NHS

South Central Ambulance Service

NHS Foundation Trust

# 2022 - 23

# Quality Account

# Contents


# Part 1: Statement on quality from the chief executive of the South Central Ambulance Service NHS Foundation Trust (SCAS)

The pressures on the ambulance service, the NHS and the country showed no sign of letting up in the past year. I need to start by paying tribute to the people who work for and support SCAS; for their dedication and commitment to providing excellent services to our patients and colleagues.

During 2022/23 our services in 999, NHS 111, Patient Transport Services (PTS) and Clinical Coordination Centres (CCCs) have faced unprecedented challenges from high demand and the ongoing impacts of the pandemic on both patients and our staff. We have continued to do everything we can to maintain the best level of service possible in the circumstances we have faced.

The incredible dedication of staff and volunteers from right across SCAS to provide services to our patients in these circumstances has again been tremendous.

## CQC inspection and recovery plan

In April 2022 a CQC inspection took place at SCAS covering the well-led domain and the Emergency Operations Centre and Urgent and Emergency Care services. Patient Transport Services and 111 were not inspected. The domains for ***effective, caring*** and ***productive use of resources*** retained their rating of good. ***Responsiveness*** was rated as requires improvement. The ***Safety*** and ***Well-led*** domains were rated inadequate. The Trust's overall rating moved from good to inadequate.

This rating was a huge disappointment to everyone at SCAS, and there was an immediate commitment to work with colleagues across the Trust and our partners to put things right as a matter of urgency.

The key areas the CQC said must be improved urgently included:

- Safeguarding – resourcing, levels of training and how we report and deal with safeguarding concerns
- Acting on staff concerns – taking concerns seriously and acting to address them
- Serious incident management – reporting and sharing learning from incidents. Spotting trends and acting to reduce future risks.
- Risk management – making sure the Board and others are fully sighted on risks and properly managing them.
- Improving policies and procedures on Duty of Candour, the Mental Health Capacity Act, and medicines management are also highlighted as must dos.

SCAS implemented an extensive improvement plan which is delivering improvements across all the areas. We are committed to making things better and will keep focused on putting things right until we and the CQC are confident all the concerns have been fixed.

## Supporting our people

This year those who work for us and with us have again needed our support both in terms of their physical and mental wellbeing. The pressure the service has been under inevitably impacts on our staff and we have a responsibility to look after their wellbeing.

SCAS continued to support staff via our Health and Wellbeing portal, and successfully trialled 'Health and Wellbeing Conversation' training with course dates planned for 2023/24. Additionally, the Freedom to Speak Guardian team has been strengthened to provide support to staff.

Over 400 of our leaders have attended Essential Skills for People Managers training, which serves as an introduction to a restorative Just and Learning Culture.

Towards the end of the year, SCAS launched our People Strategy for the next three years, which is linked to NHS People Plan. It covers four key areas: looking after our people, belonging in the NHS, new ways of working, and growing for the future. Going forward the Trust will bring it to life with enabling plans around recruitment, retention, education, and health and wellbeing.

The annual NHS Staff Survey results were published at the end of March 2023 and, once again, re-iterate the extraordinary dedication, determination, and resilience of our workforce. It is with considerable pride, gratitude and humility that we see SCAS continuing to be at the top of the ambulance sector for critical measures such as compassionate leadership, inclusion, and teamwork. Unsurprisingly the results show that many of our staff are suffering from burn out and pressures of work, and these are areas that the Trust will continue to focus on.

In 2022/23 we also supported our staff during periods of industrial action: both those at work and those exercising their right to strike. Our staff and unions worked closely with us to ensure the impact on our patients was managed and limited, and I thank everyone for their efforts in this area.

## Modernisation and improvements

The Trust always looks for ways to improve its services, to modernise and innovate, and in 2022/23 we introduced many significant developments.

Our Patient Transport Service took delivery of 60 hybrid Wheelchair Accessible Vehicles (WAV's) as part of its fleet replacement strategy. We continue to engage with NHS England to develop the ambulance sector capability for net zero and reduced emission vehicles, including the development of zero emission vehicles for mental health practitioners.

We have also increased the number of staff that are now able to undertake roles, such as call answer, vehicle dispatch and remote clinical triage from their own homes. This has required changes in our telephony and critical systems infrastructure but has enabled greater flexibility for our people and offered an improved work / life balance.

# Change of CEO

In 2022 Will Hancock announced that he would be stepping down as Chief Executive on 31 March 2023, after almost 17 years in the role. I would like to formally acknowledge the tremendous leadership of the Trust that Will provided over this period, which include the formation of SCAS from the amalgamation of four separate ambulance Trusts and the successful achievement of Foundation Trust status.

I am delighted to have joined the organisation as CEO and have been made very welcome. I have particularly enjoyed meeting SCAS staff and stakeholders and gaining a clear understanding of their issues and priorities.

We are in very challenging times and my focus will be on making sure we offer the best possible care to our patients, look after our staff, get the basics right with our Ten Point Plan and lift our heads to deliver our strategy in partnership with the local systems that we work in partnership with.

**David Eltringham**
Chief Executive Officer
29 June 2023

# What does SCAS do?

South Central Ambulance Service NHS Foundation Trust (SCAS) is part of the National Health Service. SCAS was established on 1 July 2006 following the merger of four ambulance trusts. On 1 March 2012, SCAS was awarded Foundation Trust status.

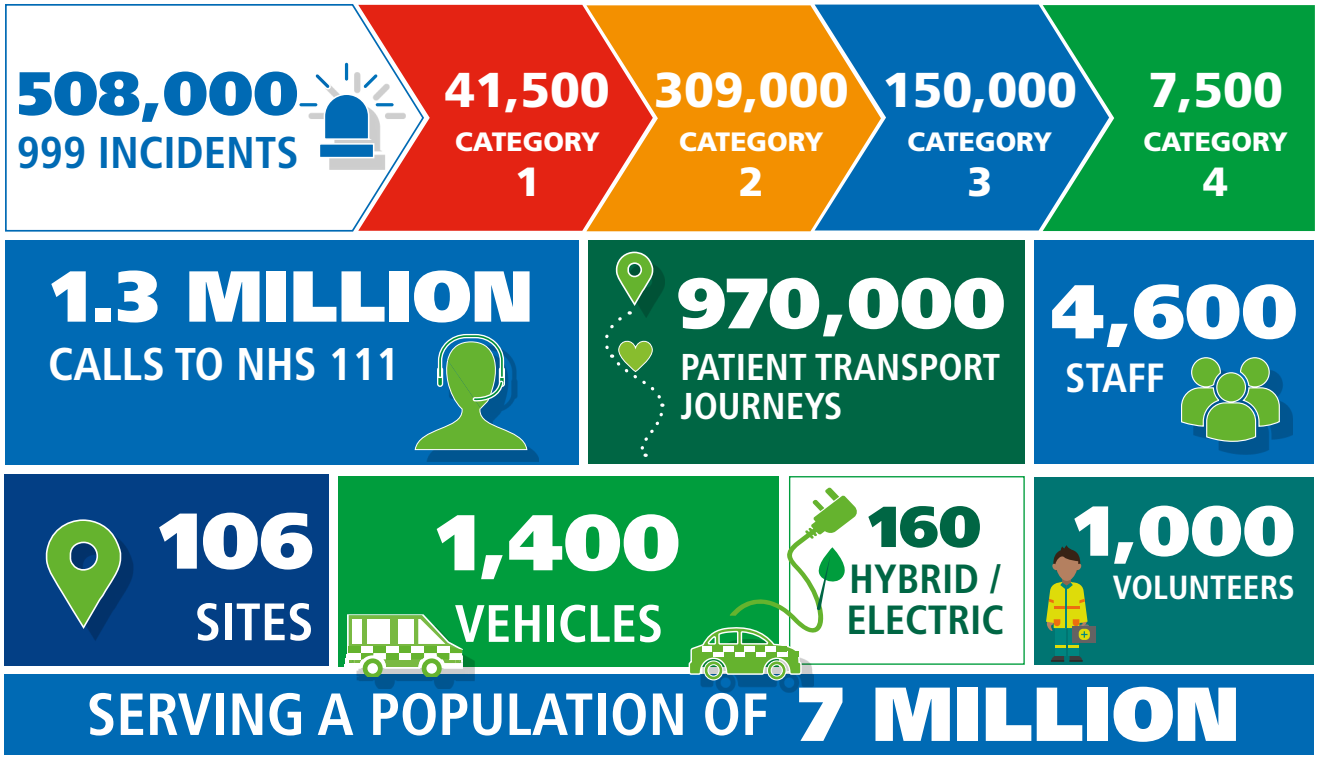
The Trust provides an emergency care service to respond to 999 calls, an NHS 111/ Integrated Urgent Care (IUC) telephone service for when medical help is needed, non-emergency patient transport services (NEPTS), logistics and commercial services. The Trust also provides resilience and specialist operations offering medical care in hostile environments such as industrial accidents and natural disasters including a Hazardous Area Response Team (HART) based in Hampshire.

- **Respond to emergency calls**
  - (999 service)
- **Respond to non-emergency calls**
  - (NHS 111 service)
- **Deliver Integrated urgent care in partnership**
  - Resilience and specialist operations
- **Offer a range of commercial services:**
  - Non-emergency patient transport services (NEPTS)
  - Logistics
  - The National Pandemic Service

Services are delivered from the Trust's main headquarters in Bicester, Oxfordshire, and a regional office in Otterbourne, Hampshire. Each of these sites, plus sites in Surrey, Sussex and Milton Keynes, includes a Clinical Coordination Centre (CCC) where 999, NHS 111/IUC and NEPTS calls are received, and clinical advice is provided.

South Central Ambulance Service NHS Foundation Trust covers the counties of Berkshire, Buckinghamshire, Hampshire, Oxfordshire, Milton Keynes and we are providers of NEPTS in Sussex and Surrey, as well as a dental service (accessed via NHS 111) in parts of Dorset. This area covers approximately 5,760 square miles and has a residential population of over seven million.

## SCAS in numbers




* All data 2022/23

The Trust works with two air ambulance partners: Thames Valley Air Ambulance (TVAA) and Hampshire & Isle of Wight Air Ambulance (HIOWAA).

The Trust also offers the following services: a commercial logistics collection and delivery service for our partners in the NHS, and Community First Responders (volunteers trained by SCAS to provide lifesaving treatment).

**Our Mission**
*Why we are here*

**We deliver the right care, first time, every time.**

**Our Vision**
*Where we want to go*

**To be an outstanding team, delivering world leading outcomes through innovation and partnership**

**Our Values**
*How we are*

- Caring
- Professional
- Innovative
- Teamwork

| Our Strategic Themes<br>*The core strategic challenge* | Our Enabling Plans<br>*How we will deliver our vision* |
|---|---|
| Clinically-Led | Clinical / Research |
| Service Quality & Patient Experience | Commercial / Procured Services |
| | Core Service Delivery Operations |
| | Quality Improvement |
| People & Organisational Development | Our People |
| | Volunteers |
| Partnerships & Stakeholder Engagement | Communications & Stakeholder Engagement |
| Technology Transformation | Digital & Management Information |
| Finance & Sustainability | Finance |
| | Sustainability (Inc. Estates) |

All KPI / Milestone

Our strategic themes influence a number of factors and cut across a variety of functions. Technology transformation for example, will influence the way our staff engage with us in addition to the way we provide our services.

We will develop strategic plans to achieve our vision, and these will be influenced by our themes – each plan will be aligned with a particular theme but may be influenced by more than one. We are developing 10 strategic enabling plans as shown here.

Each plan has a core purpose - underneath which all other activities can be planned and mapped with responsibilities for delivery and metrics/milestones for measurement defined.

**By the end of 2022/23 each of the enabling plans will have been defined and approved by our Trust Board.**

Each plan has a core purpose - underneath which all other activities can be planned and mapped with responsibilities for delivery and metrics/milestones for measurement defined.

- **Clinically-Led**
- **Service Quality & Patient Experience**
- **People & Organisational Development**
- **Partnerships & Stakeholder Engagement**
- **Technology Transformation**
- **Finance & Sustainability**


# Part 2: Priorities for improvement and statements of assurance from the board

## 2.1 Looking back at progress made

We have set out below our Quality Account priorities for 2022/23 and our progress against them. The COVID-19 pandemic, and resultant organisational pressure and demand has made some impact on our progress on the 2022/23 quality priorities.

| Priority Number | Outcome |
|---|---|
| 1a | Delivered |
| 1b | Partially delivered |
| 1c | Delivered |
| 2a | Delivered |
| 2b | Partially delivered |
| 2c | Not delivered |
| 2d | Partially delivered |
| 3a | Delivered |
| 3b | Not delivered |
| 3c | Delivered |

Partially and not delivered quality priorities form part of a continuous improvement cycle and further work will be completed in 23/24.

# 1 Patient Safety

### 1A: Further development of Structured Judgement Reviews (SJRs) to identify patient harm during periods of high demand leading to long waits in the community.

Owner: Clinical Governance Leads 999

SCAS have applied a new criterion to the monthly Long Waits review group. This was implemented specifically to review the coding of calls to identify any potential or actual harm experienced by patients accessing the service who experienced a long response time (under the Ambulance Response Programme classification (ARP)). This new criterion has provided an improved oversight of themes and trends for these patients, allowing for learning to inform service delivery changes. This process is also more flexible, being able to react to concerns each month, and include patient groups where we have increased concerns due to themes from incidents being raised.

The name 'Structured Judgement Review' has also now been changed to 'Patient Safety Review' to distinguish it from the term Medical Examiners use that has different criteria attached.

Our suite of patient safety review documents is easily adaptable to be used with other case review processes outside of long waits but in relation to clinical care and service delivery.

This improvement was applied after the change in the Trust Operational Policy and Procedure Numbers 8 & 10 and the introduction of the Enhanced Patient Safety Procedure. This now providing a clinical overview of patient safety following these improvements.

This priority was delivered in 2022/23.

