happy to be involved in any reviews that are to be carried out. We also contribute towards numerous clinical, operational, strategic and involvement meetings with various people across the region on an ongoing basis. And, we respond to invitations to one-off meetings, discussions and consultations about specific issues.	

Priority 7		
More use of other options (other than going to an emergency department) during 2013/14 if other options are available.		
	Baseline 2012/2013	**Target 2013/2014**
The number of patients treated using other options: See and Treat	30.7%	To increase

An important issue facing the NHS is the increasing demand for emergency care. The rise in demand cannot be sustained and the use of more appropriate options is critical at a time when costs and workforce pressures are rising.

As an ambulance service, we have a central role to play in the entire urgent- and emergency-care system. Traditionally, the ambulance service has been seen mainly as a call-handling and transportation service, which did cover some aspects of patient care. However, increasingly we are recognised as having a wider role, making sure that patients can access the right care, at the right place in the right time.

Providing clinical advice to callers – known as 'hear and treat'– treating patients at the scene – 'see and treat'– and taking patients to a wider range of places providing appropriate care (other than emergency departments) can help ease the pressures on emergency care by reducing the number of people taken to hospital.

We have a number of initiatives planned to increase the use of other options. Together, we hope these will result in more people using these other options.

- We will appoint a clinical development manager to review the options available and contact the commissioners and providers of other options. They will develop a clinical guidelines booklet which operational staff can use to help them make decisions about using other options.
- We will evaluate improved ways of delivering clinical assessment and referral educational (CARe). The aim of this programme is to give team leaders better skills in assessing and treating patients, to help them use other options and decide not to transport patients if this is appropriate.
- We will increase the number of requests made to the logistics desk in the control room for searches of other options on the directory of services.
- We will set up a clinical hub of clinical staff in the contact centre to support staff who have to make decisions on what priority to give cases bearing in mind the person's mental ability and ability to give consent. They will also need to consider other care options.

How we will measure, monitor and report on all of our priorities

We will report to the Quality Committee on our progress on the quality priorities for the year ahead. The Governance and Risk Committee will receive an update at each of their meetings and our Board of directors will monitor the progress of the priorities at meetings twice a year. We will draw up an action plan for the quality report, to take action and report on any areas which need to improve. The Performance Team will keep a track of this. Also, we will update our full council of governors, Overview and Scrutiny committees and healthwatch and members of NEAS. We will continue to build our dashboard that monitors the quality of our service and our quality reporting mechanisms to monitor progress.

Involving those with an interested in our work

The views of patients, public and staff

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.

After we published the 2011/2012 quality report, we produced a short questionnaire to get feedback from the public and staff about what quality meant to them.

Below are the questions we asked.

- How do you rate the Quality Report?
- How do you rate our involvement with stakeholders in producing the 2011/2012 Quality Report?
- How easy is the Quality Report to read?
- Do you agree we have taken into account local views in setting our priorities for the Quality Report?
- Do you feel any of the statements in part 2 (Statements of assurance) helped to tell the trust's story of quality improvement?
- Have you any suggestions for making the Quality Report easier to read (for example, plainer language, less jargon)?
- Do you feel that the graphs and charts used were useful to illustratethe data included in the Quality Report?
- Do you feel confident that the information presented was a true and accurate reflection of the trust?
- Have you used the trust website to read the Quality Report or to leave feedback?
- Do you have any general comments you want to make on the 2011/2012 Quality Report?
- Do you have any suggestions for the 2012/2013 Quality Report?

Some of the comments we received said the latest Quality Report was too long, too wordy and too complicated and difficult to read with too many graphs. Some stakeholders felt improving the care of people with dementia should be a priority area.

Throughout 2011/2012 we attended four LINks (Local Involvement Network) meetings and one Overview and Scrutiny Committee meeting to help us collect views on the priority areas for 2012/2013. We also set up a Governor Task and Finish Group and a staff working group to involve people further.

When making a shortlist of the priority areas we sent the draft list to all stakeholders and asked for feedback. All the feedback that we received agreed that the areas we had identified were areas where improving quality would further improve our services.

What we have done as a result of the feedback we have received

- We have asked Hippo Creative solutions, a graphic design company, to design the appearance of our report for 2012/2013, making sure it is easy to read for people who are colour-blind.
- We have illustrated the report with patients' stories – this helps make the account more 'real' and accessible.

Statements of assurance from the board

Plain English Campaign's Crystal Mark does not apply to the blue text in this section as this is set out in regulations.

The Department of Health identifies a number of mandatory statements (statements which we have to include by law) that we must report on. The information also gives assurance that the Board has reviewed and taken part in initiatives which link strongly to improving services.

During 2012/2013 the North East Ambulance Service NHS Foundation Trust (NEAS) provided three relevant health services. The North East Ambulance Service NHS Foundation Trust has reviewed all the data available to them on the quality of care in all three of these relevant health services.

The income generated by the NHS services reviewed in 2012/2013 represents 97.5 per cent of the total income generated from the provision of relevant health services by NEAS for 2012/2013.

The data reviewed within the quality report covers the area of patient experience, patient safety and clinical effectiveness, where data has not been available this has been indicated.

Clinical Audit

Clinical audit aims to improve patient care and outcomes by reviewing the care that we give. It tries to find out if things are being done correctly and asks 'Are we following best practice?'.

During 2012/2013 44 national clinical audits and 0 national confidential enquiries covered relevant health services that NEAS provides.

During 2012/2013 NEAS participated in 100% of national clinical audits and 0% of national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that NEAS was eligible to participate in during 2012/2013 are shown within table 1 (Opposite page)

The reports of 44 national clinical audits were reviewed by the provider in 2012/2013 and NEAS intends to take the following actions to improve the quality of healthcare provided:

- Two quality improvement (QI) officers will carry out clinical audits and provide feedback to front-line staff where improvement is needed. They will visit stations, discuss issues arising from the clinical audit, organise forums to improve quality and workshops to discuss, identify, apply, test and monitor appropriate ways to improve clinical outcomes and provide higher-quality patient care.
- We will continue to communicate with staff through 'The Pulse' magazine on the topic 'Delivering Quality Care for Patients through Care Bundles', through patient care updates, and by putting promotional literature, such as leaflets and posters, in ambulance stations.
- We will continue to produce information on how we are doing at divisional level so that we can monitor our progress and make improvements where necessary.

The reports of 10 local clinical audits were reviewed by the provider in 2012/2013 and NEAS intends to take the following actions to improve the quality of healthcare provided;

- We will continue to audit how we process our paper patient report forms so that we are confident the methods we are using are accurate.
- We will continue to publish best-practice guidance in 'The Pulse' and patient care updates for front-line staff.
- Our quality improvement officers will visit stations to discuss clinical quality improvement face-to-face with operational staff.

Table 1 - (Plain English Campaign's Crystal Mark does not apply to the tables in this section.)

