Contents

Introduction ........................................................................................................................................... 2
Welcome to the South Western Ambulance Service NHS Foundation Trust ........................................... 2
What is the Quality Account and what does it mean to our Patients ...................................................... 4
A Patient Story - Cathy Thanks Lifesavers After Her Heart Stopped Beating ....................................... 5
Care Quality Commission (CQC) ........................................................................................................... 7
Freedom to Speak Up and Whistleblowing .............................................................................................. 8
Quality Account - Part 1 ......................................................................................................................... 10
Statement on quality from the Chief Executive of the NHS foundation trust ............................................. 10
Part 2 - Priorities for improvement and statements of assurance from the board ...................................... 12
Priorities for Improvement ..................................................................................................................... 12
Quality Priorities for Improvement 2018/19 .......................................................................................... 12
Quality Priorities for Improvement 2019/20 .......................................................................................... 17
Statements of assurance from the board ................................................................................................. 22
Learning from Deaths ........................................................................................................................... 25
Reporting against core indicators ......................................................................................................... 26
Part 3 – Other Information ..................................................................................................................... 27
Overview of Quality of Care 2018-19 ..................................................................................................... 27
Clinical Effectiveness ............................................................................................................................. 27
Patient Safety ......................................................................................................................................... 29
Patient Experience ................................................................................................................................. 31
Performance Indicators ........................................................................................................................ 36
Ambulance Response Indicators ........................................................................................................... 36
Stroke 60 Minutes .................................................................................................................................. 37
Return of spontaneous circulation (ROSC) ............................................................................................. 37
Annex 1: Statements from commissioners, local Healthwatch organisations and overview and scrutiny committees .......................................................................................................................... 38
Clinical Commissioning Groups ............................................................................................................ 38
Health Overview & Scrutiny Committees ............................................................................................... 43
Healthwatch ........................................................................................................................................... 45
Other ..................................................................................................................................................... 50
Annex 2: Statement of directors’ responsibilities for the quality report .................................................. 53
Glossary of Terms and Acronyms ......................................................................................................... 55
Introduction

Welcome to the South Western Ambulance Service NHS Foundation Trust

We provide a wide range of emergency and urgent care services across a fifth of England covering Cornwall and the Isles of Scilly, Devon, Dorset, Somerset, Gloucestershire, Wiltshire and the former Avon area.

Our operational area, covering 10,000 square miles, is predominantly rural, but includes large urban areas such as Bristol, Plymouth, Exeter, Bath, Swindon, Gloucester, Bournemouth and Poole. SWASFT is the primary provider of 999 services across the South West.

We also provide Urgent Care Services across Dorset. The Trust employs more than 4,000 staff and we have 96 ambulance stations, three clinical control rooms, six air ambulance bases and two Hazardous Area Response Teams (HART).

The Trust serves a total population of over 5.5 million and is estimated to receive an influx of over 23 million visitors each year. The operational area is predominantly rural but also includes large urban centres including Bristol, Plymouth, Exeter, Bath, Swindon, Gloucester, Bournemouth and Poole.
South Western Ambulance Service NHS Foundation Trust (SWASFT) provides the following services.

**Emergency ambulance 999 services (A&E)**

Medical emergencies happen at all times of the day and night. SWASFT operates a 24-hour clinical response to 999 calls to ensure patients receive the right care as quickly as possible – wherever and whenever they need it.

**Urgent Care Services (UCS)**

The centre, at Tiverton and District Hospital, Kennedy Way, Tiverton, is open seven days a week between 8am and 10pm and is staffed by a team of highly qualified general practitioners (GPs) and nurse practitioners. You do not need an appointment to visit the centre and we will provide treatment for a host of minor injuries and ailments.

**GP out-of-hours medical care (Dorset)**

On behalf of GPs in Dorset SWASFT ran the Out-of-Hours doctor service across the county until 31st March 2019, when the contract ended. The Out-of-Hours telephone number covers all patients registered with a doctor’s surgery in Dorset and is a service run by dedicated staff including doctors, paramedics, nurses, control assistants, dispatchers and drivers.

**NHS 111 call-handling for Dorset**

NHS 111 is designed to make it easier for you to access local NHS healthcare services. You can dial 111 when you need medical help fast but it is not a 999 emergency. NHS 111 is a fast and easy way to get the right help, whatever the time.

NHS 111 is available 24-hours-a-day, 365 days a year. Calls are free from landlines and mobile phones.

**Air Ambulance**

The Trust provides the clinical teams for six air ambulances (two in Devon, one in Cornwall and the Isles of Scilly, one shared across Dorset and Somerset, one in Wiltshire and one based near Bristol).
What is the Quality Account and what does it mean to our Patients

The Quality Account is a report about the quality of services offered by an NHS healthcare provider, in this case the South Western Ambulance Service Foundation Trust.

The reports are published annually by each provider, including the independent sector, and are available to the public.

Quality Accounts are an important way for local NHS services to report on quality and show improvements in the services they deliver to local communities and stakeholders.

The quality of the services is measured by looking at patient safety, the effectiveness of treatments patients receive, and patient feedback about the care provided.

The Quality Account provides our patients and the public with examples of the improvement work that teams are delivering across the organization, and demonstrates that the Trust always aims to deliver high quality, safe, cost-effective and sustainable healthcare services that meet the high standards that our patients deserve.
A Patient Story - Cathy Thanks Lifesavers After Her Heart Stopped Beating

Cathy Angell went into cardiac arrest at Ashdown Riding Centre near Wootton Bassett, Swindon during her six-year-old son’s lesson in April 2018.

The 35-year-old lost consciousness, stopped breathing, and her skin went blue.

SWASFT responders used a defibrillator to administer electronic shocks in an effort to restart her heart. Cathy was taken to hospital where she was given emergency heart surgery.

Cathy, who lives locally, returned to the riding centre on Thursday 21 March to thank those who kept her alive. She has no memory of the incident.

Cathy said: “If it wasn’t for all these people, my husband would no longer have a wife and my son wouldn’t have a mum. I cannot express how grateful I am to them all.”

Cathy had no pre-existing medical conditions. She said she is still trying to come to terms with what happened.

She said: “I was a fit and healthy 35-year-old who woke up in intensive care to find out my heart had stopped beating.

“Oh. Although I don’t know why it happened to me, I’m fortunate it happened with people around me who were able to help.”
Paul Murphy, who was the first SWASFT Paramedic to treat Cathy, said: “Unfortunately a cardiac arrest can happen to anyone, of any age, and at any time.

“Cathy is not the stereotypical person to suffer this condition. Many are elderly or suffer with known heart problems, but Cathy was young and healthy.

“Cathy survived because people recognised that she wasn’t breathing effectively, and called 999. They followed instructions from the call handler to do CPR, which they continued to do even after the volunteer responder and crews had arrived. Cathy was given defibrillation at the earliest opportunity, and taken onto hospital where doctors continued her care.

“Cathy is living proof that people can and do survive cardiac arrests, if they are given the right treatment and the right time. It is hugely humbling to be a part of a team that achieves such an amazing outcome for a patient.”

If you suspect someone is having a heart attack or cardiac arrest: call 999 immediately, begin CPR, and use a public access defibrillator if one is available.

**Heart attack and cardiac arrest key facts:**

A heart attack is a serious medical emergency in which the supply of blood to the heart is suddenly blocked, usually by a blood clot.

A cardiac arrest is an urgent medical emergency when the heart suddenly stops pumping blood round the body. The brain is starved of oxygen, causing the person to fall unconscious and stop breathing.

If you think someone is having a heart attack or cardiac arrest: call 999 immediately, begin CPR, and use a public access defibrillator if one is available.

Around 30,000 people are treated for cardiac arrests in the UK every year. Just 9% survive, but their chances increase significantly when CPR and defibrillation is administered early.

For more information on SWASFT First Aid courses, including CPR training, visit: https://firstaid.swast.nhs.uk/. If you have a specific query: call 0300 369 0350 or email firstaid.training@swast.nhs.uk
Care Quality Commission (CQC)

The Trust maintains its registration with the CQC with no conditions and is proactive in ensuring compliance with CQC regulations through the maintenance of a centralised evidence system and a CQC Compliance Team.

In May 2018, the Trust’s NHS 111 service was inspected and rated as ‘Good’ with all five domains of Safe, Effective, Caring, Responsive and Well-Led all rated as ‘Good’.

<table>
<thead>
<tr>
<th>CQC Domain</th>
<th>May 2018 rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safe</td>
<td>Good</td>
</tr>
<tr>
<td>Effective</td>
<td>Good</td>
</tr>
<tr>
<td>Caring</td>
<td>Good</td>
</tr>
<tr>
<td>Responsive</td>
<td>Good</td>
</tr>
<tr>
<td>Well Led</td>
<td>Good</td>
</tr>
<tr>
<td>OVERALL</td>
<td>Good</td>
</tr>
</tbody>
</table>

The Trust underwent its second comprehensive CQC inspection under the new inspection regime of the Trust in June and July 2018. The Trust’s core services of Emergency and Urgent Care (A&E 999) and Emergency Operations Centres (EOCs or Clinical Hubs) were inspected as part of this inspection. The Trust was awarded an overall rating of ‘Good’ following this inspection. The following table details the breakdown of CQC rating:

<table>
<thead>
<tr>
<th></th>
<th>SAFE</th>
<th>EFFECTIVE</th>
<th>CARING</th>
<th>RESPONSIVE</th>
<th>WELL LED</th>
<th>OVERALL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency and Urgent Care (A&amp;E 999)</td>
<td>Requires Improvement</td>
<td>Requires Improvement</td>
<td>Outstanding</td>
<td>Good</td>
<td>Requires Improvement</td>
<td>Requires Improvement</td>
</tr>
<tr>
<td>Emergency Operations Centre (Clinical Hubs)</td>
<td>Good</td>
<td>Good</td>
<td>Outstanding</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
</tr>
<tr>
<td>Urgent and Emergency Care (Tiverton Urgent Care Centre)</td>
<td>Requires Improvement</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
</tr>
<tr>
<td>Resilience</td>
<td>Outstanding</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Outstanding</td>
<td>Outstanding</td>
</tr>
<tr>
<td>Out of Hours (Dorset)</td>
<td>Requires Improvement</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
</tr>
<tr>
<td>OVERALL</td>
<td>Requires Improvement</td>
<td>Good</td>
<td>Outstanding</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
</tr>
</tbody>
</table>
All of the CQC reports following inspections of the Trust are available at:
https://www.cqc.org.uk/provider/RYF

The Trust was pleased that the CQC recognised the care and compassion that staff demonstrate every day when treating patients in its rating of ‘Outstanding’ of the Caring domain. The Trust is also incredibly proud of the improvements made to the Effective and Well-Led domains since the CQC’s last inspection in June 2016.

Each year, the Trust develops a Quality Assurance Plan (QAP) which seeks to address ‘Must Do’ and ‘Should Do’ actions given to us by the CQC and to further embed quality across the organisation. Must Do and Should Do actions can be found on pages 9 to 12 of the Trust’s most recent CQC report. This plan builds on the learning and recommendations from CQC inspections, feedback from staff and the input of Executive Directors. Reporting and accountability for this plan is through the Trust’s Quality Committee.

**Freedom to Speak Up and Whistleblowing**

**What is freedom to speak up?**

We know that sometimes our staff can find it difficult to speak up about issues affecting patient safety or staff experience. They may not know who to speak up to. They may feel that anything they do raise might not be taken seriously, or that nothing will be done as a result.

It is really important that everyone understands and feels confident to raise concerns while at work and know that those concerns will be listened to and supported to raise them.

Every NHS trust and Foundation trust in England has a Freedom to Speak Up Guardian and last year they handled over 6,700 cases brought to them by NHS workers

**How can our staff raise their concerns?**

In many circumstances the easiest way for our staff to raise any concerns is through their line manager, however where they do not feel that this is appropriate there are several other options that any members of staff can take. These include our:

- **Freedom to Speak up Guardian** - Acts as an independent and impartial source of advice to employees at any stage of raising a concern

- **Peer Support Guardians** – Enabling local peer level support and those individuals who have also been trained in order to provide an impartial source of advice to employees at any stage of raising a concern

- **Freedom to Speak Up Champions** – Members of our HR Business Partner Team
If the staff members still remains concerned they are able to contact our:

**Executive Director** with responsibility for whistleblowing

**Non-Executive Director** with responsibility for whistleblowing

**Raising your concern with an outside body**

Alternatively, any staff member can raise their concerns outside the organisation with:

- NHS Improvement for concerns about:
  - NHS trusts and foundation trusts are being run
  - providers with an NHS provider licence
  - NHS procurement, choice and competition
  - the national tariff

- Care Quality Commission for quality and safety concerns

- NHS England for concerns about:
  - primary medical services (general practice)
  - primary dental services
  - primary ophthalmic services
  - local pharmaceutical services

- Health Education England for education and training in the NHS

- NHS Protect for concerns about fraud and corruption.

**How can our staff remain confident and feel safe about speaking up**

If a member of staff raises a genuine concern, they will not be at risk of losing their job or suffering any form of reprisal as a result. We will not tolerate the harassment or victimisation of anyone raising a concern. Nor will we tolerate any attempt to bully them into not raising any such concern. Any such behavior is a breach of our values as an organisation and, if upheld following investigation, could result in disciplinary action.

Provided that the staff member is acting honestly, it does not matter if you are mistaken or if there is an innocent explanation for your concerns.

We hope that our staff will feel comfortable raising their concerns openly, but we also appreciate that they may want to raise it confidentially and therefore, we will keep their identity confidential, if that is what they want, unless we are required to disclose it by law (for example, by the police).