## 1B: Monitoring and reporting on improvements to the storage and handling of medicines to ensure robust security.

Owner: Head of Pharmacy

In 2022/2023 we commenced our long-term plan to improve our ambulance station's medicines storage rooms, so they align to the standards established within the Safe and Secure Handling of Medicines Policy, introduced in May 2022. This assessment included the analysis of an audit conducted at all trust medicine rooms and prioritising improvements to these according to the need. This enabled the Pharmacy team to work closely with Estates and prioritise the first five station medicines rooms for improvement. Following outcome of the CQC inspection, work on this project was paused while the team focused on the installation medicines cabinets in stations that were the highest priority. It also prioritised the installation of key safes, this was to ensure security and appropriate access to medicines. With these priorities completed the team is refocusing on work to address all station improvements, beginning with these priority areas.

This priority was partially delivered in 2022/23. There is a longer-term plan in place that is monitored via the Medicine's Optimisation Governance Group.

## 1C: Further improve patient safety through the use of mental health telephone triage services in 999 and NHS 111

Owner: Mental Health Lead

This priority has been achieved as SCAS are now hosting two NHS Mental Health Trusts (Oxford Health covering Oxfordshire and Buckinghamshire and Southern Health covering Hampshire) embedded within the north and south Clinical Communications Centres respectively. Within our centres, these services offer a call-back service to patients making contact through 999 or NHS111 where a mental health concern is identified as the reason for the call but there is no threat to life, and it is appropriate for further telephone contact. When contacting the service, patients receive a standard triage to screen out any underlying physical health emergency before their information is transferred from SCAS to their respective Mental Health Trust for further triage, time-dependent call-back and clinical management.

Analysis of data from calls received via 999 or NHS111, categorised with the main reason for calling as a mental health problem, demonstrates the significant impact the provision of mental health telephone services has made within the Clinical Communications Centres.

## Outcome after mental Health Practitioner Triage (%) - Oxford Health

| | Feb 22 | Mar 22 | Apr 22 | May 22 | Jun 22 | Jul 22 | Aug 22 | Sep 22 | Oct 22 | Nov 22 | Dec 22 | Jan 23 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Self Care | 51.3% | 54.2% | 42.7% | 45.3% | 36.9% | 46.2% | 50.8% | 38.3% | 27.9% | 34.8% | 35.5% | 35.0% |
| Non Clinical | 15.5% | 14.6% | 28.6% | 27.0% | 33.4% | 27.9% | 21.7% | 31.9% | 39.4% | 24.1% | 16.6% | 30.5% |
| Speak to Primary care | 13.4% | 15.2% | 11.2% | 14.1% | 21.1% | 19.8% | 18.0% | 22.2% | 27.4% | 27.3% | 33.2% | 23.0% |
| Contact Primary care | 6.3% | 12.2% | 12.9% | 9.2% | 2.5% | 3.1% | 5.8% | 3.5% | 2.3% | 2.5% | 0.9% | 4.1% |
| Emergency Ambulance Cat 1 & 2 | 0.6% | 1.5% | 2.9% | 2.8% | 3.3% | 1.3% | 1.1% | 1.7% | 1.0% | 1.5% | 3.6% | 1.7% |
| Unknown | 0.0% | 0.2% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 1.2% | 7.5% | 7.8% | 4.2% |
| Emergency Ambulance Cat 3 & 4 | 2.5% | 1.5% | 1.4% | 1.5% | 2.6% | 1.5% | 1.6% | 2.4% | 0.7% | 1.9% | 1.7% | 1.4% |
| Attend Other Service | 0.2% | 0.4% | 0.2% | 0.0% | 0.0% | 0.0% | 1.1% | 0.0% | 0.0% | 0.2% | 0.0% | 0.0% |
| Prescription Medication | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.2% | 0.0% | 0.0% | 0.2% | 0.2% | 0.7% | 0.0% |
| Attend A&E | 0.2% | 0.2% | 0.2% | 0.2% | 0.2% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.2% |

## Outcome after mental Health Practitioner Triage (%) - Southern Health

| | Feb 22 | Mar 22 | Apr 22 | May 22 | Jun 22 | Jul 22 | Aug 22 | Sep 22 | Oct 22 | Nov 22 | Dec 22 | Jan 23 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Self Care | 51.3 | 50.3 | 47.1 | 51.2 | 46.8 | 50.2 | 49.5 | 43.2 | 44.2 | 43.1 | 41.9 | 38.5 |
| Non Clinical | 37.8 | 37.7 | 35.7 | 34.3 | 36.3 | 35.8 | 33.4 | 41 | 36.3 | 33.6 | 28.3 | 26.5 |
| Speak to Primary care | 7.8 | 9.4 | 13.2 | 11.3 | 12.5 | 9.7 | 11.8 | 11 | 12.6 | 12.4 | 18.2 | 15.7 |
| Contact Primary care | 0.1 | 0 | 0 | 0.1 | 0 | 0 | 0 | 0 | 1.6 | 7.3 | 6.1 | 13.2 |
| Emergency Ambulance Cat 1 & 2 | 1.5 | 0.9 | 2.1 | 1.1 | 1.5 | 1.3 | 3.1 | 2.1 | 3.1 | 2.3 | 3 | 3.8 |
| Unknown | 1.2 | 1 | 1.2 | 1 | 1.7 | 1.7 | 1.4 | 1.4 | 1.2 | 0.9 | 1.4 | 1.6 |
| Emergency Ambulance Cat 3 & 4 | 0.1 | 0.4 | 0.4 | 0.7 | 0.7 | 0.6 | 0.6 | 0.5 | 0.6 | 0.2 | 0.6 | 0.4 |
| Attend Other Service | 0.1 | 0.3 | 0.3 | 0.3 | 0.5 | 0.5 | 0.2 | 0.6 | 0.4 | 0.1 | 0.4 | 0.3 |
| Prescription Medication | 0.1 | 0.1 | 0 | 0 | 0 | 0.2 | 0 | 0 | 0 | 0 | 0 | 0.1 |
| Attend A&E | 0.1 | 0 | 0 | 0 | 0 | 0 | 0 | 0.1 | 0.1 | 0 | 0 | 0 |

The tables above show that after specialist contact the recommendation for patients to attend a hospital emergency department (ED) has dropped to either 3.7% (Oxford Health) or 2.1% (Southern Health). This contrasts with the initial triage outcomes by non-specialist mental health call handler algorithms which, recommended ambulance or hospital attendance in 45.8% (Oxford Health) or 37.6% (Southern Health) of patient contacts.

This decrease of 42.1% and 35.5% in recommendations for ED attendance demonstrate the impact that these services are having on the care of patients, through the reduction of those in mental health crisis having to attend an ED when they are particularly vulnerable. This specialist intervention at the point of contact is a significant improvement to better meet the needs of patients and provide the most appropriate care at a point of crisis.

This priority was delivered in 2022/23.

# 2 Clinical Effectiveness

## 2A: A clinical review of patients that 'trigger' the Wessex Trauma Triage Tool but are not conveyed to major trauma centres. This will align SCAS with the Trauma Units, who are also required to perform quarterly reviews of these patients. This will provide surveillance and identify learning in these circumstances.

Owner: Pre-hospital Consultant Practitioner

Patients with 'Major Trauma' are classified by having an Injury Severity Score (ISS) of over 15. The key principle is that patients with an ISS over 15 will be conveyed to and managed in Major Trauma Centres and not Trauma Units. The ISS score cannot be calculated at the roadside and is only entered onto TARN (the Trauma Audit Research Network) database after CT scans, X-rays and other tests have been performed and the injury status of the patient is fully understood. This TARN data also includes length of stay and survival data, which cannot be accessed by the ambulance service.

### Achievements

There are robust 3-monthly reviews of patients with an ISS over 15 that were transported to Trauma Units instead of Major Trauma Centres. This data is presented by the receiving Trauma Units. All these incidents are reviewed quarterly at the Wessex Trauma Network Clinical Governance meetings.

The common theme identified in patients that were transported to Trauma Units and then subsequently found to have an ISS of over 15, is in patients aged 80 years or over following a fall of more than two metres. This is a national issue, and SCAS are working within the Wessex Trauma Network to develop an older person trauma triage tool. One of our Trauma Units has already created a separate primary trauma team call-out criteria for older patients.

Another issue is when patients are too unwell to survive the journey to a Major Trauma Centre and are therefore taken to the nearest hospital for stabilisation. A key factor will be the availability of our Air Ambulance assets, who have the extended skills, medicines and knowledge to manage these challenging patients. For this reason, the SCAS trauma data has been shared with our air ambulance teams. The information includes:

- The mapping of incident locations
- Common mechanism of injuries
- Time-of-day data

Where concerns are raised about a patient with an ISS of under 15 (or did not trigger the Trauma By-pass Tool) and were transferred to the Major Trauma Centre, these are fed back to the attending ambulance clinicians. This is necessary to ensure learning for our crews, and to avoid overloading the Major Trauma Centres with patients from outside the hospital catchment area who do not require specialist trauma team care.

The SCAS Consultant Pre-Hospital Practitioner attends each of the monthly Wessex Trauma Network meetings, and each of the quarterly reviews of ISS over 15 patients.

This priority was delivered in 2022/23

## 2B: Improve vehicle cleanliness and awareness across the organisation, increase assurance and audit through positive engagement with operations teams.

Owner: Infection Prevention and Control (IPC) Lead

A clean environment provides the necessary setting for good patient care and sound infection prevention and control. Providing this can be a challenge in the pre-hospital environment where ambulance staff are required to treat and stabilise patients in a variety of settings that are often not clean. All staff play an important role in quality improvement, in maintaining public confidence, and in reducing infection-related risks.

The Covid-19 pandemic has placed significant challenges on the ability of the trust to monitor cleanliness through routine audit, compliance visits and IPC visits. All these functions were impacted by the requirement to reduce footfall at stations, reduce the ability to third 'man' (for observational audit) and unprecedented continued demand on the service (Resource Escalation Action Plan 4) for several months, impacting on team leaders and CTEs time to carry out planned audits.

As a result, the Quality priority set out in 2020-2021 was only partially achieved. IPC, including cleanliness, is vitally important to the running of a safe service. As we move towards the latter stages of the pandemic, IPC will focus on ensuring basic principles of cleanliness and completion of the audit cycle to meet excellent standards.

IPC improvement plan is one of the workstreams of the Trust improvement programme.

### Achievements

- The IPC audit questions have been updated and agreed
- Denominator data analysed and inconsistencies identified with both vehicle and building information. This meant it has not been possible to identify 10 specific areas or progress with further audit development
    - There is a focus on getting accurate denominator data with both fleet and estates support to achieve this

- IPC have worked with Operational Support Services to confirm vehicles in service to allow development of accurate denominator data
- Business intelligence has been engaged to create an accurate vehicle list for denominator data. IPC have been informed there is not currently a central list, however, a wider piece of work is underway to develop this.

- The IPC assurance audit programme and online assurance form has been developed outside of audit service provider to allow assurance audits by IPC to commence during Q4.

Further work

- Discussions with Audit Online are ongoing to remove old fleet from the system
- Business Intelligence are engaged to assist with development of accurate vehicle list with a view to producing a format which can be utilised by Audit Online

This priority was partially delivered in 2022/23.

## 2C: To report on Category 1 through 4 performance and Return of Spontaneous Circulation (ROSC)

Owner: Director of Operations

National Health Service Improvement (NHSi) – mandated indicators

- Category 1 emergency response (mean times)
- Category 2 emergency response (mean times)
- Category 3 emergency response (mean times)
- Category 4 emergency response (mean times)

Refer to section 2.3 Reporting against NHSi core indicators

### Achievements to date

- Cat 1 Mean 09:20
- Cat 2 Mean 34:04
- Cat 3 Mean 2:44:50
- Cat 3 90th 05:16:56
- Cat 4 90th 06:39:29

**Improvement actions**

- We continue to work with acute trusts to reduce ambulance handover delays. Daily calls are made with ICB and National Health Service England (NHSE) to ensure support with handover delays
- International recruitment is underway to increase staffing levels supported with funding from Health Education England (HEE)
- Development and implementation of new rotas during Q1 to offer improved working patterns
- Enhance flexible working offering
- Review sustainable financial offerings to new and existing staff

This priority was not delivered in 2022/23.

### 2D: To report on Stroke care bundle compliance/ STEMI care bundle compliance

Owner: Assistant Director of Quality

Refer to section 2.5 Reporting against NHSi core indicators

| Clinical Quality Indicator | Lower | Upper | Difference | National Average | South Central | Greater or lower than Average |
|---|---|---|---|---|---|---|
| **STEMI - Care** | 58.39% | 96.84% | 38.45% | 74.96% | 64.37% | Lower |
| **Stroke - Care** | 93.17% | 99.70% | 6.53% | 96.92% | 98.04% | Greater |

This priority was partially delivered in 2022/23.

## 3 Patient Experience (PE)

### 3A: Design and deliver a focused survey of patients that use the NEPTS for renal patients, to allow focussed improvements for this vulnerable group.

Owner: Head of Patient Experience

South Central Ambulance Service Non-emergency patient transport service (NEPTS) are conducting face-to-face surveys or giving paper copies to all renal patients to understand their experience when attending their regular renal dialysis appointments.

Across the NEPTS Commissioned areas covering Buckinghamshire, Milton Keynes, Oxfordshire, Berkshire, Hampshire, and Sussex there are 1016 patients that attend community and hospital renal units.

The survey obtained 300 responses throughout the collection period an overall response rate of 29%.

- 73% told us Overall, their experience as being very good or good
- 9% told us Overall, their experience as being poor or very poor
- 44.26% told us that their dialysis slot was AM
- 48.99% told us that their dialysis slot was PM

With Key Performance Indicators (KPI's) allowing us to drop you off at the unit for your appointment up to 45 mins before your pre-booked appointment, how often would you say you have experienced delays where you have waited longer?

- 20.3% patient responded - 3 times a week
- 41.46% patients responded – Less than once a month

With KPI's allowing us to collect you up to 30 mins after your pre-booked appointment time, how often would you say you have experienced delays where you have waited longer?

- 15.71% of patients responded - 3 times a week
- 29.79% of patients responded – less than once a month
- 95.59% of patients responded the booked transport is suitable for their needs
- 85.87% responded that the vehicle was comfortable
- 85.14% responded that the crew/drivers are helpful and courteous
- 79.66% responded that they are escorted to and from their home address and the unit
- 31.41% responded that they had to wait 16-30 minutes for their dialysis treatment to begin
- 6.96% told us they had to wait 30 minutes plus to be taken off the bed/couch at the end of their treatment
- 37.28% of respondents are over 75 years of age
- 74.74% of respondents told us they ethnicity is white British

Overall, the responses were positive and there were no new themes identified from this feedback. NEPTS will continue to look to reduce delays and improve communication with patients.