	Apr 12	May 12	Jun 12	Jul 12	Aug 12	Sep 12	Oct 12	Nov 12	Dec 12	Jan 13	Feb 13	Mar 13
National Clinical Performance Indicators												
STEMI			✔						✔			
Stroke				✔						✔		
Hypoglycaemia					✔						✔	
Asthma						✔						✔
Ambulance Quality Indicators												
STEMI	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
Stroke	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
Cardiac Arrest	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔

Note: Data has been produced in line with standard national definitions

Table 2 - National Clinical Audits and Confidential Enquiries NEAS Participated in with number of cases submitted

	Apr 11	May 11	Jun 11	Jul 11	Aug 11	Sep 11	Oct 11	Nov 11	Dec 11	Jan 12	Feb 12	Mar 12
National Clinical Performance Indicators												
STEMI			✔ n=78 (100% of our sample but NCPIs suggest a sample of 300 if available)					✔ n=66 (100% of our sample but NCPIs suggest a sample of 300 if available)				
Stroke				✔ n=300 (100%)					✔ n=300 (100%)			
Hypoglycaemia					✔ n=171 (100% of our sample but NCPIs suggest a sample of 300 if available)					✔ n=183 (100% of our sample but NCPIs suggest a sample of 300 if available)		
Asthma						✔ n=78 (50% of our sample – NCPIs recom-mend 300))					✔ n=194 (100% of our sample but NCPIs suggest a sample of 300 if available)	
Ambulance Quality Indicators												
STEMI	✔ n=65 (100% sample)	✔ n=102 (100% sample)	✔ n=78 (100% sample)	✔ n=95 (100% sample)	✔ n=106 (100% sample)	✔ n=74 (100% sample)	✔ n=76 (100% sample)	✔ n=67 (100% sample)	✔ (incomplete)	✔ (incomplete)	✔ (incomplete)	✔ (incomplete)
Stroke	✔ n=325 (100% sample)	✔ n=497 (100% sample)	✔ n=524 (100% sample)	✔ n=494 (100% sample)	✔ n=318 (100% sample)	✔ n=307 (100% sample)	✔ n=239 (100% sample)	✔ n=289 (100% sample)	✔ (incomplete)	✔ (incomplete)	✔ (incomplete)	✔ (incomplete)
Cardiac Arrest	✔ n=89 (100% sample)	✔ n=84 (100% sample)	✔ n=101 (100% sample)	✔ n=110 (100% sample)	✔ n=105 (100% sample)	✔ n=103 (100% sample)	✔ n=118 (100% sample)	✔ n=127 (100% sample)	✔ n=141 (100% sample)	✔ (incomplete)	✔ (incomplete)	✔ (incomplete)

- We will make changes to clinical practice where necessary to improve the care we give to patients and to keep to best practice.
- We will continue to give feedback to, and receive it from, front-line staff where clinical guidelines have not been followed, so that we know any improvements we suggest will be carried out.
- We will coach and mentor any front-line staff who need support.
- We will continue to audit call-handling in our contact centres so that we know patients are being prioritised correctly and the appropriate triage (assessment) is being given.
- We will carry out further audits of patient report forms and electronic patient report forms to make sure there are no clinical risks when crews decide, based on a patient's symptoms, not to take them to hospital or to treat a child under two years old.

This audit will also show that front-line staff are correctly recording what they do.

- We will continue to audit life-threatening incidents which had a response time of more than 20 minutes to find out why there was a delay and where we can make improvements.
- We will continue to audit patients who:
- a) contact us again within 24 hours after they were given advice during their initial call; and
- b) contact us again within 24 hours after they have been treated at the scene of the incident, when the rate of recontact is above the national average, to make sure there was no risk to them.

The number of patients receiving NHS services provided by NEAS that were recruited to participate in research was 586.

Research and Innovation

Research helps the NHS to improve the current and future health of the people it serves. It is essential in successfully promoting health and plays a major part in continuing to improve the services and supporting safe and effective care. It identifies new ways of preventing, diagnosing and treating disease (see http://www.nihr.ac.uk/Pages/QualityAccounts.aspx /).

Our involvement with clinical research shows our commitment to testing and offering the latest medical treatments and techniques.

The number of patients receiving relevant health services provided by NEAS in 2012/13 that were recruited during that period to participate in research approved by a research ethics committee was 586.

CQUIN

"CQUIN is a national framework for locally agreed quality improvement schemes. It enables commissioners to reward excellence by linking a proportion of English healthcare provider's income to the achievement of local quality improvement goals. The framework aims to embed quality within commissioner-provider discussions and to create a culture of continuous quality improvement, with stretching goals agreed in contracts on an annual basis"

(Department of Health, 2011).

We have agreed our CQUIN framework locally with our commissioners based on areas where we feel we can improve quality and increase the number of new working practices.

A proportion of NEAS income in 2012/2013 was conditional upon achieving quality improvement and innovation goals agreed between NEAS and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.
Further details of the agreed goals for 2012/13 and for the following 12 month period are available online at: **www.monitor-nhsft.gov.uk/sites/all/modules/fckeditor/plugins/ktbrowser/_openTKFile.php?id=3275**

CQUIN scheme values		
	2011/2012	2012/2013
CQUIN value (£)	£1.43 million	£2.3 million
CQUIN achieved (£)	£1.38 million	Forecast £2.3 million

CQUIN scheme 2012/2013	
Indicator	
1	Show the measures we have taken to ask patients about their experience and develop improvement plans based on that feedback.
2	Increase the number of patients referred or transported to alternative care providers rather than A&E.
3	Improve our performance in rural areas.

CQUIN scheme 2013/2014	
Indicator	
1	Involvement in whole system and pathway reviews with CCGs.
2	Increase the use of alternative dispositions other than A&E during 2013/14 where alternative pathways are available.
3	Demonstrate measures to capture & measure the patient experience, and publish patient stories.
4	Improvement in emergency response times for patients outside of national target.
5	To improve its responses times to GP urgent transport requests.
6	Reduce the number of PTS journeys that are cancelled on the day of travel.

Care Quality Commission

NEAS is required to register with the Care Quality Commission and its current registration status is registered without conditions.

The Care Quality Commission has not taken enforcement action against NEAS during 2012/2013.

NEAS has not participated in any special reviews or investigations by the Care Quality Commission during the reporting period.

In December 2012, the CQC carried out a routine, unannounced inspection to check that we met all essential standards of quality and safety.

The review looked at the following.

- The patient's ability to agree to care and treatment.
- The care and welfare of people who use services.
- The level of cleanliness and infection control.
- Requirements relating to workers.
- Complaints.

In all five areas the CQC found we kept to the relevant standards.

Quality of information

NEAS did not submit records during 2012/2013 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

NEAS Information Governance Assessment Report overall score for 2012/2013 was 85% and was graded green.

We have a Data Quality Assurance Group which aims to provide an open forum to discuss quality across our main systems. They share knowledge and expertise in the quality of information and deal with any issues to do with the quality of the information.

The group reports directly to the Information Governance Working Group and also makes sure we keep to all our legal and regulatory responsibilities in terms of what we do.

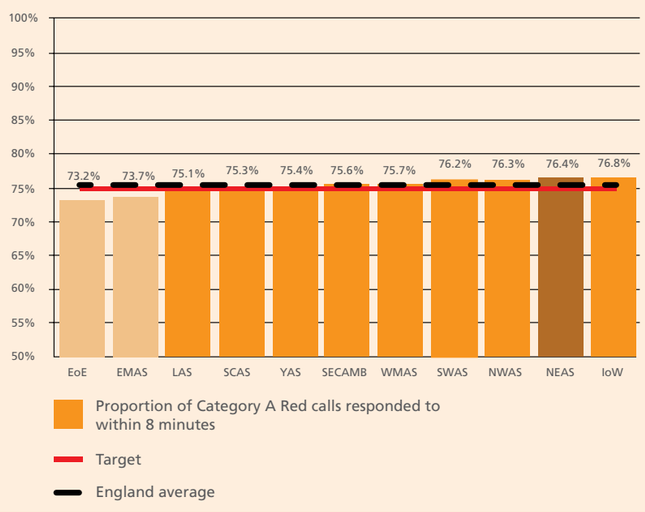
NEAS was not subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission.

