Private and Confidential

South East Coast Ambulance Service NHS Foundation Trust
Red 3 / Green 5 Pilot review
Report for SECAmb and Monitor

22 February 2016

Deloitte LLP
Athene Place,
66 Shoe Lane,
London
EC4A 3BQ
# Table of Contents

1. Introduction and Terms of Reference ......................................................... 6
2. Summary of findings ..................................................................................... 10
3. Work performed ........................................................................................... 16
4. An overview of the Pilot and Ambulance Quality Indicators ....................... 19
5. The wider context surrounding the Pilot .................................................... 23
6. SECAmb’s governance structure ................................................................. 26
7. Chronology of events ................................................................................ 34
8. Development of the Pilot through the ODSG Hear and Treat work stream: 22 July 2014 to 4 December 2014 .......................................................... 38
9. Inclusion of Red 2 calls in the Pilot: 4 December 2014 to 20 December 2014 ................................................................................................................. 52
10. The period when the Pilot was in operation: 20 December 2014 to 24 February 2015 ........................................................................................................ 64
11. The Trust’s response to the Pilot: 24 February 2015 to 24 March 2015 .. 75
12. Effect of the Pilot on performance indicators ............................................. 79
13. Broader governance and leadership at the Trust ........................................ 83
14. Wider learnings from this review ................................................................ 90

Appendices ...................................................................................................... 94
Appendices

1. List of individuals we approached and interviewed as part of the review
2. Search terms applied in our electronic data review
3. Members of the Project Board for the ODSG
4. Methodology and limitations of the performance indicators’ review
### Abbreviations and terms used in this report

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>999 CQCG</td>
<td>999 Contract and Quality Commissioning Group</td>
</tr>
<tr>
<td>AACE</td>
<td>Association of Ambulance Chief Executives</td>
</tr>
<tr>
<td>AQI</td>
<td>Ambulance Quality Indicators</td>
</tr>
<tr>
<td>BRM</td>
<td>Business Review Meeting</td>
</tr>
<tr>
<td>CAD</td>
<td>Computer Aided Despatch</td>
</tr>
<tr>
<td>CCG</td>
<td>Clinical Commissioning Group</td>
</tr>
<tr>
<td>CQC</td>
<td>Care Quality Commission</td>
</tr>
<tr>
<td>CQWG</td>
<td>Clinical Quality Working Group</td>
</tr>
<tr>
<td>CQRG</td>
<td>Clinical Quality Review Group</td>
</tr>
<tr>
<td>EOC</td>
<td>Emergency Operations Centre</td>
</tr>
<tr>
<td>DH</td>
<td>Department of Health</td>
</tr>
<tr>
<td>FPPT</td>
<td>Fit and proper person review</td>
</tr>
<tr>
<td>‘Go Live’</td>
<td>Point at which the Red 3 / Green 5 Pilot was launched at 08:45 on 20 December 2014</td>
</tr>
<tr>
<td>IR</td>
<td>Incident Report</td>
</tr>
<tr>
<td>ITK</td>
<td>Interoperability Toolkit</td>
</tr>
<tr>
<td>ITT</td>
<td>Invitation to Tender</td>
</tr>
<tr>
<td>KPI</td>
<td>Key Performance Indicator</td>
</tr>
<tr>
<td>NHSE</td>
<td>NHS England</td>
</tr>
<tr>
<td>ODSG</td>
<td>Operational Delivery Strategy Group</td>
</tr>
<tr>
<td>OPGWG</td>
<td>Operational Performance &amp; Governance Working Group</td>
</tr>
<tr>
<td>Patient Impact Review</td>
<td>A further review initiated by the Trust focusing on whether there was harm to patients arising from the Pilot.</td>
</tr>
<tr>
<td>PP</td>
<td>Paramedic Practitioner</td>
</tr>
<tr>
<td>QIA</td>
<td>Quality Impact Assessment</td>
</tr>
<tr>
<td>REAP</td>
<td>Resourcing Escalatory Action Plans</td>
</tr>
<tr>
<td>RMCGC</td>
<td>Risk Management and Clinical Governance Committee</td>
</tr>
<tr>
<td>SECAmb</td>
<td>South East Coast Ambulance Service NHS Foundation Trust</td>
</tr>
<tr>
<td>SI</td>
<td>Significant Incident</td>
</tr>
<tr>
<td>SRV</td>
<td>Single Responder Vehicle</td>
</tr>
</tbody>
</table>
### Abbreviations and terms used in this report

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Board</td>
<td>The Board of SECAmb</td>
</tr>
<tr>
<td>Trust</td>
<td>South East Coast Ambulance Service NHS Foundation Trust</td>
</tr>
</tbody>
</table>
1 Introduction and Terms of Reference

Background

1.1 Deloitte LLP (“Deloitte UK”, “we” and/or “us”) was appointed by the South East Coast Ambulance Service NHS Foundation Trust (“SECAmb”, “the Trust” and/or “you”), under the terms of our Letter of Appointment dated 20 November 2015, to undertake a forensic review of the Red 3 / Green 5 Pilot (“the Pilot”).

1.2 By an agreement dated 7 December 2015 Deloitte UK, SECAmb and Monitor have agreed that Deloitte UK will treat Monitor as a beneficiary for the purposes of the Contracts (Rights of third Parties) Act 1999 and that Deloitte recognises that we owe a duty of care to both Monitor and SECAmb pursuant to that agreement.

Review objectives

1.3 The objectives of the review were to:

1.3.1 Establish the circumstances, governance and decision making in relation to the development, initiation and implementation of the Pilot, including details of:

1.3.1.1 The steps taken with a timeline of events;
1.3.1.2 The individuals involved at each stage of the decision making and approval process, including clarity on accountabilities;
1.3.1.3 The appropriateness of the decisions made, with respect to Trust and lead CCG policies and frameworks;
1.3.1.4 The appropriateness of clinical decision making with respect to Trust and lead CCG policies and frameworks, clinical assessment and clinical evaluation;
1.3.1.5 The intentions and wider context surrounding the Pilot; and
1.3.1.6 The systems and controls in place at the time.

1.3.2 Assess the impact of the implementation of the Pilot on performance target reporting, including:

1.3.2.1 A validation of the Trust’s own exercise to analyse what performance would have been in the absence of the Pilot.

1.3.3 Assess the functioning of the Operational Delivery Strategy Group (“ODSG”); and

1.3.4 Assess the nature and level of scrutiny employed by the Trust Board and its Committees over the handling of the Pilot at each stage of the process.
Structure of this Report

1.4 This Report is set out as follows:

1.4.1 In the remainder of this section (1), we set out the limitations on the use of this Report;

1.4.2 In Section 2, we summarise our key findings;

1.4.3 In Section 3, we detail the work we have performed and its limitations;

1.4.4 In Section 4, we set out our understanding of the Pilot and Ambulance Quality Indicators;

1.4.5 In Section 5, we comment on the wider context surrounding the Pilot;

1.4.6 In Section 6, we set out our understanding of SECAmb’s governance structures;

1.4.7 In Section 7, we include a chronology of events relating to the Pilot;

1.4.8 In Section 8, we focus on the functioning of the ODSG, the actions it took and the related governance arrangements between 22 July 2014 and 4 December 2014;

1.4.9 In Section 9, we focus on the development of the Pilot and the governance arrangements in place in the period between 4 December 2014 and the Pilot going live on 20 December 2014;

1.4.10 In Section 10, we comment on the implementation of the Pilot, how it was managed and the governance arrangements in place while it was operational from 20 December 2014 to 24 February 2015;

1.4.11 In Section 11, we discuss the response of the Trust Board and its Committees to the Pilot, from its cessation on 24 February 2015 through to 24 March 2015;

1.4.12 In Section 12, we review the impact of the Pilot on the Trust’s performance target reporting;

1.4.13 In Section 13, we discuss broader governance and leadership at the Trust; and

1.4.14 In Section 14, we outline some potential wider learnings for the sector.
Background to our work

1.5 The Trust provides 999 and NHS 111 services to the population of Kent, Sussex and Surrey. In December 2014 the Trust implemented a pilot scheme that involved a change to standard operating procedures regarding the handling of certain NHS 111 calls which had been transferred to the 999 service where the NHS Pathways assessment had resulted in an ambulance despatch disposition.

1.6 Under the pilot, the Trust introduced a second triage stage for certain calls to NHS 111 to ascertain whether they required an ambulance. The second triage took place after the NHS 111 assessment had determined that an ambulance was required.

1.7 The changes effected via the pilot scheme are not in line with the NHS England NHS 111 Commissioning Standards, which state:

“NHS 111 must be able to identify potentially life threatening problems and dispatch an ambulance without any delay or re-triage, and support the patient prior to the vehicle arriving.”¹

1.8 The Trust conducted an investigation, with scrutiny by the lead Commissioners’ Clinical Quality and Safety team, into the Trust’s introduction and handling of the Pilot in February 2015 and the report was finalised on 1 July 2015. NHS England opened a separate investigation following a risk summit on 31 March 2015. The NHS England investigation report was shared with stakeholders (including Monitor) on 17 August 2015.

1.9 Monitor has decided to take enforcement action against the Trust on the basis of the findings of the reviews noted above. As part of the enforcement action, Monitor has accepted undertakings from the Trust under section 106 of the Health and Social Care Act 2012. These undertakings included a requirement for the Trust to commission a forensic review into the Pilot project.

Terminology

1.10 It is important to clarify the use of the term ‘Pilot’ throughout this document. The terms of reference for the review highlight that “In December 2014 the Trust implemented a pilot scheme that involved a change to standard operating procedures regarding the handling following the transfer of some NHS 111 service calls to the ambulance 999 service. Under the pilot, the Trust introduced a second triage stage for certain calls to NHS 111 to ascertain whether they required an ambulance. The

second triage took place after the initial triage (by NHS 111) had determined that an ambulance was required. The pilot scheme encompassed all Red 2 (R2) calls and Green 3 (G3) calls received by NHS 111”.

1.11 During the course of the review some interviewees have disputed the ‘pilot’ nature of the proposed operational changes, describing them as changes to ‘business as usual’ operational processes at times of peak pressure. Others have noted that the term ‘pilot’ was not used in conversations with them about the proposals to re-triage certain red and green calls transferred from NHS111.

1.12 So, for the avoidance of doubt, as in the terms of reference for the review, the use of the term pilot throughout this document refers in general to the events surrounding the re-triage of Red 2 and Green 3 calls received by SECAmb’s 999 service from the NHS 111 service.

**Limitations on the use of this report**

1.13 We remind you of the Terms of Business attached to our Letter of Appointment, particularly in relation to confidentiality. These preclude you from disclosing this Report to any third party other than Monitor without our prior written consent.

1.14 This Report has been prepared for use by SECAmb and by Monitor. It is confidential and was prepared for the Purpose expressed in our Letter of Appointment dated 20 November 2015. It should not be used, reproduced or circulated for any other purpose, in whole or in part, without our prior written consent except as required by law. Deloitte UK accepts no responsibility to any third parties for breach of this obligation or for any opinions expressed or information included within this Report. No other party is entitled to rely on this Report for any purpose whatsoever.

1.15 We draw attention to the Important Notice at the end of this Report.
2 Summary of findings

Overview

2.1 It is important to note the context in which the events which are the subject of this review took place. There was considerable pressure on the urgent and emergency care system in the South East during late 2014 due to a range of factors including ‘Winter pressures’, hospital hand-over delays, Ebola preparedness requirements and increased call volume from NHS 111 to 999. There was also a perception held by many SECamb staff that a significant number of calls categorised by NHS 111 as Red 2 were incorrectly classified because of the NHS Pathways algorithms for certain conditions.

2.2 In response to these pressures SECamb ran a ‘Pilot’ from 20 December 2014 to 24 February 2015 which involved the re-triaging of Red 2 and Green calls referred to the 999 service from the NHS 111 service. The Pilot allowed up to ten minutes for the re-triage of Red 2 calls and up to 20 minutes for the re-triage of Green calls before the calls were allocated for despatch. The clock start for reporting purposes was also delayed until the calls were either allocated for despatch or re-categorised.

2.3 The changes effected via the Pilot were not in line with the NHS England NHS 111 Commissioning Standards (June 2014) which state that: “NHS 111 must be able to identify potentially life threatening problems and dispatch an ambulance without any delay or re-triage, and support the patient prior to the vehicle arriving.”

2.4 In addition, the changes to the clock start did not comply with nationally agreed operating standards which require Red 2 calls to receive an emergency response within eight minutes, irrespective of location, in 75% of cases presenting.

2.5 Our overall conclusion from this review is that there were a number of fundamental failings in governance at the Trust which resulted in the implementation of a high risk and sensitive project without adequate clinical assessment or appraisal by the Board, Commissioners or the NHS 111 Service. Furthermore, the level and nature of disclosure surrounding the Pilot during the period it was live and shortly after it ceased strongly suggests there was an intentional effort by members of the executive team to present the Pilot in a positive light in certain Board discussions and to Commissioners, whilst understating some of its challenges and governance failings. The CEO made the ultimate decision to proceed with the Pilot and played a critical leadership role throughout. The key findings that underpin this conclusion are set out in section 2.6 below.
Key findings from our review of the pilot

2.6 We outline below a summary of our key findings in relation to the Pilot:

2.6.1 The concept of the Operational Delivery Strategy Group ("ODSG") in itself appears to have been well intentioned as a time limited working group designed to identify and implement opportunities for performance improvement. There is no indication that there was any intention to conceal information from the Board and Commissioners in relation to ODSG activities in general.

2.6.2 The governance arrangements around the ODSG were inadequate. It would not be unusual for a Task and Finish group such as the ODSG to have formally reported into the Operational Performance & Governance Working Group and ultimately the Risk Management and Clinical Governance Committee. As a minimum however, we would have expected the Project Sponsor and other Executive members to report material matters emerging from ODSG into the Working Groups and Committees they attended. The Project Sponsor for the ODSG was initially the CEO, but changed to the Director of Clinical Operations on 4 August 2014 (prior to the Pilot being developed), though it is apparent that the CEO still identified himself as the ‘Chair’ of the ODSG (see paragraphs 6.23 to 6.25). The Director of Clinical Operations should have reported to the OPGWG, the Medical Director should have reported to the CQWG and the CEO was ultimately responsible for ensuring appropriate reporting and governance around the ODSG.

2.6.3 Concerns were raised by a number of senior colleagues to the CEO in early December 2014 regarding the inclusion of Red 2 calls in the Pilot. These concerns were not adequately addressed and the CEO instructed that the Pilot should go ahead. The Director of Clinical Operations was also aware there were concerns (although he was not a participant on the call on 4 December 2014, when the decision to include Red 2 calls from NHS 111 in the Pilot was made) but did not challenge the CEO on the lack of response or escalate these concerns further. In addition, the deviation from AQI reporting guidelines by stopping the clock for up to ten minutes was raised to the CEO as a specific concern by a member of the information team but was not adequately addressed by the CEO.

2.6.4 The CEO’s directive and persuasive management style, coupled with an impending restructure of the executive team, meant that the level of challenge over the Pilot within the organisation was inhibited and, once the CEO issued instructions, staff set aside their concerns and focused on how to put the Pilot into operation quickly and effectively.
2.6.5 A significant proportion of interviewees cited the need to deal with demand pressures and to manage risk by protecting Red 1 and 999 Red 2 callers (ensuring the service’s ability to respond to those calls) as the primary motivation for the Pilot. Others highlighted that, given the options that could have been pursued, including not stopping the clock, it is reasonable to conclude that performance against KPIs was also a material driver.

2.6.6 Clinical involvement was insufficient throughout the Pilot with limited engagement from the Medical Director (see 8.21 and 8.23 for details) and no formal Quality Impact Assessment which the Medical Director should have ensured took place. It was inappropriate that the only formal clinical validation of the Pilot was the ‘Chair’s action’ to approve the operating procedures for the Pilot by the Director of Clinical Operations, in his role as chair of the Operational Performance & Governance Working Group. It was not tabled in other fora, such as the Clinical Quality Working Group or the Risk Management and Governance Committee, prior to the Pilot going live. We would have expected the CEO, the Director of Clinical Operations and the Medical Director to have ensured greater disclosure of the Pilot to the Risk Management and Governance Committee, particularly at the meeting on 13 January 2015, when the Pilot was in operation.

2.6.7 There was a lack of clarity over clinical accountabilities in relation to the Pilot (in particular between the Director of Clinical Operations and the Medical Director) and a culture of silo working between operational and clinical portfolios and between NHS 111 and 999. The CEO, the Director of Clinical Operations and the Medical Director should have ensured that accountabilities were clearly defined and the CEO should have ensured that as his direct reports, both individuals executed against those defined accountabilities.

2.6.8 Commissioners were advised about the Pilot but did not fully appreciate that the Pilot would include Red 2 calls or that there would be a deviation from national AQI reporting guidelines, as these decisions were taken by the Trust after the request for approval was made to the 999 Contract and Quality Commissioning Group on 3 December 2014. Trust representatives should have provided updates to Commissioners prior to the Pilot going live on 20 December 2014 and at the 999 Contract and Quality Commissioning Group on 12 January 2015 where the Pilot was not discussed.

2.6.9 The level of scrutiny applied to the Pilot by Commissioners, based on the available information, was insufficient and the references that had been made to the re-triage of Red calls at the 3 December 2015 999 CQCG meeting should have been questioned more robustly.
2.6.10 The Director of Commercial Services had overall accountability for gaining Commissioners’ approval and he attended the 999 Contract and Quality Commissioning Group on 3 December 2014, along with eight other members of SECAmb staff. The Director of Commercial Services was not available to attend the 999 Contract and Quality Commissioning Group on 12 January 2015. However, other members of SECAmb staff who did attend, most notably the Acting Associate Director of Operations, could have provided an update on the Pilot at that meeting.

2.6.11 Governance arrangements with Commissioners had become too relaxed with inappropriately low levels of documentation in relation to key decisions and approvals. Engagement between the Trust and the Lead Commissioner was overly reliant on the relationship with the Director of Commercial Services. We understand that steps have subsequently been taken to rectify this.

2.6.12 Non-Executive Directors, excluding the Chair, had no detailed knowledge of the Pilot until it had ended. This is despite there being opportunities to update the Board in relation to the Pilot at two Board meetings and a RMCGC meeting during January 2015. Furthermore, the OPGWG Chair’s action to sign-off the operating procedure referencing the Pilot (see paragraph 9.30), should have been reported to the RMCGC meeting in January 2015 by the Director of Clinical Operations, but it was not mentioned. Given the critical and sensitive nature of the Pilot, failure of the Executive Directors to disclose to the rest of the Board or its Committees in a meaningful way during January 2015 represents a serious breach of executive accountability.

2.6.13 The Chair accepts that he had access to more information about what became known as the Pilot than was made available to other Non-Executives and that he was aware of an initiative involving the re-triage of Red calls. Although different interpretations of the conversations that took place between the Chair and CEO on this matter have been presented to the review team, there is no evidence that the Chair was aware of the plan to delay the clock start by up to ten minutes. However, even in the absence of this specific information it would have been appropriate for the Chair to have led greater scrutiny of the proposals to re-triage Red 2 calls.

2.6.14 Following the suspension of the Pilot on 24 February 2015, two Operational Impact papers were presented to the RMCGC on 16 March 2015. The second paper, authored by a Senior Operations Manager, misled the Committee by playing down the implications of the Pilot. The Senior Operations Manager in question ‘cannot recall’ who instructed him to draft the paper. According to the minutes of the meeting, the second paper was tabled on the day of the meeting by the Director of Clinical Operations although he has advised us that he only subsequently became aware of the existence of a
second paper in October 2015. The second paper provided erroneous information, including for example, information regarding the commissioners knowledge of the clock-stop and ten minute delay, an overstatement of the involvement of the Medical Director and removal of references to important elements of the Pilot such as the decision to leave it on permanently and a grievance raised by clinical supervisors.

2.6.15 We found no evidence of formal engagement or communication with NHS 111 prior to or during the Pilot. The lack of dialogue and engagement between the services is likely to have exacerbated the low levels of confidence that the 999 service had in NHS 111.

2.6.16 At the time of and in the subsequent response to the Pilot, the information provided to the review suggests that the Board’s effectiveness was impacted by a number of factors including: a non-unitary Board, the style of the Chair, a lack of scrutiny, limited clinical focus and ‘silobased’ working by Executives. The circumstances surrounding the implementation of the Pilot and the way in which the Board handled the subsequent investigations were influenced by these factors. See Section 13 for further details.

Our review of performance reporting

2.7 We have reviewed the extent to which the indicators submitted to Monitor by SECAmb for the months of December 2014\(^2\), January 2015\(^3\) and February 2015\(^4\) followed NHSE 2013 guidelines. Our work, which is set out in Section 12 and summarised in Table 2.1 below indicates that SECAmb’s initial AQI calculations did not follow the NHSE 2013 guidelines and presented a positive performance differential for Red 2 calls ranging from 2.10% in December 2014 to 5.44% in January 2015. The consequence of this was that SECAmb reported that it met the 75% performance target for responding to Red 2 calls for January 2015 when this target had not been achieved. SECAmb’s post revision AQI calculations, submitted in April 2015, are in line with NHSE guidelines.