**How do we communicate with our staff during the process?**

The Trust is committed to treating all staff with respect at all times and will thank them for raising any concerns. They will discuss their concerns to ensure that we understand exactly what they are worried about. We will advise them about how long we expect the investigation to take and keep them up to date with its progress. Wherever possible, we will share the full investigation report with the staff member (while respecting the confidentiality of others).
Quality Account - Part 1

Statement on quality from the Chief Executive of the NHS foundation trust

Welcome to the Quality Account and Report for 2018/19, I am delighted to be presenting this report to you. The Quality Account and Report sets out the progress we have made in the delivery of safe and high quality care. It also identifies the challenges and opportunities the Trust has faced during the year in providing the best possible care to the people of the South West and the communities we serve. The Report also looks forward to the year ahead and the improvements in quality we plan to make over the coming year.

The Trust continues to strive to deliver excellent patient care despite the many challenges that the Trust and the NHS face. The Trust has been instrumental in supporting local STP plans for Urgent and Emergency Care as well as ensuring that we focus on the Trust priorities for improving the quality of urgent and emergency care. Our staff are at the heart of the organisation and in delivering our strategic goals of Every Patient Matters, Every Staff Member Matters and Every Pound Matters it is our duty to create a culture in which they are supported to deliver compassionate high quality care and where they feel supported to raise concerns when things go wrong.

The new National Ambulance Response Programme targets ensure that the response times for the most unwell patients are improved and that every patient receives the most appropriate response for their needs. Delivery of high quality, safe, compassionate and responsive care to all patients is at the heart of our approach to care and this is achieved by ensuring that our clinicians are supported in the workplace through a culture of inclusivity, support and development.

We remain at the forefront of the delivery of innovative urgent and emergency care and I am extremely proud of our staff and the utmost dedication and professionalism that they demonstrate at all times. In the face of increasing demand and, due to the high levels of competency and skill of our staff, the Trust remains the best Ambulance Service in the country for reducing inappropriate conveyance of patients to Emergency Departments. This not only ensures that people are able to receive more appropriate care closer to home it also supports the local health and social care systems reducing the long term impact of inappropriate hospital admissions. We continue to work in partnership with the other Emergency Services and local Health and Social Care partners in the delivery of excellence and we would like to thank them for their continued support for us.

The Trust is committed to improving the experience of people using our services and we have continued to focus on learning and improvement as a result of the feedback from patients and staff and through learning from Patient Safety issues. The Trust continues lead and participate in significant programmes of research supporting Quality Improvement and, looking ahead to 2019/20, we will look to expand the programme for Quality Improvement engaging with frontline staff in the development of this.
We have focused within the Quality Priorities for this year on improving the effectiveness of our approach to the triage of calls and to the experience of people using our service who have mental health needs. Finally we developed ‘always events’ - those aspects of the care experience that should always happen when patients access care. For 2019/20 we will focus further on improvements in responding to patients who have suffered from a cardiac arrest, continue the implementation of Always Events and develop and implement a process for the undertaking of Mortality Reviews to enable us to learn from deaths.

At the center of the provision of high quality care are our staff and the Board and I are committed to improving their health and wellbeing. During difficult and challenging times I am humbled by the commitment and compassion of our staff in caring for patients and I am immensely proud of the care they provide.

I look forward to the year ahead and I confirm that to the best of my knowledge, the information in this quality report is accurate and reflects a balanced view of the Trust, its achievements and future ambitions.

Ken Wenman
Chief Executive
23 May 2019
Part 2 - Priorities for improvement and statements of assurance from the board

Priorities for Improvement

This section of the quality report describes areas for improvement in the quality of relevant health services that the South Western Ambulance NHS Foundation Trust intends to provide or subcontract in 2019/20.

Quality Priorities for Improvement 2018/19

Clinical Effectiveness

Clinical Effectiveness of Triage within the Clinical Hubs

Why a Priority?
The Trust has played a key role in the development of the new response framework within the Ambulance Response Programme. The new approach has enabled the most appropriate resources to be focused on patients experiencing life-threatening and life-changing incidents.

When a 999 call is made to the ambulance service, a computer driven support system (MPDS) is used to prompt the call taker to ask a set of questions. The questions aim to establish the general presenting complaint and therefore determine the most appropriate response time for each incident. In an increasing number of cases, the call can be resolved over the telephone, through a discussion with an ambulance clinician, a process known as ‘hear and treat’.

With a finite number of ambulance resources available to send to incidents, it is vitally important that the response priority determined by the MPDS triage system reflects the actual severity of condition found when an ambulance response is sent. The Trust has developed a data tool which links how emergency 999 calls are initially triaged in the Clinical Hub, with the clinical data collected from every patient who is assessed by an ambulance clinician through the electronic care system (ECS). The tool examines a wide range of factors to calculate a score for each patient that represents how severely ill or injured they are. This allows the average severity of patients within each MPDS category to be calculated.

Aim

The Trust will use the tool to further refine the effectiveness of clinical triage within the Clinical Hubs, in order to improve the appropriateness of the response that patient’s receive.

Did we achieve this priority?

Yes, the following initiatives were undertaken:

The Trust used the risk stratification tool to identify a list of MPDS codes which could be managed without sending an ambulance response. The governance process required to develop the initial codes and the actual telephone process to the point where they could be implemented was
extensive, with a number of iterations being considered. Following final approval from the Board of Directors, the process will be launched on the 23/04/2019 and known as Enhanced Hear and Treat. The implementation of a variable Dispatch Code Referencing table was considered to enable enhanced hear and treat only during periods of extreme demand. However, given the safety profile of the codes, it is being implemented at all times. Therefore, it was recognised that there was no need for a variable DCR table.

The Trust implemented a Special Operations Desk to improve the utilisation of specialist resources such as critical care, HART and BASICS, together with volunteer responders. The risk stratification tool was used to develop a code set to target the dispatch of HART resources.

**Actions to be carried forward to 2019/20**

The Enhanced Hear and Treat process will be implemented during the first quarter of 2019/20. An evaluation plan for this process has been developed and will be utilised to evaluate its impact.

**Board Sponsor**
Dr Andy Smith, Executive Medical Director

**Implementation Lead**
James Wenman, Deputy Head of Operations, Clinical Hubs
Sarah Black, Head of Audit, Research and Quality Improvement

**Patient Experience**
Experiences of Mental Health Patients Using the 999 Service

**Why a Priority?**

It is recognised nationally that a proactive approach to involving patients and service users to identify what matters to them and what they would expect to happen during contact with the health service can be used to improve the safety of patients and their experience of the NHS.

The experiences of Mental Health patients using the 999 service is complex, not least because gathering feedback from patients during a mental health crisis can be further detrimental to their overall well-being. Nevertheless, the increasing use of patients with mental health difficulties of the 999 service, calls for an in-depth look at their experience of the service.

The Trust is committed to the parity of esteem and to delivering services that support the management of crisis, whether this arises from a physical or mental ill health episode. Co-production of service developments is essential if we are to fully appreciate the difficulties patients experience and to incorporate fundamental learning into every day clinical practice.

In order to ensure the work is carried out in a both effective and sensitive manner, the Trust will be seeking advice and support from gatekeepers, these will be specialist mental health organisations and peer group networks. Stakeholder organisations, such as Healthwatch, will also be consulted. If deemed appropriate, a series of focus groups will take place in order to understand the experience of people with a mental health issue who use 999 services. This will form part of the overall evidence.
Aim

To better understand the experience of Mental Health patients using the 999 service and to incorporate that learning into service development.

Did we achieve this priority?

Yes, we undertook the following initiatives:

We developed a team of staff members happy to support the work carried out on this priority from two directorates, ensuring correct governance and clinical oversight. A list of mental health charities and organisations in the South West region was collated by the team and an engagement programme was developed.

The engagement plan offered an opportunity for us to gather feedback from patients and members of the public. A questionnaire was developed and disseminated to members of the public and stakeholders with the aim of gathering feedback regarding the experiences of patients when calling 999 during a mental health crisis or difficulty. Over 140 responses were recorded from across the South West of England. The results from the questionnaires were collated and arranged into three overall themes: Emotional Needs, Competence and Training, and Choices and Alternatives. To expand on the questionnaire feedback a stakeholder and service users focus group was set up in association with Devon Partnership Trust. The feedback from the focus group focused on the importance of ensuring patients emotional needs are met; it was recognised that a failure to do so is likely to lead to the patient’s condition worsening and a more complicated treatment pathway. The feedback from the questionnaire and focus group will inform the Trust’s Mental Health action plan going forward in 2019/20.

The engagement plan with patients and stakeholders allowed us to open up a conversation around mental health internally and externally. A number of leaflets were disseminated at our events alongside stakeholder leaflets offering support and guidance when a person is experiencing mental health difficulties. We continue to be aware of the sensitive and emotional nature associated with patient’s lived experiences and the retelling of their stories.

In addition to this we have supported early intervention thought more appropriate conveyance. Many areas are creating alternatives to ED conveyance, mostly in the form of crisis cafes. They provide early intervention and often third sector support to individuals who are approaching crisis. We are continuing to work with local stakeholders and networks to ensure patients accessing support through 999 are included in the conversation.

A Mental Health Nurse Specialist pilot scheme was run in our North Clinical Hub. This allowed specialist mental health support to be offered to staff and patients during peak hours. The scheme has been extended and will continue through 2019/20 whist a review of its effectiveness is conducted.

We continue to work collaboratively with local stakeholders to ensure the best possible care if being offered to our patients.

Actions be carried forward to 2019/20

We will continue to look at staff training options and collate the feedback from the Mental Health Nurse Specialist pilot as part of an ongoing action plan. We will ensure the feedback from the
questionnaire and focus group remains an essential part of the Mental Health Action Plan 2019/20.

Board Sponsor
Jennifer Winslade

Implementation Lead
Sharifa Hashem, Patient Engagement Manager

Patient Safety
Development and Implementation of Always Events

Why a Priority?

The majority of work undertaken by the Trust to improve patient safety and experience has been driven as a result of patient and staff feedback in terms of receipt of complaints and incident reports.

It is recognised nationally that a proactive approach involving patients and service users to identify what matters to them and what they would expect to happen during contact with the health service can be used to improve the safety of patients and their experience of the NHS. This can be done by developing a series of Always Events.

Always Events, initially conceived in the US by the Picker Institute and now led by the Institute for Healthcare Improvement (IHI), are defined as those aspects of the care experience that should always occur when patients, their family members or other care partners, and service users interact with health care professionals and the health care delivery system. The Always Events approach is to accelerate improvement efforts to enhance experiences of care for patients, their family members or other care partners, and service users – the goal is for patients and service users to have an “Always Experience.” The creation of Always Events is a methodology for achieving this goal.

A key aspect of Always Events is that patients, their care partners, and service users have identified the event as fundamental to improving the experience of care. A fundamental principle in co-designing Always Events is to move from “doing for patients” to “doing with patients” (co-designing). This Quality Priority therefore focuses on proactive engagement.

The Always Events programme has four distinct phases:

1. Set up and Oversight;
2. Co-designing and testing;
3. Reliably Implementing;
4. Sustaining and Spreading.

It was anticipated that the Quality Priority for 2018/19 would focus on the first three phases with the Sustaining and Spreading phase being progressed during 2019/20 following evaluation of the implementation of Always Events within the identified patient group.

Aim

To develop Always Events for a specific patient group to enhance the delivery of care.
Did we achieve this priority?

Partially. The Always Events programme is operated over 2 years, this priority will continue throughout 2019/20. During 2018/19 we undertook the following initiatives:

The Trust’s Patient Safety Manager, Patient Engagement Manager and Patient Experience Manager attended an Always Events workshop to understand the approach and individual phases to co-designing Always Events. This was supported by regular coaching sessions with the National Always Events team.

An oversight team was established comprising of the Trust’s Continuous Improvement Group and sponsored by the Executive Director of Nursing and Quality. Following consultation it was identified that the group of patients which the Trust would focus on the Always Events project to on was those at End of Life. An opportunity was identified to work on this project alongside the MacMillan Cancer Care Team who provided support with engagement and liaison with the patient group.

Following consultation an Always Events engagement plan was developed in liaison with the MacMillan Cancer Care team. This included the most appropriate method of communicating with End of Life patients which was informed by hospices in the Trust’s area. Leaflets and posters have been carefully designed for dissemination in hospices requesting feedback from patients, their families and carers.

The oversight team established an engagement method of 1:1 interviews and two set questions for a semi-structured interview process. A list was collated of all hospices in the South West and contacts were established to scope the potential for the project to go forward. From a list of 23 hospices, 5 have agreed to collaborate on this work stream and we are now in the process of forming the correct governance to go forward with the project whilst ensuring patient’s safety, confidentiality and welfare remain a priority. The method of this was decided upon following consultation with hospices.

Weekly catch up meetings have been arranged internally, whilst monthly external coaching meetings with the National Always Events team have been attended to ensure learning is taking place in a co-design fashion.

Actions to be carried forward into 2019/20

It has been agreed that this quality priority will continue into 2019/20 with the full implementation of the engagement plan which will include interviews with patients, their families and carers. Always Events will then be co-designed and tested using Quality Improvement Methodology.

Board Sponsor
Jenny Winslade, Executive Director of Nursing and Quality

Implementation Lead
Sharifa Hashem, Patient Engagement Manager
Quality Priorities for Improvement 2019/20

Following consultation, the following quality priorities for improvement 2019/20 have been agreed:

**Patient Safety**
- Development and Implementation of Mortality Reviews

**Patient Experience**
- Implementation of Always Events (End of Life Care)

**Clinical Effectiveness**
- Cardiac Arrest

**Patient Safety**

Development and implementation of Mortality Reviews

**Why is this a priority?**

In 2016 the Care Quality Commission published their report ‘Learning, candour and accountability: A review of the way NHS Trusts review and investigate the deaths of patients in England’ which made specific recommendations predominantly focusing on maximising learning from deaths. This led to the National Quality Board (NQB) releasing ‘National Guidance on Learning From Deaths’ in March 2017 to act as a framework for identifying, reporting, investigating and learning from deaths in care.