NEAS will be taking the following actions to improve data quality:

- Develop, put into practice and review quality strategies, policies and procedures, including our confidentiality audit procedure;
- Make sure that all staff are aware of the associated strategies, policies and procedures;
- Develop, put into practice and regularly monitor standards for healthcare and corporate records;
- Report instances when we do not keep to standards on information quality;
- Match up information on trust data sets, billing data sets and Payment by Results (PbR) data sets;
- Review and update relevant evidence to support the NHS Information Governance Toolkit (IGT) and report the group's progress on IGT initiatives;
- Make sure we finish a review of documents describing databases, systems and their structure;
- Review, develop and improve the way we report on the quality of information for 999, PTS and 111 calls to find and correct inaccuracies as they arise;
- Review all procedures for reviewing and correcting the quality of information for all systems critical to continued service provision.
- Review all privileges users have for access to all business critical systems, making sure we restrict access to personal identifiable information (PII) wherever possible;
- Audit our functions against local procedures by sampling record sets
- Make sure all clinical systems keep to the NHS Number Strategy and connect to the NHS Demographic Batch Service (DBS) to check a patient's personal information, such as name and date of birth.

Quality review of mandatory measures

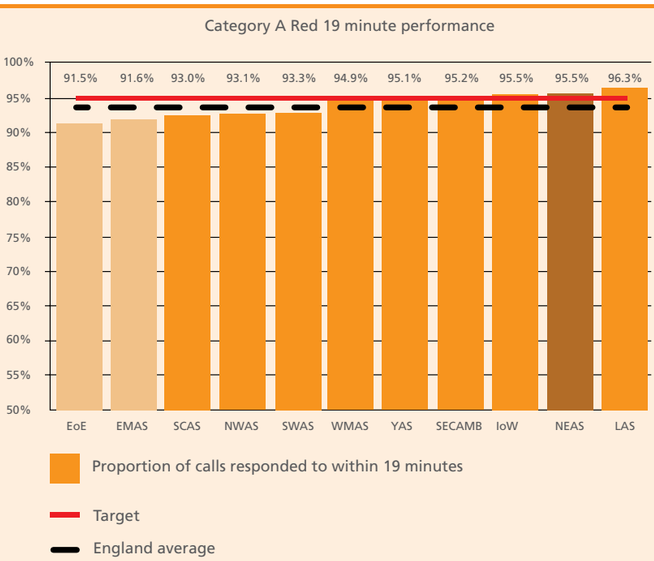
The following section sets out how we have improved, measured against the six mandatory indicators given to us by Monitor. This allows us to compare ourselves with other providers and to help you assess whether our performance was good or bad.



Category A

8-minute performance
Note: the final figures at the end of the year can alter by up to 0.5% as trusts finalise end-of-year reporting and checks on the quality of information.

Source:
www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Performancedataandstatistics/AmbulanceQualityIndicators/index.html



Category A

19-minute performance
Note: the final figures at the end of the year can alter by up to 0.5% as trusts finalise end-of-year reporting and checks on the quality of information.

Source:
www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Performancedataandstatistics/AmbulanceQualityIndicators/index.html
Note: Data has been produced in line with standard national definitions

The North East Ambulance Service considers that this data is as described for the following reasons:

- We follow national guidance and definitions for KA34 submissions to the NHS Information Centre when producing category-A performance information. This information is published every month on the DoH statistics web pages as part of the AQIs. Ambulance trusts review each other's AQI definitions and calculations as part of the yearly workload of the NAIG (National Ambulance Information Group) to make sure that all are measured consistently.

The North East Ambulance Service has taken the following actions to improve this score and so the quality of its services, by:

- Twice weekly trust-wide meetings to monitor performance led by the chief operating officer.
- Updating performance information every 15 minutes on the emergency-care score card. This information is available to all officers and displayed in the contact centre.
- Putting extra resources into place across the region, but particularly based in our more rural areas including Ashington, Cramlington, Berwick, Stanley, East Durham and Redcar.
- Increasing the use of PTS and voluntary drivers to support less critical patients.
- Targeted use of other providers such as St John Ambulance, British Red Cross and contracted taxi firms.
- Agreeing a new tender for paramedic services.
- Creating an extra desk in the contact centre dedicated to managing urgent patients. This will free up time for dispatchers to concentrate on 999 calls.
- Dentifying and training extra community first responders in areas of greatest need.
- Agreeing the process for when there is a surge in demand.

	2010/2011	2011/2012	National average 2012/2013	Trust with lowest 2012/2013	Trust with highest 2012/2013
Care bundle delivered to patients presenting with signs or symptoms of a suspected heart attack (average)	78%	84.7%*	77.6%*	67.3%* London Ambulance Service	94.1%* Great Western Ambulance Service
Care bundle delivered to patients presenting with signs or symptoms of a stroke (average)	94%	97.2%*	95.6%*	90.7%* South East Coast Ambulance Service	100%* Great Western Ambulance Service

*** Data for April-12 to December-12 inclusive**
Note: Data has been produced in line with standard national definitions

The North East Ambulance Service considers that this data is as described for the following reasons:

- We follow national guidance and definitions for clinical AQIs when producing performance information for care bundles delivered to patients. This information is published every month on the DoH statistics web pages.

The North East Ambulance Service has taken the following actions to improve this score and so the quality of its services, by:

- Carrying out monthly audits for patients who have a pre-hospital diagnosis of suspected ST elevation myocardial infarction (STEMI) confirmed on electrocardiogram, or new suspected stroke or transient ischaemic attack;
- Having two quality improvement officers carrying out audits for 100% of the cases associated with these clinical indicators and reviewing the clinical element of each record to assess whether the 'care bundle' (a set of interventions that, when used together, significantly improve patient outcome) had been delivered;
- Asking the quality improvement officers to work hard to improve performance by feeding back to those individuals who have missed a care element of the care bundle to encourage reflection and learning;
- Asking our quality improvement officers to carry out station visits and promote care bundles to those operational staff on shift with the aim of creating a quality improvement culture throughout the service;
- Promoting the care bundles using other methods of communication, for example, patient care updates, posters and inserts in the staff handbook.

	2010/2011	2011/2012	National average 2012/2013	Trust with lowest 2012/2013	Trust with highest 2012/2013
2012 staff survey results (higher the score the better)	3.34 out of 5	3.12 out of 5	3.12 out of 5	2.64 out of 5 East of England Ambulance Service	3.39 out of 5 South West Ambulance Service

Source: http://nhsstaffsurveys.com/cms/

The NHS staff survey includes the following statement: "If a friend or relative needed treatment, I would be happy with the standard of care provided by this Trust", and asks staff whether they strongly agree, agree, neither agree nor disagree, disagree, or strongly disagree with the statement.

The North East Ambulance Service considers that this data is as described for the following reasons:

- The information has been produced in line with standard national definitions.
- We measure the feedback reports produced by the Co-ordination Centre against other trusts of a similar type. This allows people to make a fair comparison between trusts.

The North East Ambulance Service has taken the following actions to improve this score and so the quality of its services, by:

- Creating a small Task and Finish group to develop trust-wide as well as local action plans to tackle the areas where staff experience has deteriorated and to build on those areas where it has improved;
- Developing a communication plan to make sure staff are aware of what action is being taken and to allow us to promote the areas where there have been some improvement.