\(^2\) Initially submitted on 22 January 2015.
\(^3\) Initially submitted on 20 February 2015.
\(^4\) Initially submitted on 23 March 2015.
Table 2.1: AQIs and performance indicators for Red 2 calls, in December 2014, January 2015 and February 2015

<table>
<thead>
<tr>
<th>Indicator’s name</th>
<th>Definition</th>
<th>Total valid Calls</th>
<th>Valid calls meeting target</th>
<th>Indicator</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>This review</td>
<td>Post-revision</td>
<td>Pre-revision</td>
</tr>
<tr>
<td>December 2014</td>
<td>R2-8</td>
<td>75% R2&lt;=8:00min</td>
<td>24,899</td>
<td>24,896</td>
</tr>
<tr>
<td>January 2015</td>
<td>R2-8</td>
<td>75% R2&lt;=8:00min</td>
<td>22,309</td>
<td>22,304</td>
</tr>
<tr>
<td>February 2015</td>
<td>R2-8</td>
<td>75% R2&lt;=8:00min</td>
<td>19,689</td>
<td>19,683</td>
</tr>
</tbody>
</table>

Source: Deloitte UK analysis, SECAmb

Wider system learnings

2.8 We have identified a number of areas during the course of this review which represent key development areas for SECAmb. A number of these points also represent important learnings for the ambulance sector and wider system, and these are outlined in Section 14.

Next Steps

2.9 We suggest that the Trust, in consultation with Monitor, should undertake the following next steps:

2.9.1 Consider the implications of the findings of this review for Executive Directors and Non-Executive Directors at SECAmb;

2.9.2 Undertake a wider governance review and develop a development plan with key actions to strengthen Board and organisational governance systems, processes and behaviours;

2.9.3 Establish an appropriate mechanism for communicating the learnings from this Pilot within the Trust and wider system;

2.9.4 Work with Commissioners to build on the steps already underway to improve commissioner oversight and Trust / Commissioner engagement; and

2.9.5 Identify and pursue key actions to improve communication and collaboration between NHS 111 and 999 as a matter of urgency.
3 Work performed

Work performed

3.1 In accordance with our Letter of Appointment, our work has comprised of the following:

3.1.1 A desk based review of relevant evidence and information. The documentation we reviewed contained, but was not limited to:

3.1.1.1 Board Meeting agendas and minutes;
3.1.1.2 Business Review Meeting agendas and minutes;
3.1.1.3 Agendas and Meeting minutes for Committees of the Board;
3.1.1.4 Meeting minutes from meetings with Commissioners;
3.1.1.5 Terms of reference for Committees and Working Groups;
3.1.1.6 Actions Trackers;
3.1.1.7 Reports and papers produced by SECAmb staff;
3.1.1.8 Emails;

3.1.2 A review of the reports from the two previous reviews (noted above in paragraph 1.8);

3.1.3 Interviews with individuals, including Executive and Non-Executive Board members, other key members of trust staff and other stakeholders with an awareness of the Pilot. A list of the persons we selected to interview is included in Appendix 1. Our interviews consisted of:

3.1.3.1 37 individuals who we selected to speak to; and
3.1.3.2 20 individuals who responded to an open invitation to speak to us.

3.1.4 Our interview questions were tailored specifically for each interview, the key topics covered included:

3.1.4.1 The wider context surrounding the Pilot;
3.1.4.2 The timeline of the development and implementation of the Pilot;
3.1.4.3 The functioning of the Operational Delivery Strategy Group;
3.1.4.4 The wider governance around the Pilot;
3.1.4.5 The Individuals involved in the decision making;
3.1.4.6 The Non-Executive Directors’ and Commissioners’ awareness of the Pilot;

5 We have not listed the individuals who responded to the open invitation to speak to us, to preserve their anonymity.
3.1.5 A review of the impact of the implementation of the Pilot on performance target reporting; and

3.1.6 A review of the internal email communications to and from the Chair and the CEO for the period from 1 July 2014 to 31 December 2015, after applying the search terms listed in Appendix 2. In total we reviewed 3,327 documents identified from this source.

Limitations of the work performed

3.2 This report sets out our findings based on work performed up to 22 February 2016. We cannot rule out the possibility that, had further work been conducted, our findings might have been different or that we may have identified additional matters to bring to your attention.

3.3 For the purposes of this report, save where we have been able to corroborate information, we have had to assume that the documents or other information (including electronic material) disclosed to us are reliable and complete. Many of our findings are based on circumstantial rather than direct evidence. This report should be considered in that light and we cannot accept any liability for our findings being prejudiced through provision of incomplete or unreliable information or material.

3.4 In accordance with the protocols agreed by the Trust and Monitor, a draft of this Report was provided to the Trust for factual accuracy check. Following completion of this check, relevant individuals as identified by the Trust were invited to participate in a ‘Salmon’ process whereby, subject to signature of a confidentiality agreement, they were provided with an opportunity to confirm the accuracy of the factual findings in our report and to respond to any perceived criticism of their conduct. The comments we received were considered as part of the process of finalising the Report and amendments were made where appropriate.

3.5 In this Report we discuss the re-triaging of Red 2 calls referred to the 999 service from NHS 111. Our comments on the re-triaging of Red 2 calls are discussed in the context of and are only attributable to the Pilot. We have not been asked to comment on whether the Pilot was the right intervention and we do not comment on whether any form of re-triage of Red 2 calls might or might not be appropriate in the future.

3.6 We did not conduct a general review of the controls within the Trust. The control weakness points noted in this report are simply those which came to our attention during the course of our work. They are not intended to be exhaustive or a comprehensive list of all the control weaknesses that may exist. Moreover, our work should not be construed as an audit. The control weaknesses that we identified were those existing at the time of the events that formed the subject of our review. Our work was designed to focus on areas identified by the Trust and by Monitor as being related to the control of, and response to, the Pilot project. This work was not
designed to identify all circumstances of fraud or other irregularity, if any, that may exist.

3.7 This report should not be construed as expressing opinions on matters of law. However, it necessarily reflects our understanding thereof.

3.8 We draw to your attention that names, dates and times associated with electronic files have been quoted in this report, but they are intended for guidance only. The nature of computer systems is such that these values can be inaccurate due to system settings or through user activity.

3.9 All data analysis is undertaken using computer processes and individual transactions are not reviewed manually in such a process. The analysis has been prepared on the basis of the instructions provided by (or agreed with) you for using a computerised process to identify relevant transactions, as set out in our Letter of Appointment of 20 November 2015.

3.10 As set out in the Letter of Appointment, the scope of our work has been limited by the time, information and explanations made available to us. The information contained in the Report has been obtained from SECAmb and third party sources that are clearly referenced in the appropriate sections of the Report. Deloitte has neither sought to corroborate this information nor to review its overall reasonableness. Further, any results from the analysis contained in the Report are reliant on the information available at the time of writing the Report and should not be relied upon in subsequent periods.

3.11 We note that in addition to the review undertaken by us, SECAmb has initiated a further review focusing on the impact (both harm and benefit) on patients as a result of the Pilot (the “Patient Impact Review”). Our review is independent of the Patient Impact Review and our review should not be relied upon to assess the harm or benefit to patients (if any) arising from the Pilot.

3.12 In order to perform our review of the internal email communications to and from the Chair and the CEO, which is explained above in paragraph 3.1.6, we were provided with live and archived email data stored on the Trust’s server. We note that data provided to us may not contain all emails to and from the Chair and the CEO in the period from 1 July 2014 to 31 December 2015. In order to access any deleted emails the Trust would need to restore backup tapes and provide us the data contained thereon.
4 An overview of the Pilot and Ambulance Quality Indicators

Introduction

4.1 In this section we describe what became known as the Pilot. We also outline the Ambulance Quality Indicators for Ambulance Trusts.

Background

4.2 Since NHS 111 went live in March 2013, calls managed by the 999 service can arrive from two sources:

4.2.1 calls made directly to the 999 service; or

4.2.2 calls made to NHS 111, which are transferred to the 999 service as a result of an NHS 111 Pathways disposition requiring an ambulance.

4.3 Both NHS 111 and the 999 service are required to categorise the calls they receive, which require an ambulance response, based on the severity of the patient’s need. In Table 4.1 below, we set out how the Ambulance Service categorises its calls. Broadly, for calls categorised as ‘Red’ there is deemed to be an immediate threat to life, whereas ‘Green’ calls are not deemed to be immediately life threatening.

**Table 4.1: Call categorisation used by Ambulance Trusts**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Explanation</th>
<th>National target</th>
</tr>
</thead>
</table>
| R1 (Red 1)                | Life-threatening conditions where speed of response may be critical in saving life or improving the outcome for the patient, for example - heart attack, trauma, serious bleeding | - 75 percent of all Red 1 patients must be reached in 8 minutes  
- 95 percent of all Red 1 patients must be reached within 19 minutes |
| R2 (Red 2)                | Serious but not the most life threatening                                   | - 75 percent of all Red 2 patients must be reached in 8 minutes  
- 95 percent of all Red 2 patients must be reached within 19 minutes |
| Category C (Green calls)  | Conditions where the patient has been assessed as not having immediately life threatening condition but does require an assessment by an ambulance clinician or transport to hospital. | Agreed locally - the patient should receive an emergency response in 30 or 60 minutes depending on the clinical need |

Source: SECAmb Website

---


The Pilot

4.4 The Pilot involved the introduction of two queues in the Computer Aided Despatch (“CAD”) system in the 999 service. The 999 service uses the CAD system to despatch ambulances.

4.5 The first queue was implemented for all emergency Red 2 calls referred to the 999 service from NHS 111 and resulted in these calls being re-categorised as ‘Red 3’. The second queue was implemented for all non-emergency Green calls referred to the 999 service from NHS 111 and resulted in these calls being re-categorised as ‘Green 5’.

4.6 The re-categorisation and queuing of the ‘Red 3’ calls allowed a team of Paramedic Practitioners (“PPs”) to re-triage these calls. The separation of the Red 3 calls was known as call partitioning or call management.

4.7 A window of up to a maximum of ten minutes, which was in addition to the eight minute AQI target for Red 2 calls, was allowed for the PPs to re-triage the calls. In the ten minutes allocated for re-triage, the intention was for the PP to call back the patient to assess their need and to determine whether an ambulance was the most appropriate response. The PP would provide suitable alternative ‘hear and treat’ advice and referral when deemed appropriate.

4.8 The re-triaging of Red 2 calls from NHS 111 is not compliant with the NHS 111 Commissioning Standards, which state that:

“NHS 111 must be able to identify potentially life threatening problems and dispatch an ambulance without any delay or re-triage, and support the patient prior to the vehicle arriving.”

4.9 This call partitioning could be switched on or off within the EOC. It was intended to be used at times of regular peaks in NHS 111 calls, in particular from 08:00 to 00:00

---

8 Red 1 calls remained in the main 999 queue and were not re-triaged.

9 PPs have a dual role, both on the road responding to calls by providing care at home and in the EOC to provide clinical support. PPs’ training is 18 months to 2 years, involving multiple placements and a degree.

10 Interviews with Trust staff indicate that Clinical Supervisors and to a lesser extent GPs also re-triaged ‘Red 3’ calls.

11 Email from an Operations Manager to all EOC staff, ‘111 Call Management Update and process V2’, 18 December 2014.

on Saturdays and Sundays. It could be switched on as a pre-planned action or in response to significant demand issues\(^\text{13}\).

4.10 PPs understood that the Pilot was only intended to be in operation while there were PPs on duty to re-triage the calls.

**Performance reporting requirements**

4.11 NHSE sets seven Ambulance Quality System Indicators (“AQIs”) to monitor Ambulance Trusts’ performance.

4.12 Ambulance Trusts are required to submit the AQIs to Monitor on a monthly basis. These indicators are used to monitor and compare Trusts’ performance in the response to Category A calls. Of these indicators, three were directly affected by the Pilot. These were:

1. **R1-8**: The proportion of Category A (Red 1) calls resulting in an emergency response arriving at the scene of the incident within 8 minutes 0 seconds is at least 75%;
2. **R2-8**: The proportion of Category A (Red 2) calls resulting in an emergency response arriving at the scene of the incident within 8 minutes 0 seconds is at least 75%; and
3. **R-19**: The proportion of Category A calls resulting in an ambulance arriving at the scene of the incident within 19 minutes 0 seconds is at least 95%.

4.13 Under the terms of its local contracts with NHS Swale CCG\(^\text{14}\), NHS North West Surrey CCG and NHS Horsham and Mid Sussex CCG\(^\text{15}\) SECAmb calculated two additional indicators with respect to Category C calls:

1. **G2-30**: The proportion of Category C (Green 2) calls resulting in an ambulance arriving at the scene of the incident within 30 minutes 0 seconds is at least 95%; and
2. **G4-60**: The proportion of Category C (Green 4) calls resulting in an ambulance arriving at the scene of the incident within 60 minutes 0 seconds is at least 95%.

4.14 SECAmb reports the G2-30 indicator to the Commissioners on a monthly basis. The G4-60 indicator is currently not reported.

---

\(^\text{13}\) Email from an Operations Manager to all EOC staff, ‘111 Call Management Update and process V2’, 18 December 2014.

\(^\text{14}\) NHS Swale CCG was the Co-ordinating Commissioner for the 22 CCGs across KMSS

\(^\text{15}\) NHS North West Surrey CCG and NHS Horsham and Mid Sussex CCG had a ‘lead associate’ role in coordinating the work with their respective counties.
NHSE AQIs guidance

4.15 NHSE publishes guidelines for providers to calculate AQIs. The guidelines that apply during the period of the Pilot were published in 2013\(^\text{16}\). In these, NHSE describes how the response time is to be calculated for each AQI, defining a Clock Start and a Clock Stop for each indicator. In Section 12, we comment on the impact of the Pilot on the AQIs.

4.16 The table below summarises the Clock Start and Clock Stop definitions as set by NHSE.

Table 4.2: Clock Start of the Clock Stop according NHSE 2013 guidelines for AQIs calculation

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Incidents included (by final priority)</th>
<th>Clock Start</th>
<th>Clock Stop</th>
</tr>
</thead>
<tbody>
<tr>
<td>R1-8</td>
<td>R1</td>
<td>Call Connect</td>
<td>Arrival of the first vehicle on the scene</td>
</tr>
<tr>
<td>R2-8</td>
<td>R2</td>
<td>Earliest of: • Chief complaint information is obtained; • Chief complaint (or Pathways initial DX code) information is obtained; • First vehicle assigned; or • 60 seconds after Call Connect.</td>
<td>Arrival of the first vehicle on the scene</td>
</tr>
<tr>
<td>R-19</td>
<td>R1 and R2</td>
<td>Earliest of: • The initial responder makes a request for transport to the control room • The information received from the emergency caller indicates that transport is needed, in which case the clock starts either when the call is presented to the control telephone switch Red 1 or for Red 2 calls the earliest of: • Chief complaint (or Pathways initial DX code) information is obtained; • First vehicle assigned; or • 60 seconds after Call Connect (i.e. 60 seconds after the time at which the call is presented to the control room telephone switch)</td>
<td>Arrival of the first ambulance service-despatched emergency responder</td>
</tr>
</tbody>
</table>

Source: NHSE, ‘Ambulance Quality Indicators’, 2013

5 The wider context surrounding the Pilot

Introduction

5.1 In this Section, we focus on the wider context surrounding the Pilot and the pressures the Trust was experiencing.

The pressures on SECAmb in mid to late 2014

Increasing call volumes from NHS 111

5.2 Following the launch of NHS 111 in March 2013, the 999 service experienced a steady increase in the volume of referrals from NHS 111 to the 999 service in 2014.

5.3 The reasons for the increase in the volume of calls received by NHS 111 and the volume of referrals from NHS 111 to the 999 service fall outside the scope of our review.

5.4 Although NHS 111 calls were increasing year-on-year, the Interim Director of NHS 111 at the time of the Pilot reported that, in January 2014, the referral rates within SECAmb were not significantly out of line with national averages: SECAmb referrals from NHS 111 to 999 were 11.5% overall compared to a national average of 10%. At the Ashford NHS 111 call centre (run by SECAmb), referrals were under the national average at 9%\(^{17}\) whereas at the Dorking call centre (run by Care UK) they were over the national average at 13%.

5.5 NHS 111 volumes and, hence, the referrals from NHS 111 were not evenly spread throughout the week, but tended to arrive in ‘spikes’ at certain points; notably in the early mornings and late evenings on weekdays and on Saturday and Sunday mornings. These peaks in demand coincided with the Out of Hours period for GPs.

5.6 The Trust uses the data from previous periods to inform its resourcing planning. The peaks in demand on the 999 service as a result of the NHS 111 referrals were not aligned with peaks in demand from direct 999 calls; hence, there was a change in the demand profile when NHS 111 was launched which initially created resourcing difficulties at the Trust\(^{18}\).

---

\(^{17}\) According to the Chairman, this was due to SECAmb putting more clinical resource in to the Ashford 111 call centre to review calls.

\(^{18}\) ‘Out of Hours Activity Review 2013/14’ – written by a Senior Operations Manager in the EOC in April 2014.
Perception that some Red 2 NHS 111 calls were not life threatening

5.7 During the course of performing our review, we were informed of a perception amongst PPs, that in the period prior to the Pilot being initiated, SECAmb was responding to a significant number of calls categorised by NHS 111 as Red 2\(^1\) (i.e. calls categorised as potentially life threatening emergencies), where in fact there was no immediate threat to life. The opinion was expressed that such calls had been incorrectly classified because of the NHS Pathways algorithms for certain conditions.

5.8 It was a strongly held view by SECAmb staff in the EOCs that Red 2 calls may have been incorrectly categorised by NHS 111 due to two primary factors:

5.8.1 NHS 111 call handlers reach a more risk-averse disposition than 999 operators would due to their application of the NHS Pathways clinical decision tool; and

5.8.2 NHS 111 call operators were required to follow NHS Pathways and that responses to certain questions in NHS Pathways, particularly about breathing and breathlessness and certain descriptions of pain, could trigger an emergency response, when it was not required.

5.9 A consistent theme in interviews with non-NHS 111 staff at the Trust was that they considered Red 2 calls referred from NHS 111 to present a patient safety risk for the population of high risk patients (Red 1 and Red 2 calls referred through 999). This was because the Red 2 calls referred from NHS 111 were perceived to be delaying the response to other high priority (Red 1 and Red 2) calls.

5.10 The majority of the PPs we interviewed spoke about their frustration and the negative impact on their morale, of the Trust having to respond to Red 2 calls which they deemed to have been incorrectly categorised by NHS 111.

Winter pressures

5.11 We understand that the demand for ambulances varies throughout the year and that Winter, and in particular the holiday period in late December and early January, is usually a time of high demand. It was widely anticipated by SECAmb and other Ambulance Trusts that operating conditions would be challenging in the Winter period of 2014/2015.

Ambulances queuing at hospitals

5.12 In late 2014, the impact of the Winter pressures was exacerbated by hand-over delays at hospitals.

\(^{1}\) The PPs are aware of the source of the call (i.e. a referral from 111, or a call direct to 999) from the mobile data terminal on the dashboard of their vehicle.
5.13 Trust staff explained to us that at peak times, hospital staff were not available to receive patients when ambulances arrived. This caused a build-up of ambulances waiting to hand over patients at hospitals and reduced the amount of ambulances available for despatch.

Potential Ebola outbreak

5.14 Senior clinical staff at the Trust told us that they had to plan for a potential outbreak of the Ebola virus, particularly given their responsibilities for Gatwick Airport, in late 2014 and that this impacted on their availability. This further exacerbated the pressures SECAmb experienced in the period directly prior to the Pilot.

Summary of context

5.15 The cumulative impact of the additional call volumes from NHS 111, the increased call volumes resulting from winter pressures, the reduction in the availability of ambulances due to queuing in hospitals and the pressure arising from a potential outbreak of Ebola meant that on occasion there were up to 80 Red 1 and Red 2 calls ‘in the stack’, i.e. awaiting despatch.

5.16 When there were such high volumes of calls in the stack, staff within the EOC explained to us that:

5.16.1 The call handlers in the EOC would regularly call patients back to assess their situation and to assess where the next available ambulance should be despatched; and

5.16.2 Waiting times for up to 60% of the Red 1 calls (both referrals from NHS 111 and calls direct to the 999 service) would exceed the eight minute target.

5.17 The CEO informed us that he deemed the level of demand on SECAmb’s services, in late 2014 and early 2015, to be ‘unprecedented’. The Chair explained that in early to mid 2014 the Trust developed an enhanced business plan to respond the pressures noted above. Commissioners also acknowledged a context of rising demand.
6 SECAmb’s governance structure

Introduction

6.1 In this section we provide an overview of SECAmb’s governance structure, in order to identify the systems and controls in place at the time of the Pilot. We have set out SECAmb’s governance structure in this section, as it provides the context for our comments on the governance around the Pilot, which we discuss further in Sections 8 to 11 below. We also set out our understanding of the function of certain committees and working groups which are relevant to the Pilot:

6.1.1 In paragraphs 6.3 to 6.8 we discuss the Risk Management and Clinical Governance Committee (“RMCGC”);

6.1.2 In paragraphs 6.9 to 6.14 we discuss the Operational Performance and Governance Working Group (“OPGWG”), a working group that reports into RMCGC;

6.1.3 In paragraphs 6.15 to 6.19 we discuss the Clinical Quality Working Group (“CQWG”), a working group that reports into RMCGC;

6.1.4 In paragraphs 6.20 to 6.30 we discuss the ODSG; and

6.1.5 In paragraphs 6.31 to 6.34 we discuss the ‘Hear and Treat’ work stream, a work-stream that reported into the ODSG.

Overview

6.2 In Figure 6.1 below, we set out the governance structures at SECAmb. The diagram is not intended provide a complete view of all working groups within the Trust; rather, it focuses on the operational and clinical working groups most closely aligned with the Pilot.
Figure 6.1 – Overview of the Trust’s Board, Committees and the operational and clinical working groups closely aligned with the Pilot
Risk Management and Clinical Governance Committee

6.3 The RMCGC “is responsible for ensuring that the Trust undertakes an integrated approach to the management of clinical governance and quality and all areas of risk.”\(^{20}\)

6.4 We would have expected the RMCGC to have had an oversight of the Pilot due to the clinical and operational risks associated with re-triaging calls, in particular Red 2 calls, from NHS 111.

