

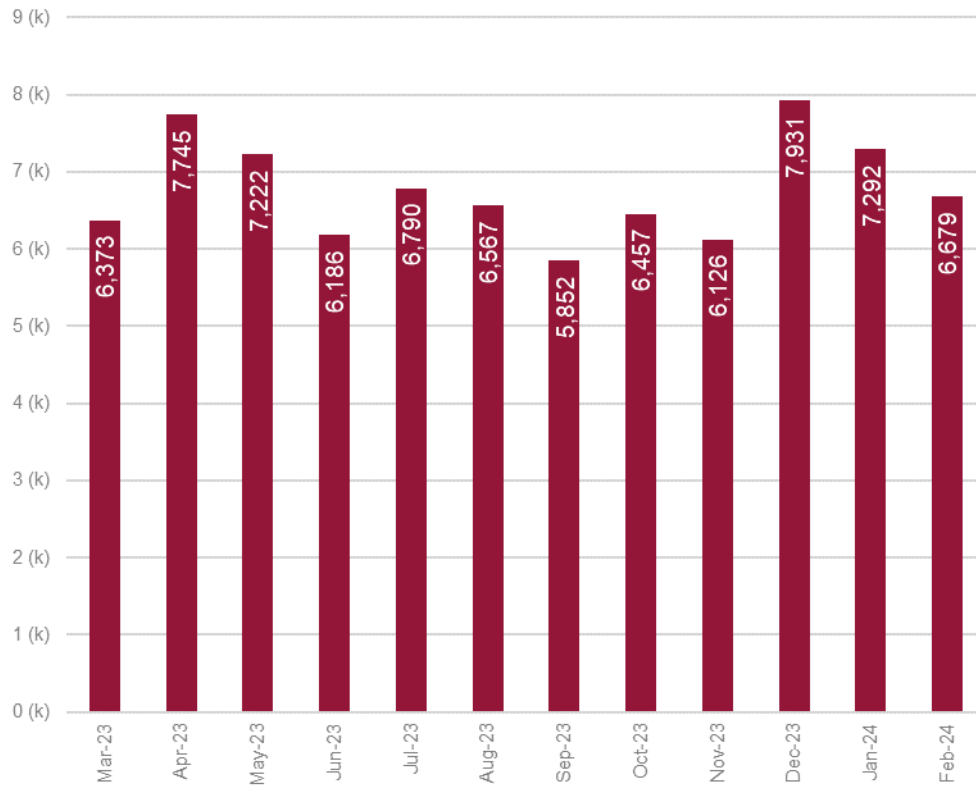


# Performance Review

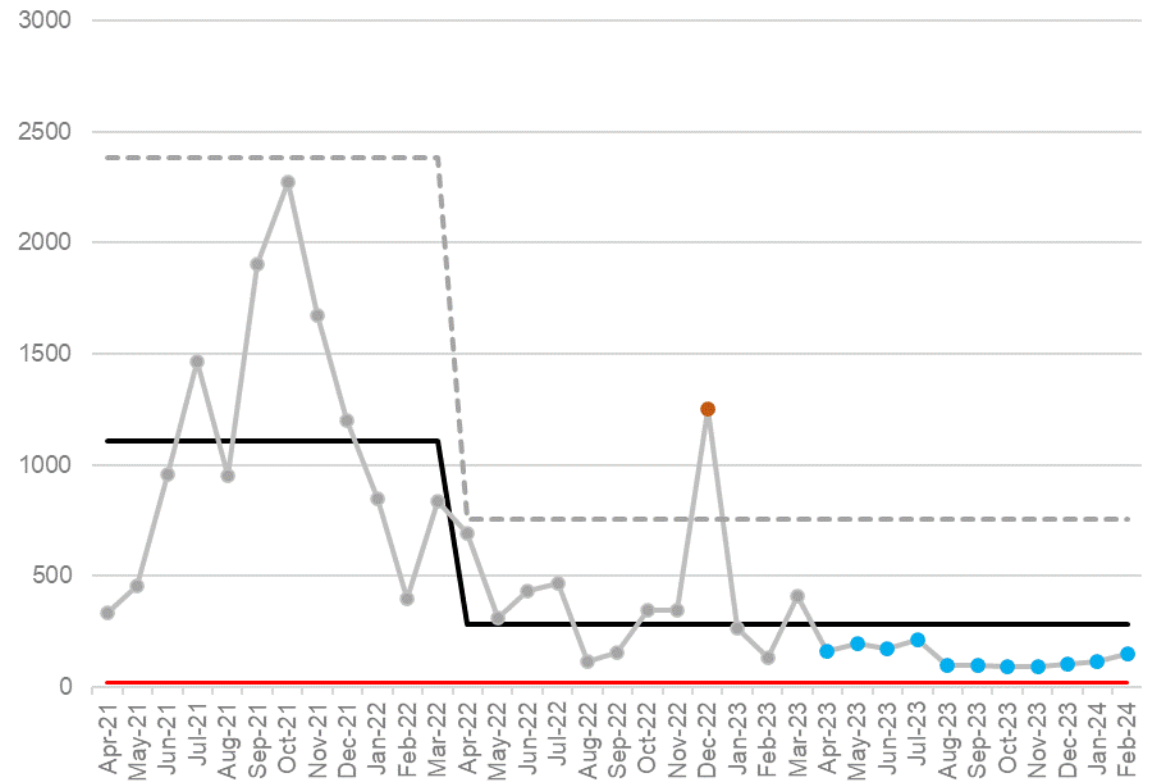
Claire Jobling – Head of Operations (North)  
Mark Cotton - Asst director of communications

