PART 1
INTRODUCTION

We are pleased to present our 2013/14 Quality Report and mandated Quality Accounts.

Part of the purpose of this report is to raise the profile of quality by outlining our quality improvement successes and challenges and set further goals to improving patient care.

SCAS acknowledges the changing architecture and landscape of the NHS which now features an underpinning structure of Clinical Commissioning Groups; and as such operates an ongoing programme of change.

Our key challenge is to protect and improve upon current levels of service for all our patients while nurturing a culture of reporting and learning, engaging with other healthcare providers and reducing costs in order to deliver the highest quality care.

Underpinning our priorities are the three dimensions of quality as defined by Lord Darzi and later enshrined in the Health and Social Act (2012).
SCAS welcomes this opportunity to share details of our approach to quality improvement, particularly in the context of increasing emphasis on transparency as detailed by The Francis Inquiry: Creating the Right Culture of Care (2013).

All sections which reference the Inquiry and its recommendations are marked with this clear symbol so that they are easily identified as a response or action.

This Quality Report is designed to help our service users, staff, partner agencies and the wider community to understand our quality agenda and priorities. We provide an essential service to our patients and the public, and our services are vital for the whole health economy.

The Quality Accounts are aligned with the requirements and targets set by the NHS standard contract for ambulance services, the Department of Health (DH) National Ambulance Indicators, the CQUIN (Commissioning for Quality Improvements) payment framework and those of our regulators Monitor and the CQC.

We will seek to continuously improve care while maintaining existing standards and aim to demonstrate our robust reporting processes which are supported by strong leadership, set actions for dealing with poor performance and a sound financial standing.

BACKGROUND

On 1 March 2012, SCAS became an NHS Foundation Trust. We have three main areas of service provision which are:

» response to 999 calls as an accident and emergency service
» non-emergency patient transport service
» NHS 111 Health Helpline service

As a Foundation Trust we are accountable to the communities which we serve. We are free from some central government control and work with our Council of Governors who ensure that we engage with and listen to the local population and their feedback.

Anyone living in the SCAS area can run for election to our Council of Governors which is made up of three different types of membership:

» Public Governors - Elected by public Foundation Trust who live in their county
» Staff Governors - Elected by SCAS staff members
» Appointed Governors - Elected from organisations that work closely with SCAS such as local charities, Clinical Commissioning Groups, and other local authorities.

At the end of March 2014, SCAS had 13,168 public members.
We believe strongly in patient and public engagement and regularly undertake promotional activities regarding our Foundation Trust membership.

SCAS plays a key role in improving patient care through clinical networks in Milton Keynes, the Thames Valley and Southern Health Partners. We are involved in stroke, heart attack and trauma networks. We work with them to create and maintain initiatives which focus on delivery of a more tailored service. Examples include our falls referral programme and the Trauma Unit Bypass tool which is used to ensure our most seriously injured patients can go straight to a specialist trauma centre.

**HOW DOES THE BOARD ASSURE ITSELF ON QUALITY?**

Our Trust Board comprises of six executive directors and seven non-executive directors who come from a wide variety of backgrounds, bringing with them a wealth of knowledge from commercial, public, healthcare and other industries.

The SCAS Board of Directors acknowledge the changing NHS and social care landscape and new architecture of the health service.

The Trust Board hears real patient stories and concerns from patients at alternate meetings to ensure they are informed and understand where changes can be made to improve services and outcomes. The Board also take into account information on areas that can be benchmarked with other ambulance services so that comparisons can be made and targets set as part of a national ambulance programme of improvement in pre-hospital and urgent care.

The governance structure is managed through the Quality and Safety Committee which reports to each Board and is responsible for monitoring and seeking assurances with regards to clinical quality, patient safety and patient experience.

Sub groups submit new guidelines and learning actions from incidents, complaints and SIRI (Serious Incident Requiring Investigation) activities to the Quality and Safety Committee.

The purpose of the Quality and Safety committee is: To enable the Board to obtain assurance that high standards of care are provided by the Trust and, in particular, that adequate and appropriate governance structures, processes and controls are in place throughout the Trust to:

» promote safety and excellence in patient care;
» identify, prioritise and manage risk arising from clinical care;
» ensure the effective and efficient use of resources through evidence-based clinical practice; and
» protect the health and safety of Trust employees.

In 2013 the Board began a robust process of improving and redefining clinical governance systems in the organisation to ensure what the Board reads, sees and hears gives assurances on quality. All membership and terms of reference of committees have been reviewed and realigned and the leadership walkaround template rewritten to include improved staff engagement, safety indicators and links to the Francis recommendations.
The changes will be implemented throughout the year to enable the Board to gain assurance that high quality care is being delivered and ensure staff can escalate concerns and refined as required on an ongoing basis.

The processes set clear standards and facilitate the management of risk. The review was in line with the guidance from Monitors Quality Governance document (April 2013):

How does a Board know that its organisation is working effectively to improve patient care?
SCAS RESPONSE TO FRANCIS, BERWICK AND KEOGH REPORTS

As an organisation SCAS fully recognises the seriousness of the findings identified in the Francis Report, and feels that it is important that this Quality Report includes workstreams relating to the relevant recommendations from the Francis Inquiry to underpin our quality position. Failures at the Mid Staffordshire Foundation Trust were so serious, so protracted and had such a devastating and widespread impact on patient care, that SCAS feels that there must be permanent lessons to be learnt.

SCAS responded immediately to the Inquiry’s recommendations with a series of internal updates to the Board, seminars and workshops which involved senior management, our Council of Governors and our executive and non-executive directors. SCAS immediately analysed the 290 recommendations made and developed a response and action plan.

THE FRANCIS REPORT’S KEY THEMES ARE:

► STANDARDS AND METHODS OF COMPLIANCE
► OPENNESS, TRANSPARENCY AND CANDOUR
► SUPPORT FOR COMPASSIONATE CARE
► STRONGER PATIENT CENTRED LEADERSHIP
► ACCURATE RELEVANT USEFUL INFORMATION
INITIATIVES
ALREADY
IMPLEMENTED
INCLUDE
► AN UPDATED CLINICAL SUPERVISION POLICY
► WE STRENGTHENED OUR CLINICAL GOVERNANCE MEETINGS AND CHECKS WITH THE PRIVATE PROVIDERS WE USE
► WE BENCHMARKED NATIONALLY ON CORE AMBULANCE QUALITY AND CLINICAL METRICS
► A ROBUST REVIEW OF OUR INTEGRATED PERFORMANCE REPORT METRICS
► INTRODUCED AN ELECTRONIC INCIDENT REPORTING SYSTEM
► WE CARRIED OUT INVESTIGATION AND ROOT CAUSE ANALYSIS TRAINING
► A REVISION OF OUR PUBLIC ENGAGEMENT STRATEGY
► THE INTRODUCTION OF THE FRIENDS AND FAMILY TEST
► OUR DUTY OF CANDOUR REQUIREMENTS AND REPORTING WERE STRENGTHENED
► A COMPASSION ELEMENT INCLUDED IN ALL STAFF APPRAISALS
► OUR SAFETY WALKROUNDS REVISED
► A STAFF SAFETY CULTURE AUDIT USING A RECOGNISED TOOL
As described in the section on Board assurance, the review of our quality assurances have been carefully aligned with themes from these key reports. From the Berwick Report (in response to the Francis Report) change will require:

| WILLINGNESS > | Recognition of the need for wide systemic change and a culture firmly rooted in continual improvement |
| OPENNESS > | Abandonment of blame, trust in good intentions |
| ENGAGEMENT > | Close working with patients and carers to achieve goals at all times |
| QUALITY FIRST > | Better care as a goal instead of quantitative targets |
| TRANSPARENCY > | Ought not to be optional and instead insisted upon at all levels, embracing and encouraging whistle blowing and reporting to identify risks and where things have gone wrong |
| RESPONSIBILITY > | Clear lines of responsibility throughout agencies |
| LEARNING SUPPORT > | Fostering career-long support for staff growth, support and quality planning |
| ACTION > | Response to safety alerts sanctions applied to reckless or wilful neglect |
| PRIDE > | In our work |
Part 2 of this Quality Account Report details our main areas of focus drawn from the Francis Report as well as other areas of strategic and regulatory importance.

OUR STRATEGIC AIMS AND HOW THEY ALIGN WITH THE FRANCIS REPORT ARE DETAILED BELOW:

❖ CLINICAL EXCELLENCE
  Providing a positive patient experience while improving clinical outcomes and ensuring patient safety through feedback, accountability and recognised best practice

❖ OPERATIONAL EXCELLENCE
  Achieving response time performance standards, resilience and efficiency whilst still putting the patient first

❖ EFFECTIVE STAKEHOLDER RELATIONSHIPS, SOUND GOVERNANCE, VALUE FOR MONEY AND A STRONG FINANCIAL STANDARDS
  Developing whole system solutions and seamless pathways of care

❖ LEADERSHIP, STAFF ENGAGEMENT AND A LEARNING CULTURE
  Developing the workforce, motivating and enabling our people to deliver excellence and compassion in a culture of openness and transparency

❖ A NETWORK OF PROFITABLE AND HIGH QUALITY NON-EMERGENCY CONTRACTS
  Which operate to the highest standards and always put the patient first

Providing high quality care is at the heart of everything SCAS does, but this can only be achieved if the organisational structure is at its strongest. To ensure that this is the case for the last 12 months we have undertaken an in-depth process of restructuring all operational and corporate roles to maximise the efficiency and performance of the Trust.
Welcome to our Quality Accounts 2013/14, our third since becoming a Foundation Trust. Our intention is to give you a real understanding of our quality performance looking back over the last 12 months and setting our improvement targets for the coming year.

SCAS faced another busy and demanding year in 2013/14. We have expanded our geographical footprint for NHS 111 services to include Berkshire, Buckinghamshire, Bedfordshire and Luton and the National Resilience service for NHS 111 based at Milton Keynes.
Our CQC inspection in August 2013 was successful and we achieved full compliance. But this does not mean we are complacent. We still face some challenges to deliver consistently high quality services to all and these areas are identified in our priorities. By achieving a collective Board understanding of the transformation required I am confident we will continue to deliver improvements.

2014/15 will continue to see NHS trusts working in a tough economic climate and we need to be evermore efficient and transformational. This will include development of local care setting initiatives, scanning the potential to provide care at home schemes and enhancing our engagement with GPs. This will involve better coordination between teams providing emergency and planned care to ensure proactive support at home for patients to prevent emergency crisis and enable people to stay at home safely.

We have also been adapting to the Clinical Commissioning Groups and strengthening our engagement with them to develop patient services across our area. We will continue to work together to reshape services and improve quality.

The coming year will continue to be challenging. But by listening to our patients, our foundation trust members, our staff and the general public, and by continuing to focus on good quality outcomes and positive patient experiences at every contact point, I am confident we can meet every challenge and enhance our reputation as a quality-focused healthcare provider.

This Quality Account has been prepared and written by South Central Ambulance Service NHS Foundation Trust under the National Health Service (Quality Accounts regulations) 2010 statutory instrument No 279. The Trust has reviewed all the data and information available on the quality of care that all the service arms provide on a daily basis.

To the best of my knowledge the information in this document is accurate.

Will Hancock  Chief Executive

28 May 2014
WHAT ARE QUALITY ACCOUNTS?

Quality Accounts are mandatory annual statements as required in the NHS Act 2009. They are written for the public by all NHS organisations that provide healthcare. Quality reports and accounts are set against the context of three overlapping key themes which can be used to define quality of care:

Quality is defined by both staff and patient experiences.

The Quality Account can be seen as a ‘self assessment tool’, the value of which has never been more relevant or vital in light of publication of the Independent Inquiry Report (2013) by Robert Francis QC, into the serious failings identified in the Mid Staffordshire Hospitals NHS Foundation Trust.

The Francis Report found that there were systemic, deep rooted and fundamental deficiencies within the Trust, which the Board, managers and staff failed to take appropriate actions to resolve.

In concluding his review Mr Francis stated:
“PEOPLE MUST ALWAYS COME BEFORE NUMBERS. INDIVIDUAL PATIENTS AND THEIR TREATMENT ARE WHAT REALLY MATTERS. STATISTICS, BENCHMARKS AND ACTION PLANS ARE TOOLS NOT ENDS IN THEMSELVES. THEY SHOULD NOT COME BEFORE PATIENTS AND THEIR EXPERIENCES. THIS IS WHAT MUST BE REMEMBERED BY ALL THOSE WHO DESIGN AND IMPLEMENT POLICY FOR THE NHS.”
We believe that the SCAS Quality Account is an integral part of patient and public engagement by encouraging ongoing dialogue with our patients, the Board, managers, clinicians and staff about improving quality of care. It allows us as an organisation to assess our quality of care and show our commitment in driving forward improvements and learning from best practice evidence.

The Quality Account enables us to tell the story of our progress against set priorities and allows us to set further key priorities for ongoing and sustained improvement. This report also meets the requirements set by Monitor in the Quality Governance Framework and Annual Reporting Manual 2013/14.

Effective quality accounts raise the profile of quality improvement across the organisation from the Board to road crews and the staff in the emergency operations centres. It provides a springboard for discussing how we are improving patient care and outcomes with those who use the services we provide, our commissioners and Health Overview and Scrutiny Panels.

External assurance for this account will be provided by our external auditors, KPMG, who will review the content of this report in line with Monitor’s requirements as outlined in the NHS Foundation Trust Reporting Manual 2013/14. They will also review the report for consistency with other sources of data available, provide a limited assurance report on two mandated indicators and one locally selected indicator.

**CQC REGULATION AND COMPLIANCE**

In August 2013 the Care Quality Commission (CQC) carried out a scheduled inspection at SCAS.

The inspectors focused on the following five outcomes:

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<thead>
<tr>
<th>OUTCOME 4 (REGULATION 9)</th>
<th>Met this standard</th>
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<tr>
<td>Care and welfare of people who use services</td>
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<tr>
<th>OUTCOME 6 (REGULATION 24)</th>
<th>Met this standard</th>
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<tr>
<td>Cooperating with other providers</td>
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<tr>
<th>OUTCOME 8 (REGULATION 12)</th>
<th>Met this standard</th>
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<tr>
<td>Cleanliness and infection control</td>
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<tr>
<th>OUTCOME 11 (REGULATION 16)</th>
<th>Met this standard</th>
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<tr>
<td>Safety and suitability of premises</td>
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<tr>
<th>OUTCOME 16 (REGULATION 10)</th>
<th>Met this standard</th>
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<tr>
<td>Assessing and monitoring the quality of service provision</td>
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The inspectors spoke to staff, examined records and reviewed what our stakeholders had to say. They looked at the personal care or treatment records of people who use the service, carried out visits on 7 August 2013, 8 August 2013 and 15 August 2013, talked with people who use the service and met with staff.