6.5 The RMCGC is chaired by a Non-Executive Director, and its members include other Non-Executive and Executive Directors. The Terms of Reference require the heads of the Trust’s Medical Services, Compliance, Operational Business Development and Information Technology departments to attend the meetings, along with the Patient Experience Lead\(^{21}\). The RMCGC meeting minutes indicate that the CEO and Chair\(^{22}\) also attended RMCGC meetings on a regular basis.

6.6 The RMCGC is scheduled to meet every two months, in advance of the Trust Board meetings\(^{23}\).

6.7 Meeting minutes are taken at each meeting and an action log is used to track the progress of any actions points arising from the meetings\(^{24}\).

6.8 The RMCGC reports directly to the Trust Board and is required to report a summary of each RMCGC meeting at the next meeting of the Trust Board\(^{25}\).

Operational Performance and Governance Working Group

6.9 The OPGWG was set up as a working group of the RMCGC with the following objectives\(^{26}\):

- To provide assurance to the RMCGC that governance and performance management systems continue to be reviewed and improve operational performance;
- To act as a ‘checks and balances’ management forum on the quality and progress of work and risk management; and

---

\(^{20}\) RMCGC Terms of Reference.
\(^{21}\) RMCGC Terms of Reference.
\(^{22}\) RMCGC Minutes.
\(^{23}\) RMCGC Terms of Reference.
\(^{24}\) RMCGC Terms of Reference.
\(^{25}\) RMCGC Terms of Reference.
\(^{26}\) OPGWG Terms of Reference.
• To review policies, procedures and associated documents before onward approval by the RMCGC.

6.10 At the time of the Pilot the OPGWG was chaired by the Director of Clinical Operations and consisted of executive members of the Trust’s Board together with senior operational and clinical staff.

6.11 Due to the changes in the operating procedures in the EOCs, as a result of the Pilot, we would have expected the OPGWG (led by the Director of Clinical Operations) to have reviewed the operational aspects of the Pilot, in line with the objectives of the working group, which are set out above in paragraph 6.9, prior to go live.

6.12 The OPGWG is scheduled to meet every two months, in advance of the RMCGC meetings²⁷.

6.13 Meeting minutes are taken at each OPGWG meeting and a log of actions was maintained²⁸.

6.14 The chair of the OPGWG reports directly to the RMCGC by presenting a report of each meeting at the next meeting of the RMCGC²⁹.

Clinical Quality Working Group

6.15 The CQWG was set up as a working group of the RMCGC to review and improve clinical quality within the Trust.

6.16 At the time of the Pilot, the CQWG was chaired by the Medical Director³⁰ and consisted of executive members of the Trust’s Board together with senior operational and clinical staff.

6.17 The Pilot involved the re-triage of Red 2 calls from NHS 111. Given the potentially life threatening nature of these calls, there were implications for clinical risk. Therefore, we would have expected the CQWG to have reviewed and approved the Pilot, prior to go live.

6.18 Meeting minutes are taken at each CQWG meeting and a log of actions was maintained.

---

²⁷ OPGWG Terms of Reference.
²⁸ OPGWG meeting minutes.
²⁹ OPGWG Terms of Reference.
³⁰ The former Medical Director left the Trust in February 2015.
6.19 The chair of the CQWG reports directly to the RMCGC by presenting a report of each CQWG meeting at the next meeting of the RMCGC.

**Operational Delivery Strategy Group**

6.20 In response to the operational pressures experienced by the Trust, which are discussed above in Section 5, the Trust’s executive setup a “task and finish” working group; known as the “Operational Delivery Strategy Group”.

6.21 The ODSG first met on 22 July 2014\(^{31}\) and had the following objectives\(^{32}\):

- Ensure optimal use of existing operational staff;
- Ensure optimal use of existing supporting systems/infrastructure (including fleet/logistics);
- Provide additional operational resources to meet demand;
- Provide enhanced support for the Hear and Treat capability; and
- Provide enhanced support from non-SECAmb resources as required.

6.22 The members of the ODSG (described in the Project Brief\(^{33}\) as the “Project Board”) consisted of Executive Directors, together with senior operational and clinical staff. A list of members of the Project Board is included in Appendix 3. At the request of the Project Board, other members of the Trust’s staff attended the ODSG meetings from time to time, for example, members of the Trust’s IT and Workforce Transformation functions\(^{34}\).

6.23 The identity of the “Project Sponsor” for the ODSG is disputed. Version five of the Project Brief identified the Chief Executive as the Project Sponsor, whereas version eight of the same document names the Director of Clinical Operations in this role, although he questioned this in his interview with us, recalling that versions of the project brief changed and that both could not be correct.

6.24 We have identified an email from the Director of Commercial Services dated 6 August 2014, which indicates that the Director of Clinical Operations agreed to take on the role of Project Sponsor from the CEO on 4 August 2014\(^{35}\). However, this email appears to conflict with the CEO in his email to the Commissioners on 26 February

---

\(^{31}\) Version: 0.5 of the “Project Brief” for the ODSG.

\(^{32}\) Version: 0.5 of the “Project Brief” for the ODSG.

\(^{33}\) Version: 0.5 of the “Project Brief” for the ODSG.

\(^{34}\) Two members of the Trust’s IT team and the Director of Workforce Transformation were assigned actions in the ODSG Actions Trackers.

\(^{35}\) Email from Director of Commercial Services to PMO for the ODSG, copying in the Director of Clinical Operations and the Acting Associate Director of Clinical Operations, titled “Operational Delivery Strategy” dated 6 August 2014.
2015, following the suspension of the Pilot, where he refers to himself as the “chair”\textsuperscript{36} of the ODSG.

6.25 We note that, although the identity of the formal ‘Project Sponsor’ may not be agreed, both the CEO and the Director of Clinical Operations were directly involved in the ODSG at the outset and throughout its existence. The absolute accountabilities for specific ODSG members were not defined and are unclear.

6.26 The ODSG had no direct reporting lines into the OPGWG, the CQWG or any other working group. However, although the ODSG existed outside of SECamb’s formal governance structure, its existence had been referred to in Board meetings and a number of its members held senior roles in the executive team and on formal Committees.

6.27 The ODSG was focused on accelerated delivery of operational improvements across four work streams\textsuperscript{37}:

- Hear and Treat;
- Fleet, Equipment and Logistics;
- People; and
- Performance.

6.28 An “Actions Tracker” was used to log the actions for each work stream. On the assumption that the Actions Tracker was updated following each meeting of the ODSG, the ODSG appears to have met, or had a conference call, at least once a week between 22 July and 4 December 2014\textsuperscript{38}. The frequency of the meetings appears to have increased in October, for instance in the weeks commencing 6 October 2014\textsuperscript{39} and 20 October 2014\textsuperscript{40} the group appears to have met on three occasions. Based on the Actions Trackers, the frequency of the meetings reduced in November 2014.

6.29 The Acting Associate Director of Clinical Operations informed us that the ODSG was cancelled in December 2014, as the Trust’s Executives\textsuperscript{41} implemented its Resourcing

---

\textsuperscript{36} Letter from the CEO to the Accountable Officer at Swale CCG on 26 February 2015.

\textsuperscript{37} Version: 0.5 of the “Project Brief” for the ODSG.

\textsuperscript{38} The ODSG Project Brief version 0.5 states that the group started on 22 July. The latest Action Tracker available to us (version 39) is dated 4 December.

\textsuperscript{39} There are Actions Trackers dated 8, 9 and 10 October (Action Tracker versions 26, 27 and 28).

\textsuperscript{40} There are Actions Trackers dated 20, 22 and 23 October (Action Tracker versions 30, 31 and 32).

\textsuperscript{41} We have not been able to establish which Executives approved the decision to implement REAP 4.
Escalatory Action Plan 4 ("REAP 4"). We understand that REAP 4\textsuperscript{42} requires all operational staff to be placed ‘on duty’, which curtails their ability to attend working groups, effectively suspending the risk management structures in the Trust.

6.30 The Actions Tracker indicates that the Pilot was developed within the ODSG, through the Hear and Treat work stream.

**Hear and Treat work stream**

6.31 As mentioned in paragraph 6.27 above, Hear and Treat was one of four work streams managed through the ODSG.

6.32 ‘Hear and Treat’ relates to instances where clinicians in the EOC provide telephone advice for callers who do not have serious or life threatening conditions, rather than despatching an ambulance. The advice the clinicians provide can either be advice on how the caller can care for themselves or as to where they might go to receive assistance.

6.33 There are no separate meeting minutes for the Hear and Treat work stream; hence, our understanding of its activities is based on the updates detailed in the ODSG Actions Trackers and through our interviews.

6.34 Our review of the ODSG Action Trackers indicates that there were five Hear and Treat actions that were either directly or indirectly associated with the Pilot and a further action labelled "111 Demand Suppression Work stream"\textsuperscript{43} which appears to have arisen from Hear and Treat. We have summarised the “What?”,”How?” and “Who?” associated with these six actions, together with the date they first appeared with Trust staff in the Actions Tracker in Table 6.1 below.

\textsuperscript{42} REAP is a national indicator of the pressure in Ambulance Services across the UK, which triggers specific measures when the Trust is operating at significant and sustained levels of increased activity. The levels of REAP range from 1 (normal service) to 6 (potential service failure).

\textsuperscript{43} This action was included in the Performance work-stream.
<table>
<thead>
<tr>
<th>Action (&quot;What?&quot;) (note 1)</th>
<th>Plan for implementation (&quot;How?&quot;) (note 1)</th>
<th>Person assigned to the action (&quot;Who?&quot;) (note 1)</th>
<th>Date and version of first Action Tracker this action appears (note 2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>PPs in EOC (note 3)</td>
<td>Consider if PPs can provide additional EOC cover undertaking call backs.</td>
<td>Senior Operations Manager – Distribution</td>
<td>13 August 2014 / v14</td>
</tr>
<tr>
<td>Additional clinical resources in 999 &amp; 111</td>
<td>Develop a proposal to outline how additional clinical resources could be made available for H&amp;T in 999 &amp; 111.</td>
<td>Senior Operations Manager – Distribution</td>
<td>13 August 2014 / v14</td>
</tr>
<tr>
<td>Core number of EOC clinicians</td>
<td>Develop an options appraisal on how to increase the core number clinicians in EOC / better utilise the existing resources.</td>
<td>Senior Operations Manager – Distribution</td>
<td>13 August 2014 / v14</td>
</tr>
<tr>
<td>Amendments to Pathways process</td>
<td>Analyse outcomes from current Pathways process to understand the viability of increasing the volume of H&amp;T calls. Review and consider learning from SWAS process</td>
<td>Senior Operations Manager – Distribution</td>
<td>13 August 2014 / v14</td>
</tr>
<tr>
<td>111 call volumes</td>
<td>Develop a proposal to only manage red1/2 calls</td>
<td>Acting Associate Director of Clinical Operations</td>
<td>20 August 2014 / v16</td>
</tr>
<tr>
<td>111 Demand Suppression Work stream (note 4)</td>
<td>Data from 111</td>
<td>Director of Commercial Services</td>
<td>2 October 2014 / v25</td>
</tr>
</tbody>
</table>

Note 1: The headings “What?”, “How?”, “Who?” and the text in these three columns are taken directly from the ODSG Actions Trackers.

Note 2: Not all of the Actions Trackers have been made available to us. For example, the earliest version provided to us is version 14 dated 13 August 2014. Therefore, the version number included in this column is based on the information we have available and may be superseded should any other versions become available.

Note 3: The action “PPs in EOC” subsequently got combined with another action “PP desk/Clinical desk productivity” and re-badged as “Clinical hub”.

Note 4: The “111 Demand Suppression Work stream” is in its own work stream, rather than being labelled as Hear and Treat.

Source: ODSG Actions Tracker, versions 14, 16 and 25.
7 Chronology of events

Introduction

7.1 In this section, we set out our understanding of the timeline of events relating to the development and implementation of the Pilot. We subsequently refer to the timeline, in Sections 8 to 11 below.

Chronology

7.2 In Figure 7.1 below, we set out a chronology of events. The chronology starts in July 2014, to coincide with the first meeting of the ODSG and ends in July 2015 when the report from the Trust’s internal review of the Pilot was issued to the Trust’s Board. Figure 7.1 below, has been developed by reviewing the following documents:

7.2.1 Board meeting agendas and minutes;
7.2.2 Business Review Meeting agendas and minutes;
7.2.3 Agendas and Meeting minutes for Committees of the Board;
7.2.4 Meeting minutes from meetings with Commissioners;
7.2.5 Terms of reference for Committees and Working Groups;
7.2.6 Actions Trackers;
7.2.7 Reports and papers produced by SECAmb staff; and
7.2.8 Emails.

7.3 We have sought to gain assurance around the contents of Figure 7.1 by corroborating the documentation with explanations provided by the individuals we interviewed.
# Figure 7.1 Chronology of events surrounding the Pilot

## 2014

<table>
<thead>
<tr>
<th>July</th>
<th>August</th>
<th>September</th>
<th>October</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pilot</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>NED</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>28/7/14 R2 performance trending down</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20/8/14 Exec to investigate update to the IT link between 111 and 999</td>
<td>5/9/14 OSDG project brief created (Uncertainty over sponsor)</td>
<td>30/9/14 Concerns expressed of not meeting future performance targets</td>
<td></td>
</tr>
<tr>
<td>8/9/14 Clinical operations meetings now split into: OPGWG and CQWG</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11/9/14 Two PPs trained and being used in EOC</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19/9/14 Exec to write ‘robust paper on findings’ on amendments of NHS Pathways</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exec to develop solution and timescale to deal with 111 call volume</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>24/9/14 Work commenced to make changes to 111 portal and queues</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2/10/14 First instance of ‘111 demand suppression workstream’</td>
<td>8/10/14 Exec go to Dorking to ‘get a grip’ on 111 calls</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10/10/14 IT changes to allow calls to be queued, ‘Governance document to be done after’</td>
<td>20/10/14 – Medical director to agree clinical governance, not happy with R2 re-triage</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enhanced triage trial to start on 3 Nov 14</td>
<td>23/10/14 Delay in go live due to IT issues</td>
<td></td>
<td></td>
</tr>
<tr>
<td>30/10/14 Pilot will be on Cat Cs, only greens will be queued</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Senior Managers</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13/8/14 Hear and Treat workflow – plan for additional clinical resources in 999 and 111</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14/8/14 First three PPs start training in Coxheath EOC Go live 18/8/14</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Commissioners</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Development on portal to add functionality of separate queue for 111 calls

#### Key

<table>
<thead>
<tr>
<th>Box colour</th>
<th>Information source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust Board Minutes</td>
<td>OPGWG Minutes</td>
</tr>
<tr>
<td>OSDG Minutes/Tracker</td>
<td>RMGC Minutes</td>
</tr>
<tr>
<td>Emails/Other documents</td>
<td></td>
</tr>
<tr>
<td>NEDS</td>
<td>Executive Directors</td>
</tr>
<tr>
<td>------</td>
<td>---------------------</td>
</tr>
<tr>
<td>24/11/14 View is that Trust is on track to meet R1 and R2 targets</td>
<td>20/11/14 Email referencing red 2 to red 3 option (paragraph 8.13)</td>
</tr>
<tr>
<td>24/11/14 Review of R2 calls from 111 raised again NEDs ask whether NHS Pathways result in more conservative triage</td>
<td>12/11/14 Go live scheduled for 13-14 Dec (restricted to greens)</td>
</tr>
<tr>
<td>6/12/14 Confirmation of 10 mins R3 queue and clock start</td>
<td>8/12/14 Manager responsible for ‘EOC PP procedure’ for Pilot selected</td>
</tr>
<tr>
<td>10/12/14 Discussions regarding flow chart of IT changes for Pilot</td>
<td>15/12/14 111 re-triage over weekend has stalled</td>
</tr>
<tr>
<td>17/12/14 – EOC PP Procedures signed off by OPGWG chair</td>
<td>13/1/15 ‘The Board was well appraised of work taking place between NHS 111 and 999’</td>
</tr>
<tr>
<td>20/12/14 Re-trie of R2 and Green calls 24/2/15</td>
<td>3/2/15 Paper on Pilot presented at CQWG meeting</td>
</tr>
</tbody>
</table>

South East Coast Ambulance Service NHS Foundation Trust – Red 3 / Green 5 Pilot Review
Final Report issued 22 February 2016 - Private and Confidential
<table>
<thead>
<tr>
<th></th>
<th>March</th>
<th>April</th>
<th>May</th>
<th>June</th>
<th>July</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pilot</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>RMCGC</td>
<td></td>
<td>Impact of Pilot on performance figures discussed</td>
<td>Progress of R3 investigation reviewed</td>
<td>Internal draft rectification plan on Pilot presented to RMCGC</td>
</tr>
<tr>
<td></td>
<td>Committee</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>updated on</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Pilot</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>7/5/15</td>
<td>29/5/15</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Internal review started</td>
<td>Trust receives term of reference for NHS Internal Review</td>
<td></td>
</tr>
<tr>
<td><strong>Executive Directors</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Senior Managers</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Commissioners</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
8 Development of the Pilot through the ODSG Hear and Treat work stream: 22 July 2014 to 4 December 2014

Introduction

8.1 In Sections 8 to 11, we discuss the circumstances and governance arrangements around the development and implementation of the Pilot, in order to identify the individuals involved at each stage of the decision making and approval process. We also discuss the Trust’s response to the Pilot.

8.2 Due to the importance of contextualising the various decisions made, we have split our analysis of the Pilot into four sections, which cover four sequential periods:

8.2.1 In this Section (8) we focus on the functioning of the ODSG and the actions undertaken between 22 July 2014 and 4 December 2014;

8.2.2 In Section 9 we focus of the decision to include Red 2 calls in the Pilot, which appears to have been made on a conference call on 4 December 2014, through to the Pilot ‘going live’ on 20 December 2014;

8.2.3 In Section 10 we focus on the period the Pilot was operational, i.e. between 20 December 2014 and 24 February 2015; and

8.2.4 In Section 11 we focus on the Board’s initial response to the Pilot, once it ended on 24 February 2015.

8.3 In each of the Sections 8 to 11, we set out our understanding of the circumstances surrounding the Pilot and also the approach to governance. At the end of each section, we also set out our findings.

8.4 Our comments on governance assess the nature and level of scrutiny employed by the Board, Committees and Working groups within the Trust. We have structured our comments on governance under three headings:

8.4.1 Operational and Clinical governance - operational and clinical leadership and decision making in relation to the Pilot;

8.4.2 Board and Committee governance - strategic oversight and scrutiny of the pilot by the Board and its Committees; and

8.4.3 Commissioner governance - Commissioner sign-off and scrutiny of the Pilot.
Early development of the Pilot through the Hear and Treat work stream in the ODSG

8.5 The Pilot appears to have evolved from the actions associated with the Hear and Treat work stream. Table 6.1 indicates that the Hear and Treat work stream initially focused on the following four actions, which although not directly related, appear to have aided the development of the Pilot: “PPs in EOC”, “Additional clinical resources in 999 & 111”, “Core number of EOC clinicians” and “Amendments to Pathways process”. A further action titled “111 call volumes” was subsequently introduced in version 16 of the ODSG Actions Tracker, on 20 August 2014.

8.6 In paragraphs 8.6.1 and 8.6.3 below, we explain how the work performed on these five actions, between August and November 2014, aided the implementation of the Pilot in December 2014.

8.6.1 Through the “Additional clinical resources in 999 & 111” action the Trust planned to recruit six additional Paramedic Practitioners (“PPs”) into the Emergency Operations Centre (“EOC”) in August 2014. We have not seen any evidence of an associated cost benefit analysis to support this decision. The six PPs provided the EOC with additional operational resources to re-triage calls. The relevant extract from the ODSG Actions Tracker is included below:

Recruitment process for 6 additional staff underway.
DH to develop paper that sets out a proposal to 'over establish' the CS desk in the short term.