# 111 Call Performance

Calls Triaged Northumberland

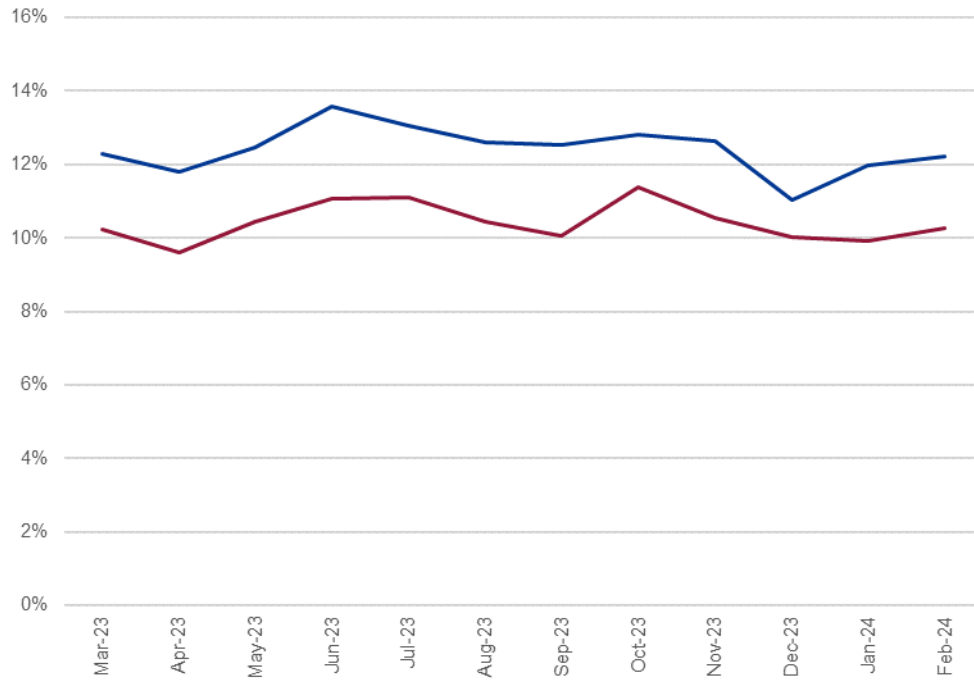


111 Mean call answer (secs)

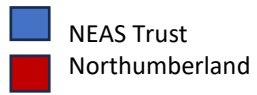
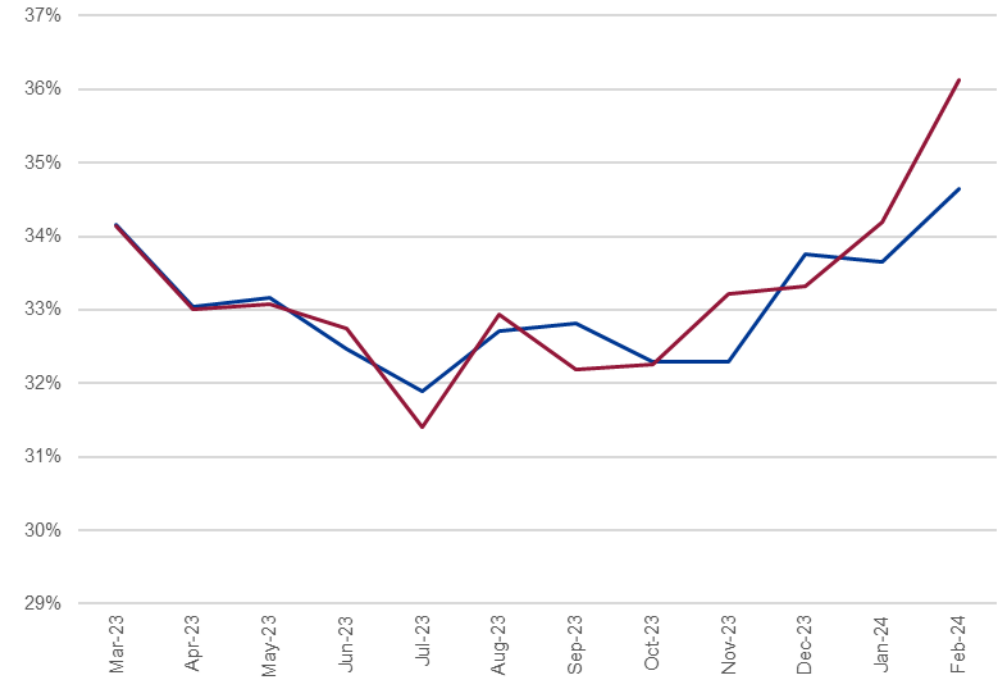