EXTRACTS FROM THE CQC REPORT STATED:

“We found there was a thorough system of monitoring of quality and performance of all areas of SCAS’s operation. We found any of the concerns raised with us had already been identified and action either had or was being taken to address them as far as possible.

“We found there were robust systems in place which identified, assessed and managed risks to patient safety and that of staff. Formal processes were in place to learn from adverse incidents; this included any findings from complaints. We were informed of concerns which had been raised about the confidentiality of patient records held at ambulance stations and resource centres. This had been addressed and we saw at the stations we visited secure, lockable storage was now provided. This provided evidence learning from incidents and investigations took place and appropriate changes were made where appropriate.”
SCAS was deemed fully compliant with the essential standards, shown previously, something which we aim to maintain.

The report can be viewed in full on the CQC website.

http://www.cqc.org.uk/sites/default/files/media/reports/RYEAA3_Bucks_and_Oxon_Divisional_HQ_INS1-888811695_Scheduled_01-10-2013.pdf

**GOVERNANCE AND ACTIVITY**

SCAS has introduced a new electronic incident reporting system in 2013 (Datix) and we have seen our reporting levels rise. This is regarded as positive as it demonstrates an open safety culture in which our staff feel able to report incidents and raise concerns. Francis reported that increases in incident reporting is a healthy position if the incidents can result in learning and not consistently harming patients.

The total number of adverse incidents reported internally was 3,489. Of these there were 16 Serious Incidents Requiring Investigation (SIRIs) which we reported externally to the Department of Health and the Clinical Commissioning Groups. These incidents are ones that have resulted in moderate or severe harm or death.

SCAS received 579,430 contacts from the public during the 2013/14 reporting period. We received 883 compliments, which far outweighed our complaints, which numbered only 382. We also received 740 concerns or comments.

**ACTIVITY (999 INCIDENTS)**

![Graph showing activity from April to March](image.png)
During the year 2013/2014 there have been three referrals to the Parliamentary Health Service Ombudsman, only two of which were investigated. However, it is good to note that neither was upheld, which was a positive outcome for the Trust and shows that we are resolving any complaints we receive in an open and honest way.

**MONITOR MANDATED QUALITY INDICATORS**

SCAS reported on mandatory core quality indicators set by Monitor and the Department of Health in last year’s accounts. These indicators are intended to strengthen the reporting process and create a comparable set of targets across all UK ambulance trusts.

The mandated core quality indicators are outlined in:


The mandatory core quality indicators relevant during 2013/14 are:

**AMBULANCE RESPONSE TIMES (RED 1 & RED 2)**

- The percentage of Red 1 and Red 2 telephone calls resulting in an emergency response by the Trust that were responded to within eight minutes of receipt of that call during the reporting period.
- The percentage of telephone calls resulting in an ambulance response by the Trust at scene of the emergency within 19 minutes of the receipt of that call during the reporting period.

**AMBULANCE CLINICAL OUTCOMES: ACUTE ST-ELEVATION MYOCARDIAL INFARCTION (STEMI) AND STROKE**

Patients that undergo a pre-hospital assessment for STEMI (heart attack) or stroke and who are then given specifically tailored care and placed on a treatment pathway that begins en route to hospital and continues after admission, have a higher incidence of improved overall outcome. This way of working helps people to recover from episodes of ill health or injury and supports the NHS as a whole to reduce the number of patients dying prematurely.

The core indicator requirements for the 2013/14 Quality Account are the following:

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

An appropriate care bundle is a package of clinical interventions that are known to benefit patients’ clinical outcomes, for instance, patients with STEMI should be administered pain relief medication to help alleviate discomfort.
OTHER MANDATED INDICATORS

- 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.
- 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.

South Central Ambulance Service NHS Foundation Trust considers that the data is as described for the following reasons:
  » Use of licensed clinical assessment tools
  » Data validation by external auditors
  » Scrutiny internal/external and national.

South Central Ambulance Service NHS Foundation Trust has taken the following actions to improve the indicators and data and so the quality of its services, by:
  » policy implementation
  » clinical campaign approach
  » benchmarking
  » scrutiny (internal and external)
  » internal auditors (validating data)
  » introduction of NHS Pathways
  » clinical audit
  » Board Assurance Framework and IPR
  » IT systems maintenance
  » training and support
  » reviewing quality assurance committee structure.
PART 2
QUALITY PRIORITIES FOR 2014/15

Our ambition is to deliver continuous improvement in patient care and outcomes...

Improve safety and reduce harm
» Show evidence of a growing safety culture within the organisation
» Reduce the number of the most frequent and potentially serious incidents.

Improve clinical effectiveness and outcomes
» Clinical teams will all be involved in improvement activities to ensure effective clinical pathways.

Improve patient experience
» Ensure patient satisfaction improves across all areas of service provision and benchmark well against national figures.

Demonstrate quality improvement
» Robust quality measurement through sound governance and audit.
» Introduce a new clinical quality and safety dashboard.
» Assurance for Board, public, Clinical Commissioning Groups (CCGs) and regulatory bodies (Care Quality Commission (CQC), NHS Litigation Authority (NHSLA) and Monitor.

Continuously improve
» Increase organisational improvement capability by training and equipping staff with improvement skills.
» Evidence of organisational learning from feedback, measures and incidents.
» Trust Board view quality improvement as a core function.

Evidence increased efficiency
» Demonstrate increased efficiency linked with quality improvement.
Each year the Quality Accounts outline a number of areas where quality improvements can and should be made. Engagement with all our internal and external partners is invaluable and imperative when defining our goals for quality improvement.

Our focus remains on providing an excellent service to our patients in an organisation where both the users and the staff feel cared for.

When areas of poor performance are identified we remain committed to learning lessons, implementing changes and supporting staff in training, learning and supervision.

Our indicators cover all services provided (111, PTS, 999) where applicable.
We have listened to feedback from patients and other professionals who tell us that they want safe, timely care delivered by competent, professional and caring staff members. Our clinical audit programmes and outcomes also assist in shaping our priorities.

We have also used our internal monitoring systems such as incident reports and audit to examine our key priorities.

SCAS has used the NHS Quality Account Toolkit 2010/11 from the DH (these guidelines remain unchanged) to inform the process of prioritisation and engagement, which has helped create this Quality Report which provides an opportunity for us to describe our performance and our improvement goals. We recognise the challenges associated with ensuring accurate and timely clinical data from complex and multifactoral sources and this remains a high priority.

Local health overview and scrutiny panels (HOSP) have given their views as have our commissioners in Clinical Commissioning Groups (CCGs) who are responsible for contracting our services. As a Foundation Trust we engage with our Council of Governors and we have welcomed their input.

Engagement on selecting our priorities needs to be relevant and credible and through the above processes we can show that the public view and a clinical view has been listened to and included in planning our priorities.

Leadership walkarounds by the executive and non-executive directors have also provided intelligence to develop areas for improvement and helped to engage frontline and support staff in discussions and debates about our clinical and patient priorities.

Our leadership walkaround template has also been revised to provide stronger assurances on elements of the Francis Report. Meetings and road shows with staff around the Trust have helped engage staff at all levels, sharing with them the Trust’s vision and strategy, but also listening to their views and ideas about changes to make service delivery more effective and patient focused.

Following all of the above, we refined our priorities to those which we felt would ‘stretch us’ in delivering the highest possible quality of care. These include the mandated priorities.

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Following all of the above, we refined our priorities to those which we felt would ‘stretch us’ in delivering the highest possible quality of care. These include the mandated priorities.

The initiatives were assessed in terms of:

**IMPACT**
By considering the likely improvement in safety, outcomes and experience.

**FEASIBILITY**
The ease of implementation, resources required and likely time to completion or delivery.

**MEASURABILITY**
Can the priority we have set be measured accurately in order that we can show improvements?

**OUTCOMES**
Will the initiative improve patient outcomes in the areas of safety, effectiveness and experience?
**AREAS FOR IMPROVEMENT FOR SCAS 2014/15**

Following a Board consultation and additional consultations with our Council of Governors, Quality and Safety Committee, the senior leadership team and staff representation the following priorities have been approved and confirmed for the Quality Accounts 2013/14:

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### 1 PATIENT SAFETY

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<tr>
<td><strong>1a</strong></td>
<td>To ensure that decisions to keep patients ‘at home’ are consistently clinically safe and appropriate for the patient condition with referral to accessible/available community services.</td>
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<tr>
<td><strong>1b</strong></td>
<td>To reduce potential harm or poor patient experience as a result of waiting too long for a response for our 999 service.</td>
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<tr>
<td><strong>1c</strong></td>
<td>To report on the number of patient safety incidents and the percentage and number that resulted in severe harm or death for all of our services (111, PTS and 999).</td>
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## 2 CLINICAL EFFECTIVENESS

<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
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<tbody>
<tr>
<td>2a</td>
<td>To report on the percentage of patients with stroke and heart attacks who receive an appropriate care bundle (mandated indicators).</td>
</tr>
<tr>
<td>2b</td>
<td>To report on the data of responses to Red 1 and 2 calls, and calls requiring a 19 minute response and benchmark nationally (core mandated indicators).</td>
</tr>
<tr>
<td>2c</td>
<td>To improve the responsiveness of consistently identifying and appropriately transferring stroke patients to a hyperacute unit within 60 minutes.</td>
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<tr>
<td>2d</td>
<td>To ensure patients receive adequate pain relief.</td>
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## 3 PATIENT EXPERIENCE

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<th>Section</th>
<th>Description</th>
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<tbody>
<tr>
<td>3a</td>
<td>To ensure that all patient complaints and concerns are consistently responded to within a mutually agreed timeframe for all of our services (111, PTS and 999).</td>
</tr>
<tr>
<td>3b</td>
<td>To learn from concerns by using ‘face to face / end to end reviews’ with partners and patients and publish the findings and actions to improve our services.</td>
</tr>
<tr>
<td>3c</td>
<td>To proactively seek patient feedback through surveying patients to improve our services, including the Friends and Family Test and gaining feedback from harder to reach groups for all of our services.</td>
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Each of our priorities and our proposed initiatives for 2014/2015 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.

All the quality metrics are included in the Trust’s Integrated Performance Report that is published monthly across the organisation and is challenged and scrutinised by the Trust Board and in all our performance meetings. This includes all SCAS provided services.

External audit assurance is provided by KPMG and through an internal audit programme.
**PRIORITY 1 - PATIENT SAFETY**

a. To ensure that decisions to keep patients ‘at home’ are consistently, clinically safe and appropriate for the patient condition with referral to accessible/available community services.

**RATIONALE**

The ambulance service works in partnership with other healthcare providers to keep patients at home where possible. To do this we work with commissioners and GPs to ensure patients left at home have the right advice or referral to another service. We have chosen this indicator to ensure decisions to convey to hospital or to refer on are clinically safe and appropriate for our patients.

We will build on work already undertaken in collaboration with our healthcare partners and through our contracted quality schedule.

We are currently compliant with CQC Outcome 4 (Care and welfare of people who use services).

**TO ACHIEVE THIS WE NEED TO:**

» produce and analyse information on non-conveyance
» review patient clinical records where non-conveyance has resulted in a recontact or subsequent admission
» analyse recontact rates/unexpected deaths within 24 hours of SCAS attendance
» review incidents and complaints relating to conveyance/non-conveyance
» analyse HCP (Healthcare Professional) feedback and actions
» conduct GP triage audits and show improvements in attempts
» report data by area to create heat maps
 » introduce and embed the use of the Electronic Patient Record (ePR) by Quarter 3 (December 2014) to enable real time data to be sent to healthcare partners and teams
 » extract monthly GP triage data per CCG

» monitor monthly GP triage attempts and GP accept or decline by CCG
» conduct GP triage audits analysing appropriate utilisation and improvement plans where variance exists.

**Board Sponsor**

Sue Byrne
Chief Operating Officer

**Implementation Leads**

Mark Ainsworth
Operations Director South

Steve West
Operations Director North
**PRIORIT Y 1 - PATIENT SAFETY**

b. To reduce potential harm or poor patient experience as a result of waiting too long for a response for our 999 service.

**RATIONALE**

We know that patients who call for our help want and often need a rapid response with no delays. Responsive ambulance services are critical for emergency patient outcomes. It remains a key priority for SCAS and one which we know is still important to the public.

Any delay can present as a complaint or incident requiring investigation and using an investigative process can help us understand where and how problems arise. Consequently SCAS is monitoring long delays on a daily basis using a ‘Red Misses’ report format which demands that all delays have to be accounted for. This daily monitoring is supported through rigorous root cause analysis at performance management meetings at both area level and director level.

The Clinical and Operations teams recognise the importance of reducing long waits to patients.

Long wait audit meetings are conducted monthly where an in-depth review of the top ten longest waits for each dispatch area is undertaken. The review includes an audit of the processes in the Emergency Operations Centre (EOC) to ensure there were no avoidable delays along with a review of the patient care record to identify any patients placed at risk or where harm has been caused by a delay in responding. These audits have confirmed that the three main reasons for the delays are:

» all operational resources are committed at the time of the call
» higher priority calls requiring attendance
» repeat calls to patients waiting our arrival where the category of call changes

It is also anticipated that the transition of 999 from AMPDS to NHS Pathways will further improve our assessment and allocation of resources thereby reducing long waits.

NHS Pathways will start rolling out to our 999 services in Quarter 3.

**TO ACHIEVE THIS WE NEED TO:**

» audit long waits and produce actions to reduce waits and improve the patient experience (each month) (remove regraded calls from the sample)
» analyse any complaints or concerns received which relate to long waits and ensure learning is extracted and implemented
» ensure staff submit an incident report when unable to get a timely response from a GP triage attempt
» review our backup responses to solo responders and introduce a categorisation system in EOC/dispatch
» report data by area to create heat maps (including complaints and incidents)
**PRIORITY 1 - PATIENT SAFETY**

**b.** To reduce potential harm or poor patient experience as a result of waiting too long for a response for our 999 service.

» carry out weekly and daily reviews of resource availability against our unit hour utilisation planned demand profile
» Clinical Support Desk (CSD) will contact any patient who experiences a long wait to assess the patient and offer appropriate clinical advice
» patients who make a repeat call will be passed through to CSD for assessment.
» work with GPs on appropriate HCP admissions using our service.

**PLAN**

» Implement a zero tolerance approach to long waits for Red 2 calls over 30 minutes
» Reduce long waits in line with IPR trajectory.

**Board Sponsor**

Sue Byrne  
Chief Operating Officer

**Implementation Leads**

Luci Stephens  
Assistant Director of Operations (EOC)

**Operations Directors**

North and South
RATIONAL

SCAS takes any incident resulting in severe harm extremely seriously and we already have a robust reporting system in place. Although this indicator is mandated SCAS wants to expand on it to ensure that lessons are learned across the whole system to prevent occurrences.

Adverse incidents are logged through our Datix reporting system and can be reported by any grade of staff. Early review of submitted Datix incidents by a dedicated management team means that any incident classified as a serious incident requiring investigation (SIRI) can be rapidly ‘flagged up’ and acted on appropriately.