8.6.2 On 20 August 2014, under the “111 call volumes” action, the ODSG decided to review the Interoperability Toolkit (“ITK”) link between NHS 111 and 999. Changes to the IT infrastructure, which are discussed in greater detail in paragraphs 9.16 to 9.23 below, allowed NHS 111 calls to be queued rather than being automatically despatched. The relevant extract from the ODSG Actions Tracker is included below:

---

44 Version 14 of the ODSG Actions Tracker dated 13 August 2014.
45 Version 16 of the ODSG Actions Tracker dated 20 August 2014.
46 “Additional clinical resources in 999 & 111” action in version 16 of the ODSG Actions Tracker dated 20 August 2014.
47 “111 Call Volumes” action in version 16 of the ODSG Actions Tracker dated 20 August 2014.
48 We understand that the ‘LAS model’ which is referred to in version 16 of the Actions Tracker related solely to the re-triage of Green calls, the implication being that the Pilot would be limited to Green calls.
8.6.3 Following the introduction of two PPs into the EOC, on 12 September 2014 the Trust sought to second other PPs into the EOC under the “PPs in EOC” action. This provided the EOC with further resources to re-triage calls. The relevant extract from the ODSG Actions Tracker is included below:

**2 PPs trained - Averaging 5 calls per hour - 50% of calls are going to H&T. PPs and CCPs can do the job nearly as well as the GPs. DH to go out to advertise and recruit quickly as a secondment opportunity.**

### 111 Demand Suppression Work stream

8.7 As we explain above in paragraph 8.5, the Pilot seems to have evolved out of a number of pre-existing Hear and Treat actions. However, the Pilot itself appears to have been managed through a separate “111 Demand Suppression Work stream”. This work stream was first included in version 25 of the ODSG Actions Tracker, on 2 October 2014, and the Director of Commercial Services was assigned as the “Who?”, i.e. the responsible Executive for this action. The first progress update for the 111 Demand Suppression Work stream reads:

**Work needs to be done on 111 call metric - difference of 50-60 calls on weekends/ bank holidays. Need to check what we are measuring against. SS/GT to discuss at 111/999 meeting with Stacey Martin arranged for 30 October. NEW ACTION! GD to get data on non-availability of GPs from 111. Use to develop strategy for commissioner negotiations. ITK link instead of auto-dispatch clinical queue. SS to update.**

8.8 The ODSG Actions Trackers and our interviews with SECAmb staff, indicate that the “111 Demand Suppression Work stream” developed throughout October and November 2014. In version 30 of the ODSG Actions Tracker dated 20 October 2014, a note was added to the 111 Demand Suppression Work stream stating that the Medical Director at the time needed to “agree clinical aspects/governance” and that she “wasn’t comfortable with some R2s“ being added to the Pilot.

---

49 Version 20 of the ODSG Actions Tracker dated 12 September 2014.
50 “PPs in EOC” action in version 20 of the ODSG Actions Tracker dated 12 September 2014.
51 Version 25 of the ODSG Actions Tracker dated 2 October 2014.
52 Version 30 of the ODSG Actions Tracker dated 20 October 2014.
A further note was added to the 111 Demand Suppression Work stream in version 33 of the ODSG Actions Tracker dated 30 October 2014, which explained that the intention was for only Green calls (Cat C’s) to be included in the pilot, on the basis that this “minimises risk” and will “free up resources”:

The Pilot was initially scheduled to ‘go-live’ on 13 December 2014. This is reflected in the progress update for the action, in version 37 of the Actions Tracker dated 20 November 2014, which reads:

Found some resolution on ITK queue - going live on weekend of 13/14 December with green calls. Commissioners have signed off to do this on greens - and expectation is that greens will make a diffs, but hope to do reds in future as well. Will need to sort governance around the latter. Will call back on greens within 50 mins. SS to meet with Keith Gait. Neil Harrison not concerned about red 5s, greens staying. Procedural issues to be ironed out in conf call on 3 December.

---

53 Version 33 of the ODSG Actions Tracker dated 30 October 2014.

54 Version 37 of the ODSG Actions Tracker dated 20 November 2014. There are two further versions of the ODSG Actions Trackers dated 27 November 2014 (version 38) and 4 December 2014 (version 39). However, there are no updates to this action in either version 38 or 39.

55 Neil Harrison (referred to in the extract from the ODSG Actions Tracker directly below paragraph 8.10) is a Manager and Paramedic within the 999 service, at the Trust.
8.11 The extract from version 37 of the ODSG Actions Tracker above, further indicates that the Pilot was initially intended for Green calls: “going live on weekend of 13/14 December with Green calls”... “Commissioners have signed off to do this on greens”. We are not aware of any formal commissioner sign-off at this point.

8.12 The Acting Associate Director of Operations informed us that the Pilot was initially intended to be limited to Green calls. We have also been provided with an email sent by the Acting Associate Director of Operations to the CEO dated 12 November 2014, in which she noted that the 111 Portal would be configured by “changing Green calls to new Green category”.

The inclusion of Red 2 calls from NHS 111 in the Pilot

8.13 Although Red 2 calls were discussed at an ODSG meeting on 20 October 2014 (see the extract from the ODSG Actions Tracker under paragraph 8.8), the shift in emphasis towards including Red 2 calls in the Pilot was driven by an email from the CEO to the Acting Associate Director of Operations on 12 November 2014, which stated:

“Great progress. Before we press the ‘go’ button id like a conf call at least to get situational awareness and id like to talk the red2 to red3 option” [sic]

8.14 It would appear that the CEO’s request in relation to the Red 2 to Red 3 option subsequently led to the reference to Red calls in version 37 of the Actions Tracker on 20 November 2014, which we refer to in paragraph 8.10 above. Though, as indicated above, it appears that the intention was still to focus on Green calls at this stage.

8.15 Our understanding is that 20 November 2014 was the last date on which the ODSG physically met as a group, although we recognise that further Actions Trackers were produced on 27 November and 4 December 2014 following conference calls. However, there are no changes to the narrative relating to the 111 Demand Suppression Work stream in either of these two Actions Trackers.

8.16 There is very little contemporary information available to track progress from 20 November through to 4 December 2014. From the 20 November 2014 Actions Tracker, the interviews we conducted with SECAmb staff and from the brief reference made to Red 2 calls in the Board meeting of 24 November 2014 (see paragraph 8.30.3 below), it is reasonable to assume that the inclusion of Red 2 calls in the Pilot

57 Email titled 111 Call Management Queue dated 12 November 2014 at 16:49.
58 Email from CEO to Acting Associate Director of Operations titled “RE: 111 Call Management Queue” dated 12 November 2014 at 17:33.
was being increasingly and actively considered during this period. This seems to have led to the re-triaging of Red 2 calls being referred to in discussions with Commissioners on 3 December 2014 (see paragraph 8.38) and subsequently to an operational call, which included a subset of members of the ODSG, on 4 December 2014, where it would appear that a decision was taken to include Red 3 calls in the Pilot (see paragraph 9.7).

**Operational and Clinical Governance**

**ODSG linkage with the Board Committee structure**

8.17 Given that the ODSG’s project brief stated that the group would focus on operational performance issues, the activities of the ODSG were relevant to the OPGWG and therefore the RMCGC. We would therefore expect the ODSG\(^{60}\) to have been formally linked to OPGWG and RMCGC.

8.18 In addition, given the clinical nature of some of the ODSG’s activities, particularly the Pilot, we would also expect the ODSG to be accountable to the CQWG.

8.19 However, we understand that the ODSG had no formal accountability to either the OPGWG or the CQWG. Furthermore, we have identified no record of the ODSG reporting into any of these working groups or Committees on an informal basis during the existence of the ODSG from July 2014 through to early December 2014\(^{61}\), one of the reasons for this being that neither the OPGWG nor the CQWG met regularly in this period\(^{62}\).

**ODSG clinical governance**

8.20 The ODSG was set up to focus primarily on operational improvements, although, as it evolved, some of the work streams, in particular the Hear and Treat and 111 Demand Suppression work streams, required the group to deal with certain clinical matters.

8.21 The Medical Director at the time of the Pilot and the Director of Clinical Operations were both members of the ODSG\(^{63}\). The former Medical Director informed us that she was involved in early ODSG meetings. She noted that subsequently the meetings became more operationally focused and this alongside the various other demands on her time led her to disengage from the group.

---

\(^{60}\) ODSG and OPGWG.

\(^{61}\) The Chair of OPGWG signed off the procedure for the Pilot as a Chair’s action, but this was on 17 December 2014, i.e. outside of the period that the ODSG was operational.

\(^{62}\) The OPGWG met on 30 September 2014, but did not meet again until 14 April 2015. Hence, the OPGWG did not meet while the Pilot was being developed in November and December 2014 or when the Pilot was in operation between December 2014 and February 2015. The CQWG met on 14 October 2014, but did not meet again until 3 February 2015. Hence, the CQWG did not meet in the period the Pilot was being developed in November and December 2014.

\(^{63}\) A full list of members is set out in Appendix 3.
Based on our interviews with Trust staff, it appears that the Medical Director and the Director of Clinical Operations did not have a close working relationship. This led the operational and clinical staff to work in silos (see paragraphs 13.22 to 13.24 for further detail). These relationship issues may have played a part in the reduced level of participation of the Medical Director in the ODSG and in the Pilot more generally, in terms of both proactively engaging and being consulted.

The result was that the Medical Director was not actively involved in the ODSG meetings as the group evolved and had little involvement in the Pilot during this period. However, from interviews with other executives, it is apparent that the Pilot was discussed at executive meetings which the Medical Director attended and we have been provided with an email to the Medical Director which made specific reference to the Pilot and to the inclusion of Red 2 calls. The email was dated 4 December 2014, which is prior to the Pilot going live.

The impact of the lack of engagement of the Medical Director on the ODSG was compounded by the fact that the Director of Nursing was on extended leave of absence due to ill health during the period when the ODSG was in place.

It should be noted that although the ODSG included experienced paramedics, with the CEO, the Director of Clinical Operations and two Senior Operational Paramedics being members, there appears to have been a lack of clarity around the accountability for ensuring clinical risk assessment amongst the executive members of the ODSG.

Overall, we are not aware of any formal Quality Impact Assessment ("QIA") having taken place during this stage of the Pilot. A QIA should have been carried out to identify and mitigate against risks to patients. We would expect the Medical Director to ensure completion of a robust QIA. However, due to her lack engagement with the Pilot and given that the Director of Clinical Operations and the CEO were better sighted, we would have expected the Director of Clinical Operations and the CEO to have ensured a QIA was undertaken.

**Our view on operational governance between 22 July and 4 December 2014**

8.27 There were positive aspects in relation to the work of the ODSG including:

8.27.1 a clear project brief;

8.27.2 good representation from executives and senior managers;

8.27.3 regular meetings with detailed discussions; and

8.27.4 a dynamic Actions Tracker which monitored progress over time.

8.28 The ODSG Actions Tracker suggests that the ODSG make good operational
progress against a range of projects over a relatively short period of time.

8.29 However, we consider that the ODSG also had fundamental weaknesses in that:

8.29.1 It did not formally report into the Trust governance structure and as a result there was no formal accountability to Committee working groups, namely the OPGWG and the CQWG;

8.29.2 There was no formal or informal disclosure of the Pilot from the ODSG at either the OPGWG meeting on 8 October 2015, or the CQWG meeting on 14 October 2015;

8.29.3 Despite the existence of an Actions Tracker, there was a lack of formality in capturing decisions which meant that key stakeholders were not informed appropriately and in some cases not at all; and

8.29.4 Clinical leadership was diluted as a result of the Medical Director not being actively engaged in the Pilot, due to a combination of factors including:

- The operationally focused nature of the meetings;
- The consideration of lower risk Green calls only during much of this period;
- Silo working between operations and clinical personnel; and
- Tensions between senior members of the ODSG.

8.29.5 The lack of clinical leadership was diminished further by the absence of the Director of Nursing and by the fact that there was a lack of clarity around responsibilities and accountabilities for clinical decision-making.

Board and Committee Governance

8.30 Given the pressures on operational performance and the objective of the ODSG to investigate performance improvements, various references to the ODSG activities appeared at Board meetings despite the ODSG not formally feeding into the Trust governance structure. A summary of Board disclosures relevant to the Pilot are outlined below:

8.30.1 A Business Review Meeting (“BRM”) of the Trust Board on 28 August 2014 received an update on initiatives to support the improvement and maintenance of operational performance standards in preparation for the upcoming Winter period. In addition, an early version of the ODSG Actions Tracker was circulated to the Board, by the Board Secretary on 29 August
2014. This was following an action raised at a Board meeting on 27 July 2014 where the new ODSG group was discussed.

8.30.2 There was no direct reference to the Pilot at the meetings of the RMCGC on 8 September 2014 and 6 November 2014 nor at Board meetings on 25 September 2014 and 23 October 2014.

8.30.3 The first specific reference to the Pilot in the Board minutes was at the 24 November 2014 Board meeting where the minutes make the following reference:

“Actions being taken to improve performance included; realigning the mix of single-response vehicles and double crewed ambulances, increasing clinical presence in the EOCs to further reduce conveyance (including clinical review of R2 calls transferred from NHS 111), refocussing the handover policy, in discussion with commissioners, to ensure the Trust was able to manage its own clinical risk.”64

8.30.4 The Trust Chair confirmed that the minutes of the 24 November 2014 Board meeting were consistent with his understanding at the time. According to the CEO, the discussion of the Pilot at the 24 November 2014 Board meeting was more detailed than appears from the minutes. In interviews, however, the Non-Executive Directors reported no recollection of “re-triage” or changes to the Clock Start of Red 2 calls from NHS 111 being discussed at the November 2014 Board.

---

64 Paragraph 139.3 of the Board meeting minutes, from the Board meeting on 24 November 2014.
Our view on Board governance between 22 July 2014 and 4 December 2014

8.31 The Board was formally aware of ODSG actions following circulation of the Actions Tracker on 29 August 2014 and the Pilot was discussed to some degree at the 24 November 2014 Board meeting.

8.32 Whilst there was scope for improved disclosure of the Pilot to the Board and RMCGC during October and particularly in November 2014, we do not view the low level of disclosure at this stage as a material issue given that the project was focused on Green calls, it was moving at pace and the ODSG was covering multiple projects.

8.33 We have identified no indication that there was any intention to conceal information in relation to ODSG activities or the Pilot in the period from 22 July to 4 December 2014. The non-executive members of the Board could have sought more information to question the implications of the ODSG improvements being proposed.

Commissioner governance

8.34 The Director of Commercial Services has responsibility for leading on engagement with the Trust’s Commissioners. We understand that he has worked with the Commissioners for a number of years and has developed a number of good working relationships, particularly with Commissioners from NHS Swale CCG, which is the lead Commissioner on behalf of 22 CCGs across Kent, Surrey and Sussex.

8.35 Both the Trust and the lead Commissioners have acknowledged to the review team that business has often been conducted in an informal way in the past and that communications were often verbal and not always supported by detailed documentation.

8.36 We understand that Commissioners originally wanted any re-triaging of calls to take place in NHS 111, but this was deemed not feasible for a variety of reasons. Commissioners were therefore actively encouraging the Trust to find ways of re-triaging Green calls in line with national recommendations. For example the Trust received a request from Commissioners on 10 November 2014 to bid for funds through the NHS 111 Learning and Development Programme phase 2 bids. The Trust subsequently submitted a bid on 28 November 2014 and was notified on 9 January 2015 that the bid was successful. The bid was entitled “Project Intercept avoidable calls from 111 to 999”. The bid did not mention Red calls, but it did refer to the interception of all calls from NHS 111 and the re-triage of these calls, using clinical skills and knowledge within the 999 service.
8.37 The key interaction between Commissioners and the Trust was the monthly 999 Contract and Quality Commissioning Group ("999 CQCG") and its sub-group, the Clinical Quality Review Group ("CQRG"), which meets earlier on the same day. The 999 CQCG met on 3 December 2014. The meeting included a discussion of the Pilot and approval was sought by the Trust for the Pilot to run from 12 December 2014 to 6 January 2015. The meeting was attended by contracting and clinical leads from Kent, Surrey and Sussex Commissioners although we understand the Quality Lead for NHS Swale CCG was absent due to illness. The Trust was represented by nine members of staff, including the Director of Commercial Services, the interim Director of NHS 111 and the Acting Associate Director of Operations.

8.38 The Director of Commercial Services informed us that it was his understanding from the meeting with the Commissioners on 3 December 2014 that the Commissioners had agreed that the Pilot would cover the re- triage of both Green and Red 2 calls. The Acting Associate Director of Operations supported the Director of Commercial Services’ view that both Red and Green calls had been discussed in this meeting. The Acting Associate Director of Operations subsequently explained to us that the Pilot had not been discussed in detail.

8.39 The Commissioners’ recollection is that they only agreed to include Green calls in the Pilot. Commissioners informed us that it was assumed that SECAmb’s reference to Red calls in the meeting was that on occasion the 999 service may need to re-triage Red 2 calls, for example a ‘comfort call’ when an ambulance was delayed.

8.40 We have included the relevant extract from the meeting minutes of the 999 CQCG meeting on 3 December 2014 below, where both Green and Red calls were discussed:

“Hear and treat has reduced, this has happened since the start of pathways 8 until pathways 9. The patients must are going to 111, there is a lot of potential to convert the numbers currently going through to 111 general to hear and treat.

There will be no dispatch on a 111 green call until it has gone through the system, they will instead be queued.

This new system will be in place until January so as to create a large amount of data to base decisions on.

There are a number of 111 red calls that could be made into green calls or hear and treat and these will be triaged.

The clinical staff will be band 7 because of the clinical risk involved. The GPs will be kept.
The change will be audited and reviewed in January; if it is successful it will be used permanently at certain times. The system can be turned on and off so it can be used as and when it is needed.

This could potentially reduce the activity that goes through to 999; this may potentially be available to expand to 111 in the future.

Friday the 12th of December through to Tuesday the 6th of January is the period that the system will be in place.\(^{65}\)

8.41 Our understanding is that no concerns were raised in the meeting by Commissioners. Commissioners have indicated that the focus of the discussion was on Green calls and as such there was no detailed discussion on risks. The Trust and Commissioners both indicated that on reflection it should have been referred to the CQRG prior to the 999 CQCG meeting on 3 December 2014.

8.42 The Director of Commercial Services subsequently reported to the Trust executive team that approval had been received from Commissioners to re-triage Green and Red 2 calls transferred from NHS 111. Consequently, the Trust executive team assumed that there was a mandate from Commissioners in respect of the re-triage of Green and Red 2 calls from NHS 111, and they proceeded on this basis.

8.43 The CEO now recognises that Commissioners may not have fully understood the detail of the Pilot prior to giving their approval.

8.44 The Director of Commercial Services also shared the approval decision with colleagues at other Ambulance Services who had shown an interest in the Pilot at the Trust. For example, the Director of Planning and Performance at SWAST informed fellow Directors on 4 December 2014 that “Email confirmation from South East Coast received. They have secured go-ahead for the R3 pilot”\(^{66}\).

---

Our view on Commissioner governance between 22 July 2014 and 4 December 2014

8.45 It is evident that Commissioners were appraised of the Trust’s intentions in relation to the re-triage of Green calls and were supportive in principle of those plans. In our interviews with Commissioners, they indicated that they assumed that the Pilot related solely to Green calls. However, the minutes from the 999 CQCG meeting on 3 December 2014 clearly reference the re-triage of Red 2 calls, as well as Green calls, so it is possible to see why the Trust concluded that they had support for both

---

\(^{65}\) Meeting minutes from the 999 CQCG meeting on 3 December 2014.

\(^{66}\) Email from an Executive at SWAST to “Directors” (at SWAS) titled “FW: SECAmb 111 to 999 transfer project with clinicians in room v 0 1” dated 4 December 2015.
Red 2 and Green calls.

8.46 The Trust could clearly have provided a more detailed and formal update of their plans regarding the Pilot to Commissioners to minimise the potential for any ambiguity. This point has been acknowledged by both the Trust and by Commissioners and our understanding is that more formal and rigorous ways of working are now emerging.

8.47 Given the detailed level of discussion described in the minutes and the range of contracting and quality leads in the meeting, it is surprising that more questions were not asked and that a greater level of scrutiny was not applied to the project by Commissioners at the time.

8.48 The critical information missing from the note of the meeting (and likely from the meeting itself) was reference to the introduction of up to ten minutes delay and the plan to stop the clock. Had this point been raised, the reference to Red 2 calls in the discussion would have had clearer context and there is the prospect that this would have triggered a more challenging debate.

8.49 We note in Section 9 below, that the decision to allocate up to ten minutes for triage had not been made by the Trust on 3 December 2014; this decision appears to have been made in the period between 4 December 2014 and 10 December 2014, as set out below in paragraphs 9.16 to 9.40. Therefore, it does not appear that the Trust had adequately developed or risk-assessed the plan before they took it to Commissioners on 3 December 2014 i.e. the Trust’s final meeting with the Commissioners, prior to the Pilot going live.

8.50 It follows that since the plan itself was not documented or completed in a material respect by 3 December 2014, Commissioners were not in a position to sign-off the plans in a considered way and that there should have been a follow-up discussion with Commissioners prior to the Pilot going live. There was an opportunity for the Commissioners to have applied a greater level of scrutiny by questioning the Trust on plans, risks and potential performance implications of the Pilot.

Overall findings relating to the period from 22 July 2014 and 4 December 2014

8.51 Between July 2014 and early December 2014 there was scope for more formal reporting by the ODSG, improved clinical decision-making, enhanced disclosure to the Board and for more formal and detailed presentation of the Pilot to Commissioners. There was also the potential for more robust questioning and challenge from both the Non-Executive Board members and Commissioners.
The proposal to request approval from Commissioners for the Pilot was made before the Trust had worked through the detail behind the Pilot in relation to a number of critical parameters such as the definitive inclusion of Red 2 calls from NHS 111, the ten minute delay or stopping the clock. However, we have seen no evidence to suggest that the Trust intentionally tried to mislead Commissioners as this was merely a function of timing which, in combination with an informal presentation, ultimately led to a situation where Commissioners and the Trust had a fundamentally different view regarding the mandate for the Pilot. The Trust failed to provide an update to the Commissioners prior to going live on 20 December 2014.
9 Inclusion of Red 2 calls in the Pilot: 4 December 2014 to 20 December 2014

Introduction

9.1 In this section, we focus on the decision to include Red 2 calls from NHS 111 in the Pilot. Although the inclusion of Red 2 calls appears to have been discussed earlier in November 2014, this decision was ultimately made on an operational conference call held on 4 December 2014.