A final report was written and sent to area managers and their teams to review any learning and actions that could be taken to improve the patient experience for patients attending Renal units.

Meetings have been arranged to go through each contracted area to review the report and enable full divisional area actions to be managed and a learning log to be designed.

The main themes identified by areas are:

- Outward journeys are often late
- Communication/calls to patients to advise that transport is on the way are inconsistent
- The geographical planning of journeys could be improved
- Taxi drivers not fully taking care of patients or following Standard operating procedures correctly.

This priority was delivered in 2022/23.

## 3B: Survey patients on their experience of accessing the Integrated Urgent Care system.

Owner: Clinical Governance Lead IUC and Head of Patient Experience

Since the Integrated Urgent Care system (IUC) in Hampshire started in June 2021, the vision has been to use a single survey that captures the patient's pathway from start to finish.

### Achievements

The Survey was designed and agreed with all IUC partners and commenced in use from July 22. This implementation included a QR code to access the survey to reach more of the population by using an online form.

In August 2022 there was a national outage of the system we use in NHS111 and IUC. This outage caused problems with data collection at the time and since. Data collection for the Integrated urgent care survey is not available.

All providers have been continuing with surveys and end-to-end reviews of cases.

| Quarter | 1 | 2 | 3 | 4 |
|---|---|---|---|---|
| Total feedback | 704 | 701 | 942 | 1,025 |

This priority was not delivered in 2022/23.

## 3C: Undertake end-to-end reviews of the patient's journey through the Integrated Urgent Care system. The reviews will cover each Clinical Commissioning Group (CCG) area - Mid and North Hants, Portsmouth and Southampton.

Owner: Integrated Urgent Care (IUC) Compliance Quality Lead

The integrated Urgent Care (IUC) service started in June 2021 within the Hampshire and Isle of Wight area. Since the start, end-to-end reviews have been undertaken to assure both patient safety and experience when using these services.

These reviews have been found to lead to an improved patient experience and enhanced safety due to highlighting issues throughout the service. For example, Adastra (the system used in NHS111) communication and changes in Standard Operating Procedures (SOP's). There are improvements that can be made to the review process.

- A new end-to-end process trial has been led by SCAS. This includes a timeline of end to ends, an end to end (E2E) proforma, to produce and disseminate an action log/minute and the use of a single inbox to collate information.
- E2E Terms of reference were reviewed to ensure up-to-date attendance and quoracy.

### Achievements

E2Es in Q2 increased, we held five end to ends, four were part of a focussed UTC meeting and the other included our mental health services.

All E2Es are included within the IUC Clinical Assurance Group meeting (CAG) and report, for upward reporting and assurance oversight by all IUC and ICB members. Cases that have brought up concerns involving NHS Pathways, have been raised to NHS Digital and any feedback is provided at the CAG.

This priority was delivered in 2022/23.

## 2.2 Statements of assurance from the board

| | Prescribed information | Form of statement |
|---|---|---|
| 1. | The number of different types of relevant health services provided or subcontracted by the provider during the reporting period, as determined in accordance with the categorisation of services:<br><br>(a) specified under the contracts, agreements, or arrangements under which those services are provided or<br><br>(b) in the case of an NHS body providing services other than under a contract, agreement, or arrangements, adopted by the provider. | During 2022/23 SCAS provided and/or subcontracted four relevant health services.<br><br>• Emergency 999 Ambulance Service<br>• Non-Emergency Patient Transport Service<br>• NHS 111 Telephone Advice Service<br>• National Covid services |

| | | |
|---|---|---|
| 1.1 | The number of relevant health services identified under entry 1 in relation to which the provider has reviewed all data available to it on the quality of care provided during the reporting period. | • SCAS has reviewed all the data available to them on the quality of care in all these relevant health services.<br>• Patient survey results<br>• Friends and family tests<br>• Staff surveys<br>• Narrative from complaints and feedback and their resolution<br>• Health Care Professional (HCP) feedback themes and actions<br>• Patient stories at public Board meetings<br>• Root cause analysis of incidents and identified learning<br>• Internal audit reports<br>• External reviews of quality including the CQC/Ofsted and commissioner visits<br>• Leadership walk-arounds and actions<br>• Upward reports to Quality and Safety Committee meetings<br>• Staff meetings<br>• Quality Impact Assessments of cost savings projects<br>• Quality and Safety papers to the Board<br>• Quality and Safety Committee minutes<br>• Patient Experience Review Group meeting minutes<br>• Patient Safety Group meeting minutes<br>• Clinical Review Group meeting minutes |
| 1.2 | The percentage that the income generated by the relevant health services reviewed by the provider, as identified under entry 1.1, represents of the total income for the provider for the reporting period under all contracts, agreements and arrangements held by the provider for the provision of, or subcontracting of, relevant health services. | The income generated by the relevant health services reviewed in 2022/23 represents 100% of the total income generated from the provision of relevant health services by SCAS for 2022/23. |

| | Prescribed information | Form of statement |
|---|---|---|
| 2. | The number of national clinical audits<br><br>(a) and national confidential enquiries<br><br>(b) which collected data during the reporting period, and which covered the relevant health services that the provider provides or subcontracts. | During 2022/23, 9 national clinical audits and 0 national confidential enquiries covered relevant health services that SCAS provides. |
| 2.1 | The number, as a percentage, of national clinical audits and national confidential enquiries, identified under entry 2, that the provider participated in during the reporting period. | During that period SCAS participated in 100% national clinical audits and 0 (none eligible) national confidential enquiries of the national clinical audits and national confidential enquiries in which it was eligible to participate. |
| 2.2 | A list of the national clinical audits and national confidential enquiries identified under entry 2 that the provider was eligible to participate in. | The national clinical audits and national confidential enquiries that SCAS was eligible to participate in during 2022/23 are as follows:<br><br>• Acute Myocardial Infarction and other Acute Coronary Syndrome (MINAP)<br><br>• Ambulance Clinical Quality Indicator S-T elevation Myocardial Infarction (STEMI) Care Bundle<br><br>• Sentinel Stroke National Audit Programme (Stroke Call to Hospital Arrival times)<br><br>• Ambulance Clinical Quality Indicator Stroke Diagnostic Bundle<br><br>• Ambulance Clinical Quality Indicator Sepsis Care Bundle<br><br>• Warwick Clinical Trials Unit Out of Hospital Cardiac Arrest Outcome (OHCAO)<br><br>• Ambulance Clinical Quality Indicator Cardiac Arrest ROSC rates (and separate Utstein ROSC measure)<br><br>• Ambulance Clinical Quality Indicator Cardiac Arrest Survival to Discharge (and separate Utstein STD measure)<br><br>• Ambulance Clinical Quality Indicator Cardiac Arrest Post ROSC Care Bundle |

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| 2.3 | A list of the national clinical audits and national confidential enquiries, identified under entry 2.1, that the provider participated in. | The national clinical audits and national confidential enquiries that SCAS participated in during 2022/23 are as follows:<br>• Acute Myocardial Infarction and other Acute Coronary Syndrome (MINAP)<br>• Ambulance Clinical Quality Indicator S-T elevation Myocardial Infarction (STEMI) Care Bundle<br>• Sentinel Stroke National Audit Programme (Stroke Call to Hospital Arrival times)<br>• Ambulance Clinical Quality Indicator Stroke Diagnostic Bundle<br>• Ambulance Clinical Quality Indicator Sepsis Care Bundle<br>• Warwick Clinical Trials Unit Out of Hospital Cardiac Arrest Outcome (OHCAO)<br>• Ambulance Clinical Quality Indicator Cardiac Arrest ROSC rates (and separate Utstein ROSC measure)<br>• Ambulance Clinical Quality Indicator Cardiac Arrest Survival to Discharge (and separate Utstein STD measure)<br>• Ambulance Clinical Quality Indicator Cardiac Arrest Post ROSC Care Bundle |

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| 2.4 | A list of each national clinical audit and national confidential enquiry that the provider participated in, and which data collection was completed during the reporting period, alongside the number of cases submitted to each audit, as a percentage of the number required by the terms of the audit or enquiry. | The national clinical audits and national confidential enquiries that SCAS participated in, and for which data collection was completed during 2022/23, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.<br><br>*Note that the data relates to April – November 2022 and not a full year due to National Ambulance Clinical Quality Indicator reporting timelines (there is a four-month reporting lag).<br><br>• Acute Myocardial Infarction and other Acute Coronary Syndrome (MINAP) Number of cases 580, 83.45%<br><br>• Ambulance Clinical Quality Indicator S-T elevation Myocardial Infarction (STEMI) Care Bundle<br><br>Number of cases 262, 64.37%<br><br>• Sentinel Stroke National Audit Programme (Stroke Call to Hospital Arrival times)<br><br>Number of cases 2453<br><br>• Ambulance Clinical Quality Indicator Stroke Diagnostic Bundle<br><br>• Number of cases 1896, 98.04%<br><br>• Ambulance Clinical Quality Indicator Sepsis Care Bundle<br><br>Number of cases 312, 71.23%<br><br>• Warwick Clinical Trials Unit Out of Hospital Cardiac Arrest Outcome (OHCAO)<br><br>Number of cases 1666<br><br>• Ambulance Clinical Quality Indicator Cardiac Arrest ROSC rates (and separate Utstein ROSC measure)<br><br>Number of cases 394, 23.65%<br><br>Utstein 113, 51.60%<br><br>• Ambulance Clinical Quality Indicator Cardiac Arrest Survival to Discharge (and separate Utstein STD measure)<br><br>Number of cases 157, 9.50%<br><br>Utstein 75, 34.56%<br><br>• Ambulance Clinical Quality Indicator Cardiac Arrest Post ROSC Care Bundle<br><br>Number of cases 141, 70.50% |

| | | |
|---|---|---|
| 2.5 | The number of national clinical audit reports published during the reporting period that were reviewed by the provider during the reporting period. | The reports of 9 national clinical audits were reviewed by the provider in 2022/23. |
| 2.6 | A description of the action the provider intends to take to improve the quality of healthcare following the review of reports identified under entry 2.5. | SCAS intends to take the following actions to improve the quality of healthcare provided<br><br>Actions<br><br>• Included resuscitation training and elements of care required by Ambulance Care Quality Indicator (ACQI) care bundles within the face-to-face clinical update programme 2022/23.<br><br>• Review and update ACQI compliance tools in the electronic patient record system, to include development of new compliance tools within the electronic records system used by private providers.<br><br>• Launch a new ACQI scorecard where compliance can be monitored by individual clinician, area, and Private Provider.<br><br>• Consistent improvement in performance against ambulance response targets |
| 2.7 | The number of local clinical audit<br><br>(a) reports that were reviewed by the provider during the reporting period. | The reports of 10 local clinical audits were reviewed by the provider in 2022/23. |

| | | |
|---|---|---|
| 2.8 | A description of the action the provider intends to take to improve the quality of healthcare following the review of reports identified under entry 2.7. | SCAS intends to take the following actions to improve the quality of healthcare provided<br>• Continuation of level 3 safeguarding training to meet trajectory.<br>• Extension of mandated pain scoring for eligible conditions in the Trusts electronic patient record system to 2 (pre and post treatment) for conditions where this is indicated.<br>• Re-audit changes made in provision of analgesia and communicate results and learning with staff. Communicate analgesia ladder as refresher for staff.<br>• Publication of patient safety newsletter |
| | **Prescribed information** | **Form of statement** |
| 3. | The number of patients receiving relevant health services provided or subcontracted by the provider during the reporting period that were recruited during that period to participate in research approved by a research ethics committee within the National Research Ethics Service. | The number of patients receiving relevant health services provided or sub-contracted by SCAS in 2022/23 that were recruited during that period to participate in research approved by a research ethics committee was 772.<br>Conference presentations and publications demonstrate our commitment to transparency and desire to improve patient outcomes and experience across the NHS.<br>Our engagement with clinical research also demonstrates the Trust's commitment to testing and offering the latest medical treatment and techniques. The areas of engagement are outlined below.<br>**Research-related activities**<br>Representation on regional and national research committees: Wessex Study Support Group, Thames Valley and South Midlands Injuries and Emergencies Specialty Group, National Ambulance Research Steering Group.<br>Publications:<br>**2022**<br>Optimizing outcomes after out-of-hospital cardiac arrest with innovative approaches to public-access defibrillation: A scientific statement from the International Liaison Committee on Resuscitation. Resuscitation 2022 172; 204-228. https://doi.org/10.1016/j.resuscitation.2021.11.032 |