SIRIs are registered on the Strategic Executive Information System (STEIS) and fully investigated in a timely manner as agreed with commissioners. All actions relating to SIRIs are monitored by the SIRI Review Group.

This indicator covers all our services and Datix affords SCAS the opportunity to triangulate information where incidents cross service boundaries.

TO ACHIEVE THIS WE NEED TO:

» report on patient safety incidents (numbers and severity)
» triangulate SIRIs with complaints to maximise learning
» further improve our partnership working on serious incidents which cross health and social care boundaries

PLAN

» Reduce incidents which result in moderate or severe harm by 10%.
» Benchmark nationally with other ambulance services to enable best practice to be shared and improve outcomes for patients.
» Adhere to the duty of candour as outlined in the Francis Report and our contractual requirements.
PRIORITY 2 - CLINICAL EFFECTIVENESS

a. To report on the percentage of patients with stroke and heart attacks who receive an appropriate care bundle (mandated indicators)

RATIONALE

SCAS has a proven track record of improvement in performance in relation to use of the stroke care bundle (98.7% *YTD Apr 13 to Dec 13).

Our challenge going forward is to improve the percentage of patients with suspected heart attack receiving the appropriate care bundle.

STROKE CARE BUNDLE

STEMI CARE BUNDLE
This indicator is mandated for our Quality Accounts; however, SCAS recognises the need to improve on care bundle application with STEMI patients in particular. We have analysed why this is the case and found it to relate to analgesics given to this cohort of patients.

SCAS has devised and is implementing a STEMI care bundle action plan which will concentrate on the assessment, treatment, feedback and the leadership that underpins this and will build on the previous initiative such as “Time is Myocardium”. It will also run similar support and review systems to the stroke plan in ‘controlling the controllables’ to enable focus on the aspects of the outcomes that we can affect.

This indicator covers all our services and Datix affords SCAS the opportunity to triangulate information where incidents cross service boundaries.

**TO ACHIEVE THIS WE NEED TO:**

- benchmark with other ambulance services as per the DH mandatory indicators and be in the top national quartile
- develop a campaign approach to include education, support and information to develop focus on treatment and time to specialist unit.
- review the human factors and behaviours which affect delivery of the care bundles
- link with specialist units - both pre-alerting and providing a feedback mechanism for crew and system learning.
- wider system networking - providing information to inform the clinical networks
- conduct regular clinical audits of patient report forms (PRFs) to analyse the quality of care provided and care pathway compliance
- a focused programme of clinical quality metrics for team leaders and their staff
- use technology developments in apps for phones and ePR to provide real time proximity information to crews which will include forced fields for care bundles.

**PLAN**

- STEMI - To achieve 80% by year end from an average in 2013/14 of 69% (1% month on month improvement)

**Board Sponsor**

John Black
Medical Director

**Implementation Leads**

Dave Sherwood
Clinical Excellence Lead

**Operations Directors**

North and South

Rob Kemp
Area Manager
PRIORITY 2 - CLINICAL EFFECTIVENESS

b. To report on the data of responses to Red 1 and Red 2 calls, and calls requiring a 19 minute response and benchmark nationally (core mandated indicators).

RATIONALE

To ensure patients in the SCAS region receive quality care from their ambulance service a set of key performance indicators and ambulance quality indicators have been set nationally. These help set our policies and guidelines and develop our organisational culture that places quality at the top of the Trust’s agenda.

Although reporting of this information is mandatory SCAS believes we should monitor and improve response times routinely.

TO ACHIEVE THIS WE NEED TO:

» report on the response times as per the indicator
» review daily
» utilise data on high demand times to match our resources
» learn from complaints and incidents relating to response times.

PLAN

» maintain a consistent plan of achieving 75% + of response times for Red 1 and 2 calls and 95% + for Red 19 calls.

Board Sponsor

Sue Byrne
Chief Operating Officer

Implementation Leads

Mark Ainsworth
Operations Director South

Steve West
Operations Director South
PRIORITY 2 - CLINICAL EFFECTIVENESS

c. To improve the responsiveness of consistently identifying and appropriately transferring stroke patients to a hyper-acute unit within 60 minutes.

RATIONALE

Stroke performance has been a SCAS and partner priority for a number of years since “Mending Hearts and Brains” in 2006 where the quality of life and long term health benefits of early thrombolysis were first outlined.

SCAS covers a broad urban and rural geographical area which overlaps with two vascular networks following the breakup of the South Central Cardio Vascular Network. The Wessex and Thames Valley networks cover SCAS with hyper-acute stroke units (HASU) coverage that does not completely cover the SCAS population within 21 minutes to HASU.

The Clinical Networks continue to review pathways and SCAS is ensuring that we have representation at all meetings. There are two clinical networks in our region and SCAS is working with both networks to ensure consistency and ensure the best clinical pathway for our patients.

SCAS performance and data can support and inform the networks on access to stroke units in the future.

Calls to Hyper-Acute Stroke Unit (HASU) within 60 minutes for all FAST+ve stroke patients is still proving to be a challenge and will remain a key focus for improvement.

Our improvements will come from bringing together under a single campaign the ideas and initiatives that led the success of the trauma campaign. This faced similar challenges, in location, early identification, crew support, on scene times and the front end model. These issues lead to a cross departmental, proactive campaign which aim to “Control the Controllable” and define outcome based results.

Work has been undertaken to improve the stroke call to hyper-acute stroke unit times by way of directives that authorise immediate backup if a solo response is sent and escalating if it is identified as a FAST+ve patient.

Team leaders and clinical mentors are encouraged to include stroke and STEMI care performance indicators in the appraisal process. This is to be further developed. Work is underway to issue a new aide memoire to all frontline staff which names all stroke centres, their locations, entry routes and drop off points.
999 call received at EOC
Card 28 stroke identified
19 minute response required DCA if available
AMPDS disposition not card 28
Crew suspect stroke patient on arrival
Take patient to the nearest ED or ASU
Crew verify stroke on arrival FAST+ve
Establish onset of symptoms <4 hrs is BGL >4.0mmol/l
Yes No
Aim to leave scene within 20 minutes
Blue light transfer to nearest HASU
Pre-alert receiving HASU on route
Aim to arrive at HASU within 60 minutes of call time
Transfer under normal road speed
If BGL <4.0mmol/l treat as hypo as per JCALC
If BGL increases to >4.0mmol/l and FAST symptoms persist
If BGL remains <4.0mmol/l after treatment

WHEN STROKE STRIKES, ACT F.A.S.T.

FACE
HAS THEIR FACE FALLEN ON ONE SIDE? CAN THEY SMILE?

ARMS
CAN THEY RAISE BOTH ARMS AND KEEP THEM THERE?

SPEECH
IS THEIR SPEECH SLURRED?

TIME
TO CALL 999 IF YOU SEE ANY SINGLE ONE OF THESE SIGNS

nhs.uk/actfast • stroke.org.uk
### 999 call received at EOC

- Card 28 stroke identified
- Card 28 stroke identified
  - AMPDS disposition not card 28
  - Crew suspect stroke patient on arrival

- Crew verify stroke on arrival FAST+ve

#### Establish onset of symptoms <4 hrs is BGL >4.0mmol/l

- Yes
  - Aim to leave scene within 20 minutes
  - Blue light transfer to nearest HASU
  - Pre-alert receiving HASU on route
  - Aim to arrive at HASU within 60 minutes of call time

- No
  - If BGL <4.0mmol/l treat as hypo as per JCALC
  - If BGL increases to >4.0mmol/l and FAST symptoms persist
  - If BGL remains <4.0mmol/l after treatment
  - Take patient to the nearest ED or ASU
  - Transfer under normal road speed
PRIORITY 2 - CLINICAL EFFECTIVENESS

c. To improve the responsiveness of consistently identifying and appropriately transferring stroke patients to a hyper-acute unit within 60 minutes.

TO ACHIEVE THIS WE NEED TO:

» Work within emergency operations centre (EOC) to increase recognition of stroke patients using the priority dispatch system
» increase resource utilisation plans to prioritise stroke patients in the community
» reissue the stroke Pathway to frontline staff
» develop a campaign approach “FAST means Fast” to include education, review, support and information to develop focus on treatment and time to unit.
» Implement early identification of stroke patients and proactive support, including pre-alert and advising on distance to HASU.
» develop local leadership - (Performance and Patients: One Outcome, One Agenda)
» ensure wider system networking providing information to inform the network

» embrace network and technologies including apps, ePR and capitalising on any changes to pathways. The transition from AMPDS to NHS Pathways will facilitate earlier identification of FAST+ve patients.

PLAN

» reduce on scene times
» map the HASU run times to ascertain if 21 minutes run time is always possible using isochrome data
» plan to increase response time to 59% by December 2014 with a month on month improvement.

Board Sponsor
John Black
Medical Director

Implementation Leads
Rob Kemp
Area Manager
Dave Sherwood
Acting Assistant Director
Operations Directors
PRIORITY 2 - CLINICAL EFFECTIVENESS

d. To ensure patients receive adequate pain relief

RATIONALE

Patients in our care often have pain. SCAS want to ensure adequate and appropriate pain relief is given to all our patients. We know pain is often distressing so want to ensure this does not contribute to poor experience.

TO ACHIEVE THIS WE NEED TO:

» audit and review incidents and complaints relating to poor pain relief
» audit how many patients have appropriate analgesia
» re-educate staff on effective pain management.

PLAN

» audit how many patients have an appropriate pain score recorded (analysed by area)
» this indicator is linked with 2a STEMI care bundle plan.

Board Sponsor
Deirdre Thompson
Director of Patient Care

Implementation Leads
Ed England
Lead Pharmacist
Ian Teague
Head of Education
PRIORITY 3 - PATIENT EXPERIENCE

a. To ensure that all patient complaints and concerns are consistently responded to within a mutually agreed timeframe for all of our services (NHS 111, PTS and 999).

RATIONALE

SCAS is committed to working with service users and their families to help make their experience as positive as it can be. We seek to continuously improve the quality and experience of care for the public we serve. To do this we need to identify learning points from complaints and other feedback to create actions to improve our service provision, but we also need to agree timeframes for responses.

TO ACHIEVE THIS WE NEED TO:

» ensure timeframes are agreed at the point of contact
» work in line with the national complaints requirements
» respond to concerns individually
» listen to patients concerns, and find answers to their queries in an agreed timeframe
» work with patients and the public to make sure their views are used to improve the service

» review, once published, the national complaints policy and apply locally
» monitor by area and service

PLAN

» To achieve and maintain a 95% response rate within 25 days.

Board Sponsor
Deirdre Thompson
Director of Patient Care

Implementation Leads
Liz Rees
Head of Patient Experience
PRIORITY 3 - PATIENT EXPERIENCE

b. To learn from concerns by using ‘face to face / end to end reviews’ with partners and patients and publish the findings and actions to improve our services.

RATIONALE

Patient experience is very important to us and our staff, who strive to deliver high quality care for all whether on the front line, on the telephone, providing routine transport or in a supporting role. While the Patient Experience Team is an excellent way to receive and resolve patient concerns and questions, it cannot capture all the various types of patient feedback that could be available to us.

Dignity and compassion are key themes of the Francis Report, both of which are never more relevant than when dealing with patients. A huge spectrum of emotion and clinical care pathways dictates the wishes of patients and their families and SCAS recognises that being able to offer a unified, comprehensive yet flexible approach for patients is paramount.

TO ACHIEVE THIS WE NEED TO:

» proactively gain feedback from patients who call 999 and NHS 111 in end to end face to face reviews
» use the information to make service changes
» publish findings and themes and any action we take

Board Sponsor

Deirdre Thompson
Director of Patient Care

Implementation Leads

Debbie Marrs
Assistant Director of Quality

Liz Rees
Head of Patient Experience
PRIORITY 3 - PATIENT EXPERIENCE

c. To proactively seek patient feedback through surveying patients to improve our services, including the Friends and Family Test and gaining feedback from harder to reach groups for all of our services.

RATIONALE

SCAS welcomes new initiatives that help us engage with our service users by collecting real time patient experience data, and in April 2013 the launch of the DH’s Friends and Family Test (FFT) question was implemented for acute providers.

We are required to introduce a friends and family test to staff from April 2014 and for patients from 2015. It is important that we ask staff if they feel they could recommend our services and if not, why not.

The FFT test will ask staff and patients one simple question:

“Would you recommend SCAS to a friend or relative?”

It is proposed that responses to this “Friends and Family Test” question will then be published on a locally determined basis.

Publishing this data will allow members of the public to compare healthcare services and clearly identify the best performers from a patient perspective. This aligns to the Francis Report recommendations about listening to patients and other feedback to improve our services.

Patient surveys are an additional way to collect feedback that may not be presented via other routes. SCAS wants to proactively seek patient feedback through surveying patients in harder to reach groups such as mental health sufferers, children, and adolescents.

TO ACHIEVE THIS WE NEED TO:

» carry out our survey plan to include harder to reach groups such as mental health patients
» ensure feedback is acted upon and service improvements made as a result of feedback
» implement further, the friends and family test for 999 patients by conducting end to end reviews
» utilise our staff survey results to improve staff and patient experience
» maintain existing patient survey routes with a minimum of six surveys in 2014/15. [Planned surveys can be seen in the table on the right]
» align FFT response data with local patient experience data to drive improvements in the commissioning and regulatory system
» utilise survey data to inform our quality priorities
**PRIORITY 3 - PATIENT EXPERIENCE**

**c.** To proactively seek patient feedback through surveying patients to improve our services, including the Friends and Family test and gaining feedback from harder to reach groups for all of our services.

- put action plans in place at a local level to implement changes required illustrated by survey responses
- take part in the national ambulance hear and treat survey (CQC)
- publish complaint themes
- use patient stories at Trust Board meetings.