Actual impact	Reported Patient Safety Incidents 2011 - 2012				Reported Patient Safety Incidents 2012 - 2013			
	Total	% against total reported incidents	Total Calls	% of incidents against call rate per 1000 calls	Total	% against total reported incidents	Total Calls	% of incidents against call rate per 1000 calls
No Harm	165	37.24	980530	0.16	144	25.71	1110700	0.12
Minor	150	33.86	980530	0.15	220	39.28	1110700	0.19
Moderate	62	13.99	980530	0.06	129	23.03	1110700	0.11
Major	0	0	980530	0	8	1.42	1110700	0.007
Catastrophic, Death	5	1.12	980530	0.005	10	1.78	1110700	0.009
Near Miss	50	11.28	980530	0.05	44	7.85	1110700	0.03
Death (not related to provision of healthcare)	11	2.48	980530	0.01	5	0.89	1110700	0.004
Totals	443		980530		560		1110700	

We cannot measure patient safety incidents nationally in 2012/2013, as the NHS Patient Safety Association has not made information available yet for the full year.

Our staff report patient safety incidents through our local risk-management systems. These reports are then forwarded to the National Reporting and Learning System (NRLS). The information collected in that national database allows trends to be identified. This information guides the development of patient safety strategies and resources.

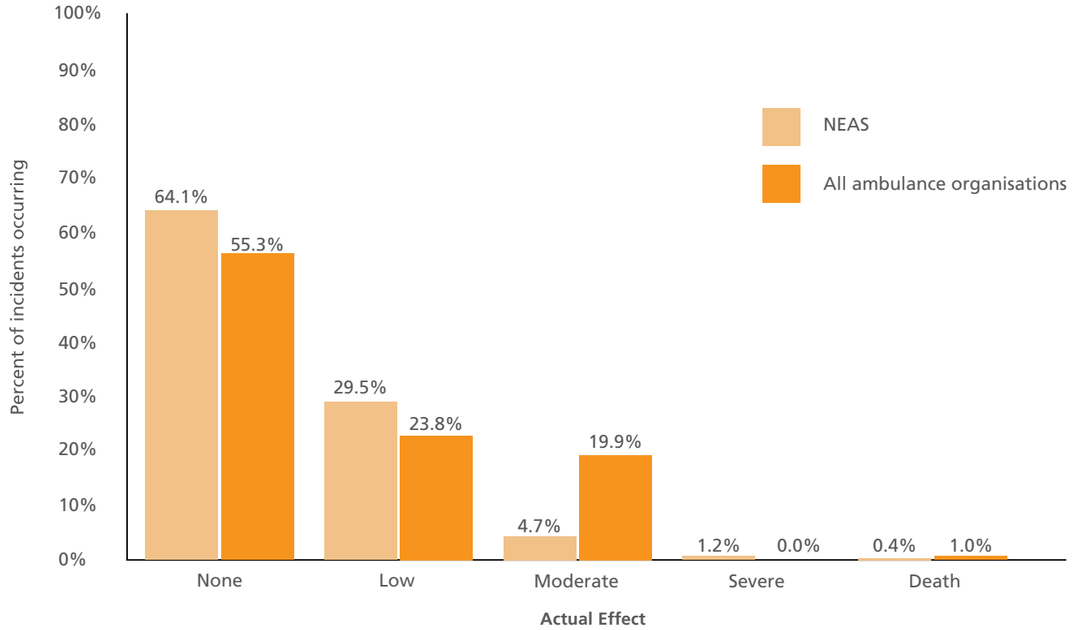
Between 1 April 2012 and 30 September 2012, we reported a total of 206 patient safety incidents. The table and graph below show a breakdown of the actual effect of the incidents and provides a comparison against all ambulance organisations for the same reporting period.

There is emerging evidence that organisations with a higher rate of reporting have a stronger safety culture, with high reporters aiming to learn from incident reporting to improve patient care and safety.

Incidents reported by degree of harm for ambulance organisations

1 April 2012 until 30 September 2012 (information taken from all ambulance Organisations xIncident Reports, ninth data release: 20 March 2013).

Actual Effect	Totals
None	114
Low	49
Moderate	41
Severe	0
Death	2
Total	206



The North East Ambulance Service considers that this data is as described for the following reasons:

- We use the Ulysses Safeguard system for reporting and managing all negative incidents. We use the system to create reports and add data to the National Risk Learning System (NRLS).

The North East Ambulance Service has taken the following actions to increase reporting of patient safety incidents whilst reducing the severity of the actual impact to the patients involved, and so improve the quality of its services, by the following measures:

- Streamlining the way we report on safety incidents by introducing online reporting (which is accessible using ambulance laptop) for operational staff, and using PCs for office-based staff.
- A weekly audit on the quality of data to make sure all patient safety incidents are correctly reported. This then makes it easier to add the data to NRLS.
- Providing feedback to those who report patient safety incidents to encourage a responsive and open culture.
- We have a dedicated clinical investigating officer in post.
- We hold a weekly panel to review cases and find the root cause of problems.
- Each month we report back information to the trust board using the Integrated Performance Report (IPR). This includes exception reports when needed.
- Data is reported and reviewed by our Experience, Complaints, Litigation, Incident and PALs group (ECLIPs).
- We will have a 'Being Open' policy and a team of family liaison officers (FLOs) in place.
- We have carried out a Manchester Patient Safety Framework (MaPSaF) review.
- We are creating a quality dashboard to display key data, including information on patient safety.
- We will develop a clinical governance, quality and patient safety strategy.
- We will continue with the Trust Quality Committee which provides direct assurance to the Board on matters of patient safety, clinical quality and our overall clinical governance.

PART 3

PART 3

Quality review: Local indicators

Local indicators			
Patient experience			
	2010/2011	**Internal target for 2011/2012**	**2012/2013**
Develop better methods of collecting patient experience, and make use of 'net promoter score'	Not available for comparison	To develop a deeper understanding of what patient experience is. Set baselines, as the methods we use to survey patients who are new to us. Work closely with healthcare partners to make sure that the method we use to collect patient information is productive.	Developed new methodology to measure patient experience. Test at RVI to test the methodology before rolling it out across the North East Region in 2013/2014. Built a relationship with PALS to put the survey into practice. Worked with other ambulance trusts to develop a national agreement to use the 'friends and family test' as a benchmark.

Our aims in this priority were to create and develop:

1. Up-to-date feedback on the experience of our services rather than reflective feedback based on a postal survey;
2. A continuous flow of information to allow us to track trends and react sooner if a problem arises;
3. A process to measure ourselves against other ambulance services when measuring patient experience;
4. A system that would increase the number of people who responded to our surveys; and
5. A better method of gathering results and independent analysis of them.

We used CQUIN funding in 2011/2012 to develop a new way of measuring patient experience. This allowed us to pay Customer Research Technology (CRT) and Ipsos Mori, two independent specialist research organisations, to develop a method for us to use with PALS.

We set up a test in 2012/2013 with North of Tyne PALS at Newcastle's Royal Victoria Infirmary (RVI) to test our new method. PALS volunteers and staff were trained to survey ambulance patients, arriving by emergency services and PTS, using a handheld, touch-screen device. The aim was to evaluate the method and survey questions before rolling the survey out across the rest of the region in 2013/2014. The full survey, once in place, should operate as a continuous project across the North-East region.