Specific guidance has been published for acute hospital trusts, but there is currently no guidance for ambulance services. It is noted that NHS Improvement are in the process (as at April 2019) of drafting guidance in liaison with the National Ambulance Medical Directors Group (NASMeD) and the National Ambulance Quality Governance and Risk Directors Group (QGARD). A workshop was hosted by NHS Improvement in November 2018 and final guidance is expected to be published in June 2019.

Whilst the guidance for ambulance trusts is yet to be published, and there is currently no requirement for ambulance trusts to undertake mortality reviews, it is recognised by the Trust that learning from deaths of people in our care has the potential to improve the quality of care we provide to patients and their families.

It has been agreed that the Trust will develop a mortality review process as one of its Quality Priorities for 2019/20 even if the national guidance is not available by June 2019. The milestones for each quarter may be amended dependent on the timing and content of any published national guidance for ambulance trusts.

This Quality Priority links to the following Trust strategic goal:
- Every Patient Matters
Aim

To develop and implement a mortality review process to learn from deaths.

Indicators

1. The Trust will have implemented an agreed process for learning from deaths via mortality reviews.
2. The Trust will demonstrate that it has undertaken the required number of mortality reviews for each quarter.
3. The Trust will have published findings of the mortality reviews undertaken in Q4.

Initiatives

Quarter 1 –

- Identify a Trust Board lead for Mortality Reviews
- Identify the Non-Executive Director with responsibility for oversight of mortality reviews.
- Review NHS Improvement guidance, as it becomes available, to understand the requirements for ambulance trusts in undertaking mortality reviews.
- Should national guidance not be published, understand what processes are currently in place within the ambulance sector.
- Draft the criteria and triggers for identifying which patient deaths should be subject to a mortality review.
- Agree methodology for undertaking mortality reviews (based on national protocol, if available).
- Develop a policy for Learning from Deaths.
- Identify individuals responsible for conducting the structured reviews.
- Access training on the structured judgment review methodology for the specific individuals identified as undertaking the reviews.
- Develop a programme for the implementation of mortality reviews, including roles and responsibilities, and milestones for quarters 2, 3 and 4 (to include the number of mortality reviews expected to be completed in each quarter).

Quarter 2 –

- Approve the Learning From Deaths Policy.
- Brief the Trust Board in relation to the implementation of mortality reviews.
- Report to the Quality Committee on the progress of implementation of mortality reviews.

Quarter 3 –

- Commence mortality review programme.
- Report to the Quality Committee on the progress of implementation of mortality reviews.

Quarter 4 –

- Continued roll out of the mortality review programme using quality improvement methodology.
- Report to the Board of Directors on learning from deaths from the previous quarter, including information as required within national guidance.
- Report to the Quality Committee on the progress of implementation of mortality reviews and plans for embedding the mortality review process as business as usual.
Board Sponsor

Jenny Winslade, Executive Director of Quality and Clinical Care

Implementation Lead

Adrian South, Clinical Director

How will we know we have achieved this priority?

- The Trust will have an established process for learning from deaths via mortality reviews by the end of Q4
- The Trust will be able to demonstrate triangulation of learning from mortality reviews with learning from patient safety, patient experience and clinical effectiveness in quality reporting.

Patient Experience

Continue to implement improvements to patient experience using Always Events methodology in end of life care

Why a Priority?

Improvements in patient safety and experience is frequently driven by patient and staff feedback. In 2018/19, the Trust focused on understanding patients’ experience of using ambulance services when under the care of a hospice. This work stream was supported by a nationally designed project called ‘Always Events’. During 2019/20, the Trust will focus on implementing the outcomes from the first phase.

Proactively involving patients and service users to identify what matters to them and what they expect in episodes of care with health services can positively impacts on the safety and experience of patients. Using the ‘Always Events’ methodology will contribute to this, as it focusses on co-designing services with patients.

The Always Events programme has four distinct phases:

1 Set up and Oversight;
2 Co-designing and testing;
3 Reliably Implementing;
4 Sustaining and Spreading.

This Quality Priority links to the following Trust strategic goal:

- Every Patient Matters

Aim

To implement improvements identified from patient and family feedback, focusing on use of the ambulance service as part of end of life care.
Indicators

1. A measurement plan will be developed which uses quality improvement methodology.
2. An agreed implementation plan will be in place.
3. A measure of improvement in patient and family experience.

Initiatives

Quarter 1:
- Evaluate the patient and family feedback and identify a small number of areas to ‘test’.

Quarter 2:
- Using quality improvement methodology, including a measurement plan, undertake a series of small tests of change to test improvements developed following feedback received during 2018/19, ensuring that patients and stakeholders remain involved in the process.
- Report to the Quality Committee on the progress of Phase 1.

Quarters 3 and 4:
- Based on the outcome of the tests of change, adopt a spread / implementation plan.
- Report to Quality Committee on the progress of Phase 2.
- Develop a staff learning package to reflect findings.
- Undertake engagement with the end of life care patient group to ascertain whether improvements have improved patient and family experience.
- Report to Quality Committee on the progress of Phase 3 and plans for moving to Phase 4.

Board Sponsor

Jennifer Winslade, Executive Director of Nursing and Clinical Care

Implementation Lead

Sharifa Hashem, Patient Engagement Manager

How will we know we have achieved this priority?
Measurement will demonstrate improvements in patient safety and experience.
Improvement in patient and family experience feedback.

Clinical Effectiveness

Cardiac Arrest

South Western Ambulance Service attends between 3,500 and 4,000 emergency calls each year where a patient’s heart stops beating, known as a cardiac arrest. These are the most time critical of emergencies, where a rapid response and early clinical care can literally make the difference between life and death.

It is recognised nationally that there is a small window of opportunity to enable the best chance of survival following out of hospital cardiac arrest and that intervention, aligned to the ‘Chain of
Survival’ is important. For every minute that passes, the chance of survival reduces by 10%.

SWAST will be undertaking a number of initiatives over a five year period to ensure the residents and visitors within the region have the best possible chance of survival.

This Quality Priority links to the following Trust strategic goal:

- Every Patient Matters

Aim

To improve survival to discharge following out of hospital cardiac arrest across the South West.

Indicators

- Improved utilisation of non – core resources for Category 1 incidents
- Increased training of non – clinical SWAST employees
- Improved ACQI performance for cardiac arrest indicators

Initiatives

1. Improved dispatch of Trust Responding Officers, CFRs and BASICS assets
   
   - This will be achieved by:
   - Clinical Hub staff education and process package.
   - Embedding the new Special Incident Desk.
   - Commitment from Responding Officers across Directorates to attend Category 1 incidents when requested to do so.
   - This will be measured by comparing the number of Category 1 incidents allocated to non-core resources during each quarter of 2018-19, compared to the same quarter in 2019-20.

2. 75% of all non-clinical SWAST employees to have attended an awareness session on delivering basic life support and the use an automated external defibrillator (AED) within the past 2 years, by 31/03/2020

   - This will be achieved by delivering a series of awareness sessions.

   - This will be measured by monitoring the percentage of non-clinical staff recorded as attending an awareness session.

3. Post ROSC care bundle completion within period of ROSC.

   - This will be achieved through an education package for ambulance clinicians, and an emphasis on the current guidance.

   - This will be measured through the national ACQI submissions.
How will we know we have achieved this priority?
Measurement will demonstrate improvements in ACQI performance for cardiac arrest indicators.

Statements of assurance from the board

1. During 2018/19 the South Western Ambulance NHS Foundation Trust provided and/or subcontracted two relevant health services.
   - Emergency (999) Ambulance Service;
   - Urgent Care Service (NHS 111; GP Out-of-Hours and Tiverton Urgent Care Centre);

1.1 The South Western Ambulance NHS Foundation Trust has reviewed all the data available to them on the quality of care in two of these relevant health services

1.2 The income generated by the relevant health services reviewed in 2018/19 represents 93.25% of the total income generated from the provision of relevant health services by the South Western Ambulance Service NHS Foundation Trust for 2018/19.

2. During 2018 – 2019 one national clinical audit and no national confidential enquiries covered relevant health services that South Western Ambulance Service NHS Foundation Trust provides.

2.1 During that period South Western Ambulance Service NHS Foundation Trust participated in 100% of the national clinical audits and 0% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

2.2 The national clinical audits and national confidential enquiries that South Western Ambulance Service NHS Foundation Trust was eligible to participate in during 2018 - 2019 are as follows:

NHS England Ambulance Quality Indicators: Clinical Outcome measures covering:
   - Outcome from cardiac arrest – return of spontaneous circulation (ROSC)
   - Outcome from cardiac arrest – survival to discharge
   - Outcome from acute ST-elevation myocardial infarction (STEMI)
   - Outcome from stroke
2.3 The national clinical audits and national confidential enquiries that South Western Ambulance Service NHS Foundation Trust participated in during 2018 - 2019 are as follows:

NHS England Ambulance Quality Indicators: Clinical Outcome measures covering:
- Outcome from cardiac arrest – return of spontaneous circulation (ROSC)
- Outcome from cardiac arrest – survival to discharge
- Outcome from acute ST-elevation myocardial infarction (STEMI)
- Outcome from stroke

2.4 The national clinical audits and national confidential enquiries that South Western Ambulance Service NHS Foundation Trust participated in, and for which data collection was completed during 2018-19, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

<table>
<thead>
<tr>
<th>National Clinical Audit*</th>
<th>Number of cases eligible for inclusion</th>
<th>Number of cases submitted</th>
<th>Percentage of cases submitted</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS England AQI: outcome from cardiac arrest – ROSC</td>
<td>a) 619 b) 158</td>
<td>a) 619 b) 158</td>
<td>a) 100% b) 100%</td>
</tr>
<tr>
<td>*This data covers the reporting period from April – Oct 2018</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a) Overall</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b) Utstein comparator group</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NHS England AQI: outcome from cardiac arrest – survival to discharge</td>
<td>a) 185 b) 64</td>
<td>a) 185 b) 64</td>
<td>a) 100% b) 100%</td>
</tr>
<tr>
<td>a) Overall</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b) Utstein comparator group</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NHS England AQI: outcome from STEMI (care bundle)</td>
<td>684</td>
<td>684</td>
<td>100%</td>
</tr>
<tr>
<td>NHS England AQI: outcome from stroke (care bundle)</td>
<td>1702</td>
<td>1702</td>
<td>100%</td>
</tr>
</tbody>
</table>

2.5 The reports of 1 national clinical audit were reviewed by the provider in 2018 - 2019 and South Western Ambulance Service NHS Foundation has taken the following actions to improve the quality of healthcare provided:

- Developed a prompt on the electronic patient clinical record to remind clinicians of care bundle elements and increase compliance.
- Developed Quality Improvement projects to maximise the appropriate assessment and management of pain.
- Established clinical priority plans aligned to key national indicators.
2.6 The reports of 5 local clinical audits were reviewed by the provider in 2018 – 2019 and South Western Ambulance Service NHS Foundation Trust took the following actions to improve the quality of healthcare provided:

- Liaison with the Learning and Development Department to ensure audit recommendations are reinforced during development days and 1:1 Learning Development Review sessions.
- Publication of audit results and recommendations on the Trust intranet and Clinical Newsletter.
- Initiated ‘Focus on...’ events to raise awareness of key clinical priorities.
- Encouraged clinicians to record their rationale when taking decisions considered to be in a patient’s best interest.
- Provision of updated guidance to staff through an app.

3 The number of patients receiving relevant health services provided or subcontracted by South Western Ambulance Service NHS Foundation Trust in 2018 - 2019 that were recruited during that period to participate in research approved by a research ethics committee was 574.

4 A proportion of South Western Ambulance NHS Foundation Trust quality improvement and innovation income in 2018/19 was conditional on achieving quality and improvement and innovation goals agreed between South Western Ambulance NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health through the Commissioning for Quality and Innovation payment framework.

4.1 Further details of the nationally agreed goals for 2017-18/19 and for the following 12-month period are available electronically at https://www.england.nhs.uk/nhs-standard-contract/cquin/

5 South Western Ambulance Service NHS Foundation Trust is required to register with the Care Quality Commission

5.1 Its current registration status is ‘registered without compliance conditions’.

South Western Ambulance Service NHS Foundation Trust has the following conditions on registration: None.

The Care Quality Commission has not taken enforcement action against South Western Ambulance Service NHS Foundation Trust during 2018-19.

6 South Western Ambulance Service NHS Foundation Trust has not participated in any special reviews or investigations by the Care Quality Commission during 2018-19
South Western Ambulance Service NHS Foundation Trust did not submit records during 2018-19 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The Data Security and Protection Toolkit has been launched as a direct replacement for the IG Toolkit. This is designed as an annual submission of the Trust to demonstrate assurance in the areas of data security and information governance compliance. The Trust published its completion on 29th March 2019 together with an associated action plan.

South Western Ambulance Service NHS Foundation Trust Information Governance Assessment Report overall score for 2018/19 was 100%.

The South Western Ambulance Service NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2018-19 by the Audit Commission.

South Western Ambulance Service NHS Foundation Trust will be taking the following action to improve data quality:

- Continue to maintain and develop the existing data quality processes embedded within the Trust.
- Hold regular meetings of the Information Assurance Group and work to reinvigorate focus in this area across the trust.
- Conduct a review of the reporting streams for data quality concerns across the Trusts and streamline data quality processes.
- Ensure completion and return of the monthly Data Quality Service Line Reports.
- Continue to provide Data Quality Assurance Reports to the Board of Directors.
- Where external assurance of data quality is required, commission an independent review from the Trust’s internal audit provider.

Learning from Deaths

In 2016 the Care Quality Commission published their report ‘Learning, candour and accountability: A review of the way NHS Trusts review and investigate the deaths of patients in England’ which made specific recommendations predominantly focusing on maximising learning from deaths. This led to the National Quality Board (NQB) releasing ‘National Guidance on Learning from Deaths’ in March 2017 to act as a framework for identifying, reporting, investigating and learning from deaths in care.