**PLAN**

- Report on FFT results for NHS 111, PTS and FT members surveys
- Conduct leadership and safety walkrounds to ask our staff if they would recommend our service
- Conduct a staff FFT survey quarterly and analyse results
- Aim for 15% + response rate

<table>
<thead>
<tr>
<th>Type of Experience Survey</th>
<th>Type / medium</th>
<th>Date of implementation and committee reported to</th>
<th>Responsible person</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Transport Service (PTS) – including FFT</td>
<td>Postal questionnaire / online</td>
<td>Quarterly reported to Patient Experience Review Group (PERG)</td>
<td>PTS Manager</td>
</tr>
<tr>
<td>Complainant satisfaction</td>
<td>Postal questionnaire</td>
<td>July 2014</td>
<td>Head of Patient Experience</td>
</tr>
<tr>
<td>Harder to reach groups</td>
<td>Telephone questionnaire</td>
<td>November 2014</td>
<td>Clinical Lead - Mental health and learning disabilities</td>
</tr>
<tr>
<td>NHS 111 patient satisfaction Hants / Oxford / Berks / Beds / Bucks – including FFT</td>
<td>Postal questionnaire (including Friends and Family Test)</td>
<td>- Hants quarterly - Oxford monthly - Berks quarterly - Bucks July 2014</td>
<td>Clinical Governance NHS 111 leads</td>
</tr>
<tr>
<td>Foundation Trust Members Survey – including FFT</td>
<td>Postal questionnaire (including Friends and Family Test)</td>
<td>May 2014</td>
<td>Communications</td>
</tr>
<tr>
<td>Front line patient satisfaction – Including FFT</td>
<td>Face to face/ End to end reviews</td>
<td>Quarter 2 and 3</td>
<td>Clinical Team - Corporate</td>
</tr>
<tr>
<td>National Hear and Treat (CQC)</td>
<td>Questionnaire</td>
<td>Report to PERG April 2014</td>
<td>Picker Institute</td>
</tr>
<tr>
<td>National Staff Survey</td>
<td>Online questionnaire</td>
<td>December 2014</td>
<td>Director of HR</td>
</tr>
<tr>
<td>Safety Culture</td>
<td>Online survey</td>
<td>June 2014</td>
<td>Clinical Risk Manager</td>
</tr>
</tbody>
</table>
1

During 2013/14 South Central Ambulance Service NHS Foundation Trust (SCAS) provided and/or sub contracted three relevant services:

» Emergency 999 Ambulance Service
» Non-Emergency Patient Transport Service
» NHS 111 Urgent Telephone Advice Service.

SCAS has reviewed all the data available to it on the quality of care in these three services. Along with qualitative data the Board has sought assurance from a variety of sources:

» Patient surveys
» Public consultation meetings
» Narrative from complaints and feedback and their resolution
» Root cause analysis of incidents and identified leaning
» Internal audit reports
» External reviews of quality
» Leadership walkarounds
» Bi-monthly committee meetings
» Staff meetings.

The income generated by the relevant services reviewed in 2013/14 represents 100% of the total income generated from the provision of relevant services by SCAS for 2013/14.

2

During 2013/14 11 national clinical audits and nil national confidential enquiries covered relevant health services that SCAS provides.

During 2013/14 SCAS participated in 100% national clinical audits and 0% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.
The national clinical audits and national confidential enquiries that SCAS was eligible to participate in during 2013/14 were as follows:

» Acute Myocardial Infarction and other ACS (MINAP)
» National Clinical Performance Indicator - Asthma
» National Clinical Performance Indicator - Hypoglycaemia
» National Clinical Performance Indicator - Febrile Convulsions
» National Clinical Performance Indicator - Below Knee Fractures
» National Ambulance Non-Conveyance Audit
» Ambulance Service Clinical Quality Indicator - Stroke Care Bundle
» Ambulance Service Clinical Quality Indicator - Cardiac Arrest ROSC Rates (and separate witnessed arrest ROSC rates)
» Ambulance Service Clinical Quality Indicator - Cardiac Arrest Survival to Discharge (STD) Rates (and separate witnessed arrest STD rates)
» Ambulance Service Clinical Quality Indicator ST elevation Myocardial Infarction Care Bundle.

The national clinical audits and national confidential enquiries that SCAS participated in during 2013/14 were as follows:

» Acute Myocardial Infarction and other ACS (MINAP)
» National Clinical Performance Indicator - Asthma
» National Clinical Performance Indicator - Hypoglycaemia
» National Clinical Performance Indicator - Febrile Convulsions
» National Clinical Performance Indicator - Below Knee Fractures
» National Ambulance Non-Conveyance Audit
» Ambulance Service Clinical Quality Indicator - Stroke Care Bundle
» Ambulance Service Clinical Quality Indicator - Cardiac Arrest ROSC Rates (and separate witnessed arrest ROSC rates)
» Ambulance Service Clinical Quality Indicator - Cardiac Arrest Survival to Discharge (STD) Rates (and separate witnessed arrest STD rates)
The national clinical audits and national confidential enquiries that SCAS participated in, and for which data collection was completed during 2013/14, are listed here alongside the numbers 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.

<table>
<thead>
<tr>
<th>National clinical audit</th>
<th>Number of cases</th>
<th>% Submitted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Myocardial Infarction and other ACS (MINAP) - entered in to the audit by acute trusts data quality checked by South Central Ambulance Service NHS Trust.</td>
<td>2,275 April to December 13</td>
<td>100%</td>
</tr>
<tr>
<td>National Clinical Performance Indicator - Asthma</td>
<td>528</td>
<td>100%</td>
</tr>
<tr>
<td>National Clinical Performance Indicator - Hypoglycaemia</td>
<td>600</td>
<td>100%</td>
</tr>
<tr>
<td>National Clinical Performance Indicator - Febrile Convulsions</td>
<td>182</td>
<td>100%</td>
</tr>
<tr>
<td>National Clinical Performance Indicator - Below Knee Fractures</td>
<td>163</td>
<td>100%</td>
</tr>
<tr>
<td>National Ambulance Non-Conveyance Audit</td>
<td>1,246</td>
<td>100%</td>
</tr>
<tr>
<td>Ambulance Service Clinical Quality Indicator - Stroke Care Bundle</td>
<td>4,742 April to December 13</td>
<td>100%</td>
</tr>
<tr>
<td>Ambulance Service Clinical Quality Indicator - Cardiac Arrest ROSC Rates (and separate witnessed arrest ROSC rates)</td>
<td>970 April to December 13</td>
<td>100%</td>
</tr>
<tr>
<td>Ambulance Service Clinical Quality Indicator - Cardiac Arrest Survival to Discharge (STD) Rates (and separate witnessed arrest STD rates)</td>
<td>818 April to December 13</td>
<td>100%</td>
</tr>
<tr>
<td>Ambulance Service Clinical Quality Indicator - ST elevation Myocardial Infarction Care Bundle</td>
<td>939 April to December 13</td>
<td>100%</td>
</tr>
<tr>
<td>Ambulance Service Clinical Quality Indicator - Primary Percutaneous Coronary Intervention (pPCI) call to Balloon within 150 minutes</td>
<td>695 as at April 14</td>
<td>100%</td>
</tr>
</tbody>
</table>
The reports of 11 national clinical audits were reviewed by the provider in 2013/14 and the Trust intends to take the following actions to improve the quality of health care provided:

» Ensure quality of data in the changeover to Electronic Patient Records (ePR)
» Implement real time data utilising ePR
» Improve call to depart scene time for stroke patients and early identification of patients affected by stroke
» Continue to reduce the number of delayed responses to patients
» Continue to review the appropriateness of conveyance decisions
» Introduce NHS Pathways to 999

The reports of four local clinical audits were reviewed by the provider in 2013/14 and the Trust intends to take the following actions to improve the quality of health care provided:

<table>
<thead>
<tr>
<th>Audit of</th>
<th>Identified Issues</th>
<th>Actions</th>
</tr>
</thead>
</table>
| Delayed responses | » Call categories inappropriate  
                    » Increase in demand                                                              | » Categories are being reviewed  
                                                                                   » Resources being reviewed against demand |
| Trauma Pathway    | » Trauma unit bypass tool not being used                                         | » Crews use mobile phone app created to encourage use of the tool     |
| Transient Ischemic Attack pathway | » Time taken to fax referral improved but needs further improvement | » Referral is being built into electronic patient record to effect real time referral |
| ACQI data quality | » Improvement needed in identifying patients for inclusion                       | » Multi system review has highlighted new methodologies that are in use to ensure a complete dataset |

The number of patients receiving NHS services provided or sub contracted by SCAS in 2012/13 that were recruited to participate in research, approved by a research ethics committee, was 101 (507 over the trial).

Participation in clinical research demonstrates the Trust’s commitment to improving the quality of care we offer and to making our contribution to wider health improvement. By enabling clinical staff to stay abreast of the latest treatment possibilities, we optimise patient outcomes.
Conference presentations and publications demonstrate our commitment to transparency and desire to improve patient outcomes and experience across the NHS:


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:

► Pre-hospital Randomised Assessment of a Mechanical compression Device In Cardiac arrest (PaRAMeDIC) trial. Warwick University.

► Developing of large multicentre randomised controlled study of adrenaline in pre-hospital cardiac arrest with Warwick University and other ambulance trusts.

► Integration with the new Comprehensive Research Networks (CRN)

► Working with National Ambulance Research Sub Group:
  » to develop a proposal “Widen the Impact of the Ambulance Services Cardiovascular Quality Initiative (ASCQI) project”;
  » to participate in “Understanding variation in rates of ‘non-conveyance to an emergency department’ of emergency ambulance users”.

► to develop a proposal “Exploring factors increasing Paramedics’ Likelihood of initiating Analgesia IN pre-hospital Pain (EXPLAIN)”

► Contributing data to the “Out of Hospital Cardiac Arrest Outcomes” study.

4

A proportion of the Trust’s income in 2013/14 was conditional upon achieving quality improvement and innovation goals agreed between SCAS and the Clinical Commissioning Groups, and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation (CQUIN) payment framework.
CQUINS achievements show that SCAS actively engages in quality improvements that cross the boundaries of our organisation. For this year the goals relate to:

- implementing the staff and patient friends and family test (FFT)
- whole system mental health improvements
- implementation of electronic patient records
- reducing conveyance further
- improving special patient notes

The income from CQUIN in 2013/14 was £2,247,182.

The Trust is required to register with the Care Quality Commission (CQC) and is currently registered without conditions in all essential standards.

The Care Quality Commission has not taken enforcement action against SCAS during 2013/14.

SCAS did not submit records during 2013/14 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The income from CQUIN in 2013/14 was £2,247,182.

The Trust’s Information Governance Assessment Report overall score for 2013/14 was 83% and was graded green from the IGT Grading scheme.

The total for CQUIN related income for 2014/15 is expected to be approximately £2,160,000.

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

South Central Ambulance Service Foundation NHS Trust was not subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission.
The Trust will be taking the following actions to improve data quality:

» Provision of an Integrated Performance Report that outlines all quality, operational and financial data
» Scrutinise and challenge data at all levels within the organisation within the performance management framework
» Timeliness of patient data improvements with ePR
» Ensure alignment and consistency across contract schedules
» Internal clinical audit plan to validate relevant data
» Internal auditors BDO to review clinical data sets
» Regular review by the Clinical Review Group (CRG) of reliability and accuracy of data
» Board assurance framework and corporate risk register to escalate data quality concerns.
PART 3

REVIEW OF 2013/14

In the 2012/13 Quality Accounts SCAS set priorities for 2013/14 which have been reviewed throughout the year and progress is presented in this part of the report.

We still face some challenges in the delivery of the quality agenda but our core values and strategic aims remain aligned with being patient focused and clinically led. It remains important to us to act in a timely manner upon feedback we receive whether it is a concern or compliment. The next part of this report shows the response we made in acting on things you, the public said, and what we did about it.
The following section provides feedback and evidence on the progress of last year’s work on our key quality priorities and our performance attainments. The table below provides an ‘at a glance’ summary of where we believe we have met, partially met or not achieved last year’s indicators.

<table>
<thead>
<tr>
<th>PRIORITY</th>
<th>ACHIEVED</th>
</tr>
</thead>
<tbody>
<tr>
<td>1a. Ensure staff can work in a culture where patient safety is paramount.</td>
<td>PARTIALLY MET</td>
</tr>
<tr>
<td>1b. Ensure patients who contact us after a fall are managed safely and appropriately.</td>
<td>ACHIEVED</td>
</tr>
<tr>
<td>1c. Ensure the regular maintenance of clinical equipment and ensure the cleanliness of vehicles.</td>
<td>ACHIEVED</td>
</tr>
<tr>
<td>1d. To investigate and maximise learning from incidents resulting in severe harm.</td>
<td>ACHIEVED</td>
</tr>
<tr>
<td>2a. Maintain and improve care bundle advancements for patients with stroke. (as above for heart attack)</td>
<td>ACHIEVED</td>
</tr>
<tr>
<td>2b. Reduce the variation of station cleanliness.</td>
<td>ACHIEVED</td>
</tr>
<tr>
<td>2c. Comply with the DH core indicators for Red 1 and Red 2 calls.</td>
<td>ACHIEVED</td>
</tr>
<tr>
<td>2d. Improve the utilisation of Community First Responders (CFR) and other indirect resources.</td>
<td>ACHIEVED</td>
</tr>
<tr>
<td>3a. Utilise feedback from other professionals to improve patient experience.</td>
<td>ACHIEVED</td>
</tr>
<tr>
<td>3b. Use feedback from patient satisfaction surveys to improve service delivery.</td>
<td>ACHIEVED</td>
</tr>
<tr>
<td>3c. Improve the experience our patients have at the end of their life.</td>
<td>ACHIEVED</td>
</tr>
</tbody>
</table>
PRIORITY 1 - PATIENT SAFETY INDICATORS

a. Ensure staff can work in a culture where patient safety is paramount.

OUR AIMS WERE:

» to ensure that our staff work in an environment where patient safety comes first
» to identify the current attitude and culture within SCAS
» to improve the safety culture where necessary
» conducting a recognised staff safety culture audit in 2013/14 using the Manchester Patient Safety Tool.
» creation of action plans based on survey results

We have partially met this indicator as we feel there is still work to do. SCAS did conduct a staff safety culture survey in the reporting year in order to establish the safety culture and will be repeating this survey to identify further actions needed.

A staff survey was designed using the MaPSaF (Manchester Patient Safety Framework). This is a system where an organisation can have its current patient safety culture evaluated by its employees.

It was designed to help the organisation measure staff perception of our current patient safety culture.

We know that the introduction of Datix (electronic reporting system) in July 2013 has received positive feedback from staff. In fact we have seen reporting rise as staff find it an easier tool to use. SCAS is working on categorisation of reported safety incidents and severity of harm in order that transparency and learning are maximised.

An example of a safety improvement can be demonstrated by the trial of the FERNO Pedi-mate (a paediatric transportation system), which will cater for our child passengers between the ages of 1 month (12 lbs) and 5 years (40 lbs) (of age / weight respectively). This ensures a safer transport system by reducing the current practice of the ‘babe in arms’. It will be trialled within SCAS over the next few months after cascade training has been completed.

The risk team is attending and participating in the national benchmarking meetings, which enable experienced and knowledgeable managers to share their expertise and experiences. This is helping to ensure improved patient outcomes and patient experience through greater awareness of patient safety culture.

All of the above is also monitored through senior leader safety walkrounds and feedback.
PRIORITY 1 - PATIENT SAFETY INDICATORS

b. Ensure patients who contact us following a fall are managed safely and appropriately.

OUR AIMS WERE:

» to improve patient safety and experience by identifying high risk (red rated) fallers
» to enable our partner agencies to organise immediate interventions as required
» to measure crew referral rates throughout 2013/14 and improve by 5%.

We have met this indicator.