We have developed the questions in the survey to decide on the key things patients value and where we need to improve our service through outcomes, staff attitude, information, timeliness, and involvement. The survey saw three ways of asking the questions following feedback from patients and PALS staff on the questionnaire as well as the service we provided.

Net promoter score

The Department of Health announced the introduction of the friends and family test for acute trusts in 2012. This was put into practice in hospitals on 1 April 2013. The friends and family test is based on the 'net promoter score' that has been used in the private sector for years to judge customer experience of services. While the friends and family test guidance we have seen is not being applied to ambulance trusts, we took a decision to develop this score when developing our survey and gained the agreement of all NHS ambulance trusts that this would be used as a measure for patient experience in the future.

Using other care options					
	2010/2011	**Target for 2011/2012**	**2012/2013**	**Trust with lowest 2012/2013**	**Trust with highest 2012/2013**
The number of patients treated using other options: Hear and treat	3.4%	Increase	4.0%	3.4% North West Ambulance Service	9.4% South East Coast Ambulance Service
The number of patients treated using other options: See and treat	33.1%	increase	30.7%	23.0% North West Ambulance Service	50.8% South West Ambulance Service

Hear and treat: The figures above have been worked out in line with the Department of Health guidance for reporting AQIs.

	2010/2011	**Internal Target for 2011/2012**	**2012/2013**
Hear and treat	3844	3.5%	13,292
See and treat	72,734	33%	99,755

Our levels of 'hear and treat' are lower than the national average. Information from patients suggests that, many times, going to hospital will not be the best outcome for patients and with some advice and guidance the patient can stay at home. Because of this, it is very important for us to try to improve our 'hear and treat' figures. With the introduction of 111, we have an ideal opportunity to develop better systems. We will continue to measure the 'hear and treat' activity and see and treat figures across the trust and measure ourselves against other organisations. We are committed to using other options to signpost the patient to the most appropriate place of care. This may well be somewhere different to an emergency department. We have been working with other providers, for example, community teams, to increase the number of other options available for our operational crews to use. This will be supported in 2013/2014 by appointing a clinical development manager to further assess the availability and use of other options of care.

We put a CARe tool into practice in 2012/2013 across two areas of the region. And, our enhanced CARe programme delivered by Teesside University has been carried out by 30 paramedics to provide them with better skills in physical assessment and taking patients' histories to allow more 'see, treat and finish' episodes. For 2013/2014 we plan to put CARe fully into place across the region and will also be increasing the number of paramedics carrying out the enhanced CARe programme.

Differences in data since the 2010/2011 Quality Report

As far as we know, there are no differences in the information since the 2011/2012 quality report.

Patient safety			
Improve performance in rural areas for incidents responded to in eight minutes.			
	2010/2011	**Target for 2011/2012**	**2012/2013**
Redcar and Cleveland	77.53%	75%	71.5%
County Durham	66.95%	71%	65.6%
Northumberland	67.79%	71%	68.2%

The performance in the rural areas is very important. Last year we were commissioned under the CQUIN scheme to achieve a year-end target of 71% of emergency incidents responded to within eight minutes in Northumberland and County Durham PCT areas. We failed to achieve this target. We have reviewed the issues that led to this failure and the main points are shown below.

- Increasing demand across all areas.
- Increasing and prolonged delays in handing patients over to hospital.
- Bad weather over certain months of the year including significant flooding and ice.
- Inability to secure the level of resources needed from other sources to achieve the performance.

Following discussion part-way through the year with our Executive team, we decided to recruit extra paramedics at risk to improve the quality of service provided. Following an extensive recruitment campaign, we have recruited extra paramedics.

The resulting performance from January to the year-end has shown a significant improvement in performance despite the continued bad weather and hospital delays.

So far, discussions with CCGs have not resolved the issue of a target for next year. We will continue to work with our commissioners to agree a way forward on this important issue.

Clinical effectiveness			
Effectively use the new emergency-care trauma pathways within the North East			
	2010/2011	**Target for 2012/2013**	**2012/2013**
Accuracy of triage	Does not apply	Set baseline	1673

A 'major trauma bypass' procedure was introduced to the region to make sure that victims of major trauma were transported to a major trauma centre to receive care. We gave staff a briefing document which contained the reason for introducing the major trauma bypass procedure, the triage tool itself and a pocket-sized guide. The major trauma bypass was put into practice on 1 April 2012, when we also introduced two senior trauma paramedics. The two paramedics are based in the contact centre and are responsible for co-ordinating the major trauma bypass and working with operational staff and the two major regional trauma centres - RVI and James Cook University Hospital (JCUH).

The two senior paramedics will monitor the quality of care delivered to major trauma victims as well as the major trauma bypass procedure. This is reported using the Trust Audit committee. In terms of improving quality, the senior paramedics provide feedback for staff and carry out a peer review to make sure there is continuous learning.

We will also:

- Produce major trauma audit reports every month, which we will report into the Clinical Audit steering group;
- Make sure we are represented on the Northern Trauma Systems Clinical Advisory Group;
- Make sure we are represented on the Multi-Disciplinary Team for major trauma at JCUH and RVI.

Complaints and compliments

We take any complaint, concern or comment we receive very seriously. We expect very high standards to be maintained in our trust, and if this is not the case we will deal with it appropriately. We do our best to fairly and thoroughly investigate every complaint we receive. We also take action to prevent the incident from happening again and improve our service where necessary.

We have a complaints policy and procedure which meets NHS complaints regulations. We work to the following principles which are set out in 'Principles For Remedy' (a publication from the Parliamentary and Health Service Ombudsman) when handling complaints.

1. Getting it right
2. Being customer focused
3. Being open and accountable
4. Acting fairly and proportionately
5. Putting things right
6. Seeking continuous improvement

How we have dealt with complaints

When we received a complaint, concern or comment we:

- Acknowledged it within three working days, either by phone or in writing; and
- Write to the person making the complaint within 25 working days (or longer if agreed), outlining the investigation we have carried out and giving our findings along with any action being taken.

What we do if we get it wrong

- We will offer an apology.
- We will review the care we provided or the way we managed the incident and reflect on what happened in a way that helps us to learn from the experience.
- We will use the experience we have gained from the incident to improve our policies and practice.
- Where appropriate, we will create a specific care plan, with the involvement and agreement of the patient involved.

Types of complaints

The most common type of complaint received is about the attitude of our staff. Another common complaint is about our response given to emergency calls where we assess a patient as not needing an ambulance. If a clinical issue is involved, we carry out a full investigation and share what we have learned. Another common type of complaint received was about how long patients have to wait for transport after treatment. We have planned to cover staff attitude as part of training in 2012/2013 and we have put in place extra training and mentoring for staff and will carry out audits to review the effect of this training.

Compliments

We receive compliments about both operational staff (for the care and treatment provided to patients) and call handlers in our Accident and Emergency Control and NHS 111 Urgent Care Service. We pass on all compliments to the staff concerned.

We need to take account of the number of calls we actually receive (1,110,700) and incidents we respond to (371,951) for all services when assessing complaints and compliments received.