# 111 Call Outcomes

Attend ETC

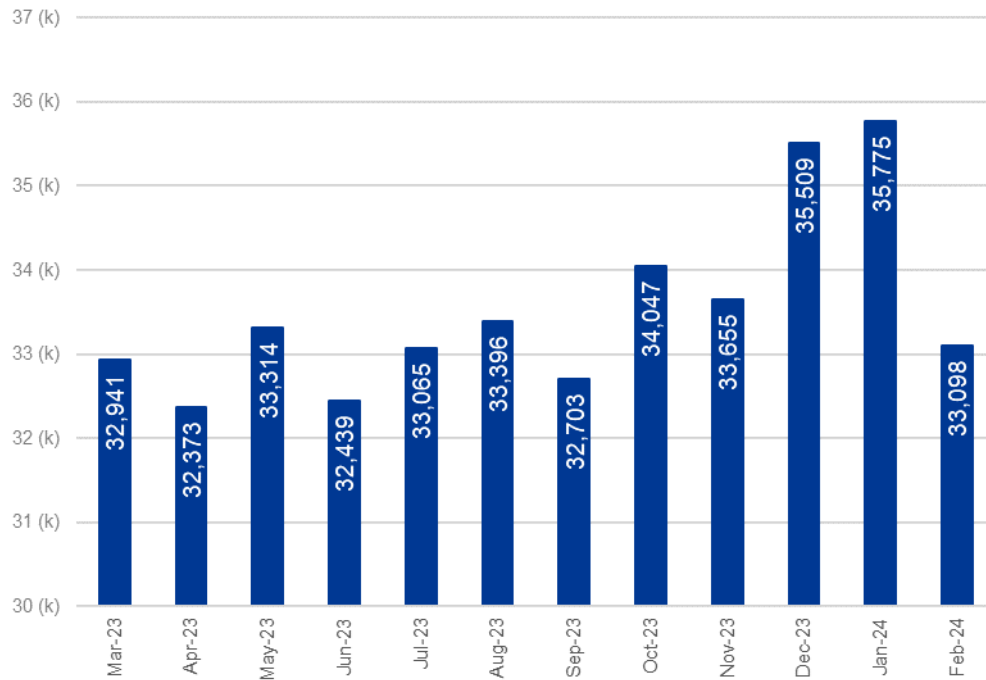


Contact Primary Care

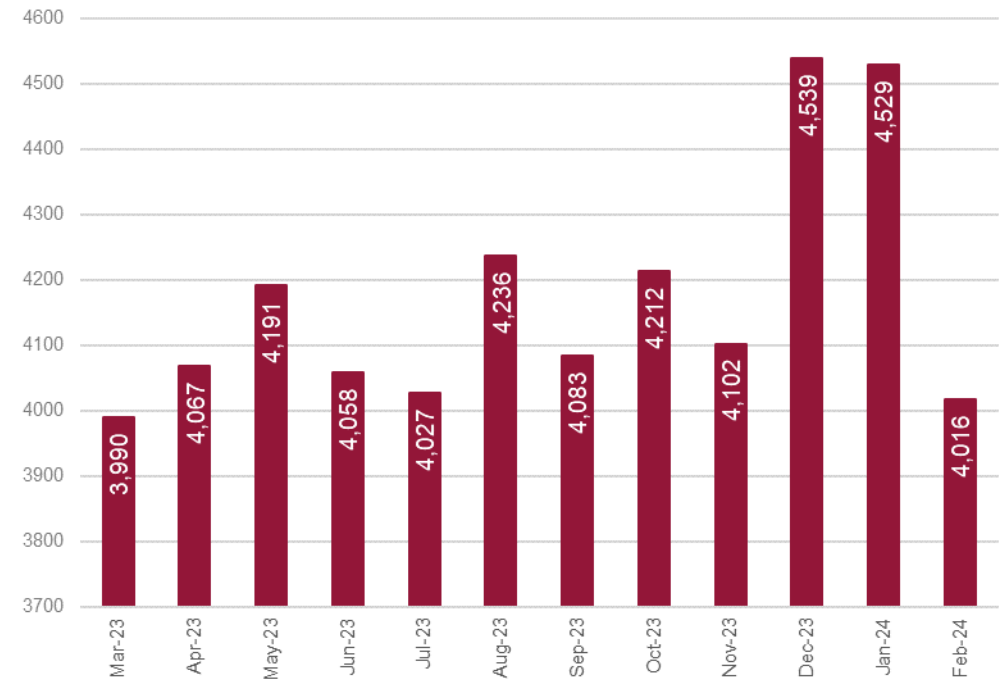


# 999 Incident Volumes

Incident volumes Trustwide

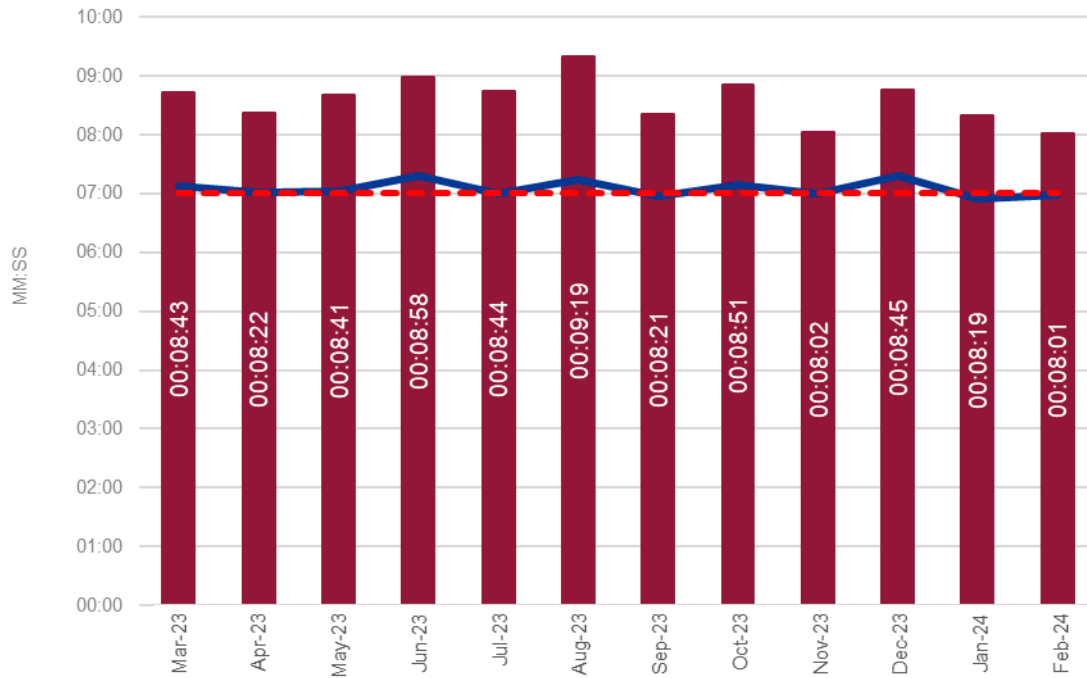


Incident volumes Northumberland

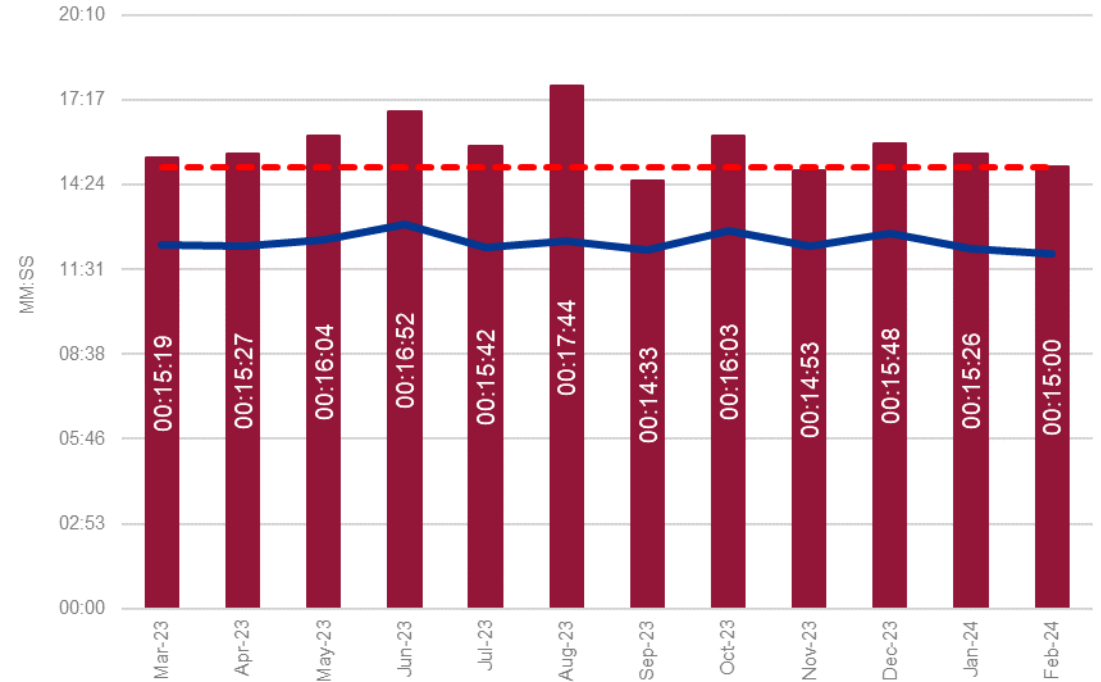


# Category 1 Response Performance

Cat 1 Mean



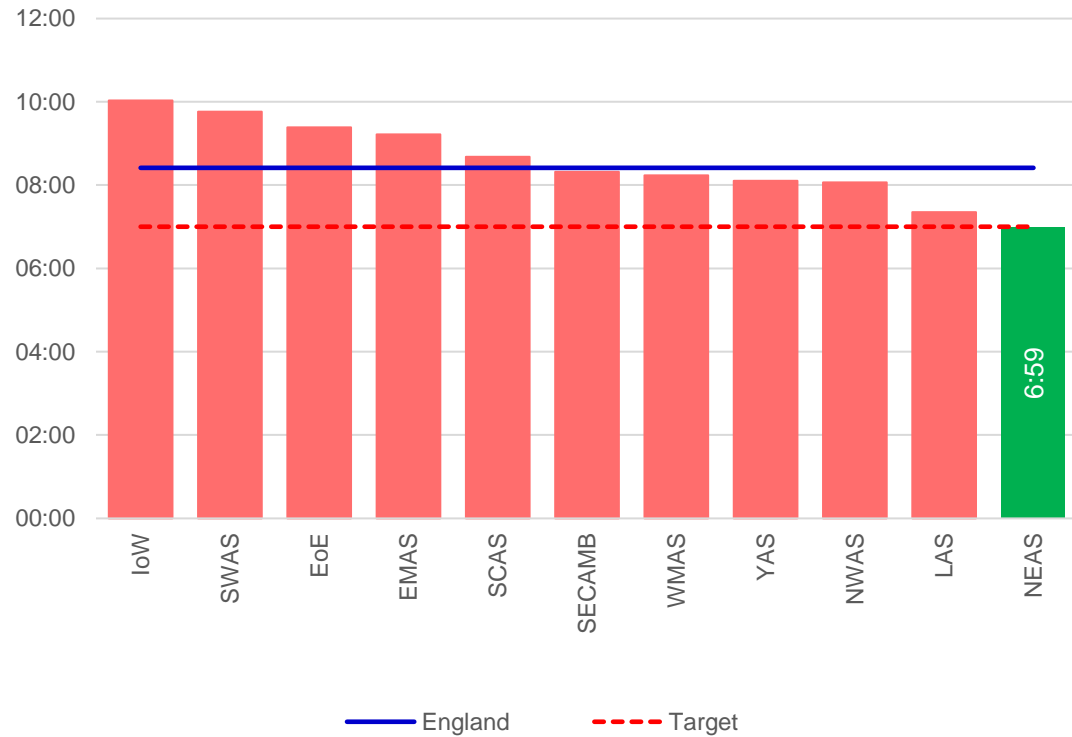