During 2012/13 patients who had fallen represented up to 18% of the entire 999 call volume. This is a significant part of our workload and it has been identified that at present staff are able to see, treat and discharge approximately 51% of fallen patients, with only 49% requiring hospital treatment. It is our desire to provide the best possible ongoing care for these patients that are non-conveyed, by working in partnership with other services.

The falls pathway allows frontline staff to notify a local community falls team by fax and more recently by telephone whenever a patient falls in their area. These teams can then arrange to visit the patient and assess their needs, putting in place measures to prevent a recurrence.

Ambulance services receive high volumes of calls from patients who fall and the challenge is to ensure they are managed safely and appropriately. In SCAS we attend significant numbers of fallers who are not taken to hospital.

We know that approximately 75% of ‘falls’ patients are medically unwell and have an underlying cause. Ambulance clinicians are the ‘eyes and ears’ in the community setting and have a real opportunity to understand contributing factors behind the fall i.e. the ‘causational factors’.

Understanding the underlying event enables us to better influence the referral, so that the patient gets the correct assessment and care they need.

Using the Red, Amber, Green (RAG) assessment within the referral provides a way of identifying patients that are at risk of repeat events. RAG rating reduces risks for patients and for some, will prevent them from sustaining serious injury and harm, following a further event.

The timeliness of community responses varies across the SCAS region.

A CQUIN on falls referrals improvements and training has resulted in a focused quality improvement initiative in 2013/14, including the introduction of a new falls referral form to ensure consistency across SCAS. Alongside this an e-learning package has been developed.

There are approximately 45 different teams (Rapid Response, CCT, Falls Services) within the SCAS area that respond to falls referrals. This creates risk for some patients, which was supported by staff and patient feedback, informing us that some patients had not received follow up, a call or appointment.
PRIORITY 1 - PATIENT SAFETY INDICATORS

b. Ensure patients who contact us following a fall are managed safely and appropriately.

In light of the above SCAS sought to understand the level of risk for patients who were referred to local providers for assessment and follow up. SCAS asked managers of some services (and their staff) in the different areas what their response times to patients were, once a referral was received.

SCAS contacted a number of teams to understand actual response times to falls referrals. In some cases we spoke to persons directly involved and in other cases it was information provided, from an individual who was not directly involved with assessment, but was aware of local working practices. SCAS therefore redesigned the RAG tool model, to give commissioners local flexibility in the falls pathway and to reduce the risk. Implementation of this pathway has been successful with crews referring 60% of all non-conveyed patients who fell for ongoing care.

SCAS ACTIONS

» We redesigned the Falls Referral and Assessment Tool (FRAT), incorporating the RAG tool into a single document, creating a single process to ensure consistency.
» We added new clinical questions to the routine falls assessment such as the recording of blood pressure, pulse and ECG results (in consultation with other partners).
» Determined RAG triggers for classification
» We issued and reviewed the e-learning package to accommodate local variance in services.
» We are reviewing the e-learning DVD to accommodate local variance.
» Printed and distributed SCAS wide new falls referral forms.
» We communicated changes, benefits and new style falls referral form to all recipient teams and provided supporting information.
**PRIORITY 1 - PATIENT SAFETY INDICATORS**

**c. Ensure the regular maintenance of clinical equipment and ensure the cleanliness of vehicles.**

**OUR AIMS WERE:**

» to ensure that all clinical equipment maintenance schedules are completed within expected time frames
» provide assurance that time scales are being adhered to
» use regular audit and Adenosine Triophosphate Testing (ATP) testing to assess and ensure the cleanliness of vehicles
» achieving 97% compliance with the cleaning plan.

We have met this indicator.

**VEHICLE CLEANLINESS**

Vehicle cleanliness remains a top priority in the fight to reduce healthcare associated infections (HCAI) and ensuring our vehicles are free from harmful bacteria and pathogens.

Vehicle cleanliness audits are carried out in three different ways:

» Crews monitor the cleanliness of the vehicle by visual inspection at the start of, and during their shift
» Each vehicle has a full cleanliness audit twice each year
» Vehicles are now subject to ATP Testing to ensure the cleaning standards are maintained

Adenosine Triphosphate (ATP) testing is now performed on a random 5% of our vehicles annually. Both Frontline and Patient Transport Services are tested. This procedure has been reviewed and percentages adjusted to reduce costs but also maintain a close watch on vehicle cleanliness.

Audit reports are now provided on a daily, weekly and monthly basis to monitor against the 97% cleaning plan. If targets are being missed then discussions are undertaken and a plan developed to address the problems that are identified to bring us back on track.

A 12 week ATP assessment was carried out on two vehicles in Oxford December 2013, to consider a move to a 12-weekly deep clean programme instead of six-weekly deep clean cycle. A comparative ATP assessment was carried out on four random vehicles from other areas of SCAS to ensure the same standard is being achieved.

Following this we have moved to a nine week cleaning schedule.
**PRIORITY 1 - PATIENT SAFETY INDICATORS**

**c.** Ensure the regular maintenance of clinical equipment and ensure the cleanliness of vehicles.

<table>
<thead>
<tr>
<th>MONTH/YEAR</th>
<th>PLANNED MAKE READY</th>
<th>ACTUAL MAKE READY</th>
<th>% MAKE READY</th>
<th>TARGET DEEP CLEAN</th>
<th>ACTUAL DEEP CLEAN</th>
<th>% DEEP CLEAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 2013</td>
<td>7,045</td>
<td>4,695</td>
<td>66.64%</td>
<td>270</td>
<td>192</td>
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<td>April 2013</td>
<td>6,818</td>
<td>4,879</td>
<td>71.56%</td>
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<td>215</td>
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<tr>
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<td>169</td>
<td>62.59%</td>
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<td>4,766</td>
<td>69.90%</td>
<td>270</td>
<td>159</td>
<td>58.89%</td>
</tr>
<tr>
<td>July 2013</td>
<td>7,045</td>
<td>4,997</td>
<td>70.93%</td>
<td>270</td>
<td>196</td>
<td>72.59%</td>
</tr>
<tr>
<td>August 2013</td>
<td>7,045</td>
<td>5,083</td>
<td>72.15%</td>
<td>270</td>
<td>246</td>
<td>91.11%</td>
</tr>
<tr>
<td>September 2013</td>
<td>6,818</td>
<td>4,669</td>
<td>68.48%</td>
<td>270</td>
<td>272</td>
<td>100.74%</td>
</tr>
<tr>
<td>October 2013</td>
<td>7,045</td>
<td>5,264</td>
<td>74.72%</td>
<td>270</td>
<td>269</td>
<td>99.63%</td>
</tr>
<tr>
<td>November 2013</td>
<td>6,818</td>
<td>5,403</td>
<td>79.25%</td>
<td>261</td>
<td>223</td>
<td>85.44%</td>
</tr>
<tr>
<td>December 2013</td>
<td>7,045</td>
<td>5,609</td>
<td>79.62%</td>
<td>261</td>
<td>210</td>
<td>80.46%</td>
</tr>
<tr>
<td>January 2014</td>
<td>5,604</td>
<td>5,502</td>
<td>98.18%</td>
<td>261</td>
<td>270</td>
<td>103.45%</td>
</tr>
<tr>
<td>February 2014</td>
<td>5,056</td>
<td>4,967</td>
<td>98.24%</td>
<td>261</td>
<td>234</td>
<td>89.66%</td>
</tr>
</tbody>
</table>

A regular review with our Make Ready (MR) contract providers has been established with weekly reporting on KPI improvements.

SCAS is working towards an ‘intelligent’ audit system that will request an action plan where failings are found within vehicle cleanliness and infection control equipment/PPE audits (implementation in Q1 2014).

**CLINICAL EQUIPMENT MAINTENANCE**

Our asset register is now comprehensive and a great deal of progress has been made on the tagging of devices with Trust asset labels and with corresponding RFID tags. We are working closely with Churchill Support Services who will be scanning the devices through their Make Ready systems and relaying the information to us.

We are confident that 98% of the critical devices on front-line double crew ambulances (DCAs) and RRVs have been serviced and a database of all equipment that requires servicing / maintenance has been developed which ensures monitoring is undertaken and timescales are adhered to.

A report is produced to identify any equipment outstanding so the appropriate action can be taken.
Currently we are in the process of setting up an equipment asset/database of all of our medical/clinical ‘hard kit’, e.g. defibrillators.

We are now in the process of inviting various companies who will be able to integrate the database with our other systems, to link all the maintenance and servicing records together. We are currently designing a specification to develop a complete maintenance package.

SCAS has delivered all its devices to the mobile field service engineers working for the various service suppliers contracted to SCAS during the 2012/13 fiscal year.

SCAS is about to be a partner in a new national service collaborative designed to keep service costs down, due to start in April 2014 for the airways devices. A new service contract with Physio Control for the Lifepak devices is due to be agreed in 2014.

PRIORITY 1 - PATIENT SAFETY INDICATORS

c. Ensure the regular maintenance of clinical equipment and ensure the cleanliness of vehicles.
PRIORITY 1 - PATIENT SAFETY INDICATORS

d. To investigate and maximise learning from incidents resulting in severe harm.

OUR AIMS WERE:

» to improve patient safety and experience by strengthening the existing investigative processes
» adhere to the duty of candour as outlined in the Francis Report
» increase partnership working for serious incidents with other healthcare providers

We have met this indicator.

SCAS has made significant improvements in learning from incidents. We have reviewed our processes for reporting and the Risk Team is continuing to strengthen its current investigation process by continually monitoring submitted Datix incidents following its successful launch. In Q3 an analysis and review of all categories and sub categories in the Datix system was undertaken to ensure accurate risk reporting.

As members of the Health and Safety and Risk Group, any areas that are discussed or raised as concerns are accordingly addressed. If needed, clinical equipment issues are also raised and actioned within the Equipment & Vehicle Review Group (EVRG).

The Francis Report (2013) ‘Duty of Candour’ states clearly that doctors and all other healthcare professionals must be open and truthful when mistakes have occurred which requires that all incidents that have caused death or severe harm to any patient to be reported as soon as possible. The Trust will maintain its current standard of reporting all incidents that have caused harm or death in our care to the NRLS (National Reporting and Learning System). As a result of Datix, the Trust is capturing in a more timely manner, those incidents reported nationally enabling national benchmarking to be more meaningful.

A new staff learning tool has been launched called SCASCADE to identify incidents where whole organisational learning can take place. This is sent anonymised to all clinical staff.

The Serious Incident Requiring Investigation (SIRI) reporting template and 72 hour report template have been improved to ensure Duty of Candour requirements have been met and deadlines are visible and achieved.
PRIORITY 2 - CLINICAL EFFECTIVENESS

a. Maintain and improve care bundle advancements for patients with stroke and heart attacks.

OUR AIMS WERE:

» to benchmark with other ambulance services as per the DH mandatory indicators and be in the top national quartile

We met this indicator for the stroke care bundle but not fully for the heart attack (STEMI) care bundle.

SCAS was required to report on the mandated indicators on the percentage of care bundles appropriately used for STEMI and stroke patients. However SCAS wanted to go further than reporting numbers and show an improvement.

Other analgesics are being used which would add 6% to the compliance rates but these are not counted in the care bundle. A new interactive training DVD has been devised to ensure staff understand the analgesia to be given to STEMI patients.

<table>
<thead>
<tr>
<th>Clinical Quality Indicator</th>
<th>Units</th>
<th>East Midlands</th>
<th>East of England</th>
<th>Great Western</th>
<th>Isle of Wight</th>
<th>London</th>
<th>North East</th>
</tr>
</thead>
<tbody>
<tr>
<td>STEMI - Care</td>
<td>%</td>
<td>76.0</td>
<td>84.6</td>
<td>-</td>
<td>76.0</td>
<td>76.7</td>
<td>84.5</td>
</tr>
<tr>
<td>Stroke - Care</td>
<td>%</td>
<td>97.3</td>
<td>95.7</td>
<td>-</td>
<td>97.4</td>
<td>94.5</td>
<td>98.0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Clinical Quality Indicator</th>
<th>Units</th>
<th>North West</th>
<th>South Central</th>
<th>South East Coast</th>
<th>South Western</th>
<th>West Midlands</th>
<th>Yorkshire</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td>STEMI - Care</td>
<td>%</td>
<td>86.4</td>
<td><strong>66.0</strong></td>
<td>79.9</td>
<td>89.3</td>
<td>74.9</td>
<td>84.8</td>
<td>80.5</td>
</tr>
<tr>
<td>Stroke - Care</td>
<td>%</td>
<td>99.3</td>
<td><strong>98.2</strong></td>
<td>91.5</td>
<td>97.2</td>
<td>94.1</td>
<td>97.8</td>
<td>96.3</td>
</tr>
</tbody>
</table>
PRIORITY 2 - CLINICAL EFFECTIVENESS

a. Maintain and improve care bundle advancements for patients with stroke and heart attacks.

STROKE CARE BUNDLE

STEMI CARE BUNDLE
PRIORITY 2 - CLINICAL EFFECTIVENESS

a. Maintain and improve care bundle advancements for patients with stroke and heart attacks.

We have continued to drill into data in key priority areas and these have informed action plans with significant challenges aimed at improving care bundle compliance. SCAS has continued high compliance in all other areas of the care bundles with the exception of the above areas.

Current internal initiatives within SCAS to ensure that the indicator targets are met include:

» regular clinical audits of patient report forms (PRFs) to analyse the quality of care provided and care pathway compliance
» an annual clinical audit plan to target key areas
» a focused programme of clinical quality metrics for team leaders and their staff
» successful roll-out of increased analgesia and anti-emetic drug options throughout the Trust

» on-going training in the stroke and heart attack pathways through face to face delivery at bimonthly training sessions and through e-learning.
» work with EOC to improve intelligent dispatch methods
» working with team leaders and clinical mentors to include stroke and STEMI care performance indicators in the appraisal process.

SCAS issued a new aide memoire to all frontline staff which names all PPCI centres, their locations, entry routes and drop off points.
OUR AIMS WERE:

» to reduce the variability of station cleanliness and become fully compliant with CQC Outcome 8 – Infection Control

» ensure 97% compliance with delivery of daily and deep cleaning schedules.

We have met this indicator.

Infection prevention and control across all areas of front line patient contact and care remains a key priority for SCAS and one which we know the public will want to be assured is being monitored and assessed. We focused on our stations to ensure the standards were consistently delivered.

Each month, the stations and stand by points go through an audit process for area cleanliness. These audits measure how the stations and stand by points are performing against Outcome 8 (Regulation 12) of the CQC regulations.

These are monitored through the Clinical Review Group.

The make ready teams have also been asked to review their stock holdings and reduce where possible.

A Trust-wide facilities database of all property floor finishes and room finishes has been completed and transfer of cleaning responsibilities has moved from in-house staff to external contractors, thus ensuring provision of services during periods of annual leave and sickness.

Following a CQC inspection in August 2013 SCAS is fully compliant in the essential standards including Outcome 8 (Infection Control).
Comply with the DH core quality indicators for Red 1 & Red 2 calls.