	2011/2012	2012/2013
Complaints received	289	410
Compliments received	271	337

Of 410 complaints received, we did not take 18 any further as we did not receive the appropriate level of agreement from the relevant patients, and we closed eight complaints by discussing the problem with out Investigating officer and giving feedback to the person who complained. Our complaints team investigated the following complaints and the outcomes were as follows:

- 183 (44.6%) complaints were upheld (the reason for the complaint was found to be valid, and we were at fault).
- 50 (12.2%) complaints were part upheld (an element of the complaint, but not all aspects of the complaint, were found to be valid and we were partially at fault).
- 89 (21.7%) complaints were not upheld (the reason for the complaint was found not to be our fault).
- 62 (15.1%) complaints are currently still under investigation at the time of writing this report. (This includes complaints that have been reopened due to further contact.)

Patient case studies

Five-year-old Olivia prepares to saddle up again after freak horse-riding accident

Five-year-old Olivia Bingham had a horse land on her during a riding lesson. The freak accident happened on a farm at West Moor, where Olivia has been riding horses since the age of three.

Olivia suffered a partially collapsed lung. Jason Orchard, the paramedic, gave her some morphine as she couldn't straighten her legs. He put a neck collar on Olivia and she was put onto a spinal board. Olivia was then taken to Newcastle's Royal Victoria Infirmary.

Mum Helen said: "The staff in A & E and on the ward were brilliant and looked after me as well as Olivia. Jason and Mark [the ambulance crew] came back a few times over the afternoon with other patients and kept popping in to visit Olivia and see how she was. They deserve medals for their work as they were outstanding. I can't thank them enough for their help and expertise on that day." Olivia has since returned to horse riding.

High school pupil rushes to aid of patient with severe head injury.

16-year-old student George Murray turned hero to save two men hurt in a serious road accident in Berwick

The A-level student ran to the rescue of a van passenger, who had suffered head, neck and spinal injuries when he went through the windscreen. George immobilised the man's neck and spine until paramedics arrived, while his dad, a traffic officer, directed oncoming traffic.

George then assisted the driver, who also suffered neck and spinal injuries, before helping paramedics put the casualties onto a stretcher. Paramedic Timothy MacDonald said George's actions have had a huge impact on the recovery of the man and he commended him for his efforts with a certificate.

Timothy said: "I was extremely impressed by the controlled manner in which this young man conducted himself and I am convinced that his actions will have had a beneficial outcome for the patient."

After completing his A-levels at Berwick Academy, George is hoping to go on to university to complete a degree in paramedic practice.

Feedback from our stakeholders

In line with the quality report guidance, we have asked for comments on the draft quality report from our lead commissioning primary care trusts, the Health and Wellbeing Boards and regional OSC. These comments are set out below and we have not edited them in any way. Plain English Campaign's Crystal Mark does not apply to these comments.

Statement from our lead commissioner -Durham Dales

Thank you for the opportunity to comment on the Quality Report for North East Ambulance Service NHS Foundation Trust for 2012/3.
As a commissioner the Durham Dales, Easington and Sedgefield Clinical Commissioning Group (DDES CCG) plays an active part in monitoring the quality of service provided by North East Ambulance Service NHS Foundation Trust (NEAS). As NEAS provides services across a wider area than DDES there has been a joint commissioning arrangement with North Tyneside PCT having been the lead commissioner. As the commissioning landscape changes DDES CCG is establishing appropriate arrangements for monitoring the quality of services provided. We are therefore only able to comment on the report on that basis.

Durham Dales, Easington and Sedgefield Clinical Commissioning Group is disappointed that the key target for Red Call responses in 8 minutes to patients in the former County Durham Primary Care Trust has not been met. The level achieved has fallen below the previous year's responses and failed to meet the commissioned targets despite the additional CQUIN funding being made available to NEAS. This is a key priority area for DDES CCG next year and we are committed to working jointly with NEAS to improve services for patients. We are also committed to working with other providers who may impact on services provided by NEAS for example the long delays that have been noted at hospitals and which prevent ambulances from getting back on the road.

DDES CCG notes the good clinical outcomes for patients being achieved by NEAS. We also welcome the innovative work being undertaken by NEAS's research and development department and hope to see improvements arising from this work in mainstream services shortly.

DDES CCG agrees with the priorities outlined in the document for the coming year and is willing to work in partnership to achieve the common goals of improving access, experience and safety for all patients.

In particular we are pleased to note the intention to have appointments for Patient Transport Services and planned improvements to urgent bookings. The work on individual treatment plans and alternatives to emergency department disposition will be the key to the overall plan to reduce hospital admissions across the NEAS area and DDES CCG is happy to work with NEAS on developing these plans.

DDES CCG notes that the version we have been given for comments still has a significant amount of gaps, where confirmation of figures are awaited. We reserve the right to amend our comments should that prove necessary once the final report is available.

Statement From Durham Overview and Scrutiny Committee

The Committee welcomes North East Ambulance Service NHS Foundation Trust's Quality Report and the opportunity to provide comment on it.

Whilst the Committee acknowledges the Trust's desire to co-ordinate engagement of local authorities' responses to their Quality Report via the Regional Joint Health Scrutiny Committee, it wishes to place on record its views regarding issues around Accident and Emergency response performance and also waiting times/queuing at Accident and Emergency departments.

The Committee particularly welcomes the following:-

- Work with the acute trusts to reduce the impact of hospital turnaround delays. In order to ensure a positive, safe patient experience and prevent adverse effects on clinical outcomes due to delays to further hospital assessment and treatment.
- To introduce an appointment based Patient Transport Service through 2013/14, across entire NEAS area.

The Committee have taken an active role in the Trust's consultation around Reconfiguration of the Accident and Emergency Ambulance Service and representations have been made around the proposals and their potential impact particularly on Rural Ambulance provision. County Durham is one of the areas where performance for Category A8 responses are below target and it is essential that this performance improves. These concerns within County Durham, particularly the Durham Dales continue and the Committee would seek assurances that any proposals to change existing arrangements within this area should not proceed without full and formal public consultation. The Committee awaits with interest the results of the recent evaluation activity undertaken within the Durham Dales to assess the effectiveness of current arrangements.

The Committee notes the proposed work to be undertaken in addressing hospital turnaround delays/ ambulance queuing at Accident and Emergency Departments and would support all steps taken in conjunction with relevant hospitals' Trusts to reduce the delays experienced by some patients being treated at Accident and Emergency Departments.

To conclude, the Committee agree that from the information received from the Trust that the identified priorities are a fair reflection of healthcare services provided by the Trust. In addition, the Committee request that a six monthly progress report on delivery of 2013/14 targets be provided.

Statement From Gateshead Overview and Scrutiny Committee

Based on Gateshead Healthier Communities OSC's knowledge of the work of the Trust during 2012-13 we feel able to comment as follows:-

We have been consulted by the Trust as part of its process for selecting its Quality Priorities for 2013/14 and consider that our views have been taken into account when identifying the final priorities for the year.

Priority 1

The proposed methods of gathering patient stories are very welcome as a shift to a narrative method of enquiry has real benefits in a service environment.

Priority 2

The OSC is particularly supportive of this priority. The OSC has previously been consulted on and expressed its support for the development of a dedicated urgent service as a result of the A & E Review. We note that this has yet to be implemented in the Gateshead locality although planned for introduction in April 2013. The OSC is keen to be kept informed of progress / developments in this area. However, the OSC considers the proposed target for 13/14 vehicles arriving within 60 and 120 minutes of request to be too vague and the 240 minute level is very disappointing.

Priority 3

The OSC considers that the target for 13-14 appears unambitious and are concerned that being 15 minutes late may mean patients miss their appointments.