Cat 1 90th centile



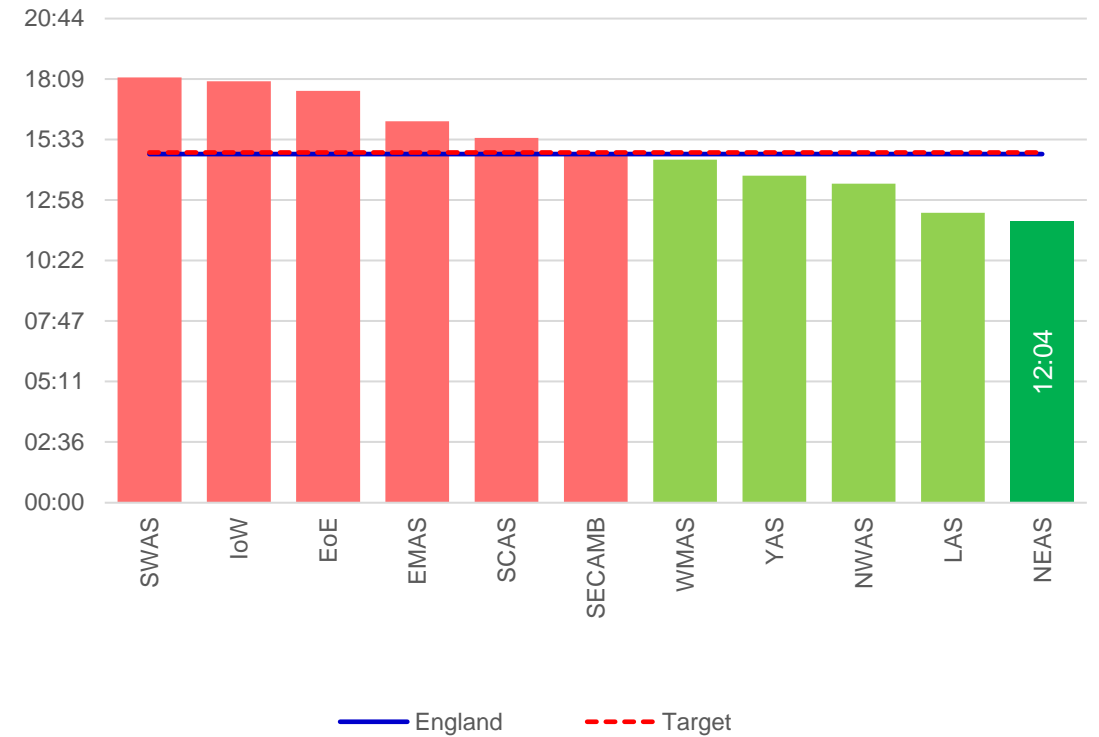
■ NEAS Trust
 ■ Northumberland

# NEAS Benchmark Performance – C1

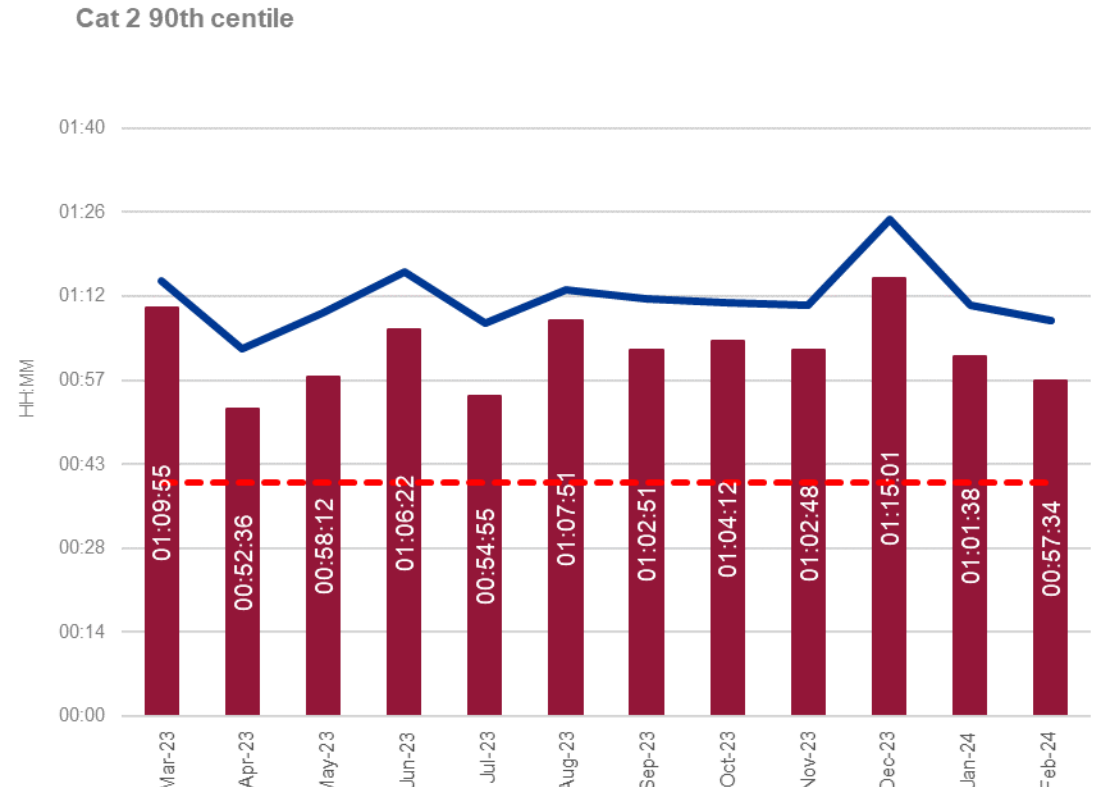
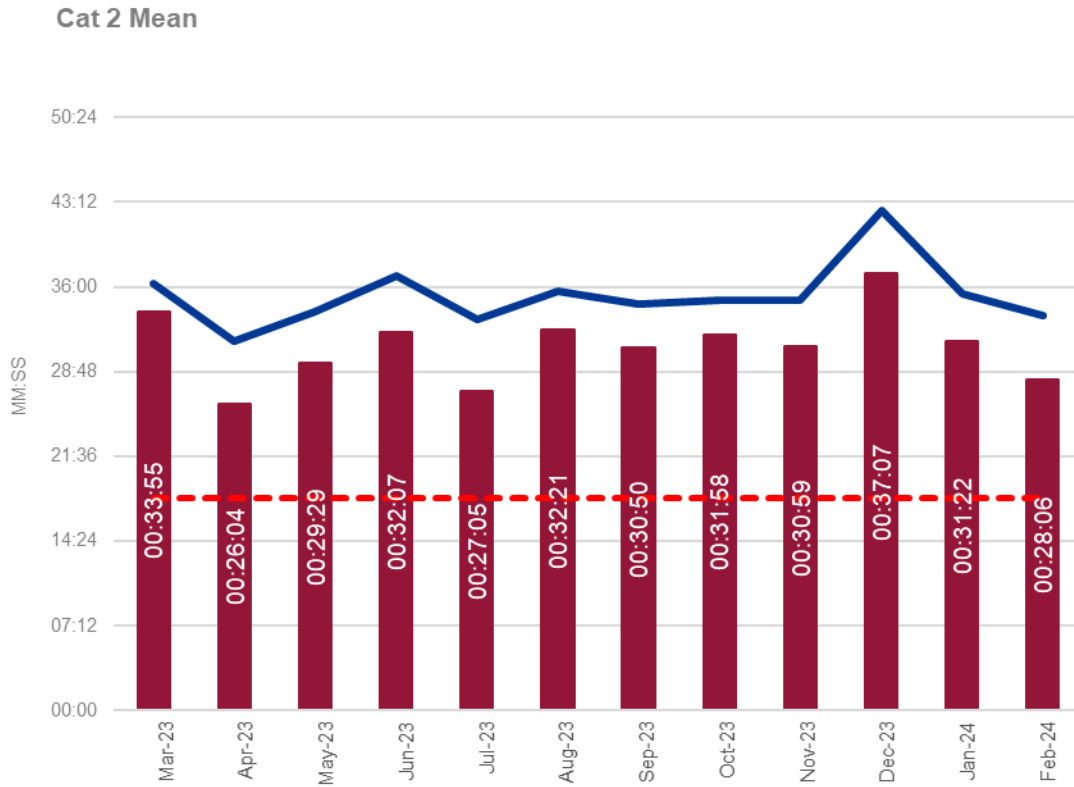
Category 1 Response Times - Mean response (min:sec) - (MTD)  
February 2023-24



Category 1 Response Times - 90th centile response (min:sec) - (MTD)  
February 2023-24