**RED 1**
% ON SCENE WITHIN 8 MINUTES

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>East Midlands</td>
<td>71.3</td>
<td>71.4</td>
<td>93.8</td>
<td>70.0</td>
<td>75.5</td>
<td>91.9</td>
</tr>
<tr>
<td>East of England</td>
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<td>69.4</td>
<td>92.9</td>
<td>74.2</td>
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<td>93.5</td>
</tr>
<tr>
<td>Great Western</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>75.3</td>
<td>76.9</td>
<td>95.7</td>
</tr>
<tr>
<td>Isle of Wight</td>
<td>80.2</td>
<td>76.1</td>
<td>96.6</td>
<td>78.7</td>
<td>76.6</td>
<td>97.4</td>
</tr>
<tr>
<td>London</td>
<td>77.4</td>
<td>75.3</td>
<td>97.9</td>
<td>77.7</td>
<td>76.3</td>
<td>98.2</td>
</tr>
<tr>
<td>North East</td>
<td>76.9</td>
<td>78.4</td>
<td>96.9</td>
<td>76.6</td>
<td>76.5</td>
<td>97.0</td>
</tr>
<tr>
<td>North West</td>
<td>75.9</td>
<td>77.4</td>
<td>95.8</td>
<td>73.5</td>
<td>76.6</td>
<td>95.1</td>
</tr>
<tr>
<td>South Central</td>
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<td>75.7</td>
<td>95.4</td>
<td>78.2</td>
<td>75.2</td>
<td>95.0</td>
</tr>
<tr>
<td>South East Coast</td>
<td>76.8</td>
<td>73.9</td>
<td>97.0</td>
<td>75.1</td>
<td>75.1</td>
<td>97.3</td>
</tr>
<tr>
<td>South Western</td>
<td>73.1</td>
<td>77.2</td>
<td>95.8</td>
<td>73.0</td>
<td>75.9</td>
<td>95.4</td>
</tr>
<tr>
<td>West Midlands</td>
<td>80.0</td>
<td>73.6</td>
<td>97.0</td>
<td>78.9</td>
<td>75.5</td>
<td>97.3</td>
</tr>
<tr>
<td>Yorkshire</td>
<td>77.4</td>
<td>75.1</td>
<td>97.3</td>
<td>71.7</td>
<td>75.2</td>
<td>97.0</td>
</tr>
<tr>
<td>All</td>
<td>75.6</td>
<td>74.8</td>
<td>96.1</td>
<td>74.0</td>
<td>75.6</td>
<td>96.9</td>
</tr>
</tbody>
</table>
c. Comply with the DH core quality indicators for Red 1 & Red 2 calls.

RED 1 PERFORMANCE

RED 2 PERFORMANCE
**PRIORITY 2 - CLINICAL EFFECTIVENESS**

c. Comply with the DH core quality indicators for Red 1 & Red 2 calls.

**OUR AIMS WERE**

- improve patient experience by increasing the proportion of Red 1 and Red 2 calls responded to without long delays
- to benchmark with other ambulance services as per the DH indicators and be in the top national quartile for Red 1 and Red 2 Calls

We know that patients who call for our help want and often need a rapid response with no delays. Responsive ambulance services are critical for emergency patient outcomes. It remains a key priority for SCAS and one which we know is still very important to the public.

Any delay can present itself as a complaint or incident requiring investigation and using an investigative process can help us understand where and how problems may arise.

Consequently SCAS is currently monitoring long delays on a daily basis using a ‘Red Misses’ report format which demands that all delays have to be accounted for.

This daily monitoring is supported through rigorous root cause analysis at performance management meetings at both area level and director level.
OUR AIMS WERE

» to increase utilisation of Community First Responders (CFRs) and other indirect resources across the Trust to 10% globally.

SCAS already has a network of around 1600 dedicated responders who cover hard to reach areas throughout the Trust area. These volunteers receive initial training and are then aided by six monthly refreshers and drop in sessions to ensure they maintain their knowledge and skill level. During 2013/14 SCAS has worked with CFR teams to ensure their views are listened to and enable improved utilisation of indirect resources.

In 2013/14, 224 schemes across SCAS will have airwave pagers that will cut communication time from the existing process.

The CFR training package has been rewritten and the category of calls that CFR’s can go to has been increased.

There are still some category of calls that will remain unsuitable for CFR responses, these are:

» fire incidents
» known violent incidents (unless a police presence is in attendance)
» industrial incidents involving chemicals or gases
» hangings
» known mental health problems
» road traffic collisions
» maternity and gynaecological incidents.

Recruitment of CFRs is now focused only on areas that require an increase in numbers; however SCAS is still processing over 48 new recruits a month across the Trust and this has resulted in the introduction of additional courses.

Over 30 Public Access Defibrillation (PAD) sites have been identified in the North and nine in the South. North Hampshire has been the primary focus so far.

As part of the assessment of the needs of high demand sites such as nursing and care homes, fusion workshops have been taking place in the South West and awareness and action plans on those with high demand have been encouraging.
PRIORITY 2 - CLINICAL EFFECTIVENESS

d. Improve utilisation of CFR’s and other indirect resources

CFR RESPONDERS

CO-RESPONDERS
PRIORITY 2 - CLINICAL EFFECTIVENESS

d. Improve utilisation of CFRs and other indirect resources

Identified areas for further improvement and actions to date

» Enhanced staff training to improve identification of CFR appropriate calls, maximise allocation and ensure rapid dispatch

» Dedicated Indirect Resources dispatch desk in North and South Emergency Operations Centres to dispatch CFR and Co Responders. This is improving activations and response times for these resources to red calls.

» SCAS is developing an indirect resources scorecard on Qlikview to monitor the performance of the indirect resources. This will provide us with the ability to monitor log on times for each scheme, allocation times, mobilisation times and response times.

» Regular audit of dispatch decisions conducted and supported by weekly performance management meetings at area level. Qlikview will be able to look at dispatch decisions by individual and can be monitored. These will be monitored through meetings between our operational and EOC teams.

» Continued CFR recruitment with a focus on high requirement areas. SCAS reviews all the missed red calls on the EOC daily shift report to identify areas where a CFR scheme would benefit the Trust. Each Community Liaison and Training Officer (CLATO) is aware of the areas requiring improvement in indirect contribution across the area they cover. Consequently they develop recruitment plans to increase numbers of responders in each scheme working with other groups in the community.

» Introduction of Public Access Defibrillation (PAD) sites in rural areas. These sites are logged on our dispatch system and those properties or places that are within a 200m radius are instructed by our control room that a shock box is close by in the event of a cardiac arrest. We will monitor the usage of these units through our regular performance review meetings.

» A program of assessment of the needs of high demand sites such as nursing and care homes.
PRIORITY 3 - PATIENT EXPERIENCE

a. Utilise feedback from other professionals to improve patient experience

OUR AIMS WERE TO:

» improve patient experience by increasing our learning actions from patient feedback collated by other professionals
» establish a link with primary care patient experience teams including those of the NHS 111 service and the Clinical Commissioning Groups
» obtain regular feedback relevant to SCAS and ensure accurate logging of records
» design a systematic process using Datix to aid learning and triangulate with complaints
» monitor Health Care Professional (HCP) feedback and actions through the Patient Experience Review Group (PERG)

We have met this indicator.

The Patient Experience Review Group (PERG) continues to meet quarterly to review all patient feedback and ensure that learning has been put in place and good practice has been shared across the whole organisation.

The complaints module in Datix has been in use since November 2013 with refining work on categories ongoing. HCP feedback is to be used in the module going forward.

An example of an improvement as a result of professional feedback was to improve emergency responses when requested by a doctor. This included reissuing response guidance to EOC staff.

Processes are in place to improve and separate HCP reporting from patient and service user feedback to ensure that learning and good practice is shared with appropriate organisations. This has particularly improved for NHS 111 services with dedicated processes for the governance of HCP feedback.

Procedures for the management of patient experience issues requires regular contact between the SCAS Patient Experience Team and those of other organisations which helps improve relationships and ensure that learning is shared across all organisations. Patients and contacts receive a ‘joined up’ response to their concerns.
PRIORITY 3 - PATIENT EXPERIENCE

a. Utilise feedback from other professionals to improve patient experience

**NHS 111 HEALTH CARE PROFESSIONAL (HCP) FEEDBACK TO IMPROVE SERVICE DELIVERY**

In the NHS 111 services SCAS provide, the HCP feedback process has rapidly improved and developed. In Q3 the creation of a streamlined process to ensure that all HCP feedback and complaints are dealt with in a timely and chronicled manner and lessons identified and learnt going forward has been introduced. This is documented and recognised by the Clinical Assurance Groups (CAG).

Specific examples from NHS 111 HCP feedback to improve the service and change practice are outlined:

» Themes from HCP feedback and incidents have been used to identify specialist speakers for the clinical development sessions (pharmacy, toxbase, social services).

» Following feedback from the NHS 111 Clinical Governance Lead in Oxfordshire, MENCAP’s guidelines for accessible writing ‘Am I making myself clear?’ was made available to all investigating managers and patient liaison personnel.

» Following investigation into a Buckinghamshire dental incident, the regional dental commissioners raised concerns over NHS Pathways; SCAS facilitated a face to face meeting with the regional dental commissioners to explore NHS Pathways solo, and this provided assurance to regional dental commissioners.

» HCP feedback has also resulted in SCAS feedback to the national NHS Pathways teams via requests for change.

» The SCAS Education Department is initiating inclusion of elements of learning related to trends from complaints within regular update training as a thread for good practice.

» The safety walkaround programme was introduced as part of the Quality Assurance Programme for NHS 111 to ensure quality is embedded in our values, behaviours and strategic themes. This was initiated by a senior clinical colleague in the NHS 111 service to allow for transparent practice and assurance.
PRIORITY 3 - PATIENT EXPERIENCE

a. Utilise feedback from other professionals to improve patient experience.

THE AIM OF THE WALKAROUND IS TO:

- INCREASE THE AWARENESS OF QUALITY AND SAFETY ISSUES AMONG ALL STAFF

- MAKE SURE SAFETY REMAINS A PRIORITY FOR SENIOR LEADERS

- INCREASE UNDERSTANDING OF SERVICE USER SAFETY CONCEPTS SUCH AS INCIDENT REPORTING

- ACT ON INFORMATION THAT IDENTIFIES AREAS FOR IMPROVEMENT

- BUILD RELATIONSHIPS WITH FRONTLINE STAFF

- ACT AS A CLINICAL FRIEND
OUR AIMS WERE TO:

» improve patient experience through analysis and action plans formed using established patient surveys and the new Friends and Family test question.

We have met this indicator.

A yearly plan of satisfaction surveys is generated and updated as the year develops to ensure that new initiatives and contracts are surveyed; outcomes of satisfaction surveys are a routine item on the agenda of PERG.

In December 2013 a survey was undertaken to elicit the experience of patients over 65 years old with a view to extracting any themes from dementia/carer perspectives.

The results demonstrate that the majority of callers were very satisfied with the care and treatment they received from SCAS.

Crews were perceived to be polite and considerate, and good at communicating.

100% of people questioned would be happy to use the ambulance service again.

As a result of this survey SCAS will take the following steps:

» Increasing education on dementia and communication skills to EOC staff.

» SCAS has also surveyed patients using NHS 111 services with satisfaction levels reported between 78% and 91.5%.

» Action plans from surveys are shared with commissioners taking into account local needs.

» The Head of Patient Experience is now attending the Foundation Trust members’ panel to listen to and act on feedback.

» SCAS has submitted data to the Picker Institute in December 2013 to participate in the trial CQC national ambulance Hear and Treat survey.

FRIENDS AND FAMILY TEST (FFT)

Surveys have been adapted to ensure that national guidelines are being followed in how the Friends and Family Test (FFT) test is applied and delivered.

It can be challenging for emergency ambulance services to initiate real time surveys, which is the ideal for FFT; however some have taken place with patients within the ED, NHS 111 and PTS. PTS is particularly effective at collecting FFT data and the outcomes are being monitored by PERG; these surveys are being further developed. NHS 111 Hants, Berks and Oxford services have all contained a FFT question in 2013.

Data from patient experience surveys is included in the performance report at Board level.
PRIORITY 3 - PATIENT EXPERIENCE

c. Improve the experience our patients have at the end of their life.

OUR AIMS WERE TO:

» ensure that all patients that contact SCAS when nearing the end of their life receive care that is specifically tailored to their needs.

We have met this indicator.

SCAS has maintained its approach to ensure that all patients that contact SCAS when nearing the end of their life, receive care that is specifically tailored to their needs.

Through ongoing training SCAS staff (which includes PTS, CSD, NHS 111 and EOC) are given the correct tools to ensure that high quality care is delivered to patients nearing the end of their life and that their families receive the appropriate support.

Engagement with local steering groups ensures that SCAS maintains its presence in the locality to support the groups and offer input where required.

SCAS is fully committed to investigate any adverse incidents relating to End of Life Care (EoLC) and Unified Do Not Attempt Cardiopulmonary Resuscitation (uDNACPR) and to extract and disseminate its findings for organisational learning. Currently a learning resource pack is being developed to allow staff to have a greater understanding of EoLC and uDNACPR to enable them to deliver the correct care at the time of need.
# PERFORMANCE OF TRUST AGAINST MANDATED QUALITY METRICS

## SAFETY MEASURES

<table>
<thead>
<tr>
<th></th>
<th>2009/10</th>
<th>2010/11</th>
<th>2011/12</th>
<th>2012/13</th>
<th>2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infection Control Training (% of all frontline staff)</td>
<td>76.35</td>
<td>100</td>
<td>63</td>
<td>60</td>
<td>60</td>
</tr>
<tr>
<td>Infection control audits – of target set 30 month</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
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<table>
<thead>
<tr>
<th></th>
<th>2009/10</th>
<th>2010/11</th>
<th>2011/12</th>
<th>2012/13</th>
<th>2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adverse Incidents total reported</td>
<td>2,091</td>
<td>2,654</td>
<td>2,819</td>
<td>2,685</td>
<td>3,489</td>
</tr>
<tr>
<td>NPSA (patient safety incidents)</td>
<td>80</td>
<td>291</td>
<td>218</td>
<td>260</td>
<td>740</td>
</tr>
<tr>
<td>RIDDOR</td>
<td>96</td>
<td>97</td>
<td>126</td>
<td>53</td>
<td>80</td>
</tr>
<tr>
<td>Serious Incidents Requiring Investigation</td>
<td>29</td>
<td>21</td>
<td>17</td>
<td>23</td>
<td>16</td>
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</table>

<table>
<thead>
<tr>
<th></th>
<th>2009/10</th>
<th>2010/11</th>
<th>2011/12</th>
<th>2012/13</th>
<th>2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complaints</td>
<td>144</td>
<td>121</td>
<td>169</td>
<td>209</td>
<td>382</td>
</tr>
<tr>
<td>Feedback / concerns</td>
<td>790</td>
<td>666</td>
<td>554</td>
<td>604</td>
<td>708</td>
</tr>
<tr>
<td>Compliments</td>
<td>682</td>
<td>667</td>
<td>758</td>
<td>695</td>
<td>883</td>
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</tbody>
</table>

*The clinical outcome measures in Table 4 have been revised and amended from previously published Quality Accounts back to 2009/10 and recalculated using the care bundle analyses method so each year can be measured more accurately against the previous year. All cells in white are National Clinical Performance Indicators (NCPI); all cells in blue are Ambulance Clinical Quality indicators (ACQI).