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|---|---|---|
| | | Optimizing outcomes after out-of-hospital cardiac arrest with innovative approaches to public-access defibrillation: A scientific statement from the International Liaison Committee on Resuscitation. Circulation. 2022;145: e776–e801. **https://doi.org/10.1161/CIR.0000000000001013**<br><br>Are there disparities in the location of automated external defibrillators in England? ***Resuscitation***, 170: 28-35. Doi: **https://doi.org/10.1016/j.resusciation.2021.10.037**.<br><br>Variability in approach to informing the relatives of non-surviving participants in cardiac arrest research: a questionnaire study: ***Resuscitation***, 175(S1): S73.<br><br>Long term outcomes of participants in the PARAMEDIC2 randomised trial of adrenaline in out-of-hospital cardiac arrest. ***Resuscitation***, 160: 84-9.<br><br>Service evaluation of the impact of direct ambulance calls from paramedics to the ambulatory assessment unit in the John Radcliffe hospital, Oxford. ***Future Healthcare Journal***. Doi: **https://doi.org/10.7861/fhj.9-2-s14**.<br><br>Perceptions and experiences of medical student first responders: a mixed methods study. ***BMC Medical Education,*** 22: 721. Doi: **https://doi.org/10.1186/s12909-022-03791-z**<br><br>To inform or not? A qualitative evaluation of patients and public opinions on providing information about research participation following out of hospital cardiac arrest. ***Resuscitation***, 175: S72. Doi: **https://doi.org/10.1016/S0300-9572(22)00510-X**.<br><br>***Protocol for a cluster randomised controlled feasibility study of Prehospital Optimal Shock Energy for Defibrillation (POSED). Resuscitation Plus, 12. Doi: https://doi.org/10.1016/j.resplu.2022.100310***.<br><br>Could we identify the Prehospital Optimal Shock Energy for Defibrillation? Answering the question that is POSED. ***Emergency Medicine Journal***, 39: e5. |

| | | |
|---|---|---|
| | | Feasibility randomised controlled trial of optimal shock energy for defibrillation. ***Resuscitation***, 175(S1): S12.<br><br>Effectiveness of alternative shock strategies for out-of-hospital cardiac arrest: a systematic review. ***Resuscitation Plus***, 10. Doi: **https://doi.org/10.1016/jresplu.2022.100232**.<br><br>Systematic review of shock strategies for out-of-hospital cardiac arrest. ***Resuscitation***, **175** (S1): S73.<br><br>Increasing use of intraosseous access at out-of-hospital cardiac arrest: a registry-based cohort study. ***Resuscitation***, 175 (1): S79. Doi: **https://doi.org/10.1016/S0300-9572(22)00527-5**.<br><br>International Consensus on Cardiopulmonary Resuscitation and Emergency Cardiovascular Care Science With Treatment Recommendations Summary From the Basic Life Support; Advanced Life Support; Neonatal Life Support; Education, Implementation, and Teams; First Aid Task Forces; and the COVID-19 Working Group. Circulation. 2022;145: e645–e721. **https://doi.org/10.1161/CIR.0000000000001017**<br><br>International Consensus on Cardiopulmonary Resuscitation and Emergency Cardiovascular Care Science With Treatment Recommendations: Summary From the Basic Life Support; Advanced Life Support; Paediatric Life Support; Neonatal Life Support; Education, Implementation, and Teams; and First Aid Task Forces. Resuscitation 2022; 181: 208-288. doi: 10.1016/j.resuscitation.2022.10.005 |
| | **Prescribed information** | **Form of statement** |
| 4. | Whether or not a proportion of the provider's income during the reporting period was conditional on achieving quality improvement and innovation goals under the Commissioning for Quality and Innovation (CQUIN) payment framework agreed between the provider and any person or body they have entered into a contract, agreement or arrangement with for the provision of relevant health services. | A proportion of SCAS income in 2022/23 was conditional on achieving quality improvement and innovation goals agreed between SCAS and any person or body they entered a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.<br><br>All payments have been made on block contract, so no payments for CQUIN in 2022/23 |

| | | |
|---|---|---|
| 4.1 | If a proportion of the provider's income during the reporting period was not conditional on achieving quality improvement and innovation goals through the CQUIN payment framework, the reason for this. | Not applicable |
| 4.2 | If a proportion of the provider's income during the reporting period was conditional on achieving quality improvement and innovation goals through the CQUIN payment framework, where further details of the agreed goals for the reporting period and the following 12-month period can be obtained. | Not applicable |
| | **Prescribed information** | **Form of statement** |
| 5. | Whether or not the provider is required to register with CQC under section 10 of the Health and Social Care Act 2008. | SCAS is required to register with the Care Quality Commission and its current registration status is without conditions in all fundamental standards. |
| 5.1 | If the provider is required to register with the CQC:<br><br>(a) whether at end of the reporting period the provider is:<br><br>(i) registered with the CQC with no conditions attached to registration,<br><br>(ii) registered with the CQC with conditions attached to registration,<br><br>(b) if the provider's registration with CQC is subject to conditions, what those conditions are and<br><br>(c) whether CQC has taken enforcement action against the provider during the reporting period. | The Care Quality Commission has taken enforcement action against SCAS during 2022/23, in the form of a Section 29a letter |

| | Prescribed information | Form of statement |
|---|---|---|
| 6. | Removed from the legislation by the 2011 amendments | |
| | **Prescribed information** | **Form of statement** |
| 7. | Whether or not the provider has taken part in any special reviews or investigations by CQC under section 48 of the Health and Social Care Act 2008 during the reporting period. | Not applicable |
| 7.1 | If the provider has participated in a special review or investigation by CQC:<br><br>(a) the subject matter of any review or investigation<br><br>(b) the conclusions or requirements reported by CQC following any review or investigation<br><br>(c) the action the provider intends to take to address the conclusions or requirements reported by CQC and<br><br>(d) any progress the provider has made in taking the action identified under paragraph (c) prior to the end of the reporting period. | Not applicable |

| | Prescribed information | Form of statement |
|---|---|---|
| 8. | Whether or not during the reporting period the provider submitted records to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest version of those statistics published prior to publication of the relevant document by the provider. | SCAS did not submit records during 2022/23 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data as it was not applicable. |
| 8.1 | If the provider submitted records to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data:<br><br>(a) the percentage of records relating to admitted patient care which include the patient's:<br><br>(i) valid NHS number<br><br>(ii) General Medical Practice Code<br><br>(b) the percentage of records relating to outpatient care which included the patient's:<br><br>(i) valid NHS number<br><br>(ii) General Medical Practice Code<br><br>(c) the percentage of records relating to accident and emergency care which included the patient's:<br><br>(i) valid NHS number<br><br>(ii) General Medical Practice Code. | |

| | Prescribed information | Form of statement |
|---|---|---|
| 9. | The provider's Information Governance Assessment Report overall score for the reporting period as a percentage and as a colour according to the IGT Grading scheme. | SCAS Information Governance Assessment Report has been replaced by Data Security and Protection Toolkit.<br><br>DSPT (Data Security and Protection Toolkit) returns are every June so last submission June 21 – June 22. The trust was "Standards not met – Plan agreed" which then became "Approaching Standards" |
| | **Prescribed information** | **Form of statement** |
| 10. | Whether or not the provider was subject to the Payment by Results clinical coding audit at any time during the reporting period by the NHSi. | SCAS was not subject to the Payment by Results clinical coding audit during 2022/23 by NHSi. |
| 10.1 | If the provider was subject to the Payment by Results clinical coding audit by the NHSi at any time during the reporting period, the error rates, as percentages, for clinical diagnosis coding and clinical treatment coding reported by the NHSi in any audit published in relation to the provider for the reporting period prior to publication of the relevant document by the provider. | |
| | **Prescribed information** | **Form of statement** |
| 11. | The action taken by the provider to improve data quality. | SCAS will be taking the following actions to improve data quality: |

## 2.3 Reporting against NHSi core indicators

### Ambulance Response Programme

Performance against national ambulance service response targets 2022/23.

Since the 2019 Detailed Requirements for Quality Report – ambulance emergency responses relate to Ambulance Response Programme – categories 1-4.

| | Prescribed information | Type of trust | Comment |
|---|---|---|---|
| 14. | The percentage of Category A telephone calls (Red 1 and Red 2 calls) resulting in an emergency response by the Trust at the scene of the emergency within 8 minutes of receipt of that call during the reporting period. | Ambulance trusts | In the table showing performance against this indicator, Red 1 and Red 2 calls should be separate. |


**Category 1 2022/2023**
09:20 (Mean)
16:45 (90th Percentile)

**Category 1 2021/2022**
08:13 (Mean)
15:16 (90th Percentile)

**Category 1 2020/2021**
06:22 (Mean)
11:42 (90th Percentile)

## Ambulance category 1 (C1) – life-threatening calls: mean average response time

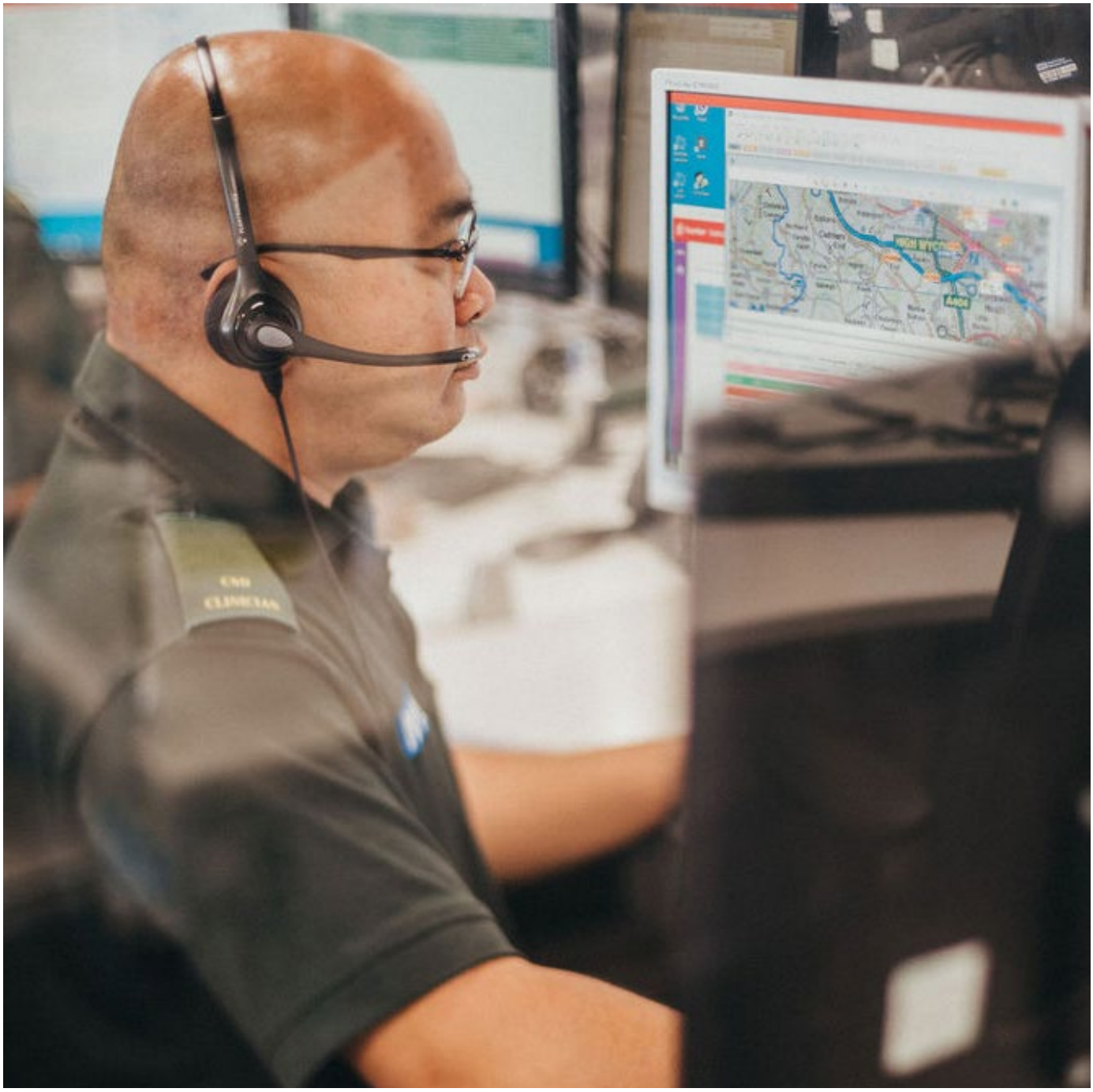
The percentage of Category A telephone calls (Red 1 and Red 2 calls) resulting in an emergency response by the Trust at the scene of the emergency within 8 minutes of receipt of that call during the reporting period.

The South Central Ambulance Service NHS Foundation Trust considers that this data is as described for the following reasons.

- Computer Aided Dispatch (CAD) system has robust fallback plans
- Ambulance response standards are measured and reported nationally
- The Trust has a robust data quality process for ensuring performance reporting which is benchmarked, and that data is scrutinised internally by the Executives, Board and by commissioners

SCAS intends to take the following actions to improve this indicator and so the quality of its services, by continually analysing the ambulance response data and continuing to model our staff rotas and fleet availability to meet the category requirements. Through the integrated performance report to Trust Board there will be clear visibility of the data and our actions. SCAS will continue to provide input to the national group, workstreams and, audit long waits.

| | Prescribed information | Type of trust | Comment |
|---|---|---|---|
| 14.1 | The percentage of Category A telephone calls resulting in an ambulance response by the trust at the scene of the emergency within 19 minutes of receipt of that call during the reporting period. | Ambulance trusts | |




**Category 2**
**2022/2023**
34:04 (Mean)
01:09:30 (90th Percentile)

**Category 2**
**2021/2022**
18:04 (Mean)
57:42 (90th Percentile)

**Category 2**
**2020/2021**
15:29 (Mean)
30:23 (90th Percentile)

## Ambulance category 2 (C2) – emergency calls: mean average response time

The percentage of Category A telephone calls resulting in an ambulance response by the Trust at the scene of the emergency within 19 minutes of receipt of that call during the reporting period (up to the introduction of the Ambulance response standards at the end of October 2017).

The South Central Ambulance Service NHS Foundation Trust considers that this data is as described for the following reasons.

- CAD system has robust fallback plans
- Ambulance response standards are measured and reported nationally
- The Trust has a robust data quality process for ensuring performance reporting which is benchmarked, and that data is scrutinised internally by the Executives, Board and by commissioners

SCAS intends to take the following actions to improve this indicator and so the quality of its services, by continually analysing the ambulance response data and continuing to model our staff rotas and fleet availability to meet the category requirements. Through the integrated performance report to Trust Board there will be clear visibility of the data and our actions. SCAS will continue to input into the national group and workstreams and audit long waits.


**Category 3 2022/23**
05:16:56
(90th Percentile)

**Category 3 2021/2022**
4:11:57
(90th Percentile)

**Category 3 2020/2021**
1:46:22
(90th Percentile)

## Ambulance category 3 (C3) – urgent calls:

The South Central Ambulance Service NHS Foundation Trust considers that this data is as described for the following reasons.

- CAD system has robust fallback plans
- Ambulance response standards are measured and reported nationally
- The Trust has a robust data quality process for ensuring performance reporting which is benchmarked, and that data is scrutinised internally by the Executives, Board and by commissioners

SCAS intends to take the following actions to improve this indicator and so the quality of its services, by continually analysing the ambulance response data and continuing to model our staff rotas and fleet availability to meet the category requirements. Through the integrated performance report to Trust Board there will be clear visibility of the data and our actions. SCAS will continue to input into the national group and workstreams and audit long waits.