Specific guidance has been published for acute hospital trusts, but there is currently no guidance for ambulance services and no requirement to undertake mortality reviews. NHS Improvement have liaised with the National Ambulance Medical Directors Group (NASMeD) and the National Ambulance Quality Governance and Risk Directors Group (QGARD) to develop guidance for ambulance trusts. This guidance is expected to be published in June 2019.
The Trust recognises the importance of learning from deaths of people in our care and the impact that this could have on improving the quality of care we provide to patients and their families. We have therefore made the decision to develop and implement a mortality review process in 2019/20, irrespective of when the national guidance for ambulance trusts is published. In addition, the implementation of a mortality review process has been approved as a Trust Quality Priority for 2019/20.

Reporting against core indicators

1. The percentage of patients with a suspected ST elevation myocardial infarction who received an appropriate care bundle from the Trust during the reporting period was 82.31%

2. The percentage of patients with a suspected stroke assessed face to face who received an appropriate care bundle from the Trust during the reporting period was 99.18%

3. The Trust received 2735 patient safety related incidents within the reporting period 18/19. 24 (0.8%) of the 2735 incidents were declared as Serious Incidents resulting in severe harm or death.

National Reporting and Learning System

All Trusts are required to provide confidential and anonymised reports of patient safety incidents to the National Reporting and Learning System (NRLS). This information is analysed to identify common risks to patients and opportunities to improve patient safety. These incidents are identified through the Trust’s incident reporting processes, and of the 9,908 incidents reported during the 2018/19 year, 1,477 have been identified as relating to patient safety.

The National Patient Safety Agency recognised that organisations that report more incidents usually have a better and more effective safety culture, stating ‘you can’t learn if you don’t know what the problems are’.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>2018/19</th>
<th>2017/18</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>01 Oct to 31 Mar</td>
<td>01 Apr to 30 Sep</td>
</tr>
<tr>
<td>Total Incidents Reported to NRLS</td>
<td>622**</td>
<td>1,107**</td>
</tr>
<tr>
<td>Number of Incidents Reported as Severe Harm</td>
<td>7**</td>
<td>9**</td>
</tr>
<tr>
<td>Number of Incidents Reported as Death</td>
<td>0**</td>
<td>0**</td>
</tr>
</tbody>
</table>
*Highest/Lowest Trust reporting has been noted for each indicator independently.

**This information is sourced from the Trust’s incident reporting system based on the criteria used in NRLS reports. All other information in this table is published by the NRLS based on the data they received and collated from the Trust during their reporting periods. Information is published in arrears, and therefore the most recent information available from the NRLS relates to the period 1 April to 30 September 2018. However, it should be noted that not all Ambulance Trusts have reported data for all six months, with the number of months reported ranging from 1 through to 6.

It should be noted that the figures for reported incidents throughout the year, as set out in the text above, and those reported to NRLS will not correlate as the incidents are reported upon completion of the investigation and closure of the incident. Those incidents uploaded to NRLS in the first half of the financial year are therefore likely to be incidents that were reported during the previous financial year. A significant number of the incidents reported during 2018/19 remain under investigation and are therefore yet to be reported to NRLS.

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

- The Trust has a good culture for reporting adverse incidents.
- Information is provided to the NRLS electronically through the upload of data taken from the Trust’s adverse incident reporting system.
- The Trust has taken the following actions to improve this number, and so the quality of its services, by:
  - Continuing to encourage the reporting of adverse incidents by all members of staff so learning can occur at all levels of the Trust.
  - Reviewing the mechanisms for learning from adverse incidents to ensure this is done quickly and effectively, and disseminated to staff so they have continued confidence in the reporting system.
  - Reviewing the mapping of coding of patient safety incidents with the NRLS to ensure reporting is consistent with national requirements.

Part 3 – Other Information

Overview of Quality of Care 2018-19

Clinical Effectiveness

1 Reducing Emergency Admissions

Over the past 15 years, the Trust has been improving the pathways and care options available to our clinicians for their patients. Ambulance services are a key provider of urgent as well as emergency care, and our workforce, pathways and clinical support have adapted to this challenge. Many of the patients that call 999 for an ambulance can be managed safely and effectively over the phone, without sending an emergency
ambulance. Where we do need to send an ambulance, over half of our patients can be managed by ambulance clinicians in their own home.

The Trust has consistently achieved the highest non-conveyance rate of any ambulance Trust in the UK, with 46.9% of patients requiring conveyance to an Emergency Department. We also have the highest rate of admission for patients we do convey to EDs, demonstrating appropriate clinical decision-making.

Our clinicians are at the heart of this work and have the greatest level of clinical autonomy of any UK ambulance service. We have continued to promote a dedicated feedback system amongst staff to identify areas for improvement as well as best practice. Over 2,647 items of feedback were received and disseminated to the teams involved between 01/02/2018 – 31/01/2019, with the Trust working closely with providers and commissioners to resolve the issues. During 2018-19 the Trust implemented the MiDoS system, which enables staff to search and access details on all relevant NHS, social care and charity pathways using their phone or the Electronic Care System computer. This allows live feedback on issues, which time and time again, has proved vital in improving access to existing pathways and creating further opportunities.

2 ECS

The trust operates a successful Electronic Care System (ECS) which includes the electronic Patient Clinical Record (ePCR). This advanced system enables staff to ensure the most appropriate care is provided to patients. It does this by providing additional information about the patient history, access to previous records, prompting clinical decision making in accordance with best practice guidance and informing audit and research, to improve patient outcomes. The introduction of access to the Summary Care Record (SCR) allows clinicians to review primary care records where available, and therefore better inform appropriate care pathways.

During 2019/20, the trust is working on the procurement, design and eventual implementation of ECS2, the replacement to the current system. This will include further developments to the system which will benefit the patient, staff and organisation. It is hoped this will include an extension of the ePCR into the clinical hub to record clinician contact with patients prior to ambulance arrival on scene or for cases of Hear and Treat.

Developments this year including Ambulance Clinical Quality Indicators (ACQI) prompting, JRCALC integration and a cardiac arrest page have improved the recording of clinical care. This has been demonstrated by a rise in compliance with the ACQI care bundles for both Stroke and STEMI patients. The use of the cardiac arrest page enables staff to ensure timely administration of interventions during high stress incidents and therefore allowing positive cognitive offload to improve the clinical care provision by a team.

The trust will continue its work on integration and is engaging actively with suppliers, other organisations and bodies such as the Local Heath Care record Exemplars (LHCREs), to improve system and data flow.

3 Research - Participation In Research

Patients and Trust staff had the opportunity to participate in a variety of research studies
during 2018/19, 574 participants were recruited into these.

Patient Safety

1 Incident Reporting

As reported previously, the Trust has a central reporting system for adverse incidents, including near misses, as well as Moderate Harm Incidents (MIs) and Serious Incidents (SIs).

All core service lines for the Trust; A&E and Urgent Care Services (UCS) are covered in the patient safety measures reported within this section, including the table below which sets out the categories and numbers of patient safety incidents managed by the Trust.

<table>
<thead>
<tr>
<th>Other Patient Safety Measures</th>
<th>2018-19</th>
<th>2017-18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adverse Incidents</td>
<td>7,896</td>
<td>8,171</td>
</tr>
<tr>
<td>Moderate Harm Incidents</td>
<td>8</td>
<td>16</td>
</tr>
<tr>
<td>Serious Incidents</td>
<td>25</td>
<td>51</td>
</tr>
</tbody>
</table>

It should also be noted that the figures for Moderate Harm and Serious Incidents are for those incidents confirmed as meeting the necessary criteria within the reporting timeframe.

The Trust uses a local definition for Adverse Incidents which is based upon national guidance. Any event or circumstance arising that could have or did lead to unintended or unexpected harm, loss or damage to any individual or the Trust is classified as an adverse incident.


It should be noted however, the incident’s included above could have been reported outside the 2018/19 timeframe of this document.

2 Central Alert System

The Central Alert System (CAS) is a national electronic web-based system developed by the Department of Health, the National Patient Safety Agency (NPSA), NHS Estates and the Medicines and Healthcare products Regulatory Agency (MHRA). This aims to improve the systems in NHS Trusts for assuring that safety alerts have been received and implemented. During 2018/19 the Trust acknowledged 99% of CAS notifications within 48 hours. The number of notifications received is set out in the following table.

<table>
<thead>
<tr>
<th>Other Patient Safety Measures</th>
<th>2018-19</th>
<th>2017-18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central Alert System (CAS)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Received</td>
<td>110</td>
<td>128</td>
</tr>
</tbody>
</table>
3 Serious Incidents

A fundamental part of the Trust’s risk management system is appropriately managing Serious Incidents (SI) to ensure lessons are learned. SIs are identified through a systematic review of both adverse incidents and patient feedback. All incidents that are believed to potentially meet the national criteria set by NHS England or are a SI are passed to the clinically qualified Patient Safety Manager or nominated clinical deputy for preliminary review, before being circulated to the dedicated Serious and Moderate Harm decision making group which consists of two clinicians and a governance representative. Other specialties are also invited to attend to contribute and advise on individual cases.

It is important to note that the proportion of SIs as a percentage of patient contact activity remains very low. Overall, fewer Serious Incidents were confirmed during 2018/19, four of these related to the UCS/111 Service Line, with the remainder related to the A&E Service Line. For the A&E Service line the predominant themes throughout the year being delays to ambulance attendances and triage decisions. The overall reduction in the number of SIs appears to be a strengthening of the process to identify SIs by having consistent panel members applying the national framework guidance.

SI investigations are considered within Serious Incident Review Meetings which are designed to identify organisational learning. These meetings are chaired by a Clinical Director or Deputy Director. All staff involved in the incident are invited to attend as this provides the best opportunity for the Trust to identify learning. Learning can either be at a local, Trust wide or at times national level, for example referring learning to NHS Pathways to help them improve the National Pathways System. A Serious Incident Action Plan is maintained to monitor progress against actions identified and this is monitored on a monthly basis by the Commissioning Support Unit.

For an organisation to be truly open, transparent and above all safe for our patients, the Trust encourages a reporting culture and full participation in the Serious Incident process. The Trust’s cultural review, undertaken in 2018/19, identified a perception by some staff that the SI process is one of a punitive action closely aligned to disciplinary or capability processes. To support a change in perception and ensure staff are fully involved in the incident investigation process, the Trust is re-branding and relaunching the Serious Incident process. The new process will be launched in April 2019 and will be named the ‘Review, Learn and Improve (RLI) process’. This work stream will also align with a review of the national Serious Incident Framework.
4 Moderate Harm Incidents

The number of Moderate Harm incidents identified has reduced from 2017/18 with 8 fewer incidents being identified. The large majority of these incidents also related to the A&E Service Line (with only 1 related to UCS/111) with the primary theme being assessment of patients (4 incidents). The remaining incidents relate to treatment (1), manual handling (1) and a road traffic collision (1) and delay (1).

Patient Experience

1 Patient Experience

Patient Experience is made up of the sum of all the interactions that a patient, or their family/care network, have with the Trust.

Patient experience and patient engagement provide the best source of information to understand whether the services delivered by the Trust meet the expectations of the patient, their family and/or representatives, including assessing whether a quality service is provided. The following table shows some of the Trust’s existing methods and quantitative information on service user experience.

The Trust received a combined number of 921,386 patient contacts (A&E Activity and Urgent Care Services) against a total of 1,334 complaints (one complainant contact equates to one complaint) equating to 0.14% of all patient contacts.

The Trust has defined a complaint as any expression of dis-satisfaction from a patient, or their duly authorised representative, or any person who is affected by, or likely to be affected by, the action, omission or decision of the Trust, whether justified or not.

<table>
<thead>
<tr>
<th>Patient Experience Measures</th>
<th>2018/19</th>
<th>2017/18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complaints, Concerns and Comments</td>
<td>1,175</td>
<td>1,334</td>
</tr>
<tr>
<td>Patient, Advice and Liaison Service (PALS) – Lost Property, signposting to other services etc</td>
<td>914</td>
<td>1,007</td>
</tr>
<tr>
<td>Health Service Ombudsman complaints upheld</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Compliments</td>
<td>2,653</td>
<td>2,235</td>
</tr>
</tbody>
</table>

2 Comments, Concerns and Complaints

All comments, concerns and complaints (referred to hereafter as ‘Patient Experiences’ otherwise known as PEs) are dealt with in line with the Trust’s Complaints Policy. This ensures that all service users feel that their feedback has been taken seriously, are dealt with appropriately and reported with complete transparency.

Of the 1,175 complaints received during the reporting period, the Patient Experience team, by employing an informative, calm, sensitive and reassuring approach, were able
to close, on receipt, 243 (equating to 21%) of these. These were closed with assurances given to, and agreement from, complainants that the necessary information would be passed to the relevant operational sectors/regional service lines.

Many Trust complaints are multifaceted, citing several areas of concern. Each concern is coded to report four subject areas in order to illustrate transparency and trends. The following table sets out the number of complaints received in 2018/19.

<table>
<thead>
<tr>
<th>Subject</th>
<th>Complaints</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access and Waiting</td>
<td>512</td>
</tr>
<tr>
<td>Communication</td>
<td>446</td>
</tr>
<tr>
<td>Clinical Care</td>
<td>367</td>
</tr>
<tr>
<td>Security Vehicles and Driving Issues</td>
<td>99</td>
</tr>
</tbody>
</table>

The majority of complaints relate to Access and Waiting. Demand on the service and the associated impact on the availability of resources is a consistent factor as evidenced by the high number of complaints received during year.

A fundamental part of the Trust’s complaint handling process is to ensure that remedial actions highlighted as a result of complaint investigations are appropriately managed to ensure lessons are learned. All remedial actions are identified, logged and monitored to ensure completion.