NCPIs are twice yearly audits and published as ambulance national benchmarking; the figure is based on the average care bundle score for the two audits. The ACQI’s are published monthly to the Department of Health as performance measures as care bundles so the figure is the average over the 12 months, except 2013/14 as the figures are submitted 3 months in arrears; this is 9 months averaged to December 2013.
<table>
<thead>
<tr>
<th>Clinical Outcome Measures Reported Aspect of Care</th>
<th>2008/09 %</th>
<th>2009/10* %</th>
<th>2010/11 %</th>
<th>2011/12 %</th>
<th>2012/13 %</th>
<th>2013/14 %</th>
<th>National Average 2013/14 %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stroke</td>
<td>84.84</td>
<td>91.42</td>
<td>96.70</td>
<td>97.10</td>
<td>97.64</td>
<td>98.70</td>
<td>96.30</td>
</tr>
<tr>
<td>STEMI</td>
<td>55.71</td>
<td>35.84</td>
<td>58.15</td>
<td>65.60</td>
<td>67.88</td>
<td>66.75</td>
<td>80.50</td>
</tr>
<tr>
<td>Cardiac Arrest</td>
<td>44.11</td>
<td>18.58</td>
<td>26.30</td>
<td>21.90</td>
<td>36.03</td>
<td>39.80</td>
<td>26.00</td>
</tr>
<tr>
<td>Asthma</td>
<td>74.40</td>
<td>40.90</td>
<td>62.85</td>
<td>73.20</td>
<td>75.20</td>
<td>83.30</td>
<td>77.50</td>
</tr>
<tr>
<td>Hypoglycaemia</td>
<td>97.24</td>
<td>96.30</td>
<td>95.80</td>
<td>98.35</td>
<td>98.20</td>
<td>98.67</td>
<td>95.90</td>
</tr>
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</table>

### National targets and regulatory requirements standard

<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Red 1 &amp; 2 - life threatening emergency calls who should receive an emergency response within 8 minutes</td>
<td>75%</td>
<td>72.60%</td>
<td>74.80%</td>
<td>77.5%</td>
<td>75.9%</td>
<td>76%</td>
<td>77.4%</td>
</tr>
<tr>
<td>Red 1 &amp; 2 - life threatening emergency calls which require a fully equipped vehicle that should receive a response within 19 minutes</td>
<td>95%</td>
<td>94.40%</td>
<td>92.70%</td>
<td>95.3%</td>
<td>95.3%</td>
<td>95.5%</td>
<td>95.4%</td>
</tr>
<tr>
<td>Category B19 Non threatening but serious cases which must receive a response within 19 minutes ** Note that SCAS has met the local commissioned target</td>
<td>95%</td>
<td>88%</td>
<td>88.30%</td>
<td>91.4%</td>
<td>90.8%</td>
<td>90%</td>
<td>95.4%</td>
</tr>
<tr>
<td>Reperfusion - Primary angioplasty (PCI) Call to balloon **</td>
<td>75% in 150 minutes</td>
<td>92%</td>
<td>91.4%</td>
<td>91%</td>
<td>89.2%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
OTHER QUALITY SUCCESSES IN 2013/14

The next section of this report highlights other successes in quality improvement which SCAS has made to improve the quality of our services to patients.

» SCAS has updated the Emergency Care Assistant (ECA) course in relation to Mental Health and Learning Disability learning outcomes to reflect pertinent issues at relevant places within the curriculum (e.g. teaching about feeding tubes when considering abdominal complaints).

» Clinical update course on suicide assessment delivered including a recap of the Mental Capacity Act (MCA).

» We introduced a new process for collecting and auditing alternative care pathways for mental health. Identifying actions to better access pathways of care for this patient group.

» Patient satisfaction survey of those people who are over 65 years of age. Actions will include improving education on dementia and communication with a bespoke MH session for call centre staff.

» SCAS is working closely with our GP commissioning groups to ensure that advanced care plans, end of life instructions and other patient care relevant data is shared in a timely manner and kept constantly updated. This information is accessible by our emergency and urgent call handlers allowing them to tailor the advice and level of response provided to a patient based on what is most appropriate to them.

» Use of computer technologies including tablet computers on our frontline resources also provides SCAS with media through which clinicians can access software applications (apps) that provide care summaries and quick reference guides for complex pathways including End of Life and Mental Health. These apps will also be accessible through the personal devices that many staff members choose to carry.

» SCAS rolled out an e-learning module together with dexamethasone for the management of croup.

» We introduced activated charcoal for the immediate treatment of poisoning.

» Introduced an oral antihistamine for the treatment of less severe allergic reactions.

» SCAS reviewed and provided an increased range of medicines on the air ambulances for the treatment of critically ill patients.

» We have revised our bereavement leaflet for patients families and carers.
» SCAS delivered training to all frontline staff in safeguarding adults and children.

» We recruited additional resource in the form of a clinical support officer for safeguarding.

» Safeguarding referrals for both children and adults have increased. Children have increased by 94% from last year. Adult referrals have increased by 191% from last year, indicating good staff awareness.

» The introduction of a pilot in South West Hampshire of safeguarding champions at ambulance stations. This is to be rolled out over the whole Trust in the next six months.

» SCAS involvement in peer reviews with other ambulance trusts for Infection Control and Safeguarding.

» Implemented an information sharing protocol with Fire and Rescue services across SCAS to ensure patient safety.

» SCAS has increased its engagement with social services resulting in improved feedback following our safeguarding referrals.

» Construction of new SCAS safeguarding form and development of an electronic version for EOC and NHS 111.

» SCAS successfully tendered for the new NHS 111 non-emergency telephone helpline service in Buckinghamshire and Bedfordshire and Luton.

» SCAS has launched a new intranet in 2014 making it easier for staff to access necessary information.

» SCAS has continued its executive and non-executive leadership walkabout; which are a structured review of clinical areas and resource centres combining quality reviews with infection control, cleanliness and information governance requirements. This process also acts as an opportunity for staff to discuss practice issues with the executives.

» Our Integrated Performance Report is robustly monitored and challenged in terms of quality performance indicators.

» We have rolled out a new electronic reporting tool for incidents and accidents called Datix.

» SCAS has introduced a monthly education and feedback tool called SCASCADE to ensure organisational learning from incidents.

» We have trained some of our resilience and specialist operations/HART staff to become certified instructors in breathing apparatus.

» HART inland water training to Level 3 to ensure safety of our patients.
A letter was sent to all Health Overview and Scrutiny Panels, Healthwatch and commissioners in February 2014 outlining our progress with our Quality Accounts and the proposed priorities for 2014/15 which asked for any comments or suggestions. The following statements were received:

HEALTHWATCH WOKINGHAM BOROUGH

22 April 2014

Healthwatch Wokingham Borough commends SCAS for such a detailed and open Quality Account. It is especially encouraging to see how you have responded to Francis Inquiry recommendations.

With regards Priority 3a it would be good to have some benchmark timeframes when dealing with complaints.

With regards Priority 3b to further enhance your commitment to patient engagement and involvement it would be good if you could formally incorporate some independent feedback of your services. Healthwatch would welcome an opportunity to regularly share the data and intelligence we have on SCAS services. Whilst you can only have so many priorities to focus on we would have expected to have seen a statement about ambulance turnaround times as this issue has been prominent the last year or so.

Kind regards

Nicola Strudley
Locality Manager
Healthwatch Wokingham Borough
SCAS Draft Quality Accounts - comment

Thank you for inviting comment from the Wokingham Borough Council Health Overview and Scrutiny Committee on the Trust’s 2013/14 quality account. Members have individually reviewed the Trust’s Draft Annual Quality Report 2013-14 and noted the proposed priorities for 2014/15.

The marking of all sections which reference the Francis Inquiry and its recommendations with a clear symbol so that they are easily identified as a response or action, is welcomed.

Regards

Madeleine Shopland

Principal Democratic Services Officer
Governance and Improvement Services
Wokingham Borough Council
HEALTHWATCH READING

5 May 2014

Thank you for your request to comment on the Quality Accounts for SCAS. Please see below comments from Healthwatch Reading. Apologies that these did not reach you yesterday.

Thank you for the opportunity to comment on the Quality Account for 2013/14.

It is comprehensive although at this stage not fully complete with further data to be added. We were pleased to read about the effective new structure to be put in place from 1 April 2014 and supportive of the strategic aims of the Trust in particular those where appropriate that put the patient first.

Safeguarding is also another important area for all trusts and commissioning groups and reference is made to the appointment of a clinical support officer to concentrate support within the trust. It is also important that the Trust demonstrates how this service will interrelate to similar services provided by the local authorities and other services to demonstrate joint working in this area.

Finally the Trust is an important contributor to the Urgent Care Programme Board led by North and West Reading CCG and more comment about how effective these arrangements are would be welcomed.

Also please can you add me to your distribution list as the contact for Healthwatch Reading. These accounts were received via a forward from a colleague and these are the first draft we have seen.

If you have any questions about any comments please do not hesitate to contact me.

Many thanks
Mandeep
HEALTHWATCH MILTON KEYNES

9th May 2014

The following is the response that I have been asked to forward to you following your consultation on the above Quality Accounts.

“We welcome the opportunity to comment on the SCAS Annual Quality Accounts.

The document contains a considerable amount of information and we believe that the report reflects a positive attitude to service provision.

The Trust covers a wide geographical area meaning that performance at a Milton Keynes level is not clearly defined in the report. Unfortunately this makes informed judgement impossible about whether the standards are being achieved for our resident population.

We would like to point out that some targets are unspecific such as “mutually agreed timeframes” for complaints. We believe that more specific targets can be developed to ensure measurable and continuous improvements are achieved by the Trust.

To date complaints about the emergency services have not been a feature of feedback to Healthwatch Milton Keynes, but there are some local concerns about non urgent patient transport. This largely relates to the fact that potential users are not clear about the availability of this transport or the criteria that are applied to enable people to access these services. We believe that better and more informative communication with the public would alleviate this situation.

A small point relates to the need to update “Statements from Local Involvement Networks” which should be altered to reflect the fact that this now refers to “Healthwatch” - final section of the report.

We are pleased to have involvement in the Buckinghamshire Patient Forum and look forward to acting as a “critical friend” to the Trust as it works to improve working practices”.

Many thanks for consulting with us.

Yours sincerely

Rachel Lewis
Support Team Manager

On behalf of Healthwatch Milton Keynes Management Group
STATEMENTS FROM HEALTHWATCH, THE OVERVIEW AND SCRUTINY PANELS AND COMMISSIONERS

HEALTH AND ADULT SOCIAL CARE SELECT COMMITTEE (MILTON KEYNES) QUALITY ACCOUNTS PANEL REPORT

8 May 2014

The Panel felt that the Quality Account presented by SCAS was a big improvement on previous years. However, even as a draft report, the Panel considered that too much information was missing and there was no explanation of the gaps or who was responsible for completing them.

SCAS covers a large area and the Panel felt that the use of average data across the region was not particularly helpful. It was difficult to identify any particular issues in local areas and the use of average data could be used to hide a poor performance in a particular locality.

The information in the Quality Account dealt with the organisation as a whole and once again the Panel commented on the lack of a local focus and felt that this must be an issue for all the local authorities in the SCAS region which had been asked to comment on the Quality Account. The Panel would like to see a short (4 sides of A4) appendix specifically relating to the work being done and progress made for each of the local authority areas in the SCAS region.

However, the Panel was not aware of any significant problems with the ambulance service provided by SCAS in Milton Keynes. Representatives of the Milton Keynes Hospital NHS Foundation Trust who were attending the meeting were able to give the Panel first-hand feedback on SCAS. They considered that they had a good relationship with SCAS and that at present there were no issues with either the emergency or non-emergency ambulance service in Milton Keynes. SCAS crews now alerted the hospital with an estimated time of arrival, which hospital staff were finding particularly helpful.

The representatives of the Milton Keynes Community Health Service commented that the SCAS response to 999 calls, and where appropriate linking to community health services, was very good and they had no complaints either.

The Panel was pleased to note the year on year improvements to the SCAS Quality Account and complimented SCAS on making the Account increasingly more accessible to the general reader.
HEALTHWATCH BRACKNELL FOREST

Quality Account Statement South Central Ambulance Service

Healthwatch Bracknell Forest collects both positive and negative feedback/concerns from their population. We also receive data from East Berkshire’s quality committee. As a result of information received Healthwatch Bracknell Forest reviewed all complaints received by SCAS and are confident that there are no patterns for the complaints and no major areas which need to be improved.

Healthwatch Bracknell Forest work with three acute trusts in the area and some feedback has indicated an increase in ambulance arrivals at Accident & Emergency departments. We will be undertaking work to see if there is a correlation with the current 111 service delivery model and, if so, if this is a positive or negative outcome.

Healthwatch Bracknell Forest have agreed to work with SCAS, where appropriate, to improve the patient experience.
STATEMENTS FROM HEALTHWATCH, THE OVERVIEW AND SCRUTINY PANELS AND COMMISSIONERS

COMMISSIONER STATEMENT

Fareham & Gosport Clinical Commissioning Group and the Associate Commissioners welcomed the opportunity to participate in the governance “sign off” process for the 2013/14 Quality Account of South Central Ambulance Service NHS Foundation Trust (SCAS) for 999 Services.

Commissioners have continued to have a positive and inclusive working relationship with SCAS since the authorisation of Clinical Commissioning Groups in April 2013. SCAS works consistently with all partners in an open and receptive manner. They are further developing the priorities for future quality improvement through the recognition of the need for a collaborative approach across the whole health system.

With advancements of IT solutions, including the introduction of an electronic patient record, and the commitment to improve data quality, commissioners anticipate that information exchange will accelerate the pace in which sustainable service improvements can be made for our population.

The quality account demonstrates the revised internal governance structure. This reflects the assurance processes for quality review and improvement. This year, SCAS has developed the governance structures which underpin the subcontracting arrangements with private providers and has continued to strengthen this.