9.2 We also set out our understanding as to why the re-triaged calls were queued as Red 3 calls, rather than remaining as Red 2 calls; why the EOC was given up to ten minutes to perform the re-triage of calls from NHS 111; and why the clock start was adjusted for Red 2 calls from NHS 111.

The decision to re-triage NHS 111 Red 2 calls

9.3 In Section 8 above, we explain that the Pilot was initially designed for the re-triage of Green calls received from NHS 111 and that Red 2 calls were included in the Pilot at a late stage in its development.

9.4 As set out in paragraph 8.13 above, the first reference to Red 2 calls being included in the Pilot that we have identified is in an email from the CEO to the Acting Associate Director of Operations on 12 November 2014. The email is a response to Acting Associate Director of Operations’ email of the same day, which we refer to above in paragraph 8.12. In the email the CEO noted: “Before we press the ‘go’ button id like a conf call at least to get situational awareness and id like to talk the red2 to red3 option.”[sic]

9.5 Red 2 calls are mentioned in version 37 of the ODSG Actions Tracker dated 20 November 2014 (an extract from the relevant Actions Tracker is included above under paragraph 8.8), which states there was a “hope to do reds in future as well”[68]. The update in version 37 of the ODSG Actions Tracker also acknowledges that the ODSG “[W]ill need to sort governance around the latter [Red 2 calls]”[69].

9.6 As explained above in paragraphs 8.34 to 8.44, representatives from SECAmb met with the Commissioners at the 999 CQCG meeting on 3 December 2014. The

---

67 Email from the CEO to the Acting Associate Director of Operations titled “RE: 111 Call Management Queue” dated 12 November 2014 at 17:33.


inclusion of Red 2 calls from NHS 111 in the Pilot appears to have been discussed in this meeting, though there is no evidence of the ten minute period for re-triaging or the adjustment to the clock start being discussed.

9.7 Based on our interviews with Trust staff, the final decision to include Red 2 calls was made on a conference call on 4 December 2014. The call was chaired by the CEO and attended by staff from the Trust’s operational and IT functions. We understand that on this call it was decided that Red 2 calls would be included in the Pilot, that up to ten minutes would be allocated to allow for the re-triage of Red 2 calls and that the clock-start would be delayed until the call has been re-triaged or ten minutes had elapsed.

9.8 We do not have access to a transcript or voice recording of the call on 4 December 2014 and so we are unable to determine exactly what was said. However, we understand from our interviews with members of staff who joined the call that there was a debate, objections were raised by senior managers on the call, but the senior managers were ultimately persuaded by the CEO to include Red 2 calls in the Pilot. Prior to this call it appears that the senior managers thought that the Pilot would be limited to Green calls.

9.9 We understand that the following objections were raised either during the call on 4 December 2014, or via email in the week following:

9.9.1 Red 2 calls from NHS 111 should not have been added to the Pilot. The Pilot should have been limited to Green calls; and

9.9.2 The clock start should not have been delayed for the Red 2 calls from NHS 111, as this resulted in the Pilot operating outside of the national AQI reporting guidelines, for Red 2 calls. Furthermore, the delay to the clock start gave rise to a perception that the Pilot was being done to enable the Trust to meet reporting targets, rather than primarily for reasons of patient safety.

9.10 Those who were on the call on 4 December 2014, where it was decided that Red 2 calls from NHS 111 would be added to the Pilot, have informed us that following the decision by the CEO, they sought to make the Pilot as ‘safe’ as possible prior to ‘go-live’.

---

70 We understand that at a minimum, the Acting Associate Director of Operations, two Senior Operating Managers and a member of the Trust’s IT team attended this call. It is possible that other members of Trust’s executive team and other senior managers also attended this call.

71 We understand that the call was not recorded and no transcript is available.

72 Email exchange between the CEO, the Acting Associate Director of Operations and member of the Trust’s IT team.
Why Red 2 calls from NHS 111 were referred to as ‘Red 3’

9.11 In order to allow the re-triage to occur, Red 2 calls from NHS 111 were included in a separate queue within the Trust’s CAD system and that vehicles needed to be manually despatched for calls in this queue (rather than being automatically despatched when an ambulance became available, as was previously the case).

9.12 All of the Red 2 calls from NHS 111 which were added to this newly implemented queue were re-labelled as ‘Red 3’ calls. These calls would remain as Red 3 until they were manually categorised as another code (e.g. Red 1, Red 2, Green 1, etc.) following re-triage, or would be categorised as Red 2 following the elapse of a ten minute ‘back-stop’.

The decision to provide ten minutes to re-triage Red 2 calls and the decision to adjust the clock start time for Red 2 calls

9.13 Between the call on 4 December 2014, where it appears that Red 2 calls were added to the Pilot, and ‘go-live’ on 20 December 2014, two other key decisions were made:

9.13.1 Ten minutes was provided to allow PPs in 999 to re-triage the NHS 111 Red 2 calls; and

9.13.2 The clock start was changed for Red 2 calls from NHS 111, such that the clock only started either when the re-triage process had been concluded or when the ten minute period allocated for re-triage had expired.

Ten minutes to re-triage Red 2 calls

9.14 The Director of Finance advised us that he had initially identified the need for a ‘back-stop’ for the re-triaging, to mitigate the risk of Red 2 calls from NHS 111 waiting in the queue indefinitely before being re-triaged.

9.15 The Director of Finance subsequently explained that clinical members of SECAmb staff decided on the ten minute timeframe for re-triaging Red 2 111 calls. The Director of Clinical Operations could not recall exactly how the ten minutes had been decided; but noted that ten minutes was the time taken to triage calls in NHS 111 and may have been perceived to be common practice.

---

73 The re-triage process had been concluded when either the call had been re-categorised or when a vehicle had been despatched.

74 The Director of Finance at the time of the Pilot has subsequently become the Trust’s Chief Operating Officer.
Adjustment to the clock start for Red 2 calls

9.16 We have been provided with a chain of emails titled “Clock start time for NHS111 Calls for Red/Green 3”. The emails are dated from 5 to 10 December 2014. The email chain was initially between the Acting Associate Director of Operations and a member of the Trust’s IT team, though other clinical, operational and IT staff were copied in and later emails in the chain were to and from the CEO. The chain suggests the Acting Associate Director of Operations included the CEO in the email to confirm ‘he was happy’ with the flowchart outlining the proposed process for handling calls within the Pilot.

9.17 The emails indicate that the clock start protocol for all Red 2 calls prior to the Pilot was that the clock would start at the earlier of:

9.17.1 Initial DX code being allocated;

9.17.2 First vehicle assigned time; and

9.17.3 60 seconds after ‘hitting’ the stack.

9.18 The Acting Associate Director of Operations was given three options for when the clock should start for the newly categorised Red 3 calls from NHS 111, being:

9.18.1 The point the CAD changes the Red 3 NHS 111 call to a different priority code;

9.18.2 First vehicle assigned time; and

9.18.3 The point the CAD changes the Red 3 NHS 111 call to a different priority code plus 60 seconds, if a vehicle is not assigned prior to this point.

9.19 The Acting Associate Director of Operations responded to the member of the Trust’s IT team and the CEO, noting that the clock start for Red 2 calls from NHS 111 would be to “assign from the R3 queue (up to 10 mins) ie when the code changes to either a R2, G3 or H&T plus 60 seconds.” The Acting Associate Director of Operations subsequently clarified that “if the call is in the R3 queue for over 10 minutes the clock should automatically start after 60 seconds.”

---

75 Email from a member of the Trust’s IT team to the Acting Associate Director of Operations on 5 December 2014 at 11:47.
76 Email from a member of the Trust’s IT team to the Acting Associate Director of Operations on 5 December 2014 at 11:47.
77 Email from the Acting Associate Director of Operations to a member of the Trust’s IT team and the CEO on 5 December 2014 at 13:44.
78 Email from the Acting Associate Director of Operations to a member of the Trust’s IT team and the CEO on 5 December 2014 at 13:51.
9.20 The Acting Associate Director of Operations provided further clarification in an email to the member of the Trust’s IT team and the CEO on 10 December 2014, noting that “Red2 calls will come over from 111 and queue as R3s for 10 minutes to call back. The clock will start 10 minutes plus 60 seconds.”

9.21 The Acting Associate Director of Operations subsequently emailed a flow diagram to the CEO, which explained when the clock would start for Red 2 calls referred from NHS 111. In response, the CEO noted: “this is only correct if this start box is only for 111 Red 2 calls – if it for all 111 calls then it is making all 111 calls R3”.

9.22 The impact of the changes to the IT infrastructure resulted in the clock starting up to ten minutes later for Red 2 calls from NHS 111 than previously, the reason being that the clock started at the earlier of: a vehicle being assigned; the call being re-categorised; or 60 seconds after the ten minute window for re-triage expired (rather than 60 seconds after appearing on the stack in the CAD (i.e. after being received)).

9.23 The impact of the change to the clock start for Red 2 calls from NHS 111 on the Trust’s performance indicators is addressed in Section 12.

**Operational and Clinical Governance**

9.24 In this section we set out our comments on operational and clinical governance under the following headings:

9.24.1 In paragraphs 9.25 to 9.26, we consider the decision to include Red 2 calls in the Pilot;

9.24.2 In paragraphs 9.27 to 9.33, we consider the operational and clinical approvals that were provided prior to go live; and

9.24.3 In paragraphs 9.34 to 9.40 we consider the decision to delay the clock start by up to ten minutes.

**Governance around the inclusion of Red 2 calls in the Pilot**

9.25 We understand from our interviews that SECAmb staff raised concerns over the inclusion of Red 2 calls from NHS 111 in the Pilot, but that the CEO ultimately authorised their inclusion. The CEO did not disagree that he was responsible for the decision, although he does not consider that he applied inappropriate pressure in gaining the approval of the meeting. Individuals whom we interviewed, made the following comments:

---

79 Email from the Acting Associate Director of Operations to a member of the Trust’s IT team and the CEO on 10 December 2014 at 16:09.

80 Email from the CEO to the Acting Associate Director of Operations and members of the Trust’s IT team on 11 December 2014 at 10:32.
9.25.1 We were informed that it was a direct instruction from the CEO to include the Red calls in the Pilot. One member of staff commented: “In the end, we all felt that it had to be done, because the CEO directed it – he was the only executive on the call”. “From that point we just made it as safe as we could”.

9.25.2 The same person commented: “I was comfortable to do green calls but was persuaded on the red calls. I was not persuaded on the clock start; the CEO gave a direct instruction.”

9.25.3 It was suggested by an interviewee that it felt like the CEO was taking control: the message that was cascaded to the group was that “we have to do this or we will sink or people [i.e. R1 patients or R2 patients not referred from NHS 111] will come to harm”. The interviewee explained that the message from the CEO was not conveyed in a threatening or malevolent way; rather it was the CEO making a ‘decisive’ move.

9.25.4 One member of staff indicated that “When the CEO chairs the group that puts the Pilot in place you don’t question it.” While another said “It is career limiting not to go forward with this as it was “coming from the top”.”

9.25.5 “The CEO made the issue clear, he said that calls from 111 were incorrectly categorised half the time. He noted that re-triaging the Red 2 calls would make the most difference and relieve the pressure on the Trust. The CEO was very open about the reasons for doing it. The CEO’s reasoning put my mind at rest with the whole pilot”.

9.25.6 A further member of staff noted that “[an improper level of pressure was applied to certain individuals]… “and [the process] was accelerated faster than it should have been.” The member of staff also commented that “everyone knew they were going into a restructure [of the executive team]. Lots of people had anxieties about the restructure.”

9.26 The CEO did not dispute that he asked for Red 2 calls to be included in the Pilot. The CEO explained that in his opinion, the Trust would not have been able to cope with the level of demand on the Service, had the Pilot been limited to Green calls.

**Operational and Clinical assessment of the Pilot**

9.27 Other than the CEO, who authorised the inclusion of Red 2 calls, we understand that there was no other executive level clinical input on the call on 4 December 2014. Specifically, neither the former Medical Director nor the Director of Clinical Operations were on the call.

9.28 We understand that the former Medical Director had effectively disengaged from the ODSG by 4 December 2014. However, from interviews with other executives, it is
apparent that the Pilot was discussed at executive meetings which the Medical Director attended\textsuperscript{81} and we been provided with an email to the Medical Director which made specific reference to the Pilot and to the inclusion of Red 2 calls. The email was dated 4 December 2014, which is prior to the Pilot going live.

9.29 As set out in paragraph 9.27, the Director of Clinical Operations was not on the call on 4 December 2014. However, he informed us that he was subsequently made aware of the inclusion of Red 2 calls in the Pilot and other key details, such as the ten minutes to re-triage calls, in the period between 4 December 2014 and 17 December 2014.

9.30 On 17 December 2014, the Director of Clinical Operations signed off a detailed operating procedure\textsuperscript{82} for the Pilot as a ‘Chair’s action’, in his role as Chair of the OPGWG.

9.31 The operating procedure was issued to ensure that all calls handled by the clinicians in the EOCs were consistently matched to the most appropriate disposition. Although the document was intended to provide general guidance for all calls handled by clinicians in the EOC, it contained a specific section titled “NHS111 Call Backs”. We have included an extract from this section below:

\textbf{“From 13 December 2014 – SECAmb CAD will have the capability to partition 111 activity into a ‘Red 3’ category, providing an opportunity to assess and further evaluate an appropriate disposition. 

This function is subject to activation via the CAD through authorisation by Distribution Silver as part of escalation or as a pre-planned action, for example, weekends. 

When activated, the CAD will provide 10 minutes to review Red 2 activity from 111 and 20 minutes to evaluate Cat C 30 activity. 

All Dispatchers will have full visibility of all 111 activity, but will not be expected to dispatch while 111 calls are within the agreed review timeframes.”} \textsuperscript{83}

9.32 As noted in paragraph 9.30 above, the Director of Clinical Operations signed off the operating procedure, which included references to the Pilot, in his capacity as Chair of the OPGWG. This is the only instance that we are aware of, prior to the project going live, of approval being provided for the Pilot through the Trust’s formal governance processes. This sign off provided an element of formality and clinical legitimacy to the Pilot.

\textsuperscript{81} There are no meeting minutes taken at the meetings between executives. 
\textsuperscript{82} EOC PP Procedure v0.1 dated 8 December 2014 
\textsuperscript{83} Paragraphs 3.6 to 3.10 of the EOC PP Procedure v0.1 dated 8 December 2014
9.33 The Director of Clinical Operations explained that he had accepted the Pilot proposal because he had received assurances from colleagues regarding Commissioner sign-up for the Pilot, he accepted that the Pilot was being initiated to respond to concerns over patient safety and he believed reporting would remain in line with AQI requirements.

Governance around the delay to the clock start

9.34 As we explain above in Section 4, the national Ambulance Quality Indicator guidance states that 75% of Red 2 calls should receive an emergency response within eight minutes.

9.35 The adjustments to the clock start for Red 2 calls from NHS 111 provided SECAmb with up to ten additional minutes to re-triage calls and this additional time was not initially captured in the Trust’s reported performance indicators but was subsequently corrected, as discussed in Section 12.

9.36 The Trust did not seek agreement from the Department of Health, NHS England or from Commissioners to deviate from this nationally agreed operating guidance.

9.37 We also explain above in paragraphs 9.16 to 9.22 that the decision to delay the clock start appears to have been discussed between the Acting Associate Director of Clinical Operations and members of the Trust’s IT function, before being authorised by the CEO.

9.38 The CEO told us that the reason for adjusting the clock start during the Pilot was that the 999 service did not have confidence in the triage process in NHS 111 and did not believe that all of the Red 2 calls received from NHS 111 were genuine Red 2 calls. In the CEO’s view, only when the 999 service had completed its re-triage did 999 consider the call to have been correctly classified.

9.39 A significant proportion of those we spoke to cited the need to deal with demand pressures and to manage risk by protecting Red 1 and non-NHS 111 Red 2 callers, ensuring the service’s ability to respond to those calls, as the primary motivation for the Pilot. However, given the various options that could have been pursued, including not stopping the clock, it is clear that performance against KPIs was also a material driver.

9.40 We note that the AQI guidance does not differentiate between Red 2 calls transferred from NHS 111 and Red 2 calls made directly to the 999 service. Hence, the guidance, set out above in Table 4.2, does not allow SECAmb to delay the clock start by ten minutes.
Our view on Operational/clinical governance between 4 December 2014 and 20 December 2014

9.41 The development of the Pilot moved at pace during December 2014 and despite concerns being raised by members of the team that developed and implemented the Pilot, it appears that certain aspects of the Pilot, namely the inclusion of Red 2 calls and the delay to the clock start were authorised by the CEO.

9.42 The AQI guidance is the same for all Red 2 calls regardless of whether they came through NHS 111 or directly to the 999 service. SECamb did not have the authority to introduce a delay to the clock start. This should have been sought through consultation with both NHS England and Commissioners, prior to the Pilot going live.

9.43 We would have expected a formal QIA to have been carried out, with the Medical Director and the Director of Clinical Operations providing sign off on clinical and operating procedures. We would also expect both the OPGWG and the CQWG to be sighted on the non-compliance of the Pilot with NHSE’s Commissioning Standards and AQI guidance and, as a result, the necessity for greater stakeholder consultation and approval.

9.44 The decision of the Director of Clinical Operations to take a ‘Chair’s action’ to approve the operating procedure on 17 December 2014 is the only evidence of the Pilot being approved in line with any of the Trust’s standard governance processes. The approval provided by the Chair of the OPGWG provided the Pilot with the appearance of clinical legitimacy.

Board / Committee Governance

Board/Committee updates

9.45 There were no Board or Committee meetings in December 2015, with the exception of the Finance and Business Development Committee (“FBDC”) on 15 December 2015, which does not focus on clinical issues. No evidence has been provided to us of other mechanisms such as flash reports or group e-mails that were used to update the Board of any developments relating to the Pilot.

9.46 We have seen no evidence, whether from our interviews or from documentation reviews, to suggest that Non-Executive Directors, other than the Chair, had any specific knowledge of the Pilot in the weeks leading up to it going live on 20 December 2014.

9.47 The Chair appears to have had a greater general awareness of the Pilot than the other Non-Executive Directors. We have been reviewed email correspondence
between the CEO and Chair that indicates that the Chair was notified about the Pilot, via an email exchange on 15 December 2014. The Chair initially emailed the CEO, noting:

“Paul, from the trend in Q3 performance I assume that the expected uplift from more cars and 999 triaging 111 calls is not coming through at the expected level”

9.48 The CEO emailed the following response to the Chair on the same day:

“Can we reschedule our meeting tomorrow to when we are together on thr? I can then spend more time on these system issues and review where our ops colleagues are with our performance plan

Dreadful weekend and today some of our mitigations have stalled such as 111 re triage over weekend”

9.49 The Chair informed us that whilst he had an awareness of aspects of the Pilot, he was unaware of key points of detail, principally in relation to the stopping of the clock and the ten minutes backstop. However, given the pressures to manage demand and the sensitivities around re-triage, it is reasonable to expect that the Chair would have asked further questions once made aware of a general intent in this regard.

Our view on Board governance between 4 December 2014 and 20 December 2014

9.50 The Pilot evolved rapidly following the Board meeting on 24 November 2014, with the inclusion of Red 2 calls from NHS 111 and the delay of the clock start by up to ten minutes. The Board did not meet again until 6 January 2015, by which point the Pilot had been underway for 18 days and as such there were limited opportunities to update the Board on developments. However, it would not have been unreasonable to have convened a special meeting or sent an interim communication to the Board on this issue given its importance.

9.51 The Chair accepts that he had access to more information about what became known as the Pilot than was made available to other non-executives and that he was aware of an initiative involving the re-triage of Red calls. Although different interpretations of the conversations that took place between the Chair and CEO on this matter have been presented to the review team, there is no evidence that the Chair was aware of the plan to delay the clock start by up to ten minutes. However, even in the absence of this specific information it would have been appropriate for the Chair to have led greater scrutiny of the proposals to re-triage Red 2 calls.

84 Email from Chair to CEO titled “Performance – deterioration” on 15 December 2014.
85 Email from CEO to Chair titled “RE: Performance – deterioration” on 15 December 2014.
Commissioner governance

9.52 We are not aware of any communications with Commissioners in the period between the 999 CGCG meeting on 3 December 2014 and the Pilot going live on 20 December 2014.

<table>
<thead>
<tr>
<th>Our view on Commissioner governance between 4 December 2014 and 20 December 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>9.53 Given the importance of the changes to the Pilot that took place immediately after the 999 CQCG meeting on 3 December 2014; in particular, the decisions to a) allow ten minutes for re-triage and, b) adjust the clock start, for Red 2 calls from NHS 111, we would have expected SECAmb to update the Commissioners on these changes. However, we have not found evidence of any relevant communication of this information to the Commissioners.</td>
</tr>
<tr>
<td>9.54 The Director of Commercial Services had overall accountability for gaining Commissioners’ approval and, following his attendance at the 999 CQCG on 3 December 2014, we would have expected him to provide the Commissioners with an update on the key changes to the Pilot prior to it going live.</td>
</tr>
</tbody>
</table>

Overall findings relating to period between 4 December 2014 and 20 December 2014

9.55 The CEO was directly involved in the implementation of the Pilot and did not refer the Pilot to the Trust’s Risk committees. Significant concerns apparently raised by senior colleagues were not addressed. No QIA was carried out. Implementation of new operating procedures were rushed through and the Trust deviated from AQI reporting guidelines. While the CEO was not directly involved in each of these items, he was ultimately accountable for ensuring each of them occurred.