It is the responsibility of the Investigating Officer (IO) to ensure staff receive feedback and closure when they have been the subject of a complaint as this is an excellent way to share any learning arising from the complaints process.

### 3 Learning from Incidents and Complaints

The Learning from Incidents process brings together learning from complaints, adverse, serious and moderate incidents, claims and inquests, HR cases and learning development reviews. Identified learning is being shared via the Trust’s Bulletin and a monthly meeting of representatives from each of the functions takes place to agree a programme and method of dissemination.

The identified programme to date has included articles on the following areas of learning:

- Injury in non-mobile babies
- Supporting patient’s end of life decisions;
- COPD;
- Intoxicated patients;
- Head injuries
- ECG recognition
- Pulmonary Embolism recognition

Further, the Trust produces quarterly Patient Safety and Experience Reports which are
presented to the Trust’s Quality Committee. This summarises themes and learning arising from Patient Safety incidents dealt with by the Nursing and Quality Directorate, incorporating, SIs, Adverse Incidents, Comments, Concerns and Complaints.

In addition a quarterly Patient Safety and Experience Report is presented to the Trust’s Board of Directors. This also includes Claims and Inquests information.

The principle theme emerging from incidents and complaints relates to delays due to demand. A significant number of complainants and healthcare professional feedbacks raised concerns that the Clinical Hub had refused to provide an estimated time of arrival (ETA) for when they could expect an ambulance resource. Due to the continuously changing nature of emergency incidents, dispatchers (responsible for the allocation of ambulance resources) often need to divert ambulance resources. Therefore call handlers are unable to confirm that an ambulance is on its way or provide an ETA at the time of the 999 call.

Further trends have been identified in relation to non-conveyance of patients, long lies following falls, pain management, hospital capacity issues, clinical validation, Urgent Care Service staffing levels, palliative care and lack of capacity to undertake patient call backs from the 111 service clinical desk within the specified timeframe.

4 Compliments

The Trust receives telephone calls, letters and emails of thanks from many patients every week. Wherever possible this gratitude is passed directly onto the members of staff who attended the patient or service user.

2,697 compliments were received during 2018/19; an increase of 1.7% on 2017/18. These provide important assurance for the Trust in public recognition for staff and their contribution to excellence in service standards and demonstrate the continuing public confidence in the Trust.

The Trust defines a compliment as any recognition by a member of the public or other Health Care Professional, for the contribution of staff in delivering a high standard of service.

5 Patient Engagement

During 2018/19 the Trust continued to develop its patient engagement activities, ensuring that its services are responsive to individual needs, are focused on patients and the local community and supporting its ongoing commitment to improving the quality of care provided.

The patient engagement team and the patient experience team source patient stories for use at the start of each meeting of the Board of Directors and of the Council of Governors.

Previously these stories were written testimonies read out by a member of the forum; however, over the last three years the Trust enhanced this project and has begun to invite patients into the Board meeting to share their stories in person. This activity has continued to be a positive experience not only for the meeting members, but also most importantly for the patients involved.
6 Care Opinion

Patients and their relatives and careers can post details of their experience on the “Care Opinion” website, with these posts being available to anybody visiting the site. The Trust responds to every comment about its service. Where the feedback is negative or indicates service failure, the individual who provided the comments is invited to contact the Trust directly with further details so that the concerns can be addressed by the patient experience team. Where the post is positive and the incident in question can be identified, the posting is passed directly to the member(s) of staff involved. If there is insufficient detail the patient engagement team will respond requesting additional information in order to be able to convey the positive feedback.

During the year 42 stories relating to the trust have been posted on Patient Opinion. This is a decrease of 23% compared to last year. The continued decrease is likely to be due to the cessation of advertising of the site; as the Trust chose not to renew its subscription to the Care Opinion site. The increasing popularity of social media may also be a contributing factor, indicating a change in the way members of the public interact.

7 Patient Experience Surveys

The Trust audits a random sample of 1% of patient contacts every month for its NHS111 contracts and separately for the GP Out of Hours contracts, with care being taken to ensure that the survey is not sent to anyone whom it would not be appropriate to contact, for example a sensitive case that may be related to a safeguarding concern.

A paper questionnaire is sent to respondents, which also contains a link to the online survey. The survey includes a series of questions under the following headings:

- Friends and Family Test
- Getting through
- After the call
- Satisfaction
- Use of NHS111/Out of Hours telephone service and satisfaction with the NHS
- Caller/patient information

The Trust provides a monthly report to its Commissioners on the number of calls taken; and the forms returned within that period, with a detailed report being submitted every six months.

During the year a total of 3202 surveys were sent out, 677 people responded to the survey in respect of their NHS111 experience; equating to a response rate of 21%. These responses highlighted that further consideration needs to be given to communication about the process of the service to manage patient expectations, whilst the issue of being given the wrong advice was also raised.

Some of the comments provided by survey respondents have raised issues about triage; the perception that questioning is too long and unhelpful, with respondents indicating that the questioning left them feeling frustrated. A small number of survey respondents have stated that the attitude from the call handler was less than favorable.
Many positive comments relate to patients feeling grateful for the service; with respondents citing how the staff they spoke to or were attended by were helpful and caring. Many respondents spoke about the reassuring nature of the service and the excellent guidance that is being offered. It is also noted that positive comments far outweigh the negative comments.

During the year 1093 GP Out of Hours Service surveys were sent out, 281 responses were received, equating to a response rate of 26%. Feedback suggests that patients are satisfied with the service received, with them being likely to recommend the service and to use it again.

Respondents cited high levels of satisfaction with the service, confirming that they were given good information regarding their care options and treatment, as well as positive staff attitude. There were some negative comments regarding delays and the quality of care received.

8 Friends and Family Test (FFT) for Patients

The FFT is a single question survey which asks patients whether they would recommend the NHS service they have received to friends and family who need similar treatment or care.

The Trust offers the FFT to patients who receive ‘See and Treat’ care across the 999 and Urgent Care service lines; this means care delivered to patients when they are seen by a Trust clinician and the patient is not conveyed to any receiving facility.

Response rates to the FFT are poor. A review of response rates across all ambulance services identifies that this is an issue across the country. In addition, it is difficult to directly compare data as each Trust is using a different response method and so it cannot be used as a reliable bench mark.

Despite the low response rate, the Trust continues to receive largely positive feedback to the FFT. However, this in itself provides a challenge for service development based on these responses as the only consistent theme offered in the feedback is that of praise and gratitude. The FFT results for 2018/19 are:

<table>
<thead>
<tr>
<th>Recommend?</th>
<th>April</th>
<th>May</th>
<th>June</th>
<th>July</th>
<th>Aug</th>
<th>Sept</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>March</th>
</tr>
</thead>
<tbody>
<tr>
<td>Would</td>
<td>94%</td>
<td>100%</td>
<td>93%</td>
<td>75%</td>
<td>87%</td>
<td>80%</td>
<td>92%</td>
<td>100%</td>
<td>91%</td>
<td>100%</td>
<td>88%</td>
<td>100%</td>
</tr>
<tr>
<td>Would not</td>
<td>6%</td>
<td>0%</td>
<td>7%</td>
<td>13%</td>
<td>0%</td>
<td>20%</td>
<td>8%</td>
<td>0%</td>
<td>9%</td>
<td>0%</td>
<td>13%</td>
<td>0%</td>
</tr>
</tbody>
</table>

9 Public and Patient Involvement

During 2018/19 the Trust attended 267 patient and public involvement events such as county shows, community fetes, school and college visits and public health awareness days. These events were staffed predominantly by volunteers drawn from clinicians, managers, administrators, governors and community first responders.

These events provide a fantastic opportunity to engage with existing patients and
potential service users. They also provide an opportunity to deliver proactive blood pressure checks and CPR and AED awareness. A total of 7224 CPR and AED awareness sessions were delivered to members of the public in 2018/19. Spreading awareness of the important of CPR remains a priority for the Trust and is highlighted at engagement events including Restart A Heart.

We have continued to improve our links with our road safety partnerships across the area with local Healthwatch. We continue developing our working relationships with partner organisations and stakeholders. Other achievements include;

- A total of five station open days were delivered across the Trust including, Taunton, Staverton, Keynsham, Burnham and Nailsea.
- Worked collaboratively with the Fire and Rescue Services and Police Forces on providing emergency services presence at the Devon County and emergency services shows.
- Completed a round of Let’s Talk events across the Trust geography to engage with members of the public on strategic and health matters.
- Increased the widening participation work stream with a focus on reaching out to more marginalised groups and communities.
- Develop our working relationship with our Healthwatch colleagues through open days showcasing latest Trust development and research.
- Improve our school resources and implement governance around school and educational visits, as well as station visits.
- Developed focused engagements around mental health and carried out the first focus group in association with Devon Partnership Trust.
- Worked alongside The Clinical Directorate to ensure the delivery of their Saving Lives Strategy and public engagement.

Performance Indicators

Ambulance Response Indicators

<table>
<thead>
<tr>
<th>ARP Response Category</th>
<th>National Standard</th>
<th>Trust Performance 23 Nov 2017 to 31 Mar 2018</th>
<th>Trust Performance 1 Apr 2018 to 31 Mar 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category 1 Mean Response Time</td>
<td>7 Minutes</td>
<td>9 minutes 42 seconds</td>
<td>7 minutes 18 seconds</td>
</tr>
<tr>
<td>Category 1 90th Centile Response Time</td>
<td>15 Minutes</td>
<td>17 minutes 36 seconds</td>
<td>13 minutes 30 seconds</td>
</tr>
<tr>
<td>Category 1T 90th Centile Response Time</td>
<td>30 Minutes</td>
<td>26 minutes 00 seconds</td>
<td>21 minutes 43 seconds</td>
</tr>
<tr>
<td>Category 2 Mean Response Time</td>
<td>18 Minutes</td>
<td>33 minutes 24 seconds</td>
<td>27 minutes 27 seconds</td>
</tr>
<tr>
<td>Category 2 90th Centile Response Time</td>
<td>40 Minutes</td>
<td>69 minutes 42 seconds</td>
<td>57 minutes 55 seconds</td>
</tr>
<tr>
<td>Category 3 Mean Response Time</td>
<td>1 Hour</td>
<td>1 hour 15 minutes 27 seconds</td>
<td>1 hour 12 minutes 09 seconds</td>
</tr>
<tr>
<td>Category 3 90th Centile Response Time</td>
<td>2 Hours</td>
<td>2 hours 59 minutes 24 seconds</td>
<td>2 hours 47 minutes 44 seconds</td>
</tr>
</tbody>
</table>
### Category 4

<table>
<thead>
<tr>
<th>Mean Response Time</th>
<th>n/a</th>
<th>2 hours 00 minutes 12 seconds</th>
<th>2 hours 06 minutes 25 seconds</th>
</tr>
</thead>
<tbody>
<tr>
<td>90th Centile Response Time</td>
<td>3 Hours</td>
<td>4 hours 29 minutes 06 seconds</td>
<td>4 hours 40 minutes 36 seconds</td>
</tr>
</tbody>
</table>

### Stroke 60 Minutes

1. Stroke 60 minutes has not been measured nationally in 2018-19 and therefore South Western Ambulance Service NHS Foundation Trust is unable to report on this.

2. South Western Ambulance Service NHS Foundation Trust considers that this data is as described for the following reasons:
   - The Trust has robust data quality processes in place to ensure the reporting of performance information is both accurate and timely.

3. The South Western Ambulance Service NHS Foundation Trust intends to take the following actions to improve this data and so the quality of its services, by:
   - Continue to maintain and develop the existing data quality processes embedded within the Trust.
   - Hold regular meetings of the Information Assurance Group and work to reinvigorate focus in this area across the trust.
   - Conduct a review of the reporting streams for data quality concerns across the Trusts and streamline data quality processes.
   - Ensure completion and return of the monthly Data Quality Service Line Reports.
   - Continue to provide Data Quality Assurance Reports to the Board of Directors.
   - Where external assurance of data quality is required, commission an independent review from the Trust’s internal audit provider.

### Return of spontaneous circulation (ROSC)

1. Return of spontaneous circulation (ROSC) where the arrest was bystander-witnessed and the initial rhythm was ventricular fibrillation (VF) or ventricular tachycardia (VT) the average for the year of the monthly reported performance was 47.16%*

   *Please note this figure includes data submitted to NHSE up to October 2018 only.

2. South Western Ambulance Service NHS Foundation Trust considers that this data is as described for the following reasons:
   - Information is collated in accordance with the technical guidance for the ACQIs and this work is subject to internal audit on an annual basis.

3. The South Western Ambulance Service NHS Foundation Trust intends to take the following actions to improve this data and so the quality of its services, by:
   - Undertaking a programme of quality improvement activity across all areas.
Annex 1: Statements from commissioners, local Healthwatch organisations and overview and scrutiny committees

Clinical Commissioning Groups

NHS Dorset Clinical Commissioning Group (CCG)

Thank you for asking NHS Dorset Clinical Commissioning Group (CCG) to review and comment on your Quality Accounts for 2018/19. Please find below the statement on behalf of all Clinical Commissioning Groups across the South West in relation to 999 services for inclusion in the final document:

The Trust fulfils an important contribution to the health and wellbeing of the population within CCG localities through the services it provides. The Quality Account is an easy to understand and comprehensive report that helps the general public to understand how their local ambulance service is performing. The document outlines the Trust’s approach to delivering quality care and quality improvements within its service in an open and transparent way in terms of patient safety, patient experience and clinical effectiveness.

The Commissioners have reviewed the Quality Account and can confirm that the information presented is consistent with quality, safety and performance information supplied to the CCGs throughout the year through both contract reporting and discussions and demonstrates a high level of commitment to safety and quality. The achievements from 2018/19 noted in the quality account reflect this and is to be commended. This includes the achievement of an overall ‘Good’ rating following a CQC inspection during the year and the caring attitude of the workforce, rated outstanding by CQC, remains evident.