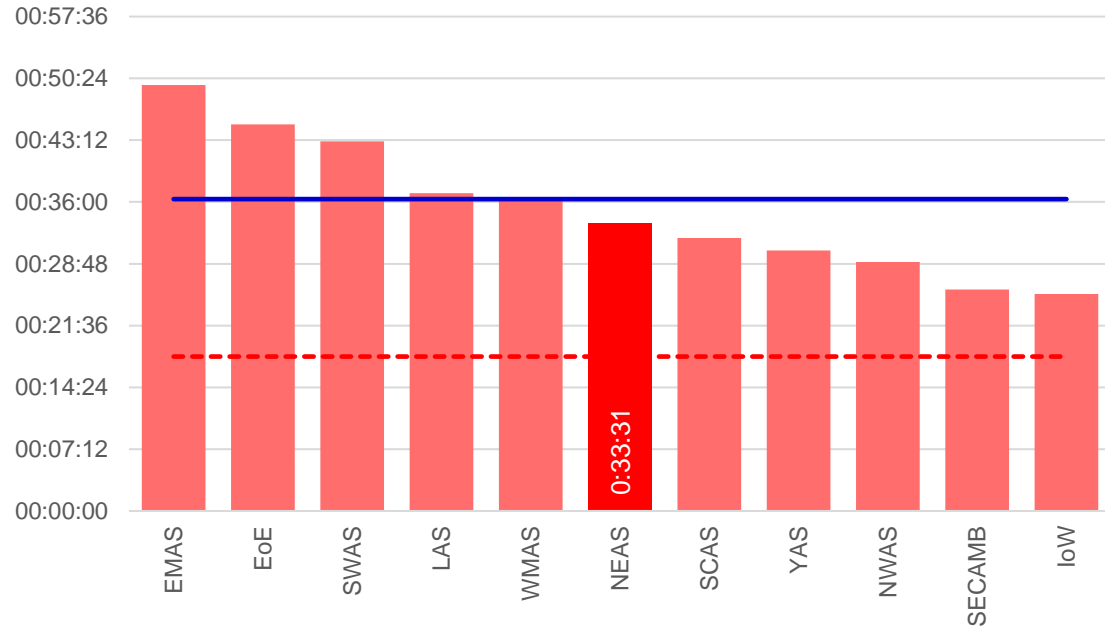
# Category 2 Response Performance



■ NEAS Trust
 ■ Northumberland

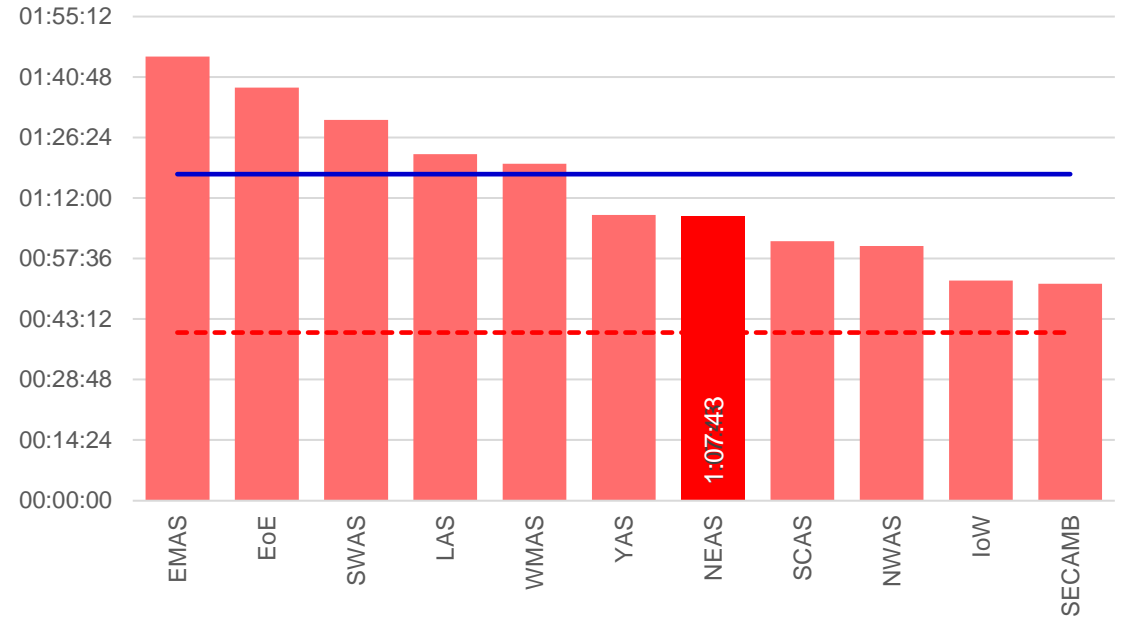
# NEAS Benchmark Performance – C2

Category 2 Response Times - Mean response (hour:min:sec) - (MTD) February 2023-24



— England    - - - Target

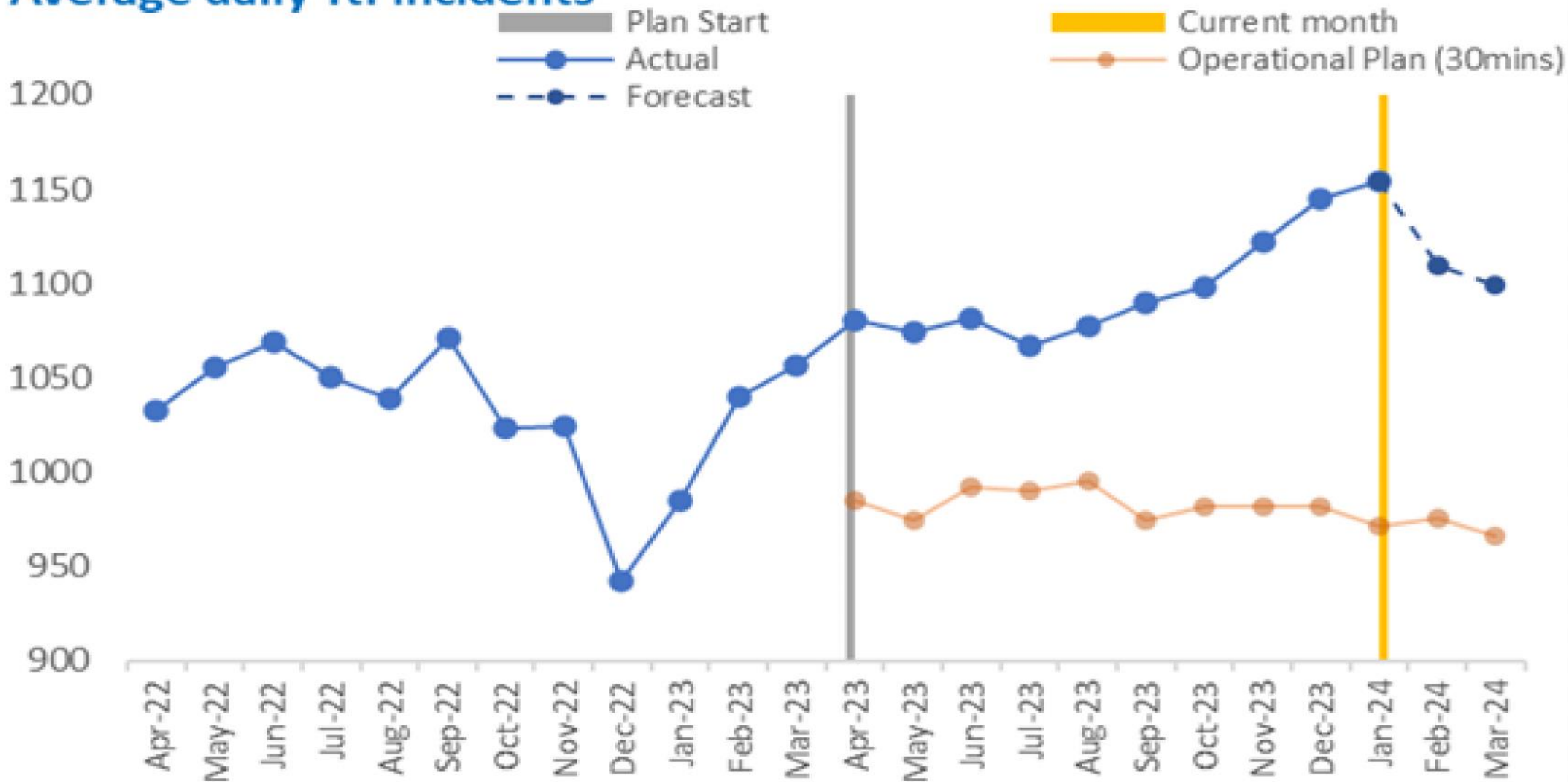
Category 2 Response Times - 90th centile response (hour:min:sec) - (MTD) February 2023-24