9.56 This was a period when the Trust was in REAP 4 and governance via key working groups was suspended, resulting in ‘sign-off’ being informal and carried out by individuals. In our view this project should have been scrutinised by RMCGC at this stage, even if it required a delay to the project or the convening of a special meeting. Executives were not fully abreast of the late changes to the Pilot and there was no update to the Board. Commissioners were not updated of developments.

9.57 Non-Executive Directors do not appear to have been sighted on the Pilot at this stage, with the exception of the Chair who was aware of the re-triage of Red 2 calls. Although different interpretations of the conversations that took place between the Chair and CEO on this matter have been presented to the review team, there is no
evidence that the Chair was aware of the plan to delay the clock start by up to ten minutes. However, even in the absence of this specific information it would have been appropriate for the Chair to have led greater scrutiny of the proposals to re-triage Red 2 calls.

9.58 Overall, this period represented a significant governance failure at the Trust when perceived operational imperative came before appropriate governance. The role of the CEO in driving the pace and parameters of this project is a critical contributor to these failings.
10 The period when the Pilot was in operation: 20 December 2014 to 24 February 2015

Introduction

10.1 In this section we explain how the Pilot was implemented on 20 December 2014, how it was subsequently managed and why it was suspended on 24 February 2015.

The launch of the Pilot

10.2 The Pilot was initially intended to go live on 13 December 2014. However, delays in updates to the IT infrastructure meant that the Pilot launched a week later, across all three of the Trust’s EOCs, at 08:45 on 20 December 2014.\(^{86}\)

10.3 We understand from our interviews with Trust staff that the Pilot could be switched ‘on’ and ‘off’ within the EOCs and that it was only intended to be switched ‘on’ by a Senior Manager in the EOC when the following two conditions were met:

10.3.1 There was a peak in demand; and

10.3.2 There were senior clinicians present in the EOC to oversee the re-triage.

10.4 When the Pilot was switched on, ‘cards’ were displayed in the EOC to inform staff that it was ‘on’.

Managing the Pilot

10.5 The Pilot was operational between 08:45 and 00:00 on Saturday 20 December 2014 and between 08:00 and 00:00 on Sunday 21 December 2014.\(^{87}\)

10.6 The information we have received indicates there was some confusion in the first few days post go-live and that, to some extent, staff ‘picked it up as they went along’. Although Trust staff who we interviewed did acknowledge that the updated operating procedure referred to in Section 9 above, had been circulated by email.

10.7 At least two members of staff raised formal concerns during the Pilot by raising an IR1. However staff did not receive adequate response to their concerns through this route (one member of staff is still awaiting a response after twelve months). We have

\(^{86}\) Report titled ‘NHS call partition report 221214’.

\(^{87}\) Report titled ‘NHS call partition report 221214’.
been advised that the responsibility to review and respond to IR1s rests between the Head of Compliance and the Director of Commercial Services. There is a lack of clarity over who was ultimately responsible.

10.8 On 22 December 2014, a “weekend performance report” was produced by a Senior Operations Manager, which focused on the effectiveness of the Pilot. The “Conclusions” from the report are included below:

“All clinical roles in the EOCs delivered well on expected outcomes, despite some disappointing whole number activity figures. Given the efforts with the 111 queue management, it was the first day of 111 call management, with very limited PP capacity available to undertake the 111 review role at peak times. In addition to this, some ambiguity existed around the process and procedures adopted for the management of 111 activity.

The number of calls being H&T was significantly lower to the previous Saturday, however this is offset to some extent in that the overall percentage of 111 R2 activity being converted to Green 2 was much higher. Compared to previous weekends, late Red responses to 111 calls remained comparable.88

10.9 The “weekend performance report”, also included the following “Recommendations”:

“Exclusive focus on R2 conversion to Cat C 30 activity. This redirected resources to the detriment of typical conversions from Green 30 and 60 111 calls to H&T.

Skills required for undertaking the review of 111 activity are not exclusive to Senior EOC Practitioner staff. The EOC Management team must undertake to re-engage with clinical supervisors, many of whom are feeling disenfranchised about the process.

Clock start appears to be an issue as does other elements of data representation. All data will need a data quality review to see if info is picking up the clock start change so there is potential for reported performance to improve.89

10.10 In response to an email from a Senior Operations Manager in the EOC dated 23 December 2014, which explained that the Pilot would be switched on permanently from 11:00 on 23 December 2014 to 5 January 2015, the Head of Compliance emailed the Director of Commercial Services on 24 December 2014, noting:

“I have just been made aware that we have implemented Red 3 and Green 5 options on emergency calls. Naturally I look for the Risk perspective and this initiative appears to be outside the National requirements.

88 Report titled “NHS call partition report 221214”.
89 Report titled “NHS call partition report 221214”.
We have incidents where Patients die and some of these are investigated as SIRIs, part of that process will determine whether we have followed the National requirements and Trust Policy and Procedures, and these documents will be provided to the Coroner and the CCGs as part of the investigation.

To ensure that Risks to the Trust are minimised we need to demonstrate that we followed our own Governance, to assist please could you advise who within the Trust approved this change and where I can obtain copies of relevant documents.40

10.11 The Director of Commercial Services responded to the Head of Compliance on 24 December 2014, explaining:

“It was agreed by the Executive Team following agreement with the commissioners and [the Acting Associate Director of Operations] should be able to get you the relevant documents.”41

10.12 The Head of Compliance subsequently emailed the Acting Associate Director of Operations on the same day asking:

“Do you have copies of the decision / approval documents - should they be needed (don’t need them now).”42

10.13 We are not aware of the Acting Associate Director of Operations’ response to this email. We have not identified any of the “decision / approval documents” the Head of Compliance requested and we have not seen any evidence of the Head of Compliance following up on his request. Had the Head of Compliance followed up on his request, he would have become aware of the lack of adequate governance for the Pilot.

10.14 On 28 December 2014, when he was operating as the Strategic (Gold) Commander in the EOC, the Director of Clinical Operations felt that the EOC did not have the operational capacity to deliver the Pilot safely, so asked for it to be temporarily switched off.

10.15 Although we are not aware of the exact date, we understand that in early January the Pilot was switched ‘on’ constantly. We understand from Trust staff working in the

---

40 Email from the Head of Compliance to the Director of Commercial Services dated 24 December 2014, titled “FW: NHS 111 Call Queue Management”

41 Email from the Director of Commercial Services to the Head of Compliance dated 24 December 2014, titled “Re: NHS 111 Call Queue Management”

42 Email from the Head of Compliance to the Acting Associate Director of Operations dated 24 December 2014, titled “RE: NHS 111 Call Queue Management”

43 We understand that SECAmb employs a three tier command system within the EOCs, comprising of a Strategic (Gold) Commander, Tactical (Silver) Commander and Operational (Bronze) Commander.
EOC that the Pilot ‘self-managed’ itself in periods of low demand, as clinicians were available to re-triage calls as soon as they were received.

10.16 A paper titled “NHS 111 call partition one month review” was presented to the CQWG on 3 February 2015. We have included the relevant extract from the CQWG meeting minutes below:

“Pilot in EOC

SS attended the meeting in order to clarify the pilot Red3/G5 call processes in EOC, with the need to understand the overall risk. A discussion took place around the governance and risk assessments.

BC informed the Group that this had been picked up at the recent Commissioners Quality Meeting as the Quality Lead had advised they have not received copies of the processes/risk assessments since the last meeting and this was an outstanding action. BC agreed to coordinate the response back to the Commissioners.

SS confirmed that in line with Trust Exec and commission’s approval from 20 December 2014 Red 2 and Green calls are all being re-triaged by PPs in EOC within ten minutes of the call. The Group agreed that the management of Red 3s needed to go on the corporate risk register and BC agreed to action this with SS.

SS sought approval from the Group that the Pilot could continue with a report being presented to the March RMCGC.

10.17 The Head of Compliance took the following action from the CQWG meeting on 3 February 2015:

“BC to report back to Commissions [sic] regarding Red3 calls and add the management of these call on to the risk register”

Circumstances resulting in the Pilot being suspended

10.18 The 999 CQCG met on 12 January 2015. There is no evidence from the meeting minutes that the Pilot was discussed.

10.19 The 999 CQCG met again on 12 February 2015, at this meeting, the Pilot was on the agenda for discussion, due to concerns raised by the Head of Quality and Safety at Swale CCG relating to Serious Incidents (“SIs”) that had been raised. According to

---

94 The CQWG meeting was on 3 February 2015 was chaired by Director of Clinical Operations, with the Medical Director dialling into the meeting.

95 Paragraphs 119.1 to 119.1.4 of the CQWG meeting minutes from 3 February 2015.

96 CQWG meeting minutes from 3 February 2015.
the Commissioners, this was when they first became aware of Red 2 calls being included in the Pilot and of the ten minute delay to allow for re-triage.

10.20 On 13th February, a representative of NHS Swale CCG wrote to a manager in the NHS111 service at SECAmb confirming that the CCG’s Deputy Chief Nurse and another representative of the CCG would visit the Ashford call centre on Tuesday 17th February and subsequently the EOC at Coxheath. The Commissioner explained that the purpose of the visit was to gain a greater understanding of the Pilot, as:

“the CCG has very real concerns that there has already been a serious incident arising from a delayed 999 ambulance dispatch since this new process and have not been assured that the risk of delays for other patients has been mitigated.”

10.21 The then Interim Director of 111 alerted the Chief Executive to the commissioners plans and this triggered a series of email communications in which EOC staff, the Chief Executive and the Director of Clinical Operations discussed how to ‘take control’ and to prepare information in support of the case for the pilot, in advance of the meeting. Within that exchange a member of the EOC staff stated the following:

“I will say that I still don’t believe we need the R3/G5 queue to achieve this, except at times of exceptional demand, but please be assured that this is not what I’ll be saying on Tuesday. I’ll present the balanced argument FOR doing it as above if you require me to.”

10.22 We understand that the Commissioner was referring to one of the nine SIs, attributable to the Pilot that were raised in the period the Pilot was in operation.

10.23 On 23 February 2015, the Accountable Officer for Swale CCG wrote to SECAmb’s CEO, raising a number of concerns around the Pilot. We have summarised the key extracts from the letter below:

- “We [Swale CCG] have been notified of three Serious Incidents (SIs) via the Strategic Executive Information System (STEIS) relating to the above process [the Pilot] which resulted in the deaths of the three patients. We have also received via the National Reporting and Learning System (NRLS) a further two incidents which relates to this process, which resulted in the death of the three patients. In addition, we have received some soft intelligence that there are incidents reported on the Datix system (approximately six) relating to this

---

97 Email from a Commissioner from North Kent CCG to member of SECAmb staff titled “Re: Visit to Ashford call centre” on 13 February 2015.

98 We have been provided with a list of Serious Incidents covering the period from 1 November 2014 to 31 March 2015.

99 Letter from the Accountable Officer at Swale CCG to the CEO on 23 February 2015.
system that have also resulted in the death of the patients. This totals eleven deaths.”

- “We would also like to gain assurance that the “111 Call Management Partition” has been properly risk assessed and the risk to patients has been considered and that the pilot is being actively monitored.”

- “In addition we would like some clarification around how you are reporting R2 performance data for calls that have gone through the re-triage process. It is our understanding that you are re-starting the clock from the re-triage call which effectively is allowing you a 10 minute ‘buffer’ on these calls and is not in line with national practice.”

10.24 The Accountable Officer for Swale CCG ended her letter by strongly advising SECamb “that the re-triage process of R2 calls is suspended, until assurance can be gained that patients are safe under the pilot scheme. We would also request that the re-triaging of Green calls is risk assessed with consideration given to ceasing the pilot until full investigation can assure patient safety.”  

10.25 The Trust suspended the Pilot on 24 February 2015.

10.26 On 26 February 2015, SECamb’s CEO replied to the Accountable Officer at Swale CCG’s letter of 23 February 2015. The CEO’s letter set out the following context, before responding to each of the points raised by the Accountable Officer at Swale CCG:

“I feel it is important to explain that there was a noticeable and steady increase in the number of Red 2 calls transferred from NHS111 to the 999 system from 6th October which put significant strain on the operational resilience, potentially leading to adverse patient care. It was in reflection of this risk to patients that we reviewed the transferred Red 2 calls and identified that many had been inappropriately assessed and did not need a Red 2 response. If this situation had continued then there were significant risks to patients who genuinely did need a Red 2 response that they would not have been unable to receive it due to the increase in the number of transferred Red 2 calls which were unnecessary. The problem was discussed in November at the Trust’s Operational Strategy Delivery Group, which is chaired by myself and is attended by other Directors and senior Operational Staff, which was the appropriate forum to consider the concern and options of mitigation.”

100 Letter from the Accountable Officer at Swale CCG to the CEO on 23 February 2015.

101 Letter from the CEO to the Accountable Officer at Swale CCG on 26 February 2015.
Operational / Clinical Governance

10.27 SECamb demonstrated some good practice in running reflection and peer review sessions during the Pilot. Feedback from PPs indicated that this was supportive and enabled them to share experience and learnings.

Clinical Quality Working Group

10.28 As set out above in paragraphs 10.16 and 10.17, the CQWG met on 3 February 2015. This is the first time the committee had met since 14 October 2014. We understand that the “111 Call Management Partitioning One Month Impact Review”, as explained above in paragraphs 10.8 and 10.9, was presented at this meeting.

10.29 In the meeting the CQWG decides to refer the Pilot to RMCGC for approval. The CQWG appears to support the continuation of the Pilot.

Our view on Operational/clinical governance during the period the Pilot was in operation

10.30 Trust staff that we interviewed indicated that there was insufficient rigour in the operational procedure to provide clear guidance on when the Pilot should have been ‘on’ or ‘off’, which initially led to confusion and ultimately resulted in the Pilot being turned ‘on’ constantly.

10.31 It is evident that the Clinical Supervisors in the EOCs did not feel engaged in the process, given that PPs were being asked to perform a similar function in re-triaging calls. Furthermore, there were times when the Pilot was left on in the absence of available PPs. However, it is apparent that in the first month, the Pilot was perceived to have delivered significant operational benefits, in terms of increasing Hear and Treat rates for Red 2 calls from NHS 111 and reducing the number of ambulance despatches.

10.32 A number of key parameters changed during the course of the Pilot, seemingly without adequate governance and oversight. Specifically, the Pilot was switched on permanently and it continued to run beyond its intended 26 day trial period. By the CQWG meeting on 3 February, the Pilot had been running for 46 days. In total, the Pilot was in operation for 69 days.

10.33 There were weaknesses in the process for investigating IR1s with a lack of clarity regarding who was conducting the investigations and failure to respond to the initiators in a reasonable amount of time.
Board / Committee Governance

10.34 The Board met on 6 January 2015. This is the first time it had met since 24 November 2014. The Board also met on 26 January 2015 and the RMCGC met on 13 January 2015. The minutes relevant to the R3 project are set out below.

Board meeting - 6 January 2015

10.35 In the Board meeting on 6 January 2015, a Governor raised a question on the changes to response times for Red 2 calls which had been proposed by AACE. The CEO’s response is summarised in the meeting minutes as follows:

“PS indicated that a proposal to make changes to response times had been considered by AACE and submitted to the Department of Health some months previously. The proposal had not been implemented across all Ambulance Trusts but was being piloted in a small number of areas. The proposed change would have given Ambulance Trusts up to three minutes to decide whether a call was a R2, and needed a response within 8 minutes. This was reasonable given that it could take up to three minutes to reach a disposition when using NHS Pathways to triage calls and would reduce the number of pre-alerts. Any cases that would deteriorate if they had to wait three minutes would automatically become Red 1 calls. PS’ view was that as this proposal had not been introduced there wasn’t a need for the Trust to publish a formal statement.”

10.36 The next paragraph from the same meeting minutes, attributes further comments to the CEO, which appear to indicate that the Trust was re-triaging calls from NHS 111:

“However, SECAmb’s commissioners had agreed that the Trust could re-triage certain ambulance dispositions from NHS 111 when under pressure.”

10.37 The meeting minutes suggest an inconsistency in the CEO’s response to the Governor’s question. The CEO initially explains that SECAmb had not implemented the AACE’s proposal, which would have provided Trust’s with an additional three minutes to re-triage calls. However, the CEO subsequently noted that the Commissioners had agreed that SECAmb could re-triage certain NHS 111 dispositions. Furthermore, the CEO does not comment on the ten minute delay to the clock start allocated for re-triaging Red 2 calls from NHS 111.

RMGCG – 13 January 2015

10.38 The Chair of the RMGCC confirmed that she first became aware of the re-triaging of certain calls from NHS 111 at the RMGCC meeting on 13 January 2015. However,

---

102 Paragraph 158.2 of the meeting minutes from the Board meeting on 6 January 2015.
103 Paragraph 158.3 of the meeting minutes from the Board meeting on 6 January 2015.
her recollection of the meeting was that the re-triaging of calls from NHS 111 was only discussed briefly, with no details being provided. The Committee Chair explained that it was only later, on reflection, that it became apparent that there were references to the Pilot in this meeting. Another opportunity for questioning and challenge was missed.

10.39 We have included the relevant extract from the meeting minutes at the RMCGC below:

“\textit{The Committee noted that SECAmb’s commissioners had agreed that the Trust could re-triage certain ambulance dispositions from NHS 111 when under pressure. The number of inappropriate 999 dispositions reached in NHS 111 had increased over the Christmas period. This was being addressed through feedback to health advisers and increasing access to clinical advice in NHS 111.}”\footnote{Paragraph 173.3 of the meeting minutes from the RMCGC meeting on 13 January 2015.}

**Board meeting - 27 January 2015**

10.40 The only reference to the Pilot in the meeting minutes from the Board meeting on 27 January 2015 is in a general performance update from the CEO.

“\textit{The key factors to maintaining a high level of performance appeared to have been increased use of SRVs [Single Responder Vehicles], the immediate handover procedure and the pilot of a clinical hub in each EOC which had resulted in higher levels of hear and treat. The RMCGC were monitoring the impact of the increased use of SRVs with a focus on both patient safety and patient experience.}”\footnote{Paragraph 169.11 of the meeting minutes from the Board meeting on 27 January 2015.}

---

**Our view on Board governance**

10.41 Despite the impact the Pilot was having on the Trust’s performance, through the increase in Hear and Treat rates and the reduction in the number of ambulance despatches for Red 2 calls from NHS 111, the Pilot does not appear to have been discussed in detail in Board meetings on 6 January 2015 and 27 January 2015 or at the RMCGC on 13 January 2015.

10.42 Given its impact on performance, we would have expected substantially greater disclosure of the Pilot by the Executive Directors at these meetings, coupled with clinical and operational appraisals of how the Pilot had performed.

10.43 Although there was limited disclosure in relation to the Pilot during this period, there was sufficient disclosure to enable the Board to question the Pilot but this did not occur and the Pilot continued unchallenged.

\footnote{Paragraph 173.3 of the meeting minutes from the RMCGC meeting on 13 January 2015.}
\footnote{Paragraph 169.11 of the meeting minutes from the Board meeting on 27 January 2015.}
Commissioner governance

10.44 The interaction with Commissioners, in this period, is set out above in paragraphs 10.18 to 10.26 above.

10.45 Following the 999 CQWG meeting on 3 December 2014, the Trust had the opportunity to share further details of the Pilot (in particular, the allocation of ten minutes to allow for re-triage and the adjustment to the clock start) in the next meeting on 12 January 2014.

10.46 The Director of Commercial Services was not available to attend the 999 CQCG on 12 January 2015. However, other members of SECamb staff who did attend, most notably the Acting Associate Director of Operations, could have provided an update on the Pilot; given that the Pilot had been running for 23 days by the time of the meeting and was only authorised to run for one month.

10.47 We would also have expected the Commissioners to have requested an update on the performance of the Pilot. However, we have seen no evidence of the Pilot being discussed in the minutes from the 999 CQCG meeting on 12 January 2014.

10.48 Commissioners responded decisively once they became aware of issues associated with the Pilot, but the lack of discussion at the meeting on 12 January 2015 suggests there was significant scope for enhanced scrutiny by the Commissioners.

Overall findings relating to the period from 20 December 2014 to 24 February 2014

10.49 The Pilot had changed significantly between the Board meeting on 24 November 2014 and the Board meeting on 6 January 2015 with the most notable developments being the decision to include Red 2 calls from NHS 111, the decision to allocate ten minutes for the re-triage of Red 2 calls and the decision to adjust the clock start for these calls. However, despite these developments and the impact the Pilot was having on the Trust’s performance, the references to the Pilot in the meeting minutes are limited.

10.50 Given this level of change, we would have expected an update to be provided at the Board and RMCGC meetings in January 2015. Failure to bring information about the Pilot in an active and transparent way to the Board and its Committees represents a fundamental failure by the relevant Trust Executives (see finding at 2.6.2).

10.51 Specifically, we would have expected the CEO, the Director of Clinical Operations and the Medical Director to have ensured greater disclosure of the Pilot to the Board and RMCGC, particularly at the Board meeting on 6 January 2015 and the RMCGC meeting on 13 January 2015, when the Pilot was in operation.
10.52 However, although the level of disclosure in relation to the Pilot was too low during this period for Non-Executives (excluding the Chair) to scrutinise the Pilot in detail, there was sufficient disclosure to enable the Board to question the Pilot but this did not occur and the Pilot continued unchallenged.