Priority 4

The OSC has previously raised particular concerns with the Trust regarding ambulance delays in the Gateshead locality and is pleased to note that work to reduce delays is being progressed as part of this priority. The OSC was also keen to see the Quality Report reference specific identified actions to meet this objective and again we are pleased to see that the Account now highlights the areas it will focus on to reduce turnaround delays. Again the OSC is keen to be kept informed of progress in this area.

However, the OSC considers the targets for reducing delays are too vague.

Priority 7

The OSC is particularly supportive of the Trust's plans to develop safe, appropriate, alternative options for patients to use other than A & E to reduce pressures on emergency care and the numbers of people taken to hospital.

However, the OSC considers the target for increasing the number of patients treated using other options is too vague.

In relation to the section on complaints and compliments the OSC considered it would be useful if in future complaints could be categorised by type so that it is possible to see if there are patterns over time and to enable evaluation of the effectiveness of interventions over time. The OSC considers that the patient cases studies should also include examples of complaints and how they have been dealt with and action taken to prevent issues reoccurring in the future.

The OSC is supportive of the Quality Report overall and is pleased to note that CQC has no compliance issues in regard to the Trust.

Statement from Newcastle Healthwatch

Healthwatch Newcastle is aware that it can make a detailed response to the North East Ambulance Service NHS Foundation Trust (NEAS) Quality Report (Quality Report) similar to those given by Newcastle LINk in previous years. However, considering the fact that Healthwatch Newcastle was established on 1 April 2013 and is currently developing its activities – including the recruitment of a Chair and Board members – the response of Healthwatch Newcastle will be limited this year to this letter.

I have viewed Newcastle LINk's response to last year's NEAS Quality Report and am pleased that the comments on the colour of text have been acted upon, but the watermark still appears in the document. Healthwatch Newcastle also hopes that NEAS receives a Crystal Mark for the final report.

In terms of Priority 1 – Patient Experience – Healthwatch Newcastle welcomes the descriptions for both the baseline of 2012/2013 and proposed target for 2013/2014. Healthwatch Newcastle may be able to support NEAS with this, if appropriate, with the involvement of volunteer Healthwatch Champions who will be recruited in the near future.

In terms of Priority 3 – To introduce an appointment-based transport service – Healthwatch Newcastle wonders how this can potentially be linked to the "Choose and Book" system that was a focus of investigation last year by Newcastle LINk.

Newcastle LINk wrote a number of reports last year around patient experience. Each report has recommendations which may help NEAS and they are below:

- An examination of the Choose and Book system
- Looking at walk in centres and minor injuries units in Newcastle

Healthwatch Newcastle may be able to support NEAS with its work, particularly around the engagement with service users and carers, when it recruits the volunteer Healthwatch Champions in the near future.

Healthwatch Newcastle will be fully operational next year and will look to provide a fuller and detailed response. However, this will be a decision by the Healthwatch Newcastle Chair and Board at the appropriate time.

Statement from NHS Northumberland Clinical Commissioning Group

The Clinical Commissioning Groups very much welcome the opportunity to comment on the draft Quality Report submitted by the North East Ambulance Service NHS Foundation Trust. We were also grateful to the representatives from the service for presenting the account to representatives of the Clinical Commissioning Groups and the Local Area Team.

Quality Reports provide an opportunity for organisations to show case the work they are doing to deliver high quality evidence based services to the local population. The report focuses heavily on performance against a range of indicators, but does not make it easy to pick out the key things that you as an organisation have achieved in relation to quality over the last year or the areas of priority for you in the coming year. Given that the document will be published, It would be helpful to have these points clearly identified.

Whilst the commitment to patient safety and care is emphasised throughout the document, the CCGs believe that greater emphasis could have been placed upon providing further information on the issues faced by the service and the impact on delivering a safe and quality service throughout the year. During the year the organisation experienced pressures associated with high levels of sickness in operational areas, difficulties in recruitment to front line posts along with delays associated with handover/ handover to clear times, issues with agency staff providing back up to substantive service provision but little reference was made to these throughout the report and the impact on performance.

As part of your drive to demonstrate a focus on patient safety, data on incidents have been included in the report. However, the data suggests a higher number of incidences reported as minor, moderate and catastrophic. It would be helpful to have some explanation in relation to this and any actions that are being taken.

Greater reference to the learning from complaints and Serious Untoward Incidences would also have been beneficial for inclusion in the account. An improvement in the handover delays were as a result of the service reporting delays experienced by patients in excess of 2 hours as a SUI.

We are encouraged by and are supportive of the priorities outlined for delivery in 2013/14 and reflect the Service's commitment to improve the patient experience and quality of care in the future.

The Service's commitment to audit and reviewing current practice is also welcomed along with the use of the benchmarking against the performance of other Ambulance Services across the country. It would however, be beneficial to understand the key findings of those audits and if there specific themes that need to be addressed.

The CCGs look forward to working on a collaborative basis with the Ambulance Trust to address some key challenges over the forthcoming year to improve the Emergency and Patient Ambulance service provision across the North East Health economy.

Statement of Director's responsibilities - May

The directors are required under the Health Act 2009 and the National Health Service Quality Report Regulations to prepare Quality Report for each financial year.

Monitor have 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 foundation trust boards should put in place to support the data quality for the preparation of the quality report.

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

- The content of the account must meet the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2012-13.
- The content must not be inconsistent with internal and external sources of information including the following:
  - Board minutes and papers for the period April 2012 to June 2013
  - Papers relating to quality reported to the Board over the period April 2012 to June 2013
  - Feedback from the commissioners dated xx/xx/20xx
  - Feedback from governors dated xx/xx/20xx
  - Feedback from Local Healthwatch organisations dates xx/xx/20xx
  - The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated xx/xx/20xx;
  - The xxxx national patient survey
  - The 2013 national staff survey
  - The Head of Internal Audit's annual opinion over the trust's control environment dated xx/xx/20xx
  - CQC quality and risk profiles dated xx/xx/20xx
- The Quality Report presents a balanced picture of the NHS foundation trusts' performance over the period covered.
- The performance information reported in the Quality Report should be 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, 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 Monitor's annual reporting guidance (which incorporates the Quality Reports regulations) (published at www.monitor-nhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality in preparation of the Quality report.
  (available at www.monitor-nhsft.gov.uk/annualreportingmanual).

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

By order of the Board

Chairman
28 May 2012

Chief Executive
28 May 2012

Contact details

If you would like a copy of this report in another format such as braille, audio tape, large print, another language or any other format, please contact:

Email:
sahdia.hassen@neas.nhs.uk

Address:
North East Ambulance Service NHS Foundation Trust
Ambulance Headquarters
Bernicia House
Goldcrest Way
Newburn Riverside
Newcastle Upon Tyne
NE15 8NY

We welcome feedback on this report. You can give your comments and suggestions in writing.