Due to demand there have been challenges in respect to achievement of the ambulance response times which have impacted on patient safety and experience during the year. Moving forward Commissioners welcome the opportunity to strengthen relationships with SWASFT to progress actions being taken to improve this situation.

The Commissioners are supportive of the Quality priorities for 2019/20 particularly the development and implementation of Mortality Reviews. Progress will be reviewed throughout the year and Commissioners look forward to working with SWASFT to maintain and improve safe, high quality services for the population it serves.

Enclosed with this letter is a summary of commissioner’s feedback from which this statement has been prepared for your information.

Vanessa Read
Director of Nursing & Quality
NHS Dorset CCG (Co-ordinating Commissioner)

General Comments and Feedback

Dorset CCG has been working closely with all the regional CCGs as well as SCWCSU throughout the
year as the co-ordinating commissioner, gaining assurance of the delivery of safe and effective services.

Areas for improvement and consideration

- SW Commissioners will be devising a CQUIN for 19/20 around appropriate conveyance and the CCG looks forward to working with the Trust on this.
- It has been noted within the Quality Account that a significant number of incidents reported during 18/19 remain under investigation and therefore are yet to be reported to NRLS. Commissioners have commented that clarity regarding this process would be welcome.
- The Trust may want to provide an explanatory note on the November 2017 – March 2018 data and why it doesn’t cover the full 12 months the public may not understand the reason for this.
- Commissioners continue to support SWASFT in ensuring that where complaints and incidents occur across a ‘system’ (and therefore a number of healthcare providers), that all parties involved contribute to the investigation process. We as Commissioners are also fully engaged in the review of Serious Incidents to ensure all opportunities for learning are taken.
- It is noted that there is a comparison of Serious Incident numbers; more narrative on this would have been welcome.
- Within the quality account SWASFT have demonstrated continued low reporting for serious incidents however similarly to 2017/18 the Commissioners would have welcomed more detail on the analysis of incidents including learning and improving practice. Additionally, the Trust notes that the main theme of waiting times for ambulances arising from complaints and incidents has arisen again this year however it is disappointing that there is no inclusion of the action undertaken with CCGs this year to address delays or acknowledgement of any future action to address any learning.
- Full implementation of the Freedom to Speak Up requirements following the learning identified in The Gosport War Memorial Hospital Independent Panel report. The account specifies how staff are able to raise concerns, however, more information regarding learning and actions from this would be valued, in line with the national requirement for inclusion in the quality account.
- The CCGs consider that there may be further opportunities for the Trust to explore the learning from clinical audits; for example, reference is made in the account to learning which indicates a need for improvement around the assessment and treatment of pain. This could be considered for a quality improvement work steam during the year. In subsequent quality accounts, the CCGs would value more a more comprehensive exploration of audit outcomes.

Response Delays/Call Stacking

- It is noted that these are mentioned throughout the Quality Account, and is obviously reflected by the “Risk Score” of 25. How has this helped to influence the new quality priorities?
- It is noted that the “theme” of delays is mentioned within the report however commissioners would welcome more narrative about this “Theme” beyond ETA related complaints.
- The Trust has continued to provide assurances through the assurance and quality review processes that harm in respect to delayed Category 1 responses has not
occurred and where delays have impacted on any of patient care and experience in
the other response categories, the provider has ensured that these issues have been
investigated and any learning considered. Commissioners will continue to closely
monitor progress during 19/20.
• Commissioners continue to support SWASFT in ensuring that where complaints and
incidents occur across a ‘system’ (and therefore a number of healthcare providers),
that all parties involved contribute to the investigation process. Commissioners are
also fully engaged in the review of Serious Incidents to ensure all opportunities for
learning are taken.
• Commissioners support the safe and effective management of patients over the
phone including the improvements made to non-conveyance rates and clinical
decision making to reduce inappropriate admission to hospital.

Handover Delays

• Hours lost to handover delays and long waits continue to be a challenge and as
Commissioners we will continue to work closely with our acute colleagues in order
to address this, including a continued focus on the safety impact of non-availability
of ambulances to respond to emergency calls.
• Commissioners recognise also that the Trust has worked with them and the acute
hospitals in order to support the better management of patient flow with the aim of
increasing the availability of ambulance resources wherever possible to deliver the
best service for patients. Commissioners can confirm that significant efforts have
been made by the Trust to ensure that delays generated by their services have been
reduced, supporting the wider healthcare system.

NHS Staff Survey 2018

• Commissioners have commented that within the Quality Account there is no
mention of the work being conducted related to neither the Staff Survey results nor
the impact of the Cultural Survey.

Priorities 2018/19

Progress on the 3 priorities identified in 2017/18 demonstrates the Trust commitment to Quality
Improvement. Below are some specific CCG comments regarding the above priorities. Analysis of the
success and impact of some these initiatives are welcome.

• Commissioners welcome the positive service developments and the progress that
has been made on the priorities for 18/19.
• Regarding Clinical Effectiveness Triage within clinical hubs—development of
enhanced hear and treat – the Commissioners look forward to receiving an update
and outcome of the SWAST’s evaluation on this at a future Quality Assurance Group.
• Regarding Patient Experience 18/19 priority the Commissioners understand that
feedback will inform the Trust’s mental health action plan going forward in 19/20
and the Commissioners would welcome a further update (at QAG) on the outcomes
and service improvements that transpired from this engagement which has now
been built into that plan.
• Regarding Patient Safety 18/19 priority The Commissioners note that the Trust’s
intention was to focus on the first 3 out of 4 phases. The Commissioners would welcome further details to better understand the challenges the Trust faced in completing steps 1-3 during the year. It is noted that this priority has been carried forward as a 19/20 priority and it appears that Q1 focus will be on progressing with step 2. As can be evident the Trust has undertaken a lot of engagement work during 18/19 and Commissioners would welcome an update on any immediate impact on patient care / QI work resulting from patient feedback.

New priorities 2019/20
The Commissioners welcome the quality improvement plan priorities the narrative to support the identification of these quality issues as priorities for 2018/19 is welcome. However the rationale for these triangulated with Patient Experience, Patient Engagement or other factors is not readily evident.

- Commissioners feel that the priorities for 19/20 are fair and transparent, and reflect positively on quality improvement within the organisation.
- The development of Mortality Reviews is very welcome the commissioners note that the Trust will publish findings of reviews in Q4. The Commissioners would welcome this publication and will be assured how learning has informed quality improvement initiatives and safer, more effective patient care.
- The Commissioners note that the Trust will be undertaking a number of initiatives over the next 5 years around the topic of Cardiac Arrest and the CCG would welcome an update on the initiatives planned and how its development / delivery follows QI principles.

The Trust’s commitment to the continued implementation of the ‘Always Events’ (focussing on supporting End of Life Care) is welcome.

Care Quality Commission (CQC) involvement
The Commissioners welcome and support the Trust’s open and transparent communication of their involvement with the CQC during 2018/19 within the quality account. The Commissioners also confirm and recognise that they have maintained their registration with the CQC with no conditions.

- Within the CQC report 4 out of 6 services are noted as “Requires improvement” within the “safety” domain. How have the quality priorities been aligned with this?
- It is also noted that within the “999” service there are 3 domains that “Require Improvement”. How have the quality priorities been aligned with this?

The Commissioners have worked closely with the Trust and SCWSCU during 2018/19 and we look forward to doing so in the future in respect to any further CQC reviews being undertaken.

NHS Kernow Clinical Commissioning Group
Thank you very much for the opportunity for NHS Kernow to comment on the South Western Ambulance Service NHS Foundation Trust, Quality Review and Quality Account 2018/19.

NHS Kernow Clinical Commissioning Group is one of a number of CCGs across seven counties in the south west of England responsible for commissioning emergency 999 care services from South Western Ambulance Service NHS Foundation Trust (SWASFT). The information contained within the report was reviewed and is considered an accurate summary reflection of the Trust’s performance.
NHS Kernow welcomes the opportunity to provide this statement and the approach taken in developing and setting out its plans for quality improvement in 2019/20. It has proved to be a busy year with the comprehensive CQC inspections in May, June and July 2018 alongside challenges across the system. The Quality Account articulates where SWASFT has achieved progress and identifies areas where further improvements are required. In the commissioner / provider relationship there is a focus on making quality the organising principle of NHS services, by embedding quality at the heart of commissioning practice.

The Trust has put recognised effort into the 2018 CQC inspections and the associated action plans. SWASFT has an overall rating of “Good” across its core services of Emergency and Urgent Care (A&E 999) and Emergency Operations Centres (EOCs or Clinical Hubs). CQC noted that there had been improvements from the previous inspection in 2016 and were complimentary about the care in the five areas inspected. SWAST gained on overall rating of “Outstanding” for the care domain. Although improvements were noted CQC have said that some concerns remain. The rating of “Requires Improvement” for safe, effective and well-led in relation to Emergency and Urgent Care (A&E 999) demonstrates that there is more to do across the Trust and this is reflected in this Quality Account (in relation to CQC and Ambulance Response Indicators). Of particular concern to CQC was the failure to meet response times to reach patients, although CQC did acknowledge that there had been an improvement to the most urgent category.

NHS Kernow would concur with the view that improvements are required in relation to other category wait times. SWAST ambulance response indicators across the entire region do show an improved performance from 2017/18 in relation to the most urgent category (category 1) and in relation to other categories (category 2, 3 and 4). Improvements in relation to Category 2, 3 and 4 still see the Trust short of meeting the mean response time and 90th centile response time for each.

Of particular concern is that whilst the regional Category 1 (mean response time and 90th centile response time) is within target, this is an aggregated response across all counties and it should be noted that these standards are not met in Cornwall or within target. We will continue to work with SWAST on improving these targets for the Cornwall population to minimise the risk of harm. The impact of the failure to deliver the nationally mandated response times is particularly important in relation to patients who wait more than double the response time for their category of call. This is especially relevant for NHS Kernow, whose ‘long wait times’ are the least positive across all of the CCGS. NHS Kernow would welcome the continued emphasis of understanding the impact of long waits in terms of potential harm and would wish to see a programme of ‘end to end’ audit of long waits, conducted in a multi-disciplinary environment.

NHS Kernow endorses the commitment within the Quality Account to addressing the challenges of 2018/19. We note the developments in the new response framework within the Ambulance Response Programme which has enabled the most appropriate resources to be focused on patients experiencing life-threatening and life-changing incidents; and that the Trust will use the tool developed to further refine the effectiveness of clinical triage in order to improve the appropriateness of the response that patients receive. We recognise the progress made against the other 2018/19 quality priorities including the experience of mental health patients using the 999 service and the development / implementation of Always Events in relation to end of life care and treatment.

We support the identified quality priorities for 2019/20, and where these will continue from the
2018/19 foundation work. They aim to deliver high quality, safe and accessible services; maximise the potential of the workforce to deliver high quality patient care and to diversify/develop services that meet patient/commissioner needs and expectations.

Whilst NHS Kernow is in agreement that SWAST has made improvements with regard to the quality and safety of their services, there are areas of continued focus for improvement required specifically for Cornwall. We hope that this feedback is helpful and look forward to continuing our productive collaborative working relationship with the Trust in 2019/20.

Nikki Thomas
Deputy Director of Nursing & Quality

Health Overview & Scrutiny Committees

Dorset Health Scrutiny Committee commentary for South Western Ambulance Service NHS Foundation Trust, May 2019:

On an annual basis, Dorset Health Scrutiny Committee appoints a Liaison Member as a point of contact with South Western Ambulance Service NHS Foundation Trust. In addition, the Trust may be invited to Committee meetings to present reports regarding any substantial changes to services or any concerns that Members may have regarding performance or quality of services. The Trust has been cooperative and helpful where requests have been made for input and it is hoped that this will continue in the coming year.

With respect to the Quality Account and Report 2018/19, the following matters were of particular interest:

- The Committee congratulates the Trust on progressing from ‘Requires Improvement’ to ‘Good’ ratings with respect to the CQC inspections of the NHS 111 service, Emergency and Urgent Care and Emergency Operations Centre. The ‘Outstanding’ rating for the Caring domain is particularly noteworthy.

- The developments in clinical triage and risk stratification demonstrate a clear focus on best use of resources. It is hoped that the evaluation of the Enhanced Hear and Treat process will provide evidence of improved outcomes and high levels of patient satisfaction over the next year.

- The work to improve the experiences of mental health patients is welcomed, particularly the engagement with stakeholders and the support for more appropriate conveyance. The Mental Health Nurse Specialist role should also provide a valuable additional resource in this sensitive area of service provision.

- The Committee recognises the importance of the quality priorities agreed for 2019/20, with the focus on mortality reviews, always events and cardiac arrest. In particular, the aim to ‘improve survival to discharge following out of hospital cardiac arrest’ resonates with the largely rural localities across Dorset. The performance against this priority will be awaited with interest.

- The Trust is to be congratulated on its continued achievements in relation to non-conveyance of patients to hospital and appropriate admissions when they are
conveyed. The extensive use of staff feedback to support the approach being taken is acknowledged.

- With regard to complaints and compliments, the Committee notes that there has been a reduction in the former and an increase in the latter, which is to be welcomed. It was also encouraging to see that learning from incidents and complaints is regularly reviewed and disseminated to staff. The identification of delays due to demand being the principal theme arising from incidents and complaints is noted, and, given that this has been a specific concern for Dorset Members, the Committee would urge that this matter be further addressed in the coming year.

- With regard to performance indicators, it is encouraging to see that ambulance response times have generally improved over the last year, particularly for Category 1 calls. It is to be hoped that this improvement can be sustained and that in due course the National Standard may be achieved for all Categories.

The Committee looks forward to the continuation of a constructive dialogue with South Western Ambulance Service NHS Foundation Trust and we thank you for the opportunity to comment on this Quality Account.