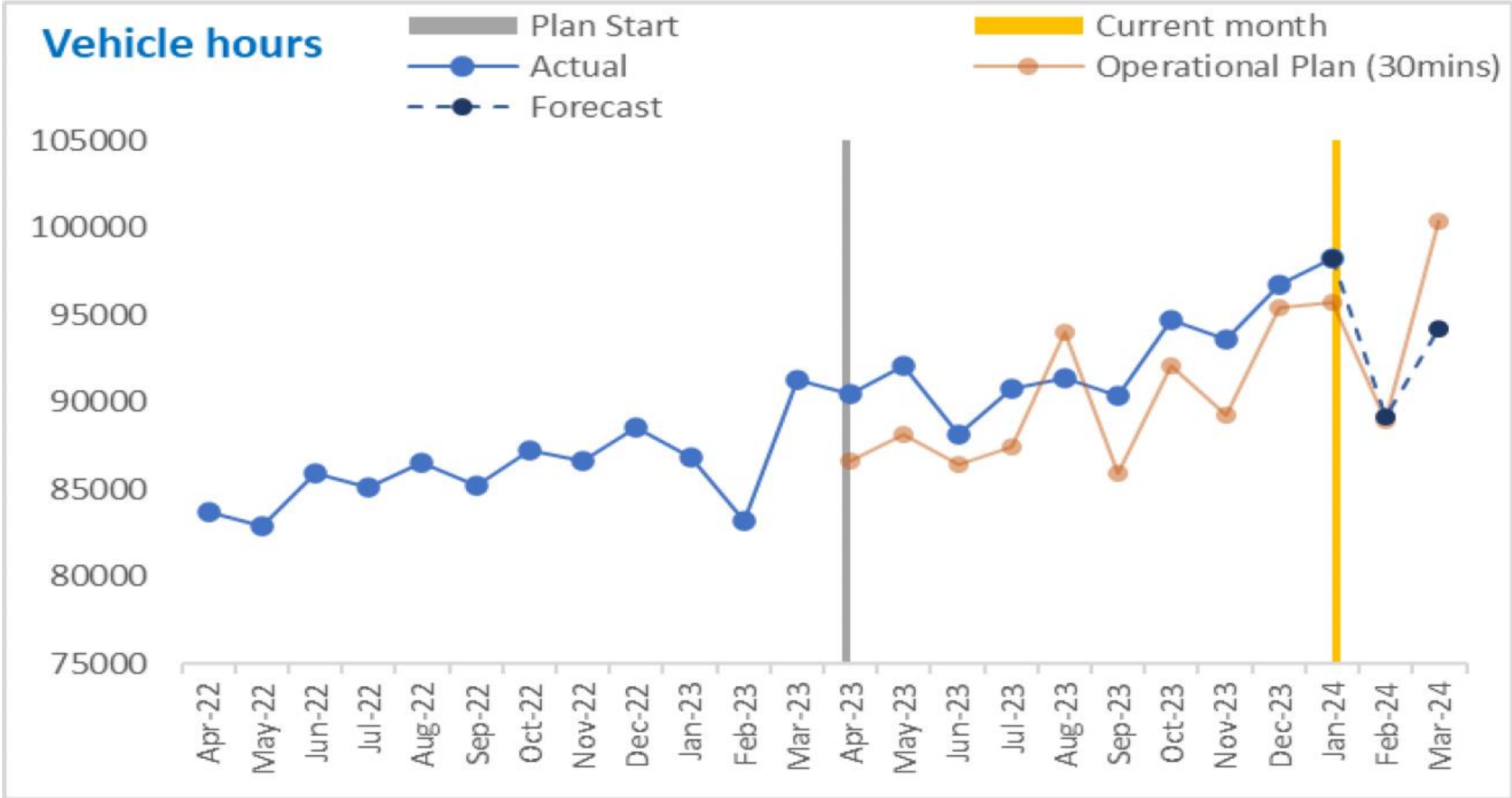


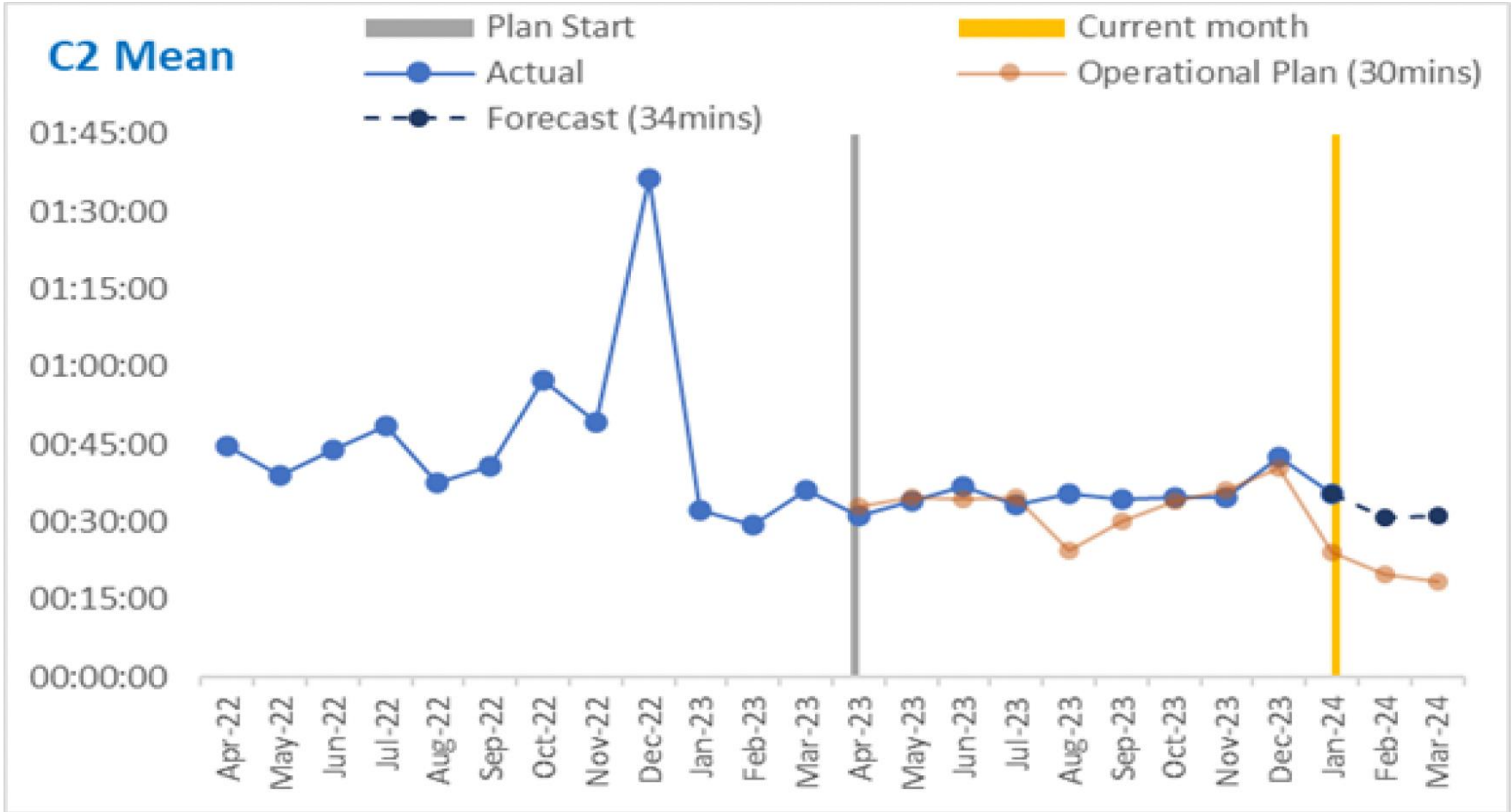
— England    - - - Target



## Average daily ftf incidents

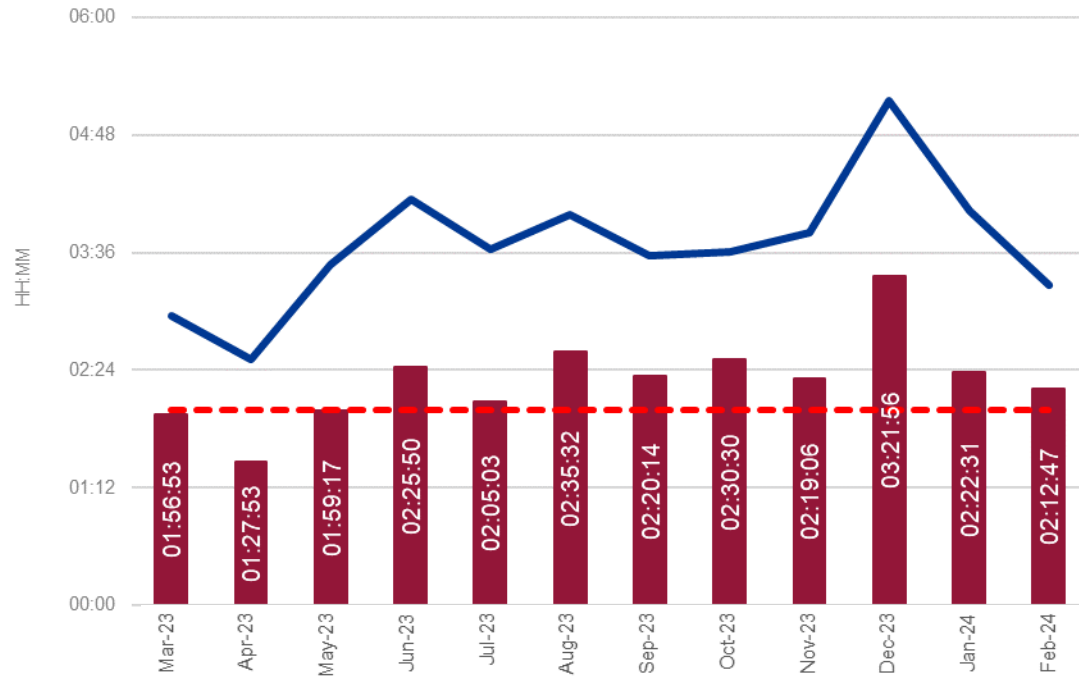




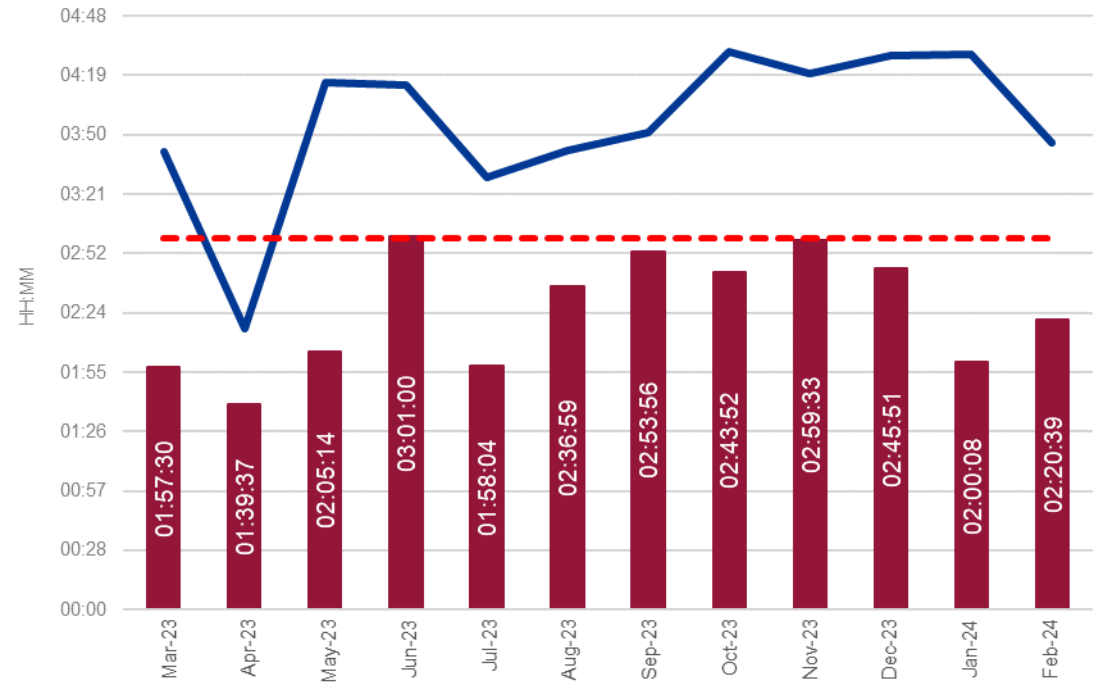


# Category 3 & 4 Response Performance

Cat 3 90th centile



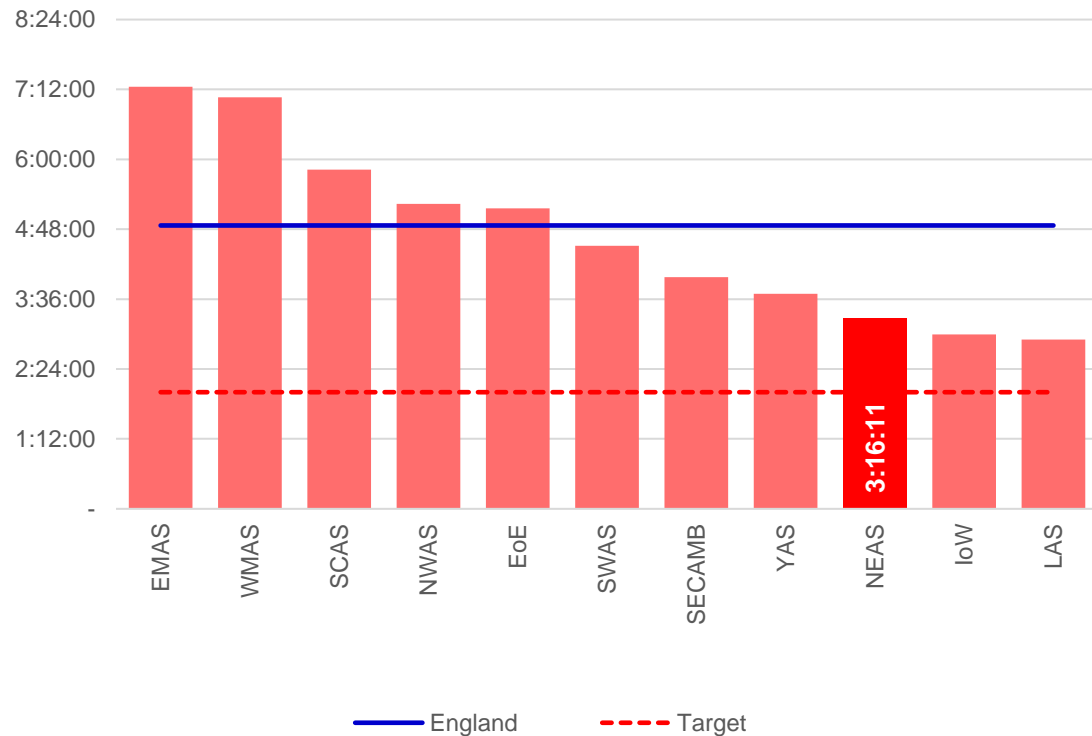
Cat 4 90th centile



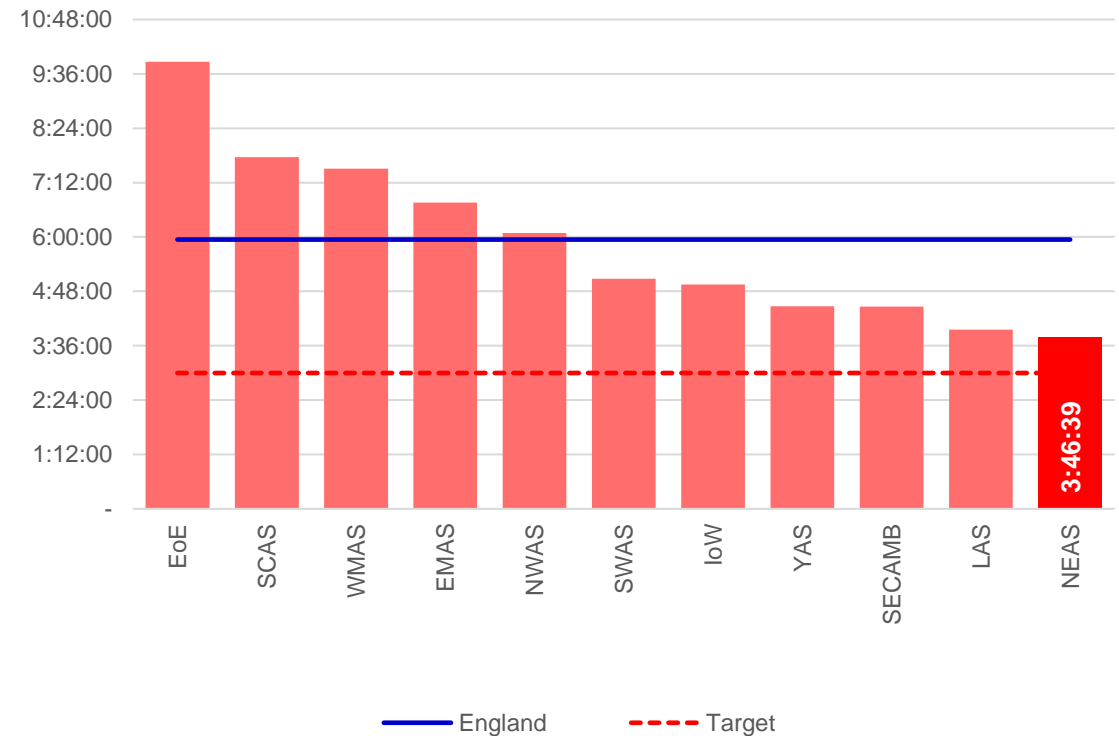
■ NEAS Trust
 ■ Northumberland

# NEAS Benchmark Performance – C3 & C4

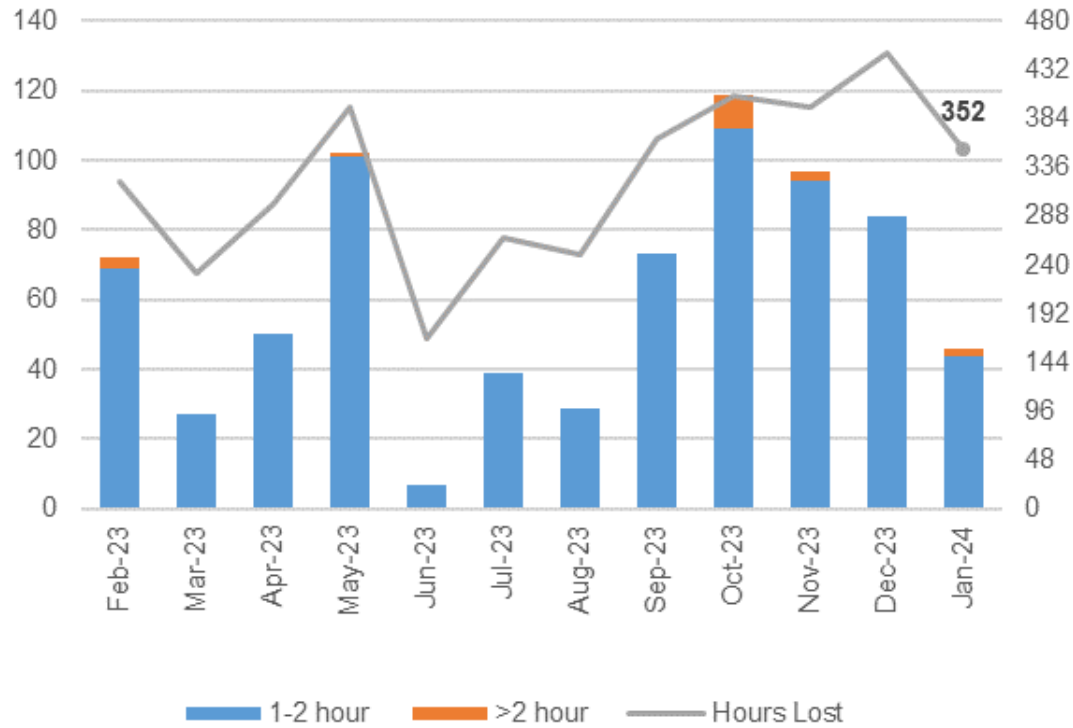
Category 3 Response Times - 90th centile response (hour:min:sec) - (MTD) February 2023-24



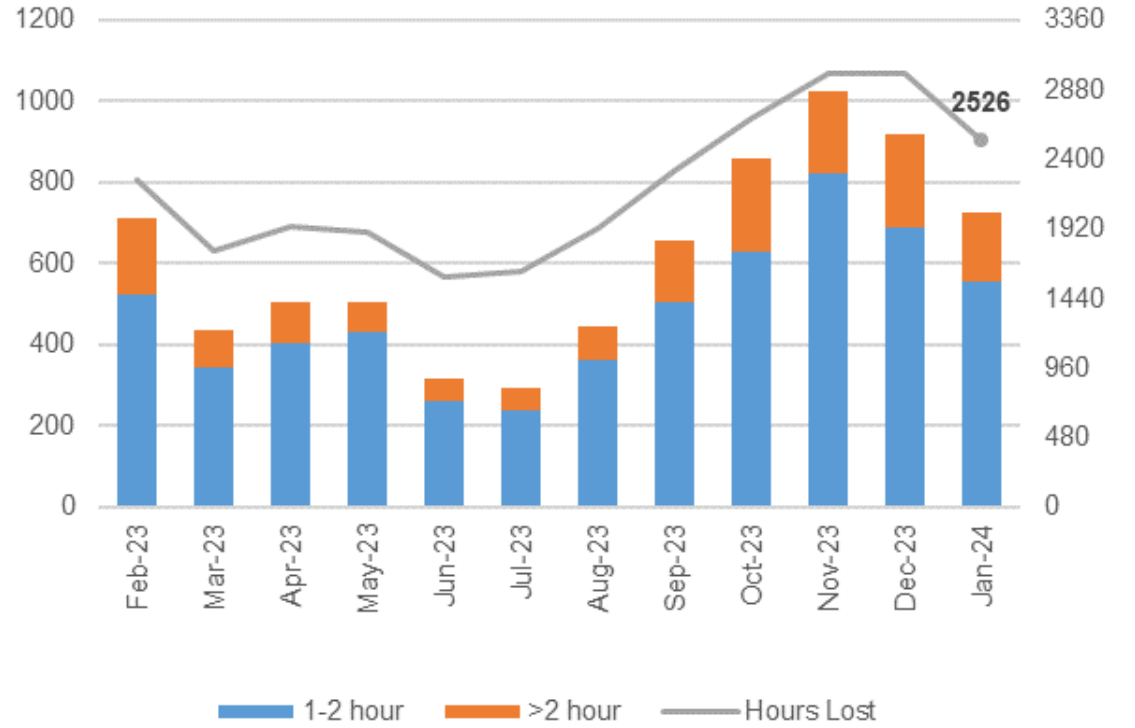
Category 4 Response Times - 90th centile response (hour:min:sec) - (MTD) February 2023-24



Handover Delays - NSECH



Handover Delays - Trustwide



# Hospital handover performance

**NHS**

**North East  
Ambulance Service**

NHS Foundation Trust



# 2023/24 Quality Report



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

**Vision:** Unmatched quality of care

# Overview of quality report requirements

- NHS Improvement provide detailed guidance on the requirements of the report
- Report must be shared with commissioners, governors, staff, Healthwatch, Overview and Scrutiny Committees or the Health and Wellbeing Board
- Consultation starts on 29 April. Deadline for responses 27<sup>th</sup> May 2024
- Providers must upload their final Quality Report onto their website by 30<sup>th</sup> June
- No requirement to obtain external auditor assurance this year



**NHS**

**North East  
Ambulance Service**

NHS Foundation Trust



# 2023/24 performance

1<sup>st</sup> April- 31<sup>st</sup> December 2023\*



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