Email:
Rachel.lonsdale@neas.nhs.uk

Address:
Rachel Lonsdale
North East Ambulance Service NHS Trust
Ambulance Headquarters
Bernicia House
Goldcrest Way
Newburn Riverside
Newcastle Upon Tyne
NE15 8NY

Or, visit the NHS Choices website to leave feedback at:
http://www.nhs.uk/Services/Trusts/Overview/DefaultView.aspx?id=29237

Jargon buster

Term	Definition
Advance care plan	A discussion to help people think about, and plan for, how they want to be cared for towards the end of their life. (http://www.endoflifecareforadults.nhs.uk/assets/downloads/pubs_Advance_Care_Planning_guide.pdf)
Call connect	The point when the 999 call is connected to the ambulance control room, and which signals the beginning of the ambulance response time.
Care bundle	A care bundle is a group of between three and five specific procedures that staff must follow for every single patient, every time, and which will have a better outcome for the patient if done together within a certain time limit, rather than separately.
Care Quality Commission	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 A8	A life-threatening 999 call that must be responded to within 8 minutes, 75% of the time.
Category A19	If a Category A patient needs transport, this should arrive within 19 minutes of the request for transport being made, 95% of the time.
Category B19	Calls concerning patients whose condition is serious but not immediately life-threatening and which must receive a response within 19 minutes in 95% of cases.
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).
Clinical governance, quality and patient safety strategy	A strategy that defines how we will demonstrate quality in patient safety, patient experience and clinical effectiveness.
Clinical Practice Circular (CPC)	The way that NEAS tell staff about clinical issues and guidance.
Commissioning for Quality and Innovation (CQUIN) payment framework	The Commissioning for Quality and Innovation (CQUIN) payment framework means that a part of our income depends on us meeting goals for improving quality.
Contact centres	The first point of contact for 999, 111 and Patient Transport Services patients who need frontline medical care or transport.
Control environment	This relates to the system of internal controls in the Trust.

Term	Definition
Core services	Our core services are accident and emergency, NHS 111, community first responders, the Patient Transport Service and emergency planning.
Crystal Mark – plain English	Plain English Campaign's Crystal Mark shows that a document is as clear as it can be for its intended audience.
Deciding Right	Deciding Right is the UK's first attempt to set up a scheme that helps patients of all ages (including children) and healthcare professionals make shared decisions about the patient's care ahead of their death. It is being introduced not only across NHS hospitals in the North East, with paramedics and in other NHS care settings, but in hundreds of nursing homes, care homes and hospices across the region.
Directory of Services	Once we have decided the appropriate type of service for the patient - so that we can direct them to a service which is available to treat them - the system is linked to a directory of service. 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.
Enforcement action	Action taken against us by the Care Quality Commission if we do not follow regulations.
e-PRF	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.
Falls service	A falls service can triage (assess and prioritise for treatment) older people who have fallen or are at high risk of falling.
First responder	A first responder is a volunteer who has had training to act on behalf of the ambulance service and can respond to emergency calls when sent by the contact centre. They deal with a specific list of emergencies and give the patient support and appropriate treatment until the ambulance arrives.
Foundation Trust Boards	These make sure that trusts are effective, run efficiently and manage resources well and are accountable 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.
Governance and Risk Committee	This committee gives the Board an independent and objective review of, and assurances about: • all aspects of risk governance, risk management frameworks and our approach to risk management; • our internal control systems and risk management arrangements, to make sure they are fit for purpose, have enough resources and support our performance and reputation; • the risk governance process, to make sure it is clear about current and future aspects of risk exposure; • the evidence to support our reports to Monitor; and • keeping to legislation, best practice and regulations.
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 Report.
Urgent care centre	Urgent care centres help to prevent people going to hospital unnecessarily, for instance at walk-in centres patients can be treated for minor injuries and ailments instead of going to hospital.

Term	Definition
Handover and turnaround process	Handover is the point when all the patient's details have been passed (verbally) 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, the control of 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 alternative pathways of care, where appropriate, for members of the public calling 999.
JRCALC	JRCALC stands for the Joint Royal Colleges Ambulance Liaison Committee. Its role is to provide reliable clinical advice to ambulance services. The JRCALC is best known for its regularly updated UK Ambulance Service Clinical Practice Guidelines.
LINks	Local involvement networks, or LINks, were set up by the Government in April 2008 to give local people a stronger voice in how their health and social care services are provided.
Logistics desk	A new logistics desk in our contact centre, which will be a point of contact for A&E crews who need guidance and advice on where to take or send non-emergency patients when the nearest A&E department is not appropriate.
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	Measures of the quality of ambulance services in England, including response time targets, call abandonment rates, rates of patients contacting us again after initial care, time taken to answer calls, time to patient 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	Confidential enquiries such as the Clinical Outcomes Report Programme (CORP) programme funded by Healthcare Quality Improvement Partnership (HQIP) are not in themselves audits, although they have similar features. Similarly, national surveys of patients' experiences and outcomes are not strictly audits although, again, they are closely related.
NHS Operating Framework	Sets out the planning, performance and financial requirements for NHS organisations and the basis on which they will be held to account.
NHS (Quality Reports) Regulations 2010	Set out the detail of how providers of NHS services should publish annual reports – Quality Reports – 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 and when the accounts should be published, and arrangements for scrutiny and assurance. The regulations also set out exemptions for small providers and primary care and community services.

Term	Definition
NHS Foundation Trust Annual Reporting Manual 2011-12	Guidance on the legal requirements for NHS Foundation Trusts' annual report and accounts.
NICE	National Institute for Health and Clinical Excellence set up in 1999 to reduce differences in the availability and quality of NHS treatments and care. Evidence-based guidance and other products help settle uncertainty about which medicines, treatments, procedures and devices represent the best-quality care and which offer the best value for money for the NHS.
Pathways	NHS Pathways is 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 answering a few more questions than previously. All questions asked 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 the out-of-hours service, visit the local minor injury unit or walk-in centre or home care.
Patient experience	Quality of care includes 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 satisified patients are, which is measured by patient experience measures (PREMS).
Patient report forms	An up-to-the-minute record of a patient's history, assessment and treatment provided by our staff.
Patient safety	Makes sure the environment the patient is being treated in is safe and clean, reducing harm from things that could have been avoided, such as drug administration errors or rates of infections. Patient safety is supported by the National Patient Safety Agency 'seven steps to patient safety'.
The Pulse	The Pulse is a magazine published once every two months that gives our staff information on a range of in-house topics such as clinical issues, good-news stories, project information and sporting events. It also includes a letters page so that staff can see letters written by members of the public.
Payment by Results	The aim of Payment by Results is to provide an open, rules-based system for paying trusts. It will reward efficiency, support patient choice and diversity and encourage reductions in waiting times. The Payment by Result tariffs system means funding is fair and consistent rather than relying on past budgets and the negotiating skills of individual managers.
Quality Committee	This committee gives the Board an independent and objective review of, and assurances about, all aspects of quality, specifically clinical effectiveness, patient experience and patient safety, and monitors whether the Board keep 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 indicators of performance.
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Special reviews or investigations	Special reports on the how particular areas of health and social care are regulated.

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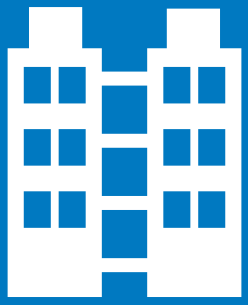
Quality dashboard	An easy-to-read, often single-page report showing the current status and historical trends of our quality indicators of performance.
Research Ethics Committee	Research Ethics Committees are the committees which give independent advice to the people who take part in research, the researchers, funders, sponsors, employers, care organisations and professionals on how far proposals for research studies meet recognised ethical standards.
Rural performance	Measurement of Category A8 response performance in all rural areas, as agreed at local level
Safeguarding referral	The process crews follow if they suspect a patient (whether a child or an adult) is vulnerable or at harm.
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.



North East Ambulance Service NHS Foundation Trust
Ambulance Headquarters
Bernicia House
Goldcrest Way
Newburn Riverside
Newburn
Newcastle Upon Tyne
NE15 8NY

Tel: 0191 430 2000 Website: www.neas.nhs.uk