**Devon County Council’s Health and Adult Care Scrutiny Committee**

Devon County Council’s Health and Adult Care Scrutiny Committee has been invited to comment on the South Western Ambulance Service NHS Foundation Trust’s Quality Account for the year 2018/19. All references in this commentary relate to the reporting period of the 1st of April 2018 to the 31st of March 2019 and refer specifically to the Trust’s relationship with the Scrutiny Committee.

The Scrutiny Committee commends the Trust on a comprehensive Quality Account for 2018-19 and believes that it provides a fair reflection of the services offered by the Trust, based on the Scrutiny Committee’s knowledge.

In terms of the priorities for 2018-19 Members appreciate the work undertaken by the Trust regarding the experiences of mental health patients using the 999 Service. Members believe that staff wellbeing and good mental health are vitally important and need to be properly supported. The Committee notes that the progress of the Trust in developing and implementing “Always Events” has been positive but recognises that that time is needed to make all the changes required.

The Committee appreciates the Trust’s first 2018/19 priority, the clinical effectiveness of triage within the clinical hubs. Members admire the Trust’s use of a risk stratification tool to identify 999 calls which could be managed without sending an ambulance response.

The Committee fully supports the Trust’s Quality Priorities for Improvement 2019/20. Members particularly appreciate the Trust’s priority of development and implementation of Mortality Reviews following the 2016 Care Quality Commission review on the matter.

The Committee also supports the Trust’s goal of continuing to implement improvements to patient experience using “Always Events” methodology in end of life care. The Trust’s five initiatives to ensure residents and visitors within the region have the best possible chance of survival in the event of a cardiac arrest is also strongly supported by members, as is the widening of defibrillator training in the community.
Members anticipate that regular information on the progress of implementing these goals for 2019/20 will be shared by the Trust. The Committee also hopes that the Trust will continue to learn from its priorities from 2018/19 and implement lessons learnt.

The Committee welcomes a continued positive working relationship with the Trust in 2019/20 and beyond to continue to ensure the best possible outcomes for Devon residents.

Bristol City Council People Scrutiny Commission

The Bristol City Council People Scrutiny Commission holds the statutory health scrutiny function for Bristol City Council. The Commission received a presentation on the 13th May and Members were satisfied with the contents of the South Western Ambulance Service NHS Foundation Trust - Quality Review and Quality Account. Members welcomed the prioritisation of the experiences of Mental Health patients using the 999 service. The rollout of Mental Health First Aid training to staff was also welcomed. This shows SWAST are committed to parity of esteem.

Members strongly supported any initiatives that strengthened the organisations ability to gather feedback from service users. While it was noted that the ambulance services face some unique challenges with regards to obtaining user feedback, the Members support ongoing improvements in this area.

Members requested further information about the CQC improvement plan which has since been received.

Shauna Nash
Policy & Scrutiny Adviser

Healthwatch

SWAST Quality Account response from Healthwatch Torbay

Healthwatch Torbay is the independent local consumer champion for people who use health and social care services within the localities of Brixham, Paignton and Torquay.

The Trust give us the opportunity to contribute patient feedback by bringing our independent knowledge of local people’s experience of their health and care service and we are also able to gain deeper insight by taking part in stakeholder events such as the Healthwatch Open Days at the Trust headquarters in Exeter. This co-operative way of working is valued by both Healthwatch Torbay and the Trust.

This year’s Quality Account presents a clear explanation of the initiatives and service re-design required to address the pressures in the system.

We commend the Trust for its GOOD CQC rating last year, particularly with its OUTSTANDING rating in the field of ‘Caring’. This reflects our own feedback from patients using the Trust, which repeatedly praised Trust staff.

The only comments for improvement from the public involved the time taken to wait for an ambulance. This is reflected in the Quality Account. We passed this onto the Trust and were delighted to receive a prompt response with a public message with regards to waiting times, telling people how to ensure they get the response they need from the ambulance service and setting out
the different ways they respond to 999 calls. This was very much appreciated by the public.

Overall we consider that the Quality Account presents a realistic overview of the Trust’s performance and identifies appropriate internal controls and assurances.

Healthwatch Torbay
May 2019

Healthwatch Dorset, Healthwatch Gloucestershire and Healthwatch Somerset joint response to the South Western Ambulance Service NHS Foundation Trust’s 2018/19 Quality Account

This statement is provided on behalf of Healthwatch Dorset, Healthwatch Gloucestershire and Healthwatch Somerset. The role of Healthwatch is to promote the voice of patients and the wider public in respect to health and social care services and we welcome the opportunity to comment.

We are pleased to see that the Trust continue to focus on the experiences of patients with mental health issues who use the 999 service and note the work carried out by the Trust in the preceding year. Mental health is a priority for all three Healthwatch teams over 2019/20 and therefore, we would be happy to share with the Trust, any relevant, anonymous feedback that we gather during our engagement.

The continued work on the ‘always events’ (aspects of care and experience that should always occur when patients and their relatives/carers interact with health professionals) programme is welcomed. In particular, the commitment to focusing on those at the end of life, their relatives and carers. We look forward to hearing more about the outcomes of the work over the coming year.

It is positive to see that the Trust’s category 1 performance times have improved bringing them in line with the national standard. We note that there are still improvements to be made across other categories. However, we acknowledge the continued pressure on the system and the impact of the rurality of many areas across the patch, on these results.

The Trust has continued to actively engage with and build on its existing relationship with local Healthwatch in 2018/19. Our Teams appreciated the opportunity to go along to the open days run by the Trust to learn more about their latest developments and research.

We acknowledge the Trust’s continued commitment to patient and public engagement and their efforts to build on relationships with local Healthwatch and look forward to working with the Trust over the coming year.

HEALTHWATCH PLYMOUTH RESPONSE TO SWASFT QUALITY ACCOUNT FOR 2018/19

Below is our statement in response to the Quality Account for 2018/19.

‘Healthwatch Plymouth has read the Quality Account with interest and note the progress made around the 2018-19 initiatives especially the work in developing the ‘Enhanced Hear and Treat’ process for clinical triage by the Clinical Hubs. Equally the work done to understand the experiences of Mental Health patients using the 999 service is welcome and Healthwatch Plymouth has received feedback from the public around this work. Finally, we note the work that has been done to understand what matters to users of the service to create an ‘Always Event’ methodology to improve the experience of care. We also note that further work is ongoing in these areas.
Priorities for the forthcoming year are welcomed especially around the Implementation of Always Events for End of Life Care and the implementation of Mortality Reviews for Ambulance Services. We also note the longer-term work around Cardiac Arrest to maximise the interventions aligned to the ‘Chain of Survival’.

Patient experience of 999 services to Healthwatch Plymouth remains generally positive and patients acknowledge the attitudes of Staff and the treatment and care received. However, waiting times for an ambulance is often viewed as negative where patients are not triaged as category 1. Whilst acknowledging that the Trust covers a large area of the South West and as with other areas of the health service is facing operational pressures, patients need to have confidence that when they need emergency health support it will be delivered in a timely manner.

Healthwatch Plymouth are looking forward to further developing its relationship with the Trust over the next 12 months and beyond.7

Healthwatch Wiltshire response to South Western Ambulance Service Quality Account

Healthwatch Wiltshire thanks the trust for sharing its Quality account and welcomes the opportunity to comment. Healthwatch Wiltshire is an independent organisation that promotes the voice of patients and the wider public with respect to health and social care services.

It is noted that there is a Glossary of terms at the end of the Quality Account, but it would be helpful if this could be referenced at the start of the document.

Healthwatch Wiltshire recognises that the trust underwent it’s inspection by the Care Quality Commission (CQC) in the summer 2018 and was awarded ‘good’ overall. We also commend the trust for receiving several ‘outstanding’ ratings particularly in the caring domain. We look forward to hearing more about improvements planned in line with CQC recommendations.

We are pleased that experiences of mental health patients was a particular priority for the trust in 2018/19. Healthwatch Wiltshire was able to support you to gather feedback and we are pleased that you are now in the process of implementing new initiatives following this feedback; for example conveyance to crisis cafes instead of the emergency department. We look forward to hearing about further changes going forwards to continue to improve the experience for these patients.

Healthwatch Wiltshire commends the priority under Patient Safety around the development of Always events (aspects of care that should always occur) for patients at End of life which was driven by patient and staff feedback. Healthwatch Wiltshire applauds the joint working with other agencies and the co-design with patients for this work. We note that this will be a continued priority for the forthcoming year. We look forward to following this as it progresses and would be happy to support planned engagement with patients and families.

We note that the trust recognises the importance of learning from deaths and the impact that this could have on improving quality going forwards and that the trust has set this as one of their quality priorities for they are ahead. This would tie in with the publication of national guidelines due in the summer.

Looking at the national Reporting and learning data, Healthwatch Wiltshire notes that the number of incidents reported as severe harm seems to have increased substantially in the period 1 April – 30 Sept compared to the previous periods and we wonder if there is a reasoning for this?

Healthwatch Wiltshire applauds the trusts work around reducing admissions and the staff feedback.
system that you have in place that allows for continual identification of areas for improvement. We recognise that there were fewer serious incidents confirmed during the past year than previously and of those the main theme was delays to ambulance attendance. The feedback that we receive has also reflects these delays.

Healthwatch Wiltshire is pleased to see a decrease in the number of complaints received and an increase in the number of compliments received about the trust over the past year. The two top areas identified through the complaints process—access and waiting times and communication—mirrors the themes from some of the feedback that we have received over the last year. This has been shared directly with the trust and acknowledged.

We commend your work around patient engagement, particularly inviting patients to share their story at your board meetings. We note the low response rate of the friends and family test but are pleased that you attend other events such as shows, fetes where patient and public involvement is sought including you ‘lets talk’ events.

The Care Forum has the contract for Healthwatch Bath and North East Somerset, Healthwatch Bristol, Healthwatch South Gloucestershire and Healthwatch Swindon.

Below is a combined response jointly agreed by these Healthwatch.

Healthwatch welcome the opportunity to respond to the draft Quality Account of the South West Ambulance Service NHS Foundation Trust (SWAST).

This is the third year since the introduction of the Accessible Information Standard that Healthwatch has requested the draft Quality Account in an accessible audio version. Every year this has not been forthcoming. As a public document the Quality Account should be available in an accessible format when requested.

Healthwatch welcomes the glossary of terms and acronyms, but notes that throughout the Quality Account there are acronyms that are not mentioned within the list.

The statement on quality from the Chief Executive details the provision of high quality care for staff and the commitment to improving their health and wellbeing.

In our reply to the 2017/18 Quality Account Healthwatch commented on the Workforce Race Equality Standards section where BME staff had been experiencing harassment, bullying or abuse from staff which had increased from 9% to 32% for BME staff who had personally experienced discrimination at work from a manager, team leader or other colleague. In the latest 2018/19 Quality Account Healthwatch are disappointed that there is no follow up on what the trust has done to address this within the 2018/19. Bullying and harassment can have serious consequences for those directly involved and those they work with causing psychological stress and reducing productivity. Healthwatch are pleased to see you are trying to create a positive workplace culture with the introduction of ‘Freedom to speak up’ and whistleblowing. Healthwatch does has a concern over the wording ‘if a member of staff raises a genuine concern, they will not be at risk of losing their job or suffering any form of reprisal as a result’. All staff concerns should be of interest and evidence will show they are genuine.

Healthwatch also notes that missing from the 2018/19 Quality Account is the section on the trusts ‘Duty of Candour’.
Healthwatch notes that for the Emergency and Urgent Care (A&E 999), although caring is rated outstanding by the Care Quality Commission the overall rating requires improvement and wonders what during 2019/20 will be done to address this?

**Priorities for 2018/19**

Healthwatch welcome the clinical effectiveness of triage within the clinical hubs and asks if there is some data on how many calls have been saved? Healthwatch look forward to hearing more about impact from the implementation of the ‘Enhanced Hear and Treat process’.

Healthwatch applaud the approach to patient experience and look forward to seeing the results of the Mental Health Nurse Specialist pilot, it will be good to know the figures of staff trained as part of this and the benefits that have been achieved so far.

In patient safety Healthwatch look forward to hearing about the ‘Always Event programme’ and particularly the End of Life work in partnership with the five hospices.

**Quality priorities for 2019/20**

The continued work around patient safety to develop and implement a mortality review is commended by Healthwatch as a very proactive approach despite the lack of national guidance and we look forward to hearing more about this.

Healthwatch are always keen to see improvements identified from patient and family feedback. Using a small number of areas to ‘test’ Healthwatch asks if there is a contingency plan in place if patients do not remain engaged?

Healthwatch welcome the cardiac awareness training for the clinical effectiveness priority and would like to see numerical proof of effectiveness as the plans develop.

**Statements of Assurance from the Board**

For the research it would be useful for Healthwatch to know if the 574 participants came from a wider cohort and how they were recruited?

The trust received 2735 patient safety incidents in 2018/19 with 24 of these declared as serious incidents resulting in severe harm or death. Healthwatch would like to see a further breakdown of the 24 incidents of severe harm reported in the Quality Account, although from the graph we can see there were no reported deaths. There are discrepancies with the figures within the Quality Account for serious harm with the text saying 24 (0.8%) and the table under ‘Incident Reporting’ saying 25 cases. Healthwatch notes that this year has been better as 51 cases were recorded in 2017/18.

**Part 3 – other information**

Healthwatch were delighted to read that the trust consistently achieved the highest non conveyance rate of any ambulance trust in the UK and the highest rate of admission for patients conveyed to Emergency Departments. Staff are to be congratulated on demonstrating appropriate clinical decision making.

Healthwatch would like to see how many complaints were found justified or partly justified and how complaints have been dealt with within a timely manner.
Healthwatch look forward to hearing more following the rebranding and relaunch of the serious incident process now renamed as ‘Review, Learn and Improve’.

Learning from incidents and complaints has identified trends in relation to non conveyance of patients who have long lies following falls. Healthwatch ask what might be done to address this as 5% of falls end up as hospitalisation.