**Vision:** Unmatched quality of care

<b>PATIENT SAFETY</b>	<b>2022-23</b>	<b>2023-24</b>
Patient safety incidents	3,702	2,209
Proportion of incidents / 1,000 calls	1.8%	2.2%
No. Serious Incidents	61	140

**Note:** 2023-24 data up to 31 Dec 2023

# Patient experience & feedback

Top three themes on complaints:

- Staff attitude
- Timeliness of response
- Quality of care

Patient Experience	2022-23	2023-24
See & treat	97.1%	93.3%
See & treat & convey to hospital	90.0%	92.0%
Planned patient transport	95.2%	94.1%
NHS111	82.7%	80.7%

Patient feedback	2022-23	2023-24
Complaints	375	316
Appreciations	812	922

**Note:** 2023-24 data up to 31 Dec 2023

# Update 2023/24 quality priorities

## Patient safety

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

## Clinical effectiveness

- Implementation of clinical supervision

## Patient experience

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



# To continue working with system partners to reduce handover delays

## What we achieved

- Thematic analysis of handover delays
- Partnership working to improve data sharing, standardise reporting to drive improvements
- Partnership working to improve effectiveness across the system
- Reviewed our risk management and escalation arrangements during times of demand

## What we need to do

- Understand the impact on patients
- Understand the impact on staff

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

## What we achieved

- 5 year review of quality & safety profile to inform local safety priorities
- Development of governance procedures
- PSIRF training provided by NHS accredited provider (including oversight training and patient safety specialist training)
- Transition to LFPSE 1<sup>st</sup> June 2023
- Transition to PSIRF 1<sup>st</sup> January 2024