**Category 4**
**2022/23**
06:39:29
(90th Percentile)

**Category 4**
**2021/2022**
5:13:05
(90th Percentile)

**Category 4**
**2020/2021**
2:29:08
(90th Percentile)

## Ambulance category 4 (C4) – less urgent calls:

The South Central Ambulance Service NHS Foundation Trust considers that this data is as described for the following reasons.

- CAD system has robust and tested fallback plans
- Ambulance response standards are measured and reported nationally
- The Trust has a robust data quality process for ensuring performance reporting which is benchmarked, and that data is scrutinised internally by the Executives, Board and by commissioners

SCAS intends to take the following actions to improve this indicator and so the quality of its services, by continually analysing the ambulance response data and continuing to model our staff rotas and fleet availability to meet the category requirements. Through the integrated performance report to the Trust Board there is clear visibility of the data and our actions to improve. SCAS will continue to input into the national group and workstreams and audit long waits.

| | Prescribed information | Form of statement | Comment |
|---|---|---|---|
| 15. | The percentage of patients with a pre-existing diagnosis of suspected ST elevation myocardial infarction who received an appropriate care bundle from the trust during the reporting period. | Ambulance trusts | |

The percentage of patients with a pre-existing diagnosis of suspected ST elevation myocardial infarction who received an appropriate care bundle from the Trust during the reporting period.

*NOTE: Data for 2022/23 is Year to Date (YTD) data in line with national reporting validation processes.*

| **Year** | **Compliance** |
|---|---|
| 2022/23 | 62.6% YTD |
| 2021/22 | 64.48% YTD |
| 2020/21 | 68.61% |

The South Central Ambulance Service NHS Foundation Trust considers that this data is as described for the following reasons.

- Electronic patient record data and analysis
- Report and data for national reporting requirements
- Board reports
- External contract reports
- Integrated performance report

SCAS intends to take the following actions to improve these indicators, and so the quality of its services, by utilising data collected from the electronic patient record system and analysing that data as per national reporting requirements. SCAS has an internal clinical audit programme and conducts deep dives where necessary (reporting to the Quality and Safety committee and Clinical Review Group). SCAS is continuing to input into the national work on revising the ambulance quality indicators.

| | Prescribed information | Form of statement | Comment |
|---|---|---|---|
| 16. | The percentage of patients with suspected stroke assessed face to face who received an appropriate care bundle from the trust during the reporting period. | Ambulance trusts | |

The percentage of patients with suspected stroke assessed face to face who received an appropriate care bundle from the Trust during the reporting period.

*NOTE: Data for 2022/23 is Year to Date (YTD) data in line with national reporting validation processes.*

| **Year** | **Compliance** |
|---|---|
| 2022/23 | 98.3% YTD |
| 2021/22 | 98.07% YTD |
| 2020/21 | 97.29% |

The South Central Ambulance Service NHS Foundation Trust considers that this data is as described for the following reasons.

- Electronic patient record data and analysis
- Report and data for national reporting requirements
- Board reports
- External contract reports
- Integrated performance report
- Corporate risk register

| Clinical Quality Indicator | Lower | Upper | Difference | National Average | South Central | Greater or lower than Average |
|---|---|---|---|---|---|---|
| **STEMI - Care** | 48.90% | 97.52% | 48.62% | 75.78% | 69.34% | Lower |
| **Stroke - Care** | 91.42% | 99.80% | 8.37% | 97.36% | 96.06% | Lower |

| | Prescribed information | Form of statement | Comment |
|---|---|---|---|
| 21. | The percentage of staff employed by, or under contract to, the trust during the reporting period who would recommend the trust as a provider of care to their family or friends. | Trusts providing relevant acute services | |

| | | Your Trust in 2022 | Average (median) for ambulance trusts | Your Trust in 2021 | Your Trust in 2020 |
|---|---|---|---|---|---|
| Q21a | "Care of patients / service users is my organisations top priority" | 60% | 60% | 63% | 65% |
| Q21b | "My organisation acts on concerns raised by patients / services users" | 58% | 58% | 67% | 71% |
| Q21c | "I would recommend my organisation as a place to work" | 48% | 59% | 51% | 65% |
| Q21d | "If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation" | 63% | 64% | 71% | 80% |

The percentage of staff employed by, or under contract to, the trust during the reporting period who would recommend the trust as a provider of care to their family or friends.

The South Central Ambulance Service NHS Foundation Trust considers that this data is as described for the following reasons:

- Website feedback, including our online PE (Patient Experience) surveys
- Establishment of a patient panel
- Robust analysis at the internal Workforce Development Board and Patient Experience Review Group
- External contractual reports to commissioners
- Continued development of 'People Voice' portfolio. People Voice aims to gather and triangulate intelligence from many sources including:
    - Annual NHS staff survey
    - National Quarterly Pulse Survey
    - Monthly People Pulse
    - New joiners / leavers surveys
    - Student placement feedback
    - FTSU themes
    - Human Resources case themes

SCAS intends to take the following actions to improve this and so the quality of its services by:

- Continue a patient experience project to seek feedback and understand our patients' experiences of urgent care pathways direct referrals.
- Launch a new NHS111 patient survey, which will seek to gain feedback related to the patient's pathway of care across the integrated urgent care service.
- Develop further digital options for collecting patient survey data.

| | Prescribed information | Form of statement | Comment |
|---|---|---|---|
| 25. | The number and, where available, rate of patient safety incidents reported within the trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death. | All trusts | |

The number and, where available, rate of patient safety incidents reported within the trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death.

SCAS intends to take the following actions to improve these indicators, and so the quality of its services, by utilising data collected from the electronic patient record system and analysing that data as per national reporting requirements. SCAS has an internal clinical audit programme and conducts deep dives where necessary (reporting to the Quality and Safety committee and Clinical Review Group). SCAS is continuing to input into the national work on revising the ambulance quality indicators.

Ambulance Clinical Quality Indicators YTD April to November 2022/23 against national average (YTD)

| Clinical Quality Indicator | Lower | Upper | Difference | National Average | South Central | Greater or lower than Average |
|---|---|---|---|---|---|---|
| **STEMI - Care** | 58.39% | 96.84% | 38.45% | 74.96% | 64.37% | Lower |
| **Stroke - Care** | 93.17% | 99.70% | 6.53% | 96.92% | 98.04% | Greater |

Ambulance Clinical Quality Indicators YTD April to March 2021/22 against national average (YTD)

| Clinical Quality Indicator | Lower | Upper | Difference | National Average | South Central | Greater or lower than Average |
|---|---|---|---|---|---|---|
| **STEMI - Care** | 60.00% | 93.57% | 33.57% | 76.07% | 65.14% | Lower |
| **Stroke - Care** | 94.68% | 99.25% | 4.57% | 97.41% | 98.23% | Greater |

Ambulance Clinical Quality Indicators April to March 2020/21 against national average

| Clinical Quality Indicator | Lower | Upper | Difference | National Average | South Central | Greater or lower than Average |
|---|---|---|---|---|---|---|
| **STEMI - Care** | 51.91% | 95.68% | 43.77% | 75.42% | 67.74% | Lower |
| **Stroke - Care** | 94.02% | 99.49% | 5.48% | 97.84% | 97.33% | Lower |

Ambulance Clinical Quality Indicators April to March 2019/20 against national average

| | 2020/21 | 2021/22 | 2022/23 |
|---|---|---|---|
| Number of incidents | 672 | 904 | 1720 |
| Number and % severe harm/death | 29<br>(4.3%) | 57<br>(6.3%) | 12<br>(0.7%) |

*Note: Rate is not calculated for ambulance services and national benchmark is not yet available.*

*Note: SCAS process revised with National Resource and Learning System (NRLS) – reporting figures accurately checked.*

The South Central Ambulance Service NHS Foundation Trust considers that this data is as described for the following reasons.

- Trust electronic reporting system (Datix) reports
- Minutes of the Datix administration group
- Board reports and scrutiny of data at the incident reporting group
- Patient Safety Group data analysis
- NRLS confirmation.

SCAS intends to take the following actions to improve this indicator and so the quality of its services:

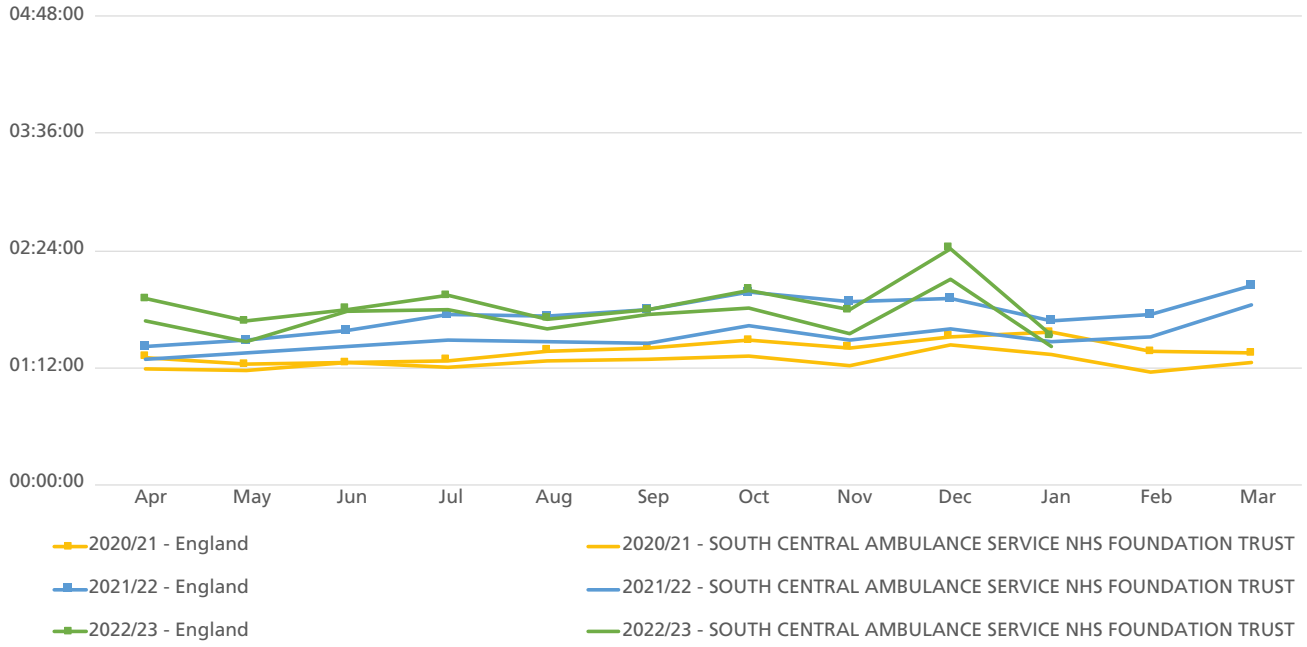
- Ongoing training for staff on Datix
- Reviewing numbers, severity and themes of incidents at the Patient Safety Group
- Trust Board scrutiny
- Safety culture survey
- Aggregated learning reports
- Campaign of awareness around incident reporting
- Reissue training and guides for staff on incident reporting
- Implement the new Patient Safety Incident Response Framework (PSIRF) when published
- HEE patient safety training modules rolled out to all staff groups

| | |
|---|---|
| Stroke 60 minutes (please see below for revised definition) | Ambulance trusts |
| Return of spontaneous circulation (ROSC) where the arrest was bystander witnessed and the initial rhythm was ventricular fibrillation (VF) or ventricular tachycardia (VT) | Ambulance trusts |

## Stroke performance

The stroke ACQI datasets comprise of timeliness and care elements (diagnostic bundle). Since November 2017 timeliness measures have moved from the previous "Stroke 60" (Call to arrival at a Hyper-acute Stroke Unit) to system-based ambulance response measures related to call to arrival at hospital, arrival at hospital to CT scan and arrival at hospital to thrombolysis. Ambulance services can only directly influence call to door element.

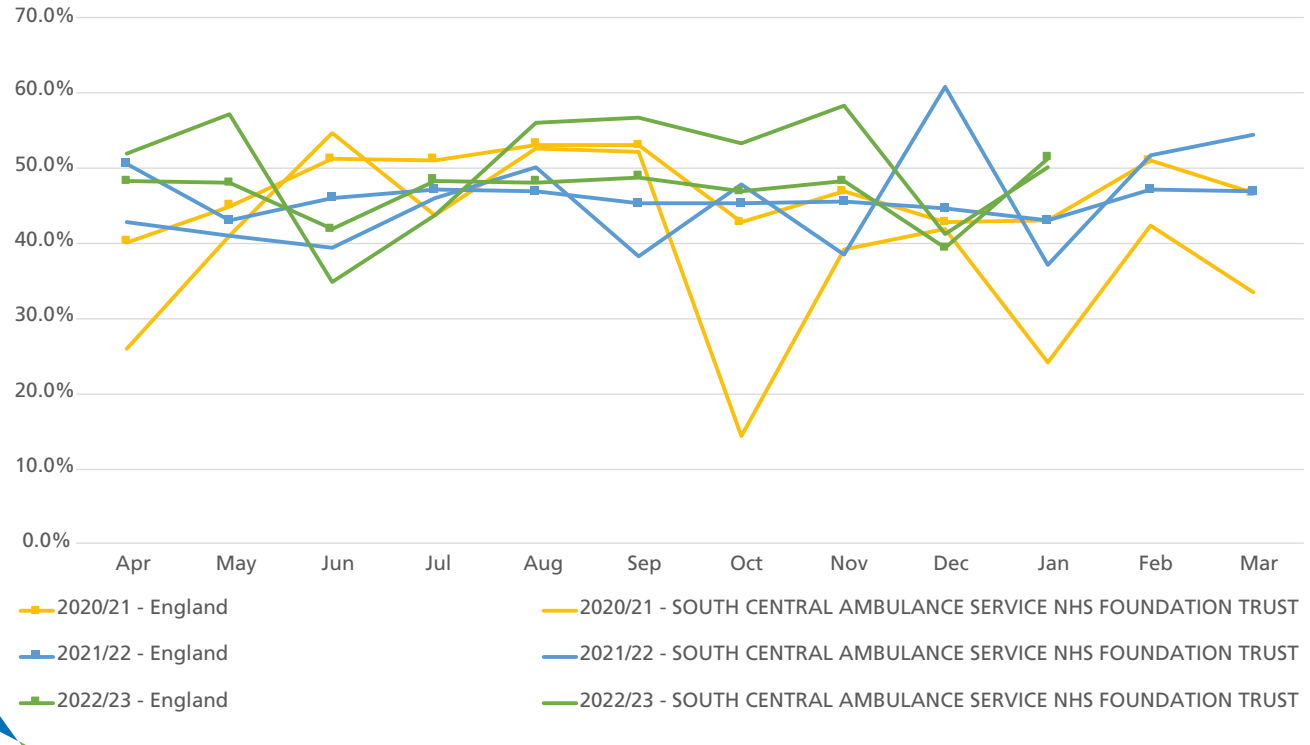
### Stroke Call To Hospital




## Return of Spontaneous Circulation (ROSC)

The charts below detail the current and historic SCAS ROSC rates for return of spontaneous circulation (ROSC) where the arrest was bystander witnessed and the initial rhythm was ventricular fibrillation (VF) or ventricular tachycardia (VT)