The increase in compliments this year provide good feedback from the public and Healthwatch is pleased that gratitude is passed to members of staff who attended the patient.

Healthwatch wonder if data on equality issues is collected as part of patient experience surveys? Healthwatch is pleased to read the ambulance response times and how these have improved since 2017/18. For the lay person, it would be useful to have an explanation of the ARP Response categories within the report. Most performance figures are still below the national standard, Healthwatch would appreciate having a breakdown of the number of calls in each geographical area. There are still many areas of data that could be included in the performance indicators that could give the lay person a more rounded understanding of the ambulance responses.

**Other**

**Swindon Borough Council**

Swindon Borough Council welcomes the Quality Account of SWAST and the commitment to continuous improvements in the services the Trust delivers so that the outcomes of patients improve”

Sue Wald Corporate Director Adult Social Services and Health, Swindon Borough Council
Response to South Western Ambulance Service NHS Foundation Trust’s Quality Account 2018/19

**Bournemouth, Christchurch and Poole Council**

We would like to thank the Trust for allowing the Council an opportunity to comment on this account regarding the achievements and areas for improvement detailed in the Quality Report for 2018/19. It is heartening that the Care Quality Commission rating is good overall. I have read the account and note the Trust’s progress in the following Quality Improvement areas:

**Clinical Effectiveness of Triage within Clinical Hubs**

It is encouraging to note that extensive work has been undertaken to stratify risk in order to prioritise and respond appropriately to any emergency calls. It is understandable that responses need to be proportionate and focussed on patients experiencing life threatening incidents. It will be interesting to understand how effective the enhanced “Hear and Treat” process is once evaluation is completed during 2019/20.

**Patient Experience-Experiences of Mental Health Patients using the 999 service**

It is pleasing to note that the Trust are taking steps to better understand patient experience for those experiencing mental health difficulties. It is encouraging to note conveyances are being directed away from emergency departments to more appropriate settings such as crisis cafes. It is also commendable that the trust is piloting having specialist mental nursing support in a locality
clinical hub in order to offer support to staff and patients during peak hours. Staff training is imperative and it is pleasing that this area will be further developed over the 19/20 period.

**Patient Safety-Development and Implementation of Always Events**

It is excellent to read that such a model of continual service improvement is being used within the Trust. It will be very interesting to understand through working with patients what improvements are identified with the end of life service and how these will be implemented and evaluated in order to improve patient experience. It will be interesting to learn more about the project as it unfolds over the 19/20 financial year.

Thank you for the opportunity to comment on an interesting Quality Review. We look forward to reading the published version but please take this letter as Borough of Poole’s response to the Quality Account.

Phil Hornsby  
Director of Adult Social Care- Commissioning and Improvement  
BCP Council

**Somerset County Council**

Thank you for giving the Somerset Health and Wellbeing Board the opportunity to comment on the quality review and quality account document. It includes a wealth of information demonstrating the important work the Trust does in our area.

There has been a concern raised by Board members that the document does not acknowledge the significant levels of concern repeatedly raised locally by GP’s, in particular regarding extended waiting times, especially for patients in a health professional setting with a proven severe diagnosis. GP Board members expected an acknowledgement of this within the document. I would just like to emphasise the rurality of the county and that the time it takes to reach more distant areas is my main concern. However, I was heartened to hear that a number of new, fully equipped vehicles are coming forwards which may alleviate some of the issues.

I attended the Adults and Health Scrutiny Meeting on 8th May where a very good presentation was made. I would ask that any discussion points raised from the meeting are included in consideration of the final report.

Cllr Christine Lawrence  
Chair – Somerset Health and Wellbeing Board  
Cabinet Member for Public Health and Wellbeing

**Cornwall Council**

Thank you for providing us with your quality account for the year 2018 - 2019.

We believe that the report adequately covers the Trust’s activities over the last year and highlights quality priorities for the forthcoming year. It is confirmed that South Western Ambulance Service NHS Foundation Trust has attended meetings and provided information when requested.

A report on the Trust performance was requested during the year. The report was warmly welcomed and the summary of performance in Cornwall was noted. Since the Trust attended the meeting in
November a number of concerns have been raised with the Committee which we will seek to discuss with the trust.

These are regarding a number of elements - the response times in rural locations, response times for lower ARP Response Categories and ‘stacking’.

At the time of the report to the Committee in November 2018, lower level geographical data for response times was not collected however following information provided to the media, we believe lower level information is now available.

The areas highlighted above will be a focus of the Committee with the Trust in the coming year in addition to how the Trust is achieving against the priorities identified in this report.
Annex 2: Statement of directors’ responsibilities for the quality report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year. NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

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

- the content of the quality report meets the requirements set out in the NHS foundation trust annual reporting manual 2018/19 and supporting guidance Detailed requirements for quality reports 2018/19

- the content of the quality report is not inconsistent with internal and external sources of information including:
  - board minutes and papers for the period 01 April 2018 to 23 May 2019
  - papers relating to quality reported to the board over the period April 2018 to 31 March 2019
  - feedback from commissioners dated 23/05/2018
  - feedback from governors dated 17/01/2019, 01/04/2019
  - feedback from local Healthwatch organisations dated 23/05/2018
  - feedback from overview and scrutiny committee dated 23/05/2018
  - the trust’s complaints report published under Regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 09/05/2018
  - the [latest] national staff survey 26/05/2019
  - the Head of Internal Audit’s annual opinion of the trust’s control environment dated 23/05/2019
  - CQC inspection report dated 27/09/2018

- the quality report presents a balanced picture of the NHS foundation trust’s performance over the period covered

- the performance information reported in the quality report is reliable and accurate
• there are proper internal controls over the collection and reporting of the measures of performance included in the quality report, and these controls are subject to review to confirm that they are working effectively in practice

• the data underpinning the measures of performance reported in the quality report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review

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

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

By order of the board

23.05.2019  Date

Chairman

23.05.2019  Date

Chief Executive
## Glossary of Terms and Acronyms

<table>
<thead>
<tr>
<th>Term</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>111</td>
<td>National phone number for people to access non-emergency healthcare and advice.</td>
</tr>
<tr>
<td>A&amp;E</td>
<td>Accident and Emergency.</td>
</tr>
<tr>
<td>ACQIs</td>
<td>Ambulance Clinical Quality Indicators – a set of nationally agreed measures for ambulance trusts which reflect best practice and stimulate continuous quality improvement.</td>
</tr>
<tr>
<td>AI - Adverse Incident</td>
<td>Any event or circumstance that could have or did lead to unintended or unexpected harm, loss or damage to any individual or the Trust. Adverse incidents may or may not be clinical and may involve actual or potential injury, mis-diagnosis or treatment, equipment failure, damage, loss, fire, theft, violence, abuse, accidents, ill health, near misses and hazards.</td>
</tr>
<tr>
<td>Board of Directors</td>
<td>Executive body responsible for the operational management and conduct of the organisation.</td>
</tr>
<tr>
<td>Clinical Audit</td>
<td>A quality improvement process that seeks to improve patient care and outcomes by measuring the quality of care and services against agreed standards and making improvements where necessary.</td>
</tr>
<tr>
<td>CCGs</td>
<td>Clinical commissioning groups – GP-led commissioners of local healthcare services.</td>
</tr>
<tr>
<td>Clinical Guidelines</td>
<td>Trust documents which introduce guidance which is either not considered within the scope of the JRCALC guidelines, or where further clarification is required.</td>
</tr>
<tr>
<td>Clinical Hub</td>
<td>SWASFT term for control room where phone calls to the Trust are handled.</td>
</tr>
<tr>
<td>CoG</td>
<td>Council of Governors – elected body that acts as guardians of NHS Foundation Trust, holding the board of directors to account and representing views of staff, public and other stakeholders.</td>
</tr>
<tr>
<td>CQC</td>
<td>Care Quality Commission - the independent regulator of health and adult social care.</td>
</tr>
<tr>
<td>CQUIN</td>
<td>Commissioning for Quality and Innovation payment framework enables commissioners to reward excellence, by linking a proportion of healthcare providers’ income to the achievement of local quality improvement goals.</td>
</tr>
<tr>
<td>DH</td>
<td>Department of Health – the government department that provides strategic leadership to the NHS and social care organisations in the UK.</td>
</tr>
<tr>
<td>ECS</td>
<td>Electronic Care System – allows the Trust to electronically capture exchange and report on patient information.</td>
</tr>
<tr>
<td>Executive Directors</td>
<td>Senior members of staff – including the Chief Executive and Finance Director – who sit on the Board of directors, have decision-making powers and a defined set of responsibilities.</td>
</tr>
<tr>
<td>FAQ</td>
<td>Frequently asked questions.</td>
</tr>
<tr>
<td>FFT</td>
<td>Friends and Family Test – NHS single question survey which asks patients whether they would recommend the service received to their friends and family.</td>
</tr>
<tr>
<td>NHS FT</td>
<td>National Health Service Foundation Trust – A not-for-profit, public benefit corporation which is part of the NHS and created to devolve decision-making from central government to local organisations and communities.</td>
</tr>
<tr>
<td><strong>Governance</strong></td>
<td>‘Rules’ that govern the internal conduct of an organisation by defining the roles and responsibilities of key offices/groups and the relationships between them, as well as the process for due decision making and the internal accountability arrangements</td>
</tr>
<tr>
<td><strong>GP</strong></td>
<td>General Practitioner</td>
</tr>
<tr>
<td><strong>Health Service Ombudsman</strong></td>
<td>Full title is the Parliamentary and Health Service Ombudsman established by Parliament to investigate complaints that individuals have been treated unfairly or have received poor service from government departments, the NHS and other public organisations in England.</td>
</tr>
<tr>
<td><strong>Healthwatch</strong></td>
<td>Organisations comprised of individuals and community groups working together to improve health and social care services. They represent the views of the public, people who use service and carers on the Health and Wellbeing boards set up by local authorities.</td>
</tr>
<tr>
<td><strong>HOSCs</strong></td>
<td>Health Overview and Scrutiny Committees – local authority committees with powers to scrutinise local health services to ensure improvements are made and inequalities reduced.</td>
</tr>
<tr>
<td><strong>Hospital Episode Statistics</strong></td>
<td>A data warehouse containing details of all admissions, outpatient appointments and A&amp;E attendances at NHS hospitals in England.</td>
</tr>
<tr>
<td><strong>ICPR</strong></td>
<td>Integrated Corporate Performance Report – a document which reports the Trust’s progress against its business plans; highlights where performance targets have not been met; describes the corrective action and timescales to address any performance issues.</td>
</tr>
<tr>
<td><strong>IG</strong></td>
<td>Information Governance is a framework which brings together all the legal rules, guidance and best practice that apply to the handling of information. It demonstrates that an organisation can be trusted to maintain the confidentiality and security of personal information and is consistent in the way in which it handles personal and corporate information.</td>
</tr>
<tr>
<td><strong>JRCALC Guidelines</strong></td>
<td>National clinical practice guidelines for NHS paramedics developed by the Joint Royal Colleges Ambulance Liaison Committee.</td>
</tr>
<tr>
<td><strong>KPIs</strong></td>
<td>Key performance indicators – a set of quantifiable measures used to demonstrate or compare performance in terms of meeting strategic and operational objectives.</td>
</tr>
<tr>
<td><strong>Local Clinical Audit</strong></td>
<td>A quality improvement project involving healthcare professionals evaluating aspects of care they have selected as being important to the organisation and service users.</td>
</tr>
<tr>
<td><strong>Moderate Harm Incident</strong></td>
<td>A patient safety incident that resulted in a moderate increase in treatment and that caused moderate, but not permanent, harm to one or more patients. A moderate increase in treatment is defined as a return to surgery, an unplanned readmission, a prolonged episode of care, extra time in hospital or as an outpatient, cancellation of treatment, or transfer to another area such as intensive care as a result of the incident.</td>
</tr>
<tr>
<td><strong>National Clinical Audit</strong></td>
<td>A clinical audit involving healthcare professionals across England and Wales in the systematic evaluation of their clinical practice against standards and to support and encourage improvement and deliver better outcomes in the quality of treatment and care. The priorities for national clinical audits are set centrally by the Department of Health and all NHS Trusts are expected to participate in the national audit programme.</td>
</tr>
</tbody>
</table>
| **NEDs** | Non-Executive Directors – members of the Board of Directors, but not part of the
<table>
<thead>
<tr>
<th><strong>Executive Management Team</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NICE</strong></td>
</tr>
<tr>
<td><strong>NRLS</strong></td>
</tr>
<tr>
<td><strong>OoH</strong></td>
</tr>
<tr>
<td><strong>PALS</strong></td>
</tr>
<tr>
<td><strong>Patient Opinion</strong></td>
</tr>
<tr>
<td><strong>Payment by Results</strong></td>
</tr>
<tr>
<td><strong>PPI</strong></td>
</tr>
<tr>
<td><strong>Priorities for Improvement</strong></td>
</tr>
<tr>
<td><strong>Right Care</strong></td>
</tr>
<tr>
<td><strong>Secondary Uses Service</strong></td>
</tr>
<tr>
<td><strong>Sepsis</strong></td>
</tr>
<tr>
<td><strong>SI – Serious Incident</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>SPoA</strong></td>
</tr>
<tr>
<td><strong>STEMI</strong></td>
</tr>
<tr>
<td><strong>SWASFT</strong></td>
</tr>
<tr>
<td><strong>Triage</strong></td>
</tr>
<tr>
<td>from immediate medical treatment to ensure a fair, appropriate allocation of resources</td>
</tr>
</tbody>
</table>
© South Western Ambulance Service NHS Foundation Trust 2018

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

Email: publicrelations@swast.nhs.uk Telephone: 01392 261649 Fax: 01392 261510

Post: Communications Department, South Western Ambulance Service NHS Foundation Trust, Abbey Court, Eagle Way, Exeter, Devon, EX2 7HY