10.53 Similarly, the Pilot should have been discussed with Commissioners at the 999 CQCG meeting on 12 January 2015.
11 The Trust’s response to the Pilot: 24 February 2015 to 24 March 2015

Introduction

11.1 In this section we comment on the response of the Board and the RMCGC to the Pilot, in the period directly after it had been suspended.

Board Response

Business Review Meeting – 24 February 2015

11.2 Following the Commissioner’s letter of 23 February 2015, the Pilot was suspended on 24 February 2015. On the same day, there was a BRM, which was attended by both the Executive and Non-Executive Directors.

11.3 The minutes from this meeting, which are included below, indicate that the CEO set out the circumstances around the Pilot being suspended, before commenting that the suspension of the Pilot would likely result in performance being adversely impacted over the upcoming weekend, resulting in increased clinical risk.

11.4 The meeting minutes suggest Board agreement that the re-triaging of calls should be considered a ‘business as usual’ process and that this assessment was supported by clinical staff.

“PS reported that a whistle blower had contacted the commissioners expressing concern that the re-triage of R2 calls coming from NHS 111, which was currently being piloted, was impacting on patient safety. Feedback on the new process from staff was that the number of inappropriate ambulance responses was reducing. The commissioners had reviewed the process and had been supportive. There had been three SIRIs relating to patients who had been re-triaged but on initial investigation the issues did not seem to relate to the re-triage process.

The re-triage process had been suspended while a rapid external clinical assessment of the process took place. The Board supported this position. The length of the suspension would need to be discussed with the commissioners. The suspension could still be in place over the weekend. If so, this was likely to impact on performance and might result in an increase in incidents reported where staff were sent to inappropriate calls and were therefore unable to answer calls from patients at greater clinical risk.

Given that inappropriate referrals from NHS 111 to 999 were an ongoing problem, which could not be resolved quickly, it was proposed that retriage should be a
business as usual process to avoid confusion about when it was and was not to be used. This view was supported by clinical staff. The Executive were asked to keep a clear record of the cost to the Trust of managing inappropriate referrals from NHS 111.\[106\]

11.5 The tone and content of the meeting minutes from the BRM on 24 February 2015 does not reflect the severity of the situation; instead, the focus appears to be on the negative implications on performance and clinical risk arising from the Pilot being suspended. The absence of any reflection on the basis for suspension is noteworthy and concerning.

11.6 Based on the content of the meeting minutes, the Non-Executive Directors do not appear to have challenged the key aspects of the Pilot at this time. Instead there appears to be an acceptance of the explanations provided by the Executive Directors, whose attitude was one of defending the Pilot and wishing it to continue in its material respects.

**RMCGC Response**

RMCGC – 16 March 2015

11.7 We understand that two papers relating to the Pilot were presented to RMCGC for discussion at the meeting on 16 March 2015:

11.7.1 a paper drafted by a Senior Operations Manager, which was submitted by the Acting Associate Director of Operations to members of the RMCGC in advance of the meeting, titled “111 Call Management partition (Red 3/Green 5) Operational Impact Review”; and

11.7.2 a second paper drafted by a different Senior Operations Manager, which was tabled on the day of the meeting by the Director of Clinical Operations\[107\], titled “111 Call Management Partition Pilot (Red 3/Green 5) Operational Impact Review”.

11.8 We understand from the Acting Associate Director of Operations that she was on leave on the day of the RMCGC meeting, and was unaware that the second paper had been submitted until she came to review the papers in connection with the present investigation.

11.9 The Senior Operations Manager who authored the second paper, which was tabled on the day of the RMCGC meeting, could not recall who had asked him to produce

---

\[106\] Paragraphs 7.4 to 7.6 of the meeting minutes from the Business Review Meeting on 24 February 2015

\[107\] Paragraph 221.1 of the meeting minutes from the RMCGC meeting on 16 March 2015 state that “[the Director of Clinical Operations] tabled an updated paper at the meeting.”
the document. However, he explained that there was a tight turnaround and he claimed that none of the Executive team had influenced him when he produced the paper. He also commented that when he produced his paper, the author of the first paper had left the Trust and that may have been why he was asked. We have summarised the key differences between the two papers below:

11.9.1 The following wording was included in the second paper, which implied that the Acting Associate Director of Operations had discussed key details of the Pilot with Commissioners. We understand that the Acting Associate Director of Operations and the Director of Commercial Services were in the meeting with Commissioners on 3 December 2014, but there is no evidence of the additional ten minutes being discussed:

“… the commissioners were approached by the Acting Associate Director of Operations and it was agreed that we could make available an extra 10 minutes on each Red 2 111 call, and an extra 20 minutes on each Green 2 111 call for the purposes of re-triage.” \(^{108}\)

11.9.2 The second paper implied that the Medical Director was involved in the development and risk assessment of the Pilot, while the first paper does not mention the Medical Director. This contradicts the Medical Director’s recollection, which we set out above in paragraph 9.28, as she explained that she was not involved in any clinical appraisal of the Pilot. The relevant extract from the second paper is included below:

“… having considered all of the risks presented, the operational delivery task and finish group, which included the Medical Director, decided that the risk present in the delayed response to multiple 999 patients on a regular basis far outweighed the risk to a small cohort of patients inadvertently calling 111 for a life-threatening complaint.” \(^{109}\)

11.9.3 The second paper does not include certain challenges which arose during the Pilot, such as the formal grievances raised by clinical supervisors, the references to incident reports and the issues raised through the 999 Hear & Treat audit. Also, the second paper does not refer to the fact that the Pilot remained on constantly throughout January and February.

11.10 The individuals we interviewed, including the author of the second paper and the Director of Clinical Operations who tabled the second paper in the RMCGC meeting on 16 March 2015, were not able to explain the reason for the second paper being

\(^{108}\) Paragraph 2.2.1 of the paper titled “111 Call Management Partition Pilot (Red 3/Green 5) Operational Impact Review” submitted on the day of the RMCGC on 16 March 2015.

\(^{109}\) Paragraph 3.6 of the paper titled “111 Call Management Partition Pilot (Red 3/Green 5) Operational Impact Review” submitted on the day of the RMCGC on 16 March 2015.
drafted. It is apparent that this paper is misleading in a number of regards and presents a more positive view than that expressed in the first paper produced for and distributed in advance of the meeting.

### Our view on Board governance following the suspension of the Pilot

11.11 The level of disclosure at Board level increased significantly in the BRM on 24 February 2015; as would be expected given the Commissioner’s instruction to suspend the Pilot the previous day. However, the position presented to the Board did not reflect the severity of the situation and there does not appear to have been any challenge to the explanations provided.

11.12 The second paper, tabled on day of the RMCGC meeting on 16 March 2016 has the effect of erroneously attributing accountability for decisions made prior to the Pilot going live to certain individuals (see paragraphs 11.9.1 and 11.9.2 for further details).

### Data review performed by the CEO

11.13 While performing our review of the CEO’s email data, we identified a series of emails between the CEO and member of the Trust’s IT team, on 3 June 2015 and 4 June 2015, where the CEO requests access to emails relating the Pilot. The CEO subsequently provided the member of the Trust’s IT team with a list of search terms. The CEO’s initial email stated:

> “Would someone be able to pull any emails to and from me with the subject of red 3 within them from june to jan 14/15?

> Also, would we be able to do something similar to Jane pateman’s inbox as was

> We need to find out the sequence of events as you know and we need to see where it was referred to etc”

110

The email chain indicates that the CEO has been provided with correspondence to and from SECAmb staff relating to the Pilot.

---

110 Email from the CEO to a member of the Trust’s IT team, untitled on 3 June 2015.
12 Effect of the Pilot on performance indicators

Introduction

12.1 This section reviews the impact of the Pilot on the performance reported by SECAmb. The review covers two main aspects:

1. Whether SECAmb followed the appropriate methodology in the calculation of the performance indicators; and

Adherence with NHSE methodology in the AQIs calculation

12.2 SECAmb submits monthly AQIs to Monitor 20 to 25 days after the end of the month. For the three months affected by the pilot, the indicators were submitted on 22 January 2015 for December 2014, on 20 February 2015 for January 2015 and on 23 March 2015 for February 2015.

12.3 Our review of the methodology used to calculate these submissions highlighted that the methodology does not seem to conform to the NHSE 2013 guidance. Specifically, during the pilot, the Call Connect for re-triaged calls (i.e. calls originating on the 111 system and categorised as R2 or G2 following the 111 assessment) was moved from the time a call exited the 111 system to the time a call exited the re-triage. The effect was to exclude the re-triage time from the calculation of call response times, resulting in the reporting of shorter incident times and thus impacting the AQIs. The reasons for the delay to the clock start are set out in Section 9.

12.4 The time that was not accounted for corresponded to either:

1. The time until the call exited the queue plus the time taken for the clinician to conduct the re-assessment, if the call was picked up and re-triaged; or

2. The time until the call exited the queue for re-triage, potentially occurring if a clinician did not respond within the required timeframes (ten minutes for R3, 20 minutes for G5).

12.5 Figure 12.1 below shows the path followed for Category A calls’ during the Pilot and in the absence of the Pilot, and the Call Connect used for AQIs’ calculations under the two call paths.
12.6 The re-definition of Call Connect affected directly the R2-8, R-19 and G2-19 indicators.\(^{111}\)

12.7 In April 2015 SECAmb re-calculated the three nationally captured AQIs, and following discussion with Monitor, chose to provide Monitor with revised indicators. While SECAmb’s original submissions (paragraph 12.2 above) used the incorrect Call Connect time, the revised submissions reverted to the correct Call Connect time, and therefore should be consistent with NHSE 2013 guidelines.

12.8 While also affected by the re-definition of Call Connect, none of the Green codes indicators were revised. For the G4-60 indicator, this is due to the indicator not being captured.

12.9 Our review of SECAmb’s methodology highlighted another issue of non-compliance, not related specifically to the Pilot. The NHSE 2013 guidelines require that for Red 2 calls the Clock Start should also consider the point at which the appropriate response is determined (see Table 12.2). However, this element of the guidelines is currently not considered by SECAmb. This may result in shorter reported incident response times where the DX code information obtained is earlier than the Call Connect plus 60 seconds and the time the first vehicle is assigned (being the other measures to be considered in setting R2’s Clock Start) (see Table 12.1).

### Testing submissions

12.10 To assess whether, and if so, by how much, the initial AQIs submitted by SECAmb overestimated the Trust’s performance and hence impacted on the

---

\(^{111}\) In addition, all other indicators may have been affected insofar the priority code may have changed during the re-triage re-assessment.
accuracy of the revised AQIs, we have performed a high-level estimation for the December 2014, January 2015, and February 2015 AQIs. The Green codes indicators were also estimated for these months.

12.11 In estimating the AQIs, the Call Connect consistent with the National Guidelines was used. Further, in setting the Clock Start for the calculations, the Pathways Initial DX Code Information time was considered for those incidents for which it was available. The methodology adopted and associated limitations are set out in more detail in Appendix 4. Note that, while the methodology followed is in line with NHSE 2013 guidelines, some variation to the revised indicators is expected given the different levels of data validation and the inclusion of DX Code Information time in the calculation of the Clock Start for R2 calls.

12.12 The tables below compare the three sets of indicators: the AQIs and Green codes indicators estimated in this review, the first set of AQIs submitted by SECAmb to Monitor (Pre-revision AQIs), and the second set of AQIs submitted by SECAmb to Monitor (Post-revision AQIs).

### Table 12.1: AQIs and performance indicators for December 2014

<table>
<thead>
<tr>
<th>Indicator’s name</th>
<th>Definition</th>
<th>Total valid Calls</th>
<th>Valid calls meeting target</th>
<th>Indicator</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>This review</td>
<td>Post-revision</td>
<td>Pre-revision</td>
</tr>
<tr>
<td>R1-8</td>
<td>75% R1&lt;=8:00min</td>
<td>1,345</td>
<td>1,345</td>
<td>1,345</td>
</tr>
<tr>
<td>R2-8</td>
<td>75% R2&lt;=8:00min</td>
<td>24,899</td>
<td>24,896</td>
<td>24,894</td>
</tr>
<tr>
<td>R-19</td>
<td>95% R&lt;=19:00min</td>
<td>26,244</td>
<td>26,241</td>
<td>26,239</td>
</tr>
<tr>
<td>G2-30</td>
<td>95% G2&lt;=30:00min</td>
<td>28,837</td>
<td></td>
<td>25,228</td>
</tr>
<tr>
<td>G4-60</td>
<td>95% G4&lt;=60:00min</td>
<td>5,317</td>
<td></td>
<td>4,815</td>
</tr>
</tbody>
</table>

Source: Deloitte UK analysis, SECAmb

### Table 12.2: AQIs and performance indicators for January 2015

<table>
<thead>
<tr>
<th>Indicator’s name</th>
<th>Definition</th>
<th>Total valid Calls</th>
<th>Valid calls meeting target</th>
<th>Indicator</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>This review</td>
<td>Post-revision</td>
<td>Pre-revision</td>
</tr>
<tr>
<td>R1-8</td>
<td>75% R1&lt;=8:00min</td>
<td>1,350</td>
<td>1,350</td>
<td>1,351</td>
</tr>
<tr>
<td>R2-8</td>
<td>75% R2&lt;=8:00min</td>
<td>22,309</td>
<td>22,304</td>
<td>22,299</td>
</tr>
<tr>
<td>R-19</td>
<td>95% R&lt;=19:00min</td>
<td>23,659</td>
<td>23,654</td>
<td>23,650</td>
</tr>
<tr>
<td>G2-30</td>
<td>95% G2&lt;=30:00min</td>
<td>24,892</td>
<td></td>
<td>22,044</td>
</tr>
<tr>
<td>G4-60</td>
<td>95% G4&lt;=60:00min</td>
<td>4,916</td>
<td></td>
<td>4,622</td>
</tr>
</tbody>
</table>

Source: Deloitte UK analysis, SECAmb

### Table 12.3: AQIs and performance indicators for February 2015

<table>
<thead>
<tr>
<th>Indicator’s name</th>
<th>Definition</th>
<th>Total valid Calls</th>
<th>Valid calls meeting target</th>
<th>Indicator</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>This review</td>
<td>Post-revision</td>
<td>Pre-revision</td>
</tr>
<tr>
<td>R1-8</td>
<td>75% R1&lt;=8:00min</td>
<td>1,020</td>
<td>1,020</td>
<td>1,020</td>
</tr>
<tr>
<td>R2-8</td>
<td>75% R2&lt;=8:00min</td>
<td>19,689</td>
<td>19,683</td>
<td>19,683</td>
</tr>
<tr>
<td>R-19</td>
<td>95% R&lt;=19:00min</td>
<td>20,709</td>
<td>20,703</td>
<td>20,703</td>
</tr>
<tr>
<td>G2-30</td>
<td>95% G2&lt;=30:00min</td>
<td>22,617</td>
<td></td>
<td>19,615</td>
</tr>
<tr>
<td>G4-60</td>
<td>95% G4&lt;=60:00min</td>
<td>4,159</td>
<td></td>
<td>3,821</td>
</tr>
</tbody>
</table>

Source: Deloitte UK analysis, SECAmb
12.13 The indicators estimated in this review using NHSE methodology are broadly in line with the Post-revision indicators submitted by SECAmb to Monitor\textsuperscript{112}. This suggests that the methodology used by SECAmb in the Post-revision AQIs calculation is in line with NHSE 2013 guidelines, except for the exclusion of DX Code Information time from the Clock Start calculations.

12.14 Pre-revision AQIs are higher than the AQIs estimated in this review in all but one instance, where there is no difference between the two estimates. The Pre-revision AQIs overstate performance due to the re-definition of Call Connect, by up to 5.44\% (R2-8 in January 2015).

12.15 The review suggests that, when the appropriate methodology is applied, most performance targets were not been met by SECAmb during the months considered. In December 2014 and February 2015, none of the indicators satisfy the targets set by NHSE and the local contracts. In January 2015, the targets were satisfied for R1-8 and R-19: 76\% of R1 incidents were resolved within eight minutes, and 95.2\% of all Category A incidents were resolved within 19 minutes.

12.16 The review highlighted that none of the local targets for the Green code indicators were met by SECAmb during the three months affected by the pilot. In particular, the G2-30 indicator misses the target by more than 6.3\% percentage points in all three months.

\textsuperscript{112} SECAmb submitted the Pre-revision AQIs to Monitor for December 2014, January 2015 and February 2015 on 22 January 2015, 20 February 2015 and 23 March 2015 respectively. SECAmb subsequently sought to remove the impact of the Pilot on the reporting indicators and submitted further AQIs, in early April 2015, for the R2-8 and R-19 indicators, for the quarters October to December 2014 and January to March 2015. After performing additional data validation, SECAmb submitted the Post-revision AQIs to Monitor later in April 2015. We understand that the additional data validation the Trust performed on the Post-revision AQIs meant that the data used to calculate these AQIs does not reconcile to the data used to calculate the quarterly AQIs submitted previously.
13 Broader governance and leadership at the Trust

Introduction

13.1 Notwithstanding previous efforts to review and develop the SECAmb Board\textsuperscript{113}, during the course of this review we have identified a number of areas where we believe there is scope for significantly enhancing the effectiveness of board governance and leadership at the Trust. Whilst these issues are wider than the Pilot specifically, they do provide considerable insight into how the functioning of the Board may have contributed to the circumstances surrounding the Pilot and merit exploration. This analysis is consistent with section 1.3.1.5 of our Terms of Reference which requires us to consider ‘the intentions and wider context surrounding the Pilot’ and is also relevant in the context of adequately addressing 1.3.4. i.e. ‘assess the nature and level of scrutiny employed by the Trust Board and its Committees over the handling of the Pilot at each stage of the process’.

13.2 Events which have followed the emergence of the facts about the Pilot have clearly placed strains on the Board. However, our interviews with Executive Directors, Non-Executive Directors and other senior leaders in the Trust have exposed weaknesses in the operation of the Board which pre-date the Pilot. We outline the key areas below. We have included references to board dynamics and leadership style where there was consistency in views expressed and in cases where perception itself (even if a counter argument were to be levelled) could have a detrimental impact on the effectiveness of the Board. We suggest further investigation and consideration of these points should be undertaken as a matter of urgency.

A non-unitary Board

13.3 We have not observed any Board or Committee meetings as part of this review. We understand that the Board has had some external support in the form of a development programme following an effectiveness review in 2013. The work has involved sessions aimed at enhancing working relationships between Executive Directors and Non-Executive Directors. Despite these sessions, at the point in time the current review was undertaken, scope for greater cohesion at board-level and in particular for improvement in the way in which Executive Directors and Non-Executives work together as a unitary Board was identified by interviewees. However their respective perspectives on the reasons why the Board does not currently

---

\textsuperscript{113} SECAmb Board Review performed by Canterbury Christ Church University in November 2013.
operate in a unitary manner are different. These respective positions are outlined below.

13.4 Non-Executive Directors outlined some frustrations regarding the way in which Executive Directors share information with the Board. Specifically, the view was expressed that it can be challenging to access insightful information from executives. Some highlighted a concern that information is unlikely to be forthcoming unless the Non-Executive Directors ‘spot’ an issue. There were specific criticisms of the CEO report and other papers that were described as lacking clarity on the crucial points. This feedback is consistent with our review of a sample of papers relating to the Pilot. It was also reported that some papers arrive late or even after the event.

13.5 Executive Directors, on the other hand, indicated a perception that Non-Executive Directors seem to regard their role as to challenge rather than to support the executive team and that the Board has become a forum for non-executives to ask questions of their executive colleagues rather than a place to engage in meaningful dialogue. A number of Executive Directors also referenced the fact that the Chair regularly referred to the Non-Executives as “the Board” and noted the impact this had on setting the wrong tone for a unitary Board.

13.6 The subject of how much members of the Board, and the Chair in particular, knew about the Pilot featured prominently in our interviews. The view offered by multiple interviewees at various levels of seniority within the organisation was that the Chair spends so much time at the Trust (regularly five days per week) and is so involved in operational detail, his lack of knowledge of the Pilot was inconsistent with his normal level of engagement. As discussed above, the Chair was aware of an initiative to re-triage Red 2 calls, but, in line with his own stated position, there is no evidence that he was aware of the clock-stop and the delay of up to ten minutes to re-triage Red 2 calls.

**Style of the Chair**

13.7 Responses to our enquiries regarding the Chair’s knowledge of the Pilot have highlighted aspects of his style and approach which in turn raise a number of key issues regarding board governance. Specifically, he is viewed by a number of those interviewed as behaving like an executive chair. Concerns were also raised to us about the Chair’s decision to personally conduct the Fit and Proper Person review as it is viewed by some Board members as not being appropriate given his personal levels of involvement in Trust operations and his awareness of re-triaging of Red 2 calls.

13.8 The view that the Chair is ‘too executive’ and gets too much into detail was a strong and consistent theme throughout our interviews. A tendency to call people into his office with little or no notice for ad hoc discussions was highlighted, together with examples of where he had gone to second, third or even fourth line staff to obtain
detailed operational information. The considerable amount of time he spends with the CEO in his office was also widely mentioned. The Chair does not agree that he spends ‘too much’ time at the Trust and explained that in his opinion the Chief Executive ‘needed his support’. The CEO disputes that he needed this ‘support’ and described that the risk which in his view manifested in this whole situation was a blurring of the lines of governance.

13.9 There is also a view that the Chair is dominant in meetings. Executive interviewees described the Chair as vocal and controlling in meetings, the impact of which is to create an environment where others may not have the opportunity to express their own opinions and views. Specifically, many perceive him as being too controlling of non-executives. However, it should be noted that there was a view also expressed that the Chair has been working on this particular area and has shown some improvement following feedback received during recent development sessions. The Chair acknowledged this point and said that he has tried hard not to be ‘executive’. We are also aware that the Chair has previously received a number of appraisals that were positive overall.