### ROSC Utstein



| | Prescribed information | Form of statement |
|---|---|---|
| 27.1 | The number of its patients who have died during the reporting period, including a quarterly breakdown of the annual figure. | During 01/04/2022-31/03/2023, 316 of SCAS patients met the Learning from Deaths criteria of requiring review following cardiac arrest. This comprised the following number of deaths which occurred in each quarter of that reporting period:<br><br>85 in the first quarter; 60 in the second quarter; 88 in the third quarter; 83 in the fourth quarter. |
| 27.2 | The number of deaths included in item 27.1 which the provider has subjected to a case record review or an investigation to determine what problems (if any) there were in the care provided to the patient, including a quarterly breakdown of the annual figure. | By 31/03/2023, 316 case record reviews and 59 investigations have been carried out in relation to 59 of the deaths included in item 27.1.<br><br>In 59 cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:<br><br>7 in the first quarter; 15 in the second quarter; 19 in the third quarter; 18 in the fourth quarter. |
| 27.3 | An estimate of the number of deaths during the reporting period included in item 27.2 for which a case record review or investigation has been carried out which the provider judges as a result of the review or investigation were more likely than not to have been due to problems in the care provided to the patient (including a quarterly breakdown), with an explanation of the methods used to assess this. | 0 representing 0% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.<br><br>In relation to each quarter, this consisted of:<br>0 representing 0% for the first quarter;<br>0 representing 0% for the second quarter;<br>0 representing 0% for the third quarter;<br>0 representing 0% for the fourth quarter. |
| 27.4 | A summary of what the provider has learnt from case record reviews and investigations conducted in relation to the deaths identified in item 27.3. | Documentation could have been improved in 15 cases. Presence of a do not attempt cardiopulmonary resuscitation (DNACPR) would have helped in 2 cases. Excellent care identified in 12 cases |
| 27.5 | A description of the actions which the provider has taken in the reporting period, and proposes to take following the reporting period, in consequence of what the provider has learnt during the reporting period (see item 27.4). | Feedback given to SCAS crews on improving documentation.<br><br>Timely discussions on DNACPR fed back to Primary Care.<br><br>Excellent care fed back to SCAS crews |

| | | |
|---|---|---|
| 27.6 | An assessment of the impact of the actions described in item 27.5 which were taken by the provider during the reporting period. | Monitoring documentation quality continues |
| 27.7 | The number of case record reviews or investigations finished in the reporting period which related to deaths during the previous reporting period but were not included in item 27.2 in the relevant document for that previous reporting period. | Covered in 27.2. |
| 27.8 | An estimate of the number of deaths included in item 27.7 which the provider judges as a result of the review or investigation were more likely than not to have been due to problems in the care provided to the patient, with an explanation of the methods used to assess this. | Covered in 27.3. |
| 27.9 | A revised estimate of the number of deaths during the previous reporting period stated in item 27.3 of the relevant document for that previous reporting period, taking account of the deaths referred to in item 27.8. | Covered in 27.3 |

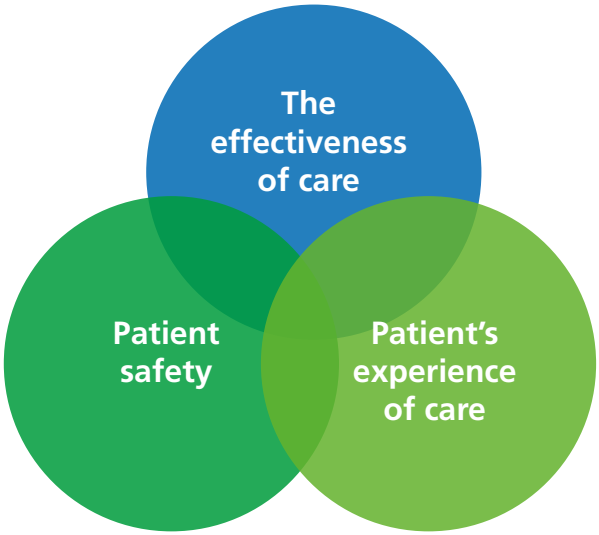
# Part 3: Other Information and Quality Priorities for 2023/2024

In this part of the report, we will outline several areas where we have identified quality improvements for the coming year. These have been developed in partnership and demonstrate our commitment to improve care.

Priorities are identified through a scrutiny of a wealth of information collated via robust operational and engagement practices which are shared at Board level through our governance structures.

These accounts are created in line with the SCAS strategy and strategic themes and NHSi strategy as well as linking to priorities within the NHS 10-year plan.

## The three dimensions of quality




1.0 Regulation assurance and compliance

These Quality Accounts are aligned with the requirements and targets set by the NHS standard contract for ambulance services, the NHS England National Ambulance Indicators, the CQUIN payment framework and those of our regulators, NHS Improvement, and the Care Quality Commission.

The table below shows the current SCAS CQC rating.

## Rating for ambulance services

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| Emergency operations centre (EOC) | Requires Improvement ▼ Aug 2022 | Good ⋈ Aug 2022 | Good ⋈ Aug 2022 | Requires Improvement ▼ Aug 2022 | Requires Improvement ▼ Aug 2022 | Requires Improvement ▼ Aug 2022 |
| Patient transport services | Requires Improvement ▼ Jun 2020 | Good ⋈ Jun 2020 | Good ⋈ Jun 2020 | Good ⋈ Jun 2020 | Good ⋈ Jun 2020 | Good ⋈ Jun 2020 |
| Emergency and urgent care | Inadequate ▼▼ Aug 2022 | Requires Improvement ▼ Aug 2022 | Good ⋈ Aug 2022 | Requires Improvement ▼ Aug 2022 | Inadequate ▼▼ Aug 2022 | Inadequate ▼▼ Aug 2022 |
| Resilience | Good ⋈ Nov 2018 | Good ⋈ Nov 2018 | Not rated | Good ⋈ Nov 2018 | Good ⋈ Nov 2018 | Good ⋈ Nov 2018 |
| Overall | Inadequate | Good | Good | Good | Inadequate | Inadequate |

Overall ratings for ambulance services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

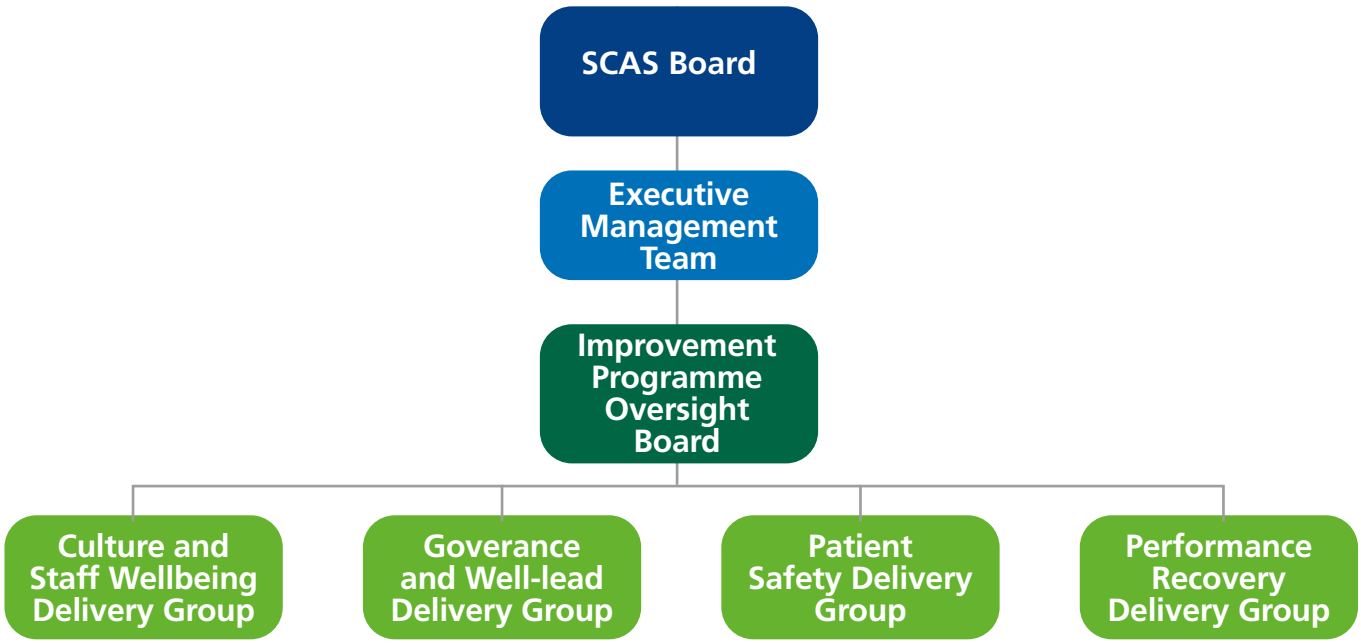
Overall ratings are from combining ratings for services.

## 2.0 CQC inspections

The Trust had a planned core service inspection of the Emergency Operations Centre and Urgent and Emergency Care service in April 2022. The Well-Led inspection was then undertaken in May 2022. The report, including ratings matrix, for this inspection was published on 25th August 2022.

## 2.1 Trust Improvement Programme

Workstreams have developed detailed action plans to cover all CQC observations with short-, medium- and longer-term actions. Progress is monitored by a dedicated programme team with regular reporting to a programme board and the Trust board.




The four workstreams have individual plans. The areas covered in each are listed below.

**Culture and staff wellbeing**

- People voice – speak up, listen up, follow up
- Compassionate leadership
- Abuse of power and sexual safety
- Personal development, talent and continuous

**Governance and well-led**

- Board information
- Risk management
- Communications and engagement

**Patient safety**

- Safeguarding
- Patient safety and incident management
- Medical devices
- Medicines management
- Infection prevention and control

**Performance recovery**

- Response / waiting times
- Demand / capacity
- Staffing:
- Training / support
- Recruitment / retention

Being rated inadequate puts the Trust into level 4 of the System Oversight Framework (SOF4 (System Oversight Framework level 4)). Additional support is being provided by NHS England and Integrated Care System partners. Oversight and assurance of delivery is through a multi-partite approach between SCAS, NHS England and Integrated Care Boards.

## 3.0 Freedom to Speak Up (FTSU)

SCAS is strongly committed to FTSU and encourages staff at all levels to Speak Up, Listen Up and Follow Up when things go wrong, might go wrong or when things are good, but could be even better.

We have an improved FTSU provision, with an established full-time FTSU Guardian in post with the increase in the team with an additional substantive full-time Deputy FTSU Guardian who is in post from February 2023 and seconded interim Deputy FTSU Guardian their role commenced in November 2022.

Our FTSU Guardians provide another channel to enable workers to raise concerns, seek advice, and for them to be supported, and thanked. FTSU also ensures that the concerns are listened too, followed through, acted upon and appropriate feedback is shared with worker and any organisational learning is captured.

We have established a FTSU Champions programme and training schedule, and currently have 16 trained Champions across the Trust. There is a dedicated NGO (National Guardian's Office) Training programme, which we follow. There are three further cohorts planned for June 2023, September 2023 and January 2024. We are focussing on increasing the number of Champions to support our more vulnerable and diverse workforce, in collaboration with the Trusts Staff networks and our ED&I (Equality, Diversity & Inclusion) Lead.

The National Guardian's Office published a Speak Up Review of Ambulance Trusts in England on 23rd February 2023 **Listening to Workers**. The review found the culture in English ambulance trusts did not support workers to speak up and that this was having an impact on worker wellbeing and ultimately patient safety. The National Guardian was invited to meet our Board in April 2023.

The National Guardians Office and Health Education England (HEE) released 'Follow Up' training for Senior Leaders complimenting 'Listen Up' training for leaders/managers. and 'Speak Up' training for workers. This training is now mandated for SCAS employees from 1st April 2023. It is hoped that these formats will help learners at all levels and roles understand the vital role they can play in a healthy speaking up culture which protects patient safety and enhances worker experience.

In 2022/2023 the SCAS FTSU received 116 FTSU concerns, this was a slight increase from the previous year of 104. 7% of cases were reported anonymously which is below the national average of 10.4%. The number of concerns reported in confidence was 50%, whilst higher than the 37% reported last year, it remains lower than the 59% raised in confidence seen previously.

### SCAS FTSU – Concerns by Primary Category 2022/23

The categories are new for this Financial Year.

The highlights of this data, show our patient safety average of 13% is positive against the national average of 19.1%; and Bullying and Harassment of 10% compared to national average of 32.3%

However, our results are high for Worker safety & Well-being at 31% compared to the national average of 13.7%. We are reviewing this further.

| | Q1 | Q2 | Q3 | Q4 | Running percentage |
|---|---|---|---|---|---|
| Bullying and harassment | 4 | 1 | 2 | 4 | 10% |
| Other inappropriate attitudes or behaviours | 9 | 3 | 10 | 10 | 29% |
| Patient Safety / Quality | 2 | 6 | 3 | 3 | 13% |
| Where people indicate that they are suffering disadvantageous and/or demeaning treatment as a result of speaking up | 0 | 1 | 0 | 0 | 1% |
| Worker safety and wellbeing | 14 | 1 | 5 | 14 | 31% |

## 4.0 2022 Staff Survey results

### NHS Staff survey

The NHS staff survey is completed in October and November of each year. Each question feeds into one of nine sections - the seven promises + two themes (staff engagement + morale). For example, 'We are always learning' is made up of the nine questions about appraisal & development opportunities.