- Introduction of x3 patient safety partners

## What we need to do

- Closure of all serious incidents & actions by 31<sup>st</sup> March 2024
- Embed PSIRF governance and organisational learning

# Implementation of clinical supervision

## What we achieved

- Policies and procedures for clinical supervision developed
- Clinical supervision launched across unscheduled care in August 2022
- Audit roadmap for Clinical Team Leaders (CTLs) introduced to managers understand individual clinical performance
- CTLs complete clinical supervision shifts with individuals including protected time for discussions
- Clinical staff are also provided with 5 hours to support with any CPD needs identified through clinical supervision

## What we need to do

- Development of electronic audit tool and dashboards
- Development and roll out of a bespoke university module to help ensure that our CTLs have the appropriate skills, knowledge and experience (to be completed in 2024)

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

## What we achieved

- Multidisciplinary working groups established for PSIRF implementation and patient safety improvement activities
- Introduction of patient safety partners
- Board level lead identified for patient safety partners
- Stakeholder involvement in patient safety meetings
- Collaborative working with stakeholders and partners
- Stakeholder involvement in recruitment for patient safety roles

## What we need to do

- To establish patient feedback group
- Implement a patient and carer feedback survey (post investigations)
- Wider patient and colleague involvement in recruitment activities





# Questions



## North East Ambulance Service

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Newcastle upon Tyne  
NE15 8NY