This account rightly recognises the role of the “independent” voice in quality processes and includes details of the external assurance mechanisms, illustrating how the public view is incorporated into priority setting and monitoring the delivery of quality improvements. For example, through the trust’s annual survey programme and “Friends and Family Test” implementation, the public has an opportunity to feed in their views. Ensuring that all staff are actively engaged in this process is also being supported by the commitment to embed a safety and listening culture across all levels of the organisation. An example of this is the introduction of “SCASCADE”, an informative bulletin to all staff sharing lessons learnt from incidents and feedback and the utilisation of an electronic based tool to record all patient safety incidents.
Commissioners recognise the value of senior leadership and accountability in this process and are pleased to see that “quality improvement” is stated as a core function of the trust’s board. The trust has also committed, for 2014/15, to fully implement the duty of candour requirements by including patient safety incidents which result in moderate as well as severe harm.

Commissioners welcome that SCAS continue to develop their strategic aims, structures and priorities taking into account the recommendations from key national quality reviews, such as Keogh, Berwick and Francis. In addition Commissioners were pleased to hear about the trust’s unconditional registration from the Care Quality Commission and full compliance with the assessed quality outcomes.

This assurance may be further strengthened in the quality account by including outcomes from other external assessments. For example, commissioners are aware that the trust has received the recommendations from the safeguarding peer review.

A statement within the quality account highlighting the progress made with implementation of the recommendations and the outstanding actions would have been welcomed.

The phased introduction of a common clinically based assessment tool (NHS Pathways), aims to enable seamless transfer of calls between the 999 and 111 telephone operation centres. With the reported increased demand on SCAS 999 services, it will be essential that the open and collaborative relationship between commissioners and SCAS is maintained, to jointly address challenges of transition, quality, capacity and efficiency.

Report Structure

The quality account provides information across the three elements of quality. These are:

» Patient safety
» Patient experience
» Clinical effectiveness.

The account incorporates the mandated elements required and SCAS has used a variety of quality intelligence and external consultations with stakeholders to support the development of the quality priorities for 2014/15. External assurance mechanisms have also featured in the assessment of the quality position to date, for example audits. In future accounts, more extensive use of benchmarking data will enhance the presentation of quality information.
Quality Improvement Priorities for 2014/15

SCAS has outlined its priorities for 2014/15 and commissioners support the process the trust has used to identify these and in principle, the priorities chosen. However, some priorities are those which are mandated, for example response times to calls, and it will be good to see how the stretch in quality improvement is driven across the organisation in the coming year.

Patient Safety

Commissioners welcome the focus on ensuring that decisions to keep patients at home and not convey to hospital, are safe and appropriate. This is an essential safety priority and will support caring for people in the most appropriate place. This will rely on having access to a variety of services and a commitment to work with other health partners.

In addition, commissioners are aware of the real challenge, and potential quality concerns, arising when people wait too long for an emergency response. This includes calls generated from the public and health care professionals.

It is essential that the needs of patients are met in a timely manner across the whole geographical area, irrespective of rural or urban demographics and that the resource despatched is aligned with the clinical need of the patient.

It would have been good to set a measure around this to provide public assurance that “very long waits” are being eliminated. Commissioners are committed to work with SCAS to support the quality initiatives to improve safety and patient experience. SCAS has set an ambition to reduce, by 10%, incidents which cause moderate and severe harm to patients.

Commissioners support this and will work with the trust to ensure that lessons learnt from incident analysis are fed into demonstrable service improvements. It would be good to review performance against other ambulance providers in future reports.

Commissioners will also monitor the progress of improving medicines management within the service. A welcome addition would have been reference to any continued commitment to supporting the safeguarding agenda and the inter-agency work needed to strengthen this service. The progression of these priorities will obviously be dependent on ensuring the appropriately skilled workforce to meet patient needs and it is welcomed that SCAS will ensure that safety reviews include analysis of staffing issues.
One further area of consideration is promoting safety for the more vulnerable groups of our population, for example patients with mental health needs. Commissioners will be working with the trust to support improvements.

Clinical Effectiveness

SCAS has set a priority for improvement on performance for two care bundles, both of which are mandatory elements.

Commissioners support this, although it is noted that compliance with the stroke care bundle is already in the top performance bracket. It is recognised that improvements are required for the ST Elevated Myocardial Infarction (STEMI) care bundle, primarily around pain management. In this respect, it is good to see this as a priority. Both care bundles were highlighted as priorities for 2013/2014.

Again, the priority for reporting emergency response times is mandated, and for this year, SCAS commit to learning from complaints and incidents in relation to response times. A recognised area of under-performance has been in the identification and timely response to stroke patients. Commissioners support this quality priority and are aware of the work programmes in place to support sustainable improvements. Commissioners will review the delivery of the improvement trajectories and work in partnership with SCAS to enable better outcomes for patients. The trust may wish to consider setting specific in year milestones and targets for improvement in this area. In addition, commissioners are aware that the “Return of Spontaneous Circulation” following cardiac arrest performance data is currently being reviewed.

Patient Experience

Commissioners have committed to incentivise the further utilisation of the “Friends and Family Test” for both patients who are using the 999 service and the staff working for the service. It is essential that patient and staff satisfaction are interlinked in any analysis and work programmes.

SCAS quite rightly, has acknowledged that they need to sustain improvements in responding to complaints and have linked the Francis recommendations into their aspiration for complaints management. It will be useful to see within the next quality account, the service improvements which have been made, especially in relation to key themes, such as “staff attitude.” SCAS set a commitment to learn from concerns from both patients and partners in health care. It is anticipated that staff will also proactively feed into this intelligence.
STATEMENTS FROM HEALTHWATCH, THE OVERVIEW AND SCRUTINY PANELS AND COMMISSIONERS

We look forward to receiving assurance through improved patient and staff reported experience. Commissioners support the focus on “seldom heard groups”, which is essential in providing an equitable service for the population.

Achievements reported against 2013/14 priorities and overall Quality Performance

Achievements against objectives and targets in 2013/14 are outlined in Part 3 of the account. SCAS provide a chart demonstrating where they consider the priorities have been achieved or partially met. It would be good to have cross referenced where the same priorities have been set for 2014/15. Commissioners support the assessment of “partially met” for staff culture. The survey was used with a small number of staff and SCAS are committed to extend this to other staff groups.

In addition, it would have been useful to reflect the outcomes of the survey in this account. Excellent progress has been made in improving the care management for patients who have fallen and SCAS will continue to work with other health partners to sustain this and address challenges of timely responses to referrals. The priority set for equipment maintenance and vehicle cleanliness has provided some good outcomes. However, in spite of regular audits, compliance with the cleaning plan appears variable. We understand that SCAS has strengthened their monitoring with their “make ready” teams.

SCAS has indicated that they have met the priority to maximise learning from severe harm incidents. Commissioners consider this a fair statement and have seen progress in the quality of data reported from Datix (an electronic storage and analysis system for quality data).

This is an ongoing area for improvement.

SCAS has also complied with duty of candour requirements for severe harm incidents and will include moderate harm incidents in the forthcoming year. Future quality accounts, may be strengthened by providing a summary of the analysis undertaken on patient safety incidents and evidence of clinical practice changes made.

SCAS has reported organisational compliance for meeting the national targets on Department of Health core response times and this position is welcomed.

However, performance does show variation and it would be good to see how delays differ in urban and rural areas and the challenges and actions to eliminate delays across these geographical areas.
Further information on long waits in respect of call outs from health care professionals and the range of waiting times would also be useful. It will be good to see continued robust management of this alongside the monitoring of patient outcomes and experience as a result of delays.

The target of improving utilisation of community first responders was set at 10%. However we are unclear, from the quality account, whether the threshold has been consistently met.

The patient experience priorities for 2013/14 are reported as being achieved. Examples are given of how feedback from health care professionals have also been used to support service changes and it would now be advantageous for SCAS to consider how this can be consistent across 999, 111 and patient transport services.

Examples are also given on how feedback on dementia care has led to education programmes for staff. The information contained in the quality account, as evidence for improving end of life care provision, does provide some assurance that the processes put in place have enhanced staff awareness.

Mandatory data is given around performance against national targets and regulatory requirements. However, from the quality account version reviewed, more data presented at CCG level would have been beneficial. It would also be helpful to include compliance levels for mandatory training. SCAS reference the Commissioning for Quality (CQUIN) incentive schemes and although detail on achievement is not included, a web link is given.

Data Quality

SCAS quite rightly commit to ongoing improvements in data quality. This will be enhanced by the implementation of the electronic patient record and integrated IT systems. We have seen improvements in data analysis for incidents and agree with SCAS that further improvements are still required.

Clinical Audit and Research

The clinical audit section details that SCAS report they have participated in 100% of eligible national clinical audits and that zero national confidential enquiries were applicable. The data contribution to these audits is shown at 100%.

Commissioners have used national data sets to verify the numbers presented in the quality account and, where any variance exists, this has been communicated to SCAS.
Commissioner Assessment Summary

This account demonstrates the many positive outcomes which continue to be driven through the quality agenda and collaborative working. The open and transparent working ethos of SCAS is welcomed.

We would like to see quality indicators presented through benchmarking, where possible, and continued work to improve data quality and analysis. It was good to see the outcomes of the priorities identified in 2013/14, which may have been further strengthened with quantifiable trajectories.

Commissioners recognise some key challenges in the forthcoming year and will welcome secure governance processes to ensure the safe transition to NHS Pathways and electronic patient records and improved performance for stroke patients and patients who are experiencing long waits. SCAS has identified the more vulnerable patient in their quality priorities and it would be good to have seen greater focus on patients with mental health issues. Likewise it would be good to have included the commitment to support improvements in the safeguarding agenda.

Commissioners welcome the opportunity to continue the good work with SCAS as a health care partner for the benefit of our population.

Richard Samuel
Chief Officer

Fareham & Gosport and South Eastern Hampshire Clinical Commissioning Groups
SOUTH CENTRAL AMBULANCE SERVICE
COUNCIL OF GOVERNORS

The Chairman stated that the Trust was looking for the input of governors on the proposed priorities for 2014/15 across the categories of patient safety, clinical effectiveness and patient experience. Comments were received as follows:

» Patient safety – it was felt that, in the delivery of these priorities, the Trust needed to focus on recruiting more community first responders in rural areas (e.g. West Oxfordshire)
» Clinical effectiveness – it was noted two of the four priorities were mandated and that the Trust were likely to add adequate pain relief as a further priority based on the feedback received
» Patient experience – the Council highlighted the importance of gaining patient feedback on the experience of using telephone-based advisory services (e.g. NHS 111) and also of ensuring that the SCAScade system was not used to the extent of burdening staff with too much information.

Finally, it was agreed that governors would feed any further thoughts on the proposed quality account priorities for 2014/15 to the Company Secretary, and that a discussion would be held at the next meeting on how the governors could contribute to the delivery of the priorities.
STATEMENT OF DIRECTORS’ RESPONSIBILITIES IN RESPECT OF THE QUALITY REPORT

Directors’ responsibilities in respect of the Quality Report as outlined in the NHS Foundation Trust Annual Reporting Manual 2013/14 (Monitor).

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.

Monitor 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 2013/14
» 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 2013 to March 2014
  › papers relating to quality reported to the board over the period April 2013 to March 2014
  › feedback from the commissioners dated 7 May 2014
  › feedback from governors dated 24 March 2014
  › feedback from Local Healthwatch organisations dated April 2014 - May 2014
  › the Trust’s complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 2 May 2014;
  › the national patient survey - not applicable
  › the national staff survey dated November 2013
  › the Head of Internal Audit’s annual opinion over the Trust’s control environment dated 28 May 2014
  › CQC quality and risk profiles dated April 2013 to March 2014
» 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; and the Quality Report has been prepared in accordance with Monitor’s annual reporting guidance (which incorporates the Quality Accounts regulations) (published at www.monitor.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor.gov.uk/annualreportingmanual).

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

NB: sign and date in any colour ink except black

Trevor Jones  Chairman
Date: 28 May 2014

Will Hancock  Chief Executive
Date: 28 May 2014
INDEPENDENT AUDITOR’S REPORT TO THE COUNCIL OF GOVERNORS OF SOUTH CENTRAL AMBULANCE SERVICE NHS FOUNDATION TRUST

We have been engaged by the Council of Governors of South Central Ambulance Service NHS Foundation Trust to perform an independent assurance engagement in respect of South Central Ambulance Service NHS Foundation Trust’s Quality Report for the year ended 31 March 2014 (the “Quality Report”) and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2014 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

» 1) category A call – emergency response within eight minutes; and

» 2) category A call – ambulance vehicle arrives within 19 minutes.

We refer to these national priority indicators collectively as the “indicators”.

Respective responsibilities of the Directors and auditors

The Directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the NHS Foundation Trust Annual Reporting Manual issued by Monitor.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

» the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual;

» the Quality Report is not consistent in all material respects with the sources - specified in the Detailed Guidance for External Assurance on Quality Reports; and.

» the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Detailed Guidance for External Assurance on Quality Reports.

We read the Quality Report and consider whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual, and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with:

» Board minutes for the period April 2013 to March 2014;
QUALITY REPORT

We permit the disclosure of this report within the Annual Report for the year ended 31 March 2014, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and South Central Ambulance Service NHS Foundation Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Papers relating to Quality reported to the Board over the period April 2013 to March 2014;
Feedback from the Commissioners dated May 2014;
Feedback from local Healthwatch organisations dated May 2014;
The Trust’s complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, 2013/14;
The 2013/14 national staff survey;
CQC quality and risk profiles dated 2013/14; and
The 2013/14 Head of Internal Audit’s annual opinion over the Trust’s control environment.

Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Council of Governors of South Central Ambulance Service NHS Foundation Trust as a body, to assist the Council of Governors in reporting South Central Ambulance Service NHS Foundation Trust’s quality agenda, performance and activities.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively, the “documents”).
Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – ‘Assurance Engagements other than Audits or Reviews of Historical Financial Information’ issued by the International Auditing and Assurance Standards Board (‘ISAE 3000’). Our limited assurance procedures included:

» Evaluating the design and implementation of the key processes and controls for managing and reporting the indicators.

» Making enquiries of management.

» Testing key management controls.

» Limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation.

» Comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the Quality Report.

» Reading the documents.

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time.

It is important to read the Quality Report in the context of the criteria set out in the NHS Foundation Trust Annual Reporting Manual.

The scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by South Central Ambulance Service NHS Foundation Trust.
Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2014:

» the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual;

» the Quality Report is not consistent in all material respects with the sources specified above; and

» the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual.

KPMG LLP
Chartered Accountants
100 Temple Street
Bristol
BS1 6AG

29 May 2014
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INVITATION TO FEEDBACK ON THE QUALITY ACCOUNT

PLEASE TELL US WHAT YOU THOUGHT OF THIS REPORT:

☒ Did you find it useful?
☒ Did the report tell you what you wanted to know?
☒ Do you agree with our priorities for 2014/15?
☒ Is there anything else you would like to see included in future reports?

Please tell us by contacting SCAS in the following ways:

EMAIL: patientexperience@scas.nhs.uk

PHONE: 01869 365159

POST:
Debbie Marrs
Assistant Director of Quality
South Central Ambulance Service
7 & 8 Talisman Business Centre
Talisman Road
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OX26 6HR