In 2022 there was a 10% drop in the survey response rate.

| 4489 | 4404 | 50% | 50% | 60% |
|---|---|---|---|---|
| Invited to complete the survey | Eligible at the end of the survey | Completed the survey (2187) | Average response rate for similar organisations | Previous response rate |

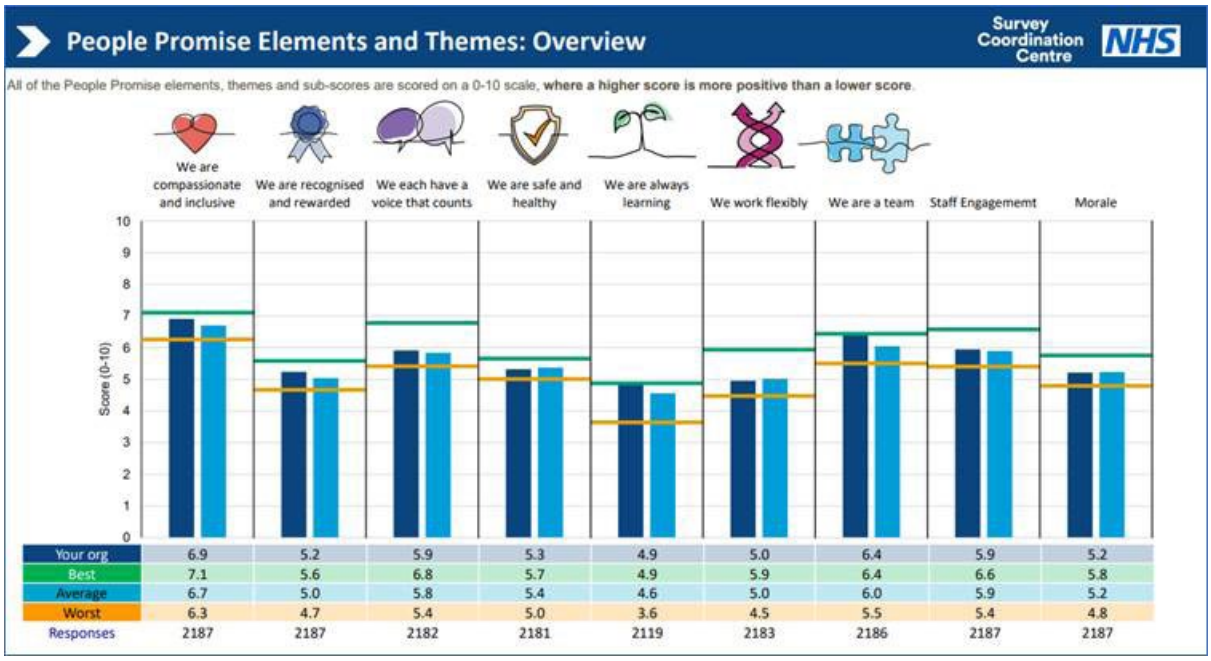
48% (q23c) Would recommend the organisation as a place to work

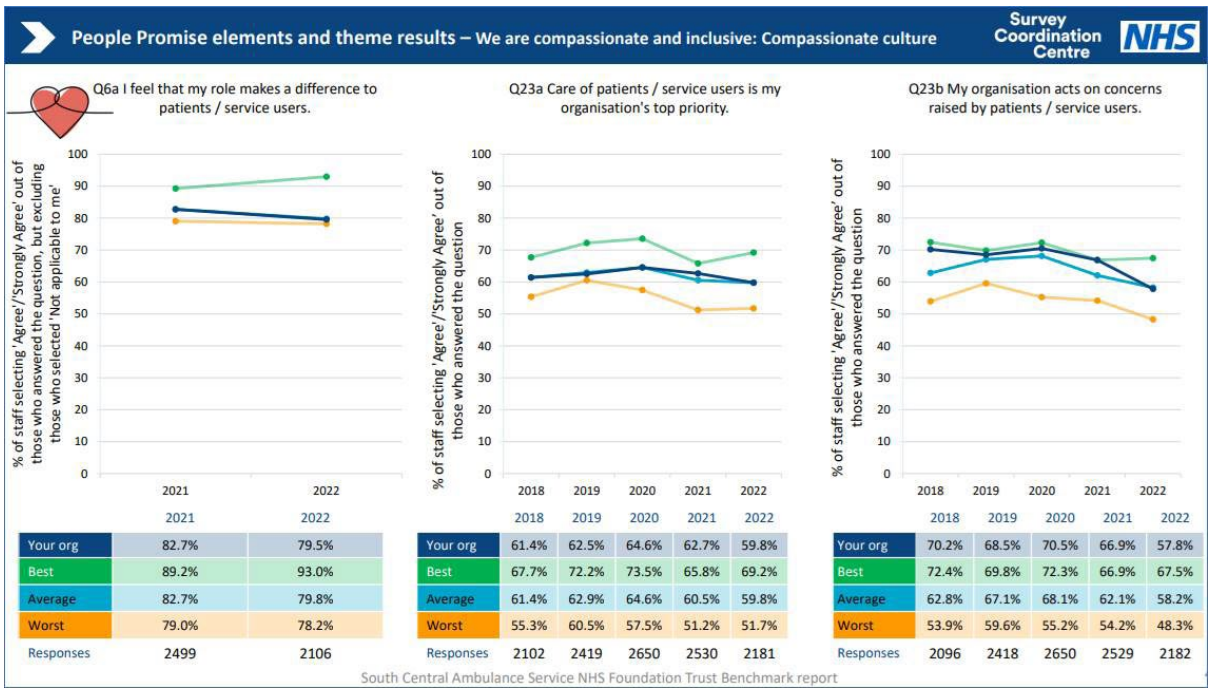
63% (q23d) If a friend/relative needed treatment would be happy with the standard of care provided by the organisation

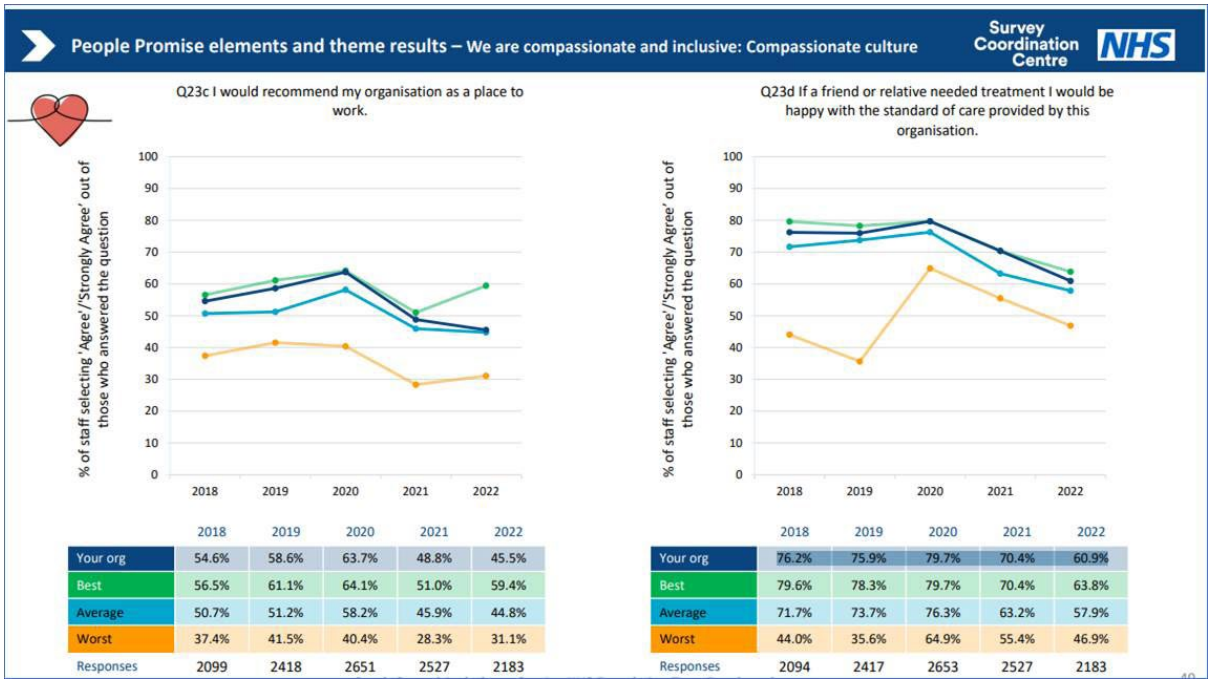
63% (q23a) Care of patients/service users is the organisation's top priority

As always, the trust compares itself to best in class not to average or worst.

This year we compared all provider trusts in southeast region. Compassion and Team are high; Flexible working is noticeably lower than average.






## Areas of focus last year

- Discrimination, focus on responses from minority groups rather than the specific discrimination questions.
- Developing People Voice, establishing a regular data feed into Organisational Development and cascading this to the senior leadership group.
- Burnout and stress, new questions, as the previous year we were below average and near worst in class
- Staff re-engagement, focus on recovery after the pandemic and return to the office, as well as the re-introduction of activities alongside high demand. For example, team time, appraisals and listening exercises.
- Appraisals, launch new site and documentation alongside high activity and demand levels.

## Areas for focus going forward 2023-24

- People Voice - continue to build *and publicise* FTSU and safeguarding improvements to re-establish staff confidence. There has been substantial investment in both areas this year.
- Burnout / stress – seek understanding and target factors for different areas of the organisation, but some age groups seem to be doing better than others.
- Appraisals – improve both quality *and* quantity by introduction of training, audit of quality and align with annual planning cycle and objectives cascade.
- Staff with disabilities, a significant proportion of our workforce (30% of respondents) reporting markedly lower scores - we will re-establish networks, review our EDI strategy and WDES / Disability Confident recruiter

## Looking forward 2023/24 Choosing and prioritising Quality Improvement initiatives


We engage with our clinical commissioning groups and other external partners when defining our goals for quality improvement and we place high importance on the feedback we receive from patients and other healthcare professionals.

- Internal and external influences
- Feedback from staff and patients and partners
- Patient safety workstreams

## Quality Priorities for 2023/24

Following consultation with the Quality and Safety Committee, the senior leadership team and staff representation the following priorities have been approved and confirmed for the Quality Accounts.

### Patient Safety

1a. Implementation of Patient Safety Incident Response Framework (PSIRF), with implementation plans measured quarter on quarter

1b. Implementation of Learn from Patient Safety Events (LFPSE) (DATIX changes Q1 implement Q3)

1c. Implement Health Education England (HEE) patient safety training modules (trajectory by Q)

1d Ensure Level 3 safeguarding training is met

### Clinical Effectiveness

2a. Analgesia: admin to ensure appropriate patient (to include pain score audit/improvements)

2b. Enhanced CFR (Community First Responders) – falls care (audited and linked to experience for staff and patients)

2c. To report on Category 1 through 4 performance and ROSC (mandatory – to be confirmed (TBC))

- Category 1 emergency response (mean times)
- Category 2 emergency response (mean times)
- Category 3 emergency response
- Category 4 emergency response

2d To report on Stroke care bundle compliance/ STEMI care bundle compliance (mandatory - TBC)

- Stroke and STEMI care bundles.

### Patient / Staff Experience

3a. Staff wellbeing: staff survey - Confidence that the trust addressed concerns regarding speaking up about unsafe care – 49%)

3b. Roll out of patient panel Patient Safety Partners (PSP)

3c. Survey of NEPTS patients undergoing chemotherapy and radiotherapy – failed journeys – impact on experience and treatment

Each of our priorities and our proposed initiatives for 2023/24 accounts, are described in detail on the following pages. They will be monitored through the quality improvement plans that are presented to the executive and senior management teams and the Quality and Safety Committee.

## Our quality priorities for 2023/24

### Patient Safety

1a. Implementation of Patient Safety Incident Response Framework (PSIRF), with implementation plans measured quarter on quarter

#### Why we have chosen this priority

The implementation and compliance with the new national Patient safety strategy is required in this year. PSIRF is being implemented to ensure we learn from all harm events, gathering more thematic overviews for learning. The involvement of patients and their families is also at the centre of PSIRF.

**What we will do**

We will complete all actions on our detailed project plan led by a newly appointed PSIRF lead. Progress will be monitored via the programme board and Quality and Safety Committee as this indicator is included in our improvement plans.

**Implementation Lead**

Assistant Director Safety - sponsored by Executive Chief Nurse

**Patient Safety**

1b. Implementation of Learning from Patient Safety Events (LFPSE) (DATIX changes Q1 implement Q3)

**Why we have chosen this priority**

Although LFPSE is a requirement, it will ensure reporting of incidents are benchmarked and trends analysed. It will also mean we can re-educate staff on reporting, test the culture and implement changes in practice or training programmes.

**What we will do**

We will complete all actions on our improvement plan. Progress will be monitored via the programme board and Quality and Safety Committee as this indicator is included in our improvement plans.

**Implementation Lead**

Datix System Manager - sponsored by Executive Chief Nurse.

**Patient Safety**

1c. Implement Health Education England (HEE) patient safety training modules (trajectory by Q).

**Why we have chosen this priority**

Training staff in patient safety is key to deliver the national incident framework. Equipping our people to report, learn and engage at all levels and in all services in a just and learning culture is pivotal in reducing harm.

**What we will do**

Modules level 1 and 2 will be available via the trust e learning platform. By the end of Q4 we will meet the trajectory set for the number of staff compliant with training. This will be monitored via the programme board. This indicator is included in our improvement plan.

**Implementation Lead**

Patient Safety Specialist - sponsored by Education Lead.

**Patient Safety**

1d. Ensure Level 3 safeguarding training compliance meets trajectory by the end of March 2023.

**Why we have chosen this priority**

This is one measure to assess the progress of the Safeguarding Improvement Workstream. The provision of Safeguarding Training is a statutory requirement of all healthcare providers. The Trust workforce must be equipped with the skills and knowledge to recognise signs of abuse and maltreatment and respond appropriately to the remit and level of their responsibility within their role.

Provision of adequate training will lead to a better quality of referral, improve relationships with our external organisations and ultimately allow our patients to be appropriately protected from abuse or neglect.

**What we will do**

We will provide safeguarding level 3 training within a Prioritisation framework dependent on role and responsibilities.

We will provide monthly compliance figures to Trust Board, Quality and Safety Committee, NHSE Scrutiny Group and Safeguarding Committee for each Priority Group as well as a trust wide figure.

We will obtain feedback from delegates to inform future practice.

We will adapt training in line with national, local policy or learning.

**Implementation Lead**

Associate Director of Safeguarding, Mental Health and Complex Care – sponsored by Executive Chief Nurse

## Clinical Effectiveness

### 2a. Ensure patients recieve appropriate analgesia based on their pain score (to evidence improvement with audit)

**Why we have chosen this priority**

SCAS undertook a pain management audit last year in which areas of improvement were identified as the pain relief chosen did not always correspond with pain scores. Areas of good practice were recognised within the audit.

Since conducting this audit, the trust has removed codeine from general ambulance medicine provision and adjusted guidance for moderate pain relief. All staff have been provided with education on the analgesia pain ladder guidelines.

**What we will do**

We plan to re-audit this year to establish if actions last year have been successful and we have improved the management of pain across the organisation. An action plan will be in place, if necessary, from the findings and monitored via the medicine's optimisation governance group

**Implementation Lead**

Head of Pharmacy sponsored by Medical Director.

## Clinical Effectiveness

### 2b. Enhanced CFR – falls care (audited and linked to experience for staff and patients)

**Why we have chosen this priority**

Falls, especially in older people are associated with poor outcomes. A quick response to patients that have fallen, especially those that suspect no injury can avoid a potential admission to hospital and further harm if assisted up in a timely way, after assessment.

**What we will do**

We will continue our project utilising volunteer responders with extended skills to attend calls as determined by a clinician in the clinical coordination centre (CCC). The volunteers will be able to utilise the 'GoodSam' video link when necessary to allow the CCC clinician to see the patient and use the volunteer responder to carry out essential observations, gaining a history, and general environmental overview of the patient and their surroundings. By doing this we will avoid the patient waiting on the floor for an unnecessary ambulance attendance.

We will assess the impact on the patients themselves and on service delivery. We will collect data to inform and evaluate the project and look at possible investment in dedicated clinical resource to allow discharge at scene.

**Implementation Lead**

Head of Operations – Community Engagement and Training - sponsored by Chief Operations Officer.

## Clinical Effectiveness

### 2c. To report on Category 1 through 4 performance and ROSC (mandatory - TBC)

**Why we have chosen this priority**

Reporting against NHSi core indicators for Quality Accounts.

**What we will do**

Reported in the Quality Account in the section named NHS Core Indicators.

**Implementation Lead**

Director of Operations - sponsored by the Chief Operating Officer and Medical Director

## Clinical Effectiveness

### 2d. To report on Stroke care bundle compliance/ STEMI care bundle compliance (mandatory - TBC)

**Why we have chosen this priority**

Reporting against NHSi core indicators for Quality Accounts.

**What we will do**

Reported in the Quality Account in the section named NHS Core Indicators.

**Implementation Lead**

Assistant Director of Quality - sponsored by the Chief Operating Officer and Medical Director

## Patient / Staff Experience

### 3a. Staff wellbeing: staff survey - Confidence that the trust addressed concerns regarding speaking up about unsafe care – 49%)

**Why we have chosen this priority**

The staff survey has told us that staff do not feel as confident as they did regarding speaking up about unsafe care. We need to engage with staff to find out why and restore confidence in our speaking up options.

**What we will do**

Invest in the freedom to speak up team, to ensure there is consistency and capacity. We will also share and promote the improvements made within the FTSU and Safeguarding teams to raise their profile and staff understanding. The staff survey question will show an improved position in the 2023/24 staff survey.

**Implementation Lead**

Assistant Director Organisational Development - sponsored by Chief People Officer.

## Patient / Staff Experience

### 3b. Establish patient panel

**Why we have chosen this priority**

We are introducing a Patient Panel (also known as a Patient and Public Council) as we want to hear from patients and their relatives/carers regarding the care and services we provide to them. We want to identify what matters most in our local communities and therefore the Panel will give members of the public a voice to have their views acknowledged and where possible acted on. This should improve quality of care, target health inequalities and improve patient satisfaction.

This priority also aligns with the SCAS Annual Plan that includes a commitment to engaging more patients in helping design new services and improve the delivery of existing ones. This indicator is also aligned to the improvement programme.

**What we will do**

Continue to learn from best practice and engage with other NHS Patient Panels to see how they work.

Finalise and approval for the following documents

- Role descriptions x 3 – Council Chair, Vice Chair and Council Member
- Renumeration policy and expenses claim form (process agreed with Finance Team)
- Draft Confidentiality Statement, Terms of Reference, Code of conduct, Equality statement
- Why you should join, how to apply
- Conflicts of Interest
- Patient Council Handbook
- Develop and agree an induction programme
- Agree application process
- Identify Development opportunities for the Patient Panel members

**Implementation Lead**

Assistant Director of Quality/ Head of Patient Experience - sponsored by Executive Chief Nurse.

## Patient / Staff Experience

### 3c. Survey of NEPTS patients undergoing chemotherapy and radiotherapy – failed journeys – impact on experience and treatment.

**Why we have chosen this priority**

Patients using the NEPTS who attend outpatient clinics for radiotherapy and chemotherapy need a prompt, reliable and quality service. We acknowledge that there may be a reason for the transport booking to be aborted due to unforeseen circumstances this may have a significant impact on the patient themselves.

**What we will do**

We will engage with our patients via a short survey designed to capture their views and lived experiences of the service. Feedback these patients provide will enable us to better define their priorities, make changes to improve their experience and develop our service to better meet their needs.

**Implementation Lead**

Patient Experience Manager - sponsored by Executive Chief Nurse

# Annex 1: Statements from commissioners, local Healthwatch organisations and overview and scrutiny committees

Copies of correspondence received from the following Trusts and organisations commenting on the SCAS 2022/23 Quality Account:

**Subject:** FW: Letter regarding quality accounts and copy of the draft report for comment

Dear Jen

Further to your email below to my colleague Ross this is to let you know that Surrey Heartlands ICB is content with the attached.

With best wishes,

Kind regards,

Iwona

My normal office hours are Monday – Thursday 7am-4pm, Friday 7am-2.30pm.

**Iwona Reynard-Nowicka | Quality & Safety Support Officer**
Surrey Heartlands Integrated Care System | NHS Surrey Heartlands

T 0300 561 1576 | **Iwona.reynard-nowicka@nhs.net**
**@Surreyheartland** **@SurreyheartlandsHCP** **Surreyheartlands**

NHS
Hampshire and Isle of Wight

Hampshire and Isle of Wight Integrated Care Board
Hampshire Fire & Police Headquarters
Leigh Road
Eastleigh
Hampshire
SO50 9SJ

5th July 2023

Dear Guy

**SCAS Quality Account 2022/23**

Please find below, the formal response to your Quality Account for 2022/23 from Hampshire and the Isle of Wight Integrated Care Board:

**2021/22 Quality Review**

Hampshire and the Isle of Wight Integrated Care Board are pleased to be able to comment on South Central Ambulance Service (SCAS) Quality Account for 2022/23.

Thank you for enabling us to work alongside your Trust to monitor the quality of care provided to our local population, to support the identification of opportunities for quality improvement and to share learning.

We recognise this has been another incredibly challenging year for the Trust and the wider health economy. The continuation of the COVID-19 pandemic had a significant impact on the health and social care system which has been seen through the challenges within the urgent and emergency care pathway. Despite the ongoing pressures, the ICB recognise the Trust's continued achievements during this year and the achievements that have been made possible through the care, compassion, and resilience of the staff at SCAS to deliver outstanding care every day.

We are satisfied with the overall content of the Quality Account and believe that it meets the required mandated elements.

**2022/23 Quality priorities for improvement**

We supported SCAS' 2022/23 quality improvement priorities, of which there were ten, covering a number of areas including monitoring and reporting on improvements to the storage and handling of medicines to ensure robust security, improve vehicle cleanliness and awareness across the organisation, increase assurance and audit through positive engagement with operations teams, to report on Category 1 through 4 performance and ROSC, to report on Stroke care bundle compliance/ STEMI care bundle compliance and survey patients on their experience of accessing the Integrated Urgent Care system.

We recognise that whilst not fully achieving all their key priorities, SCAS has made some considerable improvements, which will have a positive impact on patient experience, safety, and outcomes, for example:

- Further development of Structured Judgement Reviews (SJRs) to identify patient harm during periods of high demand leading to long waits in the community.
- Further improve patient safety through the use of mental health telephone triage services in 999 and NHS111.
- A clinical review of patients that 'trigger' the Wessex Trauma Triage Tool but are not conveyed to major trauma centres. This will align SCAS with the Trauma Units, who are also required to perform quarterly reviews of these patients. This will provide surveillance and identify learning in these circumstances.
- To design and deliver a focussed survey of renal patients that use the Non-Emergency Patient Transport Service to allow focussed improvements for this vulnerable group.
- Undertake end-to-end reviews of the patient's journey through the Integrated Urgent Care system. The reviews will cover each Clinical Commissioning Group (CCG) area - Mid and North Hants, Portsmouth, and Southampton.

It is recommended that the provider measures the impact that the 2022/23 priorities have had on patient outcomes during 2023/24.

It was positive to read about the support SCAS have continued to provide to their staff during such challenging times. In particular, the NHS Staff Survey reported that SCAS continues to be at the top of the ambulance sector for critical measures such as compassionate leadership, inclusion, and teamwork. We note however that there is still more work to do around burn out and pressures of work and look forward to seeing these improvements.

**Care Quality Commission/Improvement Plans**

Following a Care Quality Commission visit in April 2022 which focussed on the well-led domain, the Emergency Operations Centre and Urgent & Emergency Care services, the Trust's overall rating moved from good to inadequate. It is recognised that the organisation maintained a good rating for the domains of effective, caring, and productive use of resources.

We recognise SCAS' commitment in making the necessary improvements and, along with NHSE England are supporting the organisation in their improvement journey. We are pleased to note progress in a number of areas will continue to provide the necessary level of support to the organisation during 2023/24.

**National confidential enquiries, audits and local audits**

We are pleased that SCAS participated in 100% of 9 national clinical audits and 0 (none eligible) national confidential enquiries.

It is noted that, where relevant, actions identified to improve practice and/or patient outcomes have been undertaken, for example, included resuscitation training and elements of care required

by Ambulance Care Quality Indicator (ACQI) care bundles within the face-to-face clinical update programme 2022/23, review and update ACQI compliance tools in the electronic patient record system, to include development of new compliance tools within the electronic records system used by private providers, launch a new ACQI scorecard where compliance can be monitored by individual clinician, area, and Private Provider and Consistent improvement in performance against ambulance response targets.

The results of your audits demonstrate improvements in practice in a number of areas, including, continuation of Level 3 safeguarding training to meet trajectory, extension of mandated pain scoring for eligible conditions in the Trust's electronic patient record system, re-audit changes made in provision of analgesia and communicate results and learning with staff and, publication of patient safety newsletter.

**Collaborative working:**

We would like to thank SCAS for inviting us to participate in internal quality meetings to support our assurances processes. Thank you for supporting local and system quality improvement by being an active, respected, and valued member of the:

- Portsmouth and South East Hampshire Local Delivery System Quality Group
- Portsmouth and South East Hampshire Urgent and Emergency Care Board
- Hampshire and Isle of Wight Patient Safety Incident Response Framework (PSIRF) Implementation Group
- Hampshire and Isle of Wight Patient Safety Specialist Network Meeting

**2023/24 Quality priorities for improvement**

We fully support SCAS' eleven quality priorities for 2023/24 which include but are not limited to:

• Implementation of Patient Safety Incident Response Framework (PSIRF), with implementation plans measured quarter on quarter.

• Ensure Level 3 safeguarding training is met.

• To report on Category 1 through 4 performance and ROSC Staff wellbeing: staff survey.

• Survey of NEPTS patients undergoing chemotherapy and radiotherapy – aborted journeys – impact on experience and treatment.

During 2023/24, we look forward to working with and supporting the Trust on implementing PSIRF to ensure that SCAS can develop and maintain effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.

The ICB are also keen to see the outcomes from the survey of NEPTS patients undergoing chemotherapy and radiotherapy as this is part of one of the local quality requirements in the NEPTS quality schedule for 2023/24.

Finally, we would like to thank the Trust for their continued support and commitment to the delivery of safe, effective, and patient-centred care during what has been a challenging year.

Overall, we are pleased to endorse the Quality Account for 2022/23 and look forward to continuing to work closely with SCAS during 2023/24 in further improving the quality of care delivered to our population.

Yours sincerely

Nicola Lucey
Chief Nursing Officer
Hampshire and Isle of Wight Integrated Care Board

CC:

Jane Thomson-Smith
Deputy Director of Nursing
Berkshire West ICB

Sara Courtney
Deputy Director of Quality and Nursing
Hampshire & IOW ICS

Ross Emmens
Head of Quality – Community
Surrey Heartlands CCGs

Debra Flynn
Quality Manager, Quality Assessment, Operations Management
Coastal West Sussex CCG

# Annex 2: Statement of directors' responsibilities for the quality report

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

NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the quality report, directors are required to take steps to satisfy themselves that:

- the content of the quality report meets the requirements set out in the NHS foundation trust annual reporting manual 2020/21 and supporting guidance Detailed requirements for quality reports 2018/19
- the content of the quality report is not inconsistent with internal and external sources of information including:
    - board minutes and papers for the period April 2022 to March 2023
    - papers relating to quality reported to the board over the period April 2022 to March 2023
    - feedback from commissioners dated June 2023
    - feedback from governors dated January 2023
    - feedback from local Healthwatch organisations June 2023
    - feedback from overview and scrutiny committee
    - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated July 2022
    - the national staff survey February 2023
    - the Head of Internal Audit's annual opinion of the trust's control environment dated (not required for this year)
    - CQC inspection report dated August 2022
- the quality report presents a balanced picture of the NHS foundation trust's performance over the period covered
- the performance information reported in the quality report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the quality report, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the quality report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review

- the quality report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the quality accounts regulations) as well as the standards to support data quality for the preparation of the quality report.

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

By order of the board

**Chairman**
30 JUNE 2023

Professor Sir Keith Willett

**Chief Executive**
30 JUNE 2023

David Eltringham

## PRODUCED BY

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