13.10 In response to our draft report the Chairman has provided us with various pieces of documentation relating to activities undertaken to review and develop the Board. One particular document, titled “Report for the SECAmb Board: Your Development Journey 2014-2015”, issued in May 2015, describes the outcomes of a Board review undertaken at SECAmb (concluded in November 2013), an overview of a 10 month Board Development Programme and details on the outcomes of that programme. The report states (p5):

“The [Board] review highlighted a number of strengths of the Board including:

1. SECAmb’s reputation in the sector both with the health economy and internationally;
2. Being on top of financial and operational performance;
3. A Board that is committed to SECAmb’s vision and aspirations;
4. A powerful Chair and well regarded Chief Executive.

There were also three key areas for concern highlighted. These were:
1. The dynamic between the Chair and Chief Executive;
2. The interface between the Board and senior managers in the trust;
3. The impact of roles, responsibilities and relationships between Executives and Non-Executives.”

13.11 The report concludes that the Board Development Programme (p.11), “has had a significant impact on the way the Board is operating. As a whole, the Board is working more effectively, with clearer roles and more open, mature and honest interactions between Board members. There is strong unity about the vision and strategy for the organisation, and an awareness of the need to challenge thinking to ensure a drive to improve still underpins its activities”. In relation to the Chair it concludes, “[t]he Chair of the Board is strong and engaged. This is positive but also has inherent risks. The
challenge for the other Non-Executives is to ensure they retain their individual independence.” It also concludes that the work with the senior management group is still on-going, both to ensure there is a strong senior management group and to establish greater links with the Board. The report is silent on whether there have been any improvements in the dynamic between the Chair and Chief Executive.\(^{114}\)

**Fit and Proper Person review (FPP review)**

13.12 The Health and Social Care Act 2008 (Regulated Activities) Regulation 14 (the 2014 Regulations) places a duty on NHS providers not to appoint or allow a person to continue to be an executive director (or equivalent) or non-Executive director under certain circumstances. The test is supervised by the Care Quality Commission but decisions are made by individual Trusts.

13.13 The Chair decided to conduct a FPP review on the CEO, the Director of Clinical Operations, the Director of Commercial Services and the Acting Associate Director of Operations given their close involvement with the Pilot in response to Monitor’s stated concerns regarding potential ‘serious mismanagement’ at the Trust. The Chief Operating Officer volunteered to be included in the process. The Chair decided to conduct the review personally after seeking advice from the Trust's legal advisers and the Chair has indicated that he was given ‘directive advice’ that the fit and proper person test assessment should be done and that he should do it himself, because it was he as the Chair of the Trust who had to satisfy himself that the events did not impugn the fitness of the senior staff involved. We understand from the legal advisers involved that the advice given was that the Chair would normally undertake the FPP review themselves unless there was a reason not to.

13.14 The FPP review was led by the Chair with support from the Chair of the Audit Committee. We agreed that it would not be appropriate for us to review the FPP report which was finalised during the course of this review.

13.15 It was reported to us that given his detailed involvement with the Trust, the Chair’s decision to conduct the FPP review personally gave some Board members a cause for concern. Some highlighted the risk that the review would be perceived to lack objectivity, if conducted by the Chair. We also heard what appear to be conflicting views on the interpretation of the Regulation\(^{115}\) which limits the application of FPP processes to directors or those performing functions ‘equivalent or similar to’ board-

\(^{114}\) The methodology that the authors have used to arrive at their conclusions on the outcomes of the Board Development Programme is not clear from the report. In addition, the authors of the report also facilitated the programme and undertook the 2013 review.

\(^{115}\) Care Quality Commission, March 2015: Regulation 5: Fit and proper persons: directors 5 (2) (b).
level directors. Specifically, questions were asked as to why an Acting Associate Director was included in the process.\footnote{The Chair noted that he was advised by the Trust’s solicitors to interview the Acting Associate Director, due to her involvement in the development and implementation of the Pilot. We have not had sight of the legal advice referred to by the Chair.}

13.16 In addition to the comments made to us and noted above, significant concerns were raised with us about the process and conduct surrounding the FPP review. Several of the individuals involved described the way in which the end to end process was conducted as ‘unfair’, ‘predetermined’ and ‘threatening’. The Chair disputes this.

**A lack of scrutiny**

13.17 Disclosure around the Pilot was not sufficient to provide all Non-Executive Directors with an appropriate level of detail to fully appreciate the risk implications of the Pilot. However, there were a number of missed opportunities to probe further in various meetings. For example, both the Board meeting on 6 January 2015 and the RMCGC on 13 February 2015 noted that “SECAmb’s commissioners had agreed that the Trust could re-triage certain ambulance dispositions from NHS 111 when under pressure”. However, this led to limited discussion or scrutiny by Non-Executive Directors.

13.18 The CEO was the sponsor of ODSG at the point in which the group was convened. The Director of Clinical Operations was also a member and the Medical Director was a member although frequently absent from key discussions. The CEO himself gave the direction to include Red calls in the Pilot. This created a dynamic where accountability for review and challenge to the ideas emerging from the group was unclear and actual review and challenge were absent. Given the failure of key executives to ensure appropriate non-executive oversight and scrutiny, this resulted in a complete absence of independent scrutiny.

**Board focus**

13.19 The Board includes a Chair, eight Executive\footnote{Only seven of the Executive Directors have voting rights. The Director of Workforce transformation is a non-voting member of the Board.} and seven Non-Executive Directors. The Non-Executive Directors have a range of experience in finance, healthcare, business, local government, HR, education and the military. The opinion was expressed that Non-Executive Directors could make a greater contribution to the Board if they were given more of a voice. It was specifically pointed out that there is scope for making greater use of Non-Executive Directors’ professional experience.

13.20 According to a number of interviewees, the Non-Executive Directors have a focus on financial and business activities at present. It has been suggested by some Executive Directors that the Board has insufficient focus on clinical issues and that the Non-Executive Directors, need to focus more on the clinical impact of operating
decisions. This point has been made in connection with the 24 February 2015 BRM where the main action following the Board being briefed on the Pilot for the first time was “for the Executive to keep a clear record of the cost to the Trust of managing inappropriate referrals from NHS 111...” possibly indicating a financial, rather than clinical, response to the issues raised. We would have expected the outcome of the discussion at this point to have had a greater focus on the quality impact of the Pilot.

13.21 A number of interviewees suggested that the Board would benefit from greater levels of scrutiny if it had more Non-Executive Directors with a clinical focus. Whilst the skill set of the non-executive cohort is not a significant outlier compared with other NHS Boards, we can see how the Trust Board could benefit from more NHS experience and a stronger clinical focus.

‘Silo based’ working

13.22 It has been suggested by a number of Board members, executive and non-executive, that there is scope for improved cohesion within the executive team and across services. In particular, a tendency for ‘silo based’ working across executive portfolios was highlighted by interviewees. The most pronounced area where this is apparent is in relation to operational and clinical portfolios. This is evident from the separate governance routes for example where the CQWG runs in parallel with the OPGWG. We understand that the CQWG was set-up because clinicians were not involved in the OPGWG.

13.23 We understand that there have been tensions between operational and clinical leaders in the past which has led to difficulties in relationships. In particular there was a broadly held perception that the professional relationship between the Director of Clinical Operations and the previous Medical Director was strained. An example cited was where operational staff signed-off on clinical instructions without approval from the Medical Director\[118\]. The Director of Clinical Operations explained that this has also happened in reverse. This is illustrative of the lack of clarity around accountabilities.

13.24 A lack of dialogue between those responsible for managing the NHS 111 service and the 999 service managers was also consistently reported. This is consistent with the other elements of the review where we identified no evidence of formal engagement or communication with NHS 111 prior to or during the Pilot, despite both services being provided by SECAmb. We understand that the Interim Director of 111 first became aware of the Pilot anecdotally during the third week of January 2015, when the matter was mentioned by a colleague. Other members of the NHS 111 team became aware of the Pilot anecdotally and some raised concerns with supervisors. The Interim Director of NHS 111 was only formally invited to attend the executive

\[118\] ‘In call’ Clinical Support Operational Instruction in August 2014
meetings in January 2015. Morale in NHS 111 was described by the Clinical Advisors and Clinical Operations managers in NHS 111, who we interviewed, as being impacted once it became apparent that, during the Pilot, the 999 service was re-triaging their calls, particularly clinical staff who were having their calls reviewed again.

**Commissioner engagement**

13.25 In interviews, both Trust representatives and Commissioners indicated that business has been conducted in an overly informal way in the past and that all parties have committed to a more robust and formal approach to governance in the future. There has been an effort to engage Non-Executive Directors with Commissioners as demonstrated by a recent session held between the SECAmb and Swale CCG Boards.

13.26 Wider discussions with commissioners suggest that engagement with the Trust became too reliant on the relationship with the Director of Commercial Services and steps have been taken to open this up to include other key executives such as the Chief Operating Officer, Medical Director and Director of Nursing. This is in addition to engagement at CEO and Chair level.
14 Wider learnings from this review

Introduction

14.1 While the focus of this review has been on the specific circumstances surrounding the Pilot, we have identified a number of fundamental themes which we believe are critical learnings for SECAmb but also for the wider ambulance sector. We therefore set out below a summary of these key learnings and there relevance for the wider sector.

Wider learning from this review

14.2 Operational and clinical activities in SECAmb were not appropriately coordinated and there was a tendency for staff to work in silos. The existence of two separate working groups reporting to the RMCGC (OPGWG and CQWG) further reinforced this. A higher level of engagement and consultation between clinical and operational workgroups should be adopted to reduce risks.

14.3 Both NHS 111 and 999 are critical parts of the urgent and emergency care system. While they are distinct services with different remits, workforces and operating models, they need to work effectively together in the best interests of patients. In SECAmb, the NHS 111 and 999 services operate in silos with limited communication between the services. Commissioners and providers of both services should prioritise effective service integration and co-operation and in particular where ambulance services deliver both NHS 111 and 999, the Board should take care to ensure that both governance and operations are designed in a way that guards against the development of silos and which optimises understanding of the service model and effective communication and collaboration.

14.4 In our discussions with interviewees for this review, SECAmb’s ‘reputation for innovation’ was cited a number of times. The ability to identify innovative solutions to key operational challenges and the appetite to continuously review and challenge custom and practice is to be commended. The problem at SECAmb was that the innovation process happened in isolation from the core governance arrangements and appropriate risk assessment was not applied. The challenge for both SECAmb and for the wider system is to create fora outside of core business-as-usual where ideas can be generated and analysed. However, it is critical that any innovations or material process or system modifications are risk assessed, consulted upon and approved through an appropriate governance structure before piloting or implementation commences. A Quality Impact Assessment should be carried out for any changes to operational processes that could impact quality – including safety, patient experience, or effectiveness of care.
14.5 In SECAmb during periods of high demand when REAP 4+ is implemented, staff are assigned to operational roles only and do not participate in working groups. An impact of this was that governance of working groups was suspended during REAP 4+ i.e. the period during which the Pilot was defined and implemented. Governance should not be universally suspended during REAP 4+ as this results in key decisions resting with individuals. During REAP 4+ robust governance should remain in place and careful consideration should be given to appropriately differentiating between non-essential management meetings and those with key decision making or governance implications.

14.6 The number and configuration of executive level clinical roles varies across Ambulance Trusts. In the case of SECAmb there were three key clinical roles, the Medical Director, the Director of Clinical Operations and the Nursing Director. In addition, the Chief Executive Officer is a paramedic. There was insufficient clarity around responsibilities for clinical decision-making and accountability for advising the Board on clinical risk regarding the Pilot particularly between the Medical Director and the Director of Clinical Operations. All ambulance trusts should ensure that where there are several senior executives with clinical responsibilities, that both accountabilities and responsibilities of each should be absolutely clear.

14.7 A level of informality developed in the relationship between SECAmb and its Lead Commissioners. The lack of formal documentation in relation to the presentation of the Pilot to Commissioners by SECAmb and in the recording of key decisions essentially led to a situation where there was a fundamental mismatch between what SECAmb believed it had a mandate to do and what Commissioners thought they had agreed to. This ultimately resulted in SECAmb proceeding with a major operational initiative without the appropriate clinical scrutiny from its Commissioners. The SECAmb experience highlights an important learning for the wider NHS in terms of the need to retain an appropriate level of formality in the relationship with commissioners and specifically to ensure that there are robust processes in place in relation to the recording of decision making around key proposals.

14.8 We have found numerous references to elements of the Pilot in Board and Committee meetings both before and during the Pilot. The executive team have pointed to these references as evidence that the Board was aware of the Pilot and that there was no intention to conceal the plans. However, our review suggests that the references do not provide sufficient disclosure to enable Non-Executive Directors to gain an appreciation of the significance or risks of the Pilot. Whilst there is an onus on Non-Executive Directors to scrutinise Trust activities, their ability to do so relies heavily on the quality, depth and timeliness of the information furnished to them by the executive team. The experience of the Pilot is an important reminder of this obligation Executive Directors have to provide the Board with the appropriate level of information which enables all members to understand and therefore scrutinise risks associated with operational and clinical activities.
“Deloitte” refers to one or more of Deloitte Touche Tohmatsu Limited (“DTTL”), a UK private company limited by guarantee, and its network of member firms, each of which is a legally separate and independent entity. Please see www.deloitte.co.uk/about for a detailed description of the legal structure of DTTL and its member firms. Deloitte LLP (“Deloitte UK”) is the United Kingdom member firm of DTTL.
**Important Notice**

This Report has been prepared by Deloitte LLP for South East Coast Ambulance Services NHS Foundation Trust and Monitor in accordance with our engagement terms and on the basis of the scope and limitations set out below. It has been prepared solely for the purposes of assisting South East Coast Ambulance Services NHS Foundation Trust and Monitor in connection with a review of the Red 3 / Green 5 Pilot. It should not be used for any other purpose or in any other context, and Deloitte LLP accepts no responsibility for its use in either regard.

This Report is provided exclusively for use by South East Coast Ambulance Services NHS Foundation Trust and by Monitor. No party other than South East Coast Ambulance Services NHS Foundation Trust or Monitor is entitled to rely on this Report for any purpose whatsoever and Deloitte LLP accepts no responsibility or liability to any party other than South East Coast Ambulance Services NHS Foundation Trust and Monitor in respect of this Report or its contents.

In the event that South East Coast Ambulance Services NHS Foundation Trust or Monitor discloses this Report pursuant to its obligations under the Freedom of Information Act 2000, we also draw to the attention of any subsequent reader that:

1) This Report and its contents do not constitute financial or other professional advice to you. You should seek specific advice about your specific circumstances.

2) To the fullest extent possible by law, both Deloitte LLP and South East Coast Ambulance Services NHS Foundation Trust disclaim any liability arising out of your use (or non-use) of this Report and its contents, including any action or decision taken as a result of such use (or non-use).

3) You should keep this Report confidential and not copy or circulate this Report, or any extracts therefrom.
### Appendix 1

**List of individuals we approached and interviewed**

<table>
<thead>
<tr>
<th>Interviewee</th>
<th>Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>1  Al Rymer</td>
<td>Non-Executive Director</td>
</tr>
<tr>
<td>2  Andy Newton</td>
<td>Director of Clinical Operations (formerly Director of Clinical Operations)</td>
</tr>
<tr>
<td>3  Daniel Garratt</td>
<td>Operations Manager, Coxheath</td>
</tr>
<tr>
<td>4  Dave Hawkins</td>
<td>Senior Operations Manager – Distribution</td>
</tr>
<tr>
<td>5  David Hammond</td>
<td>Interim Director of Finance</td>
</tr>
<tr>
<td>6  Dean Jarvis</td>
<td>Operations Manager, Lewes</td>
</tr>
<tr>
<td>7  Francesca Okosi</td>
<td>Director of Workforce Transformation</td>
</tr>
<tr>
<td>8  Geraint Davies</td>
<td>Director of Commissioning (formerly Director of Commercial Services)</td>
</tr>
<tr>
<td>9  Graham Colbert</td>
<td>Non-Executive Director</td>
</tr>
<tr>
<td>10 Greg Timmins</td>
<td>Head of Operational Finance and Resources</td>
</tr>
<tr>
<td>11 Helen Medlock</td>
<td>Director of 999 and 111 Commissioning for Kent and Medway, formerly Associate Partner, South East Commissioning Support Unit</td>
</tr>
<tr>
<td>12 James Kennedy</td>
<td>Chief Operating Officer (formerly Director of Finance)</td>
</tr>
<tr>
<td>13 Jane Pateman</td>
<td>Former Medical Director</td>
</tr>
<tr>
<td>14 Janine Compton</td>
<td>Head of Communications</td>
</tr>
<tr>
<td>15 Jon Amos</td>
<td>Customer Account Manager</td>
</tr>
<tr>
<td>16 Julia Ross</td>
<td>Accountable Officer, NW Surrey CCG</td>
</tr>
<tr>
<td>17 Kate Seaman</td>
<td>Senior Clinical Operations Manager 111</td>
</tr>
<tr>
<td>18 Kath Start</td>
<td>Director of Nursing</td>
</tr>
<tr>
<td>19 Katrina Herren</td>
<td>Non-Executive Director</td>
</tr>
<tr>
<td>20 Keith Gait</td>
<td>Former Interim Director of 111</td>
</tr>
</tbody>
</table>

---

This is a list of the individuals we approached and subsequently interviewed. We have not listed the individuals who approached us to be interviewed.
<table>
<thead>
<tr>
<th>No.</th>
<th>Name</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>21</td>
<td>Louise Hutchinson</td>
<td>Patient Experience Lead</td>
</tr>
<tr>
<td>22</td>
<td>Lucas Hawkes-Frost</td>
<td>Senior Operations Manager</td>
</tr>
<tr>
<td>23</td>
<td>Lucy Bloem</td>
<td>Non-Executive Director</td>
</tr>
<tr>
<td>24</td>
<td>Mark Bailey</td>
<td>Operations Manager, Banstead</td>
</tr>
<tr>
<td>25</td>
<td>Mike Plowman</td>
<td>Corporate Information Manager</td>
</tr>
<tr>
<td>26</td>
<td>Nicola Leach</td>
<td>Senior Clinical Advisor 111 (formerly Clinical Advisor)</td>
</tr>
<tr>
<td>27</td>
<td>Nicola Pease</td>
<td>Critical Systems Business Analyst</td>
</tr>
<tr>
<td>28</td>
<td>Patricia Davies</td>
<td>Accountable Officer, Swale CCG</td>
</tr>
<tr>
<td>29</td>
<td>Paul Sutton</td>
<td>Chief Executive Officer</td>
</tr>
<tr>
<td>30</td>
<td>Rob Mason</td>
<td>Head of PTS</td>
</tr>
<tr>
<td>31</td>
<td>Dr Rory McCrea</td>
<td>Medical Director</td>
</tr>
<tr>
<td>32</td>
<td>Sue Skelton</td>
<td>Associate Director of Operations (formerly Acting Associate Director of Operations)</td>
</tr>
<tr>
<td>33</td>
<td>Suzie Cro</td>
<td>Head of Quality (South), NHS England, Author of NHS England report</td>
</tr>
<tr>
<td>34</td>
<td>Terry Parkin</td>
<td>Non-Executive Director</td>
</tr>
<tr>
<td>35</td>
<td>Tim Howe</td>
<td>Non-Executive Director</td>
</tr>
<tr>
<td>36</td>
<td>Tony Thorne</td>
<td>Chairman</td>
</tr>
<tr>
<td>37</td>
<td>Trevor Willington</td>
<td>Non-Executive Director</td>
</tr>
</tbody>
</table>
### Appendix 2

**List of search terms applied in our electronic data review**

<table>
<thead>
<tr>
<th>Keyword</th>
<th>Search Term</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 R3</td>
<td>&quot;R3&quot;</td>
</tr>
<tr>
<td>2 Red 3</td>
<td>&quot;Red 3&quot;</td>
</tr>
<tr>
<td>3 10 minutes</td>
<td>&quot;10 minutes&quot;</td>
</tr>
<tr>
<td>4 111 call management</td>
<td>&quot;111 call management&quot;</td>
</tr>
<tr>
<td>5 Clock start</td>
<td>&quot;Clock start&quot;</td>
</tr>
<tr>
<td>6 re-triage or re triage</td>
<td>&quot;re triage&quot;</td>
</tr>
<tr>
<td>7 Operational Delivery</td>
<td>&quot;Operational Delivery&quot;</td>
</tr>
<tr>
<td>8 AQI</td>
<td>&quot;AQI&quot;</td>
</tr>
<tr>
<td>9 Fit and proper</td>
<td>&quot;Fit and proper&quot;</td>
</tr>
<tr>
<td>10 10 mins</td>
<td>&quot;10 mins&quot;</td>
</tr>
<tr>
<td>11 retriage</td>
<td>&quot;retriage&quot;</td>
</tr>
<tr>
<td>12 111 demand suppression</td>
<td>&quot;111 demand suppression&quot;</td>
</tr>
<tr>
<td>13 Operational Delivery</td>
<td>&quot;Operational Delivery Strategy&quot;</td>
</tr>
<tr>
<td>14 retriaging</td>
<td>&quot;retriaging&quot;</td>
</tr>
<tr>
<td>15 FPPT</td>
<td>&quot;FPPT&quot;</td>
</tr>
<tr>
<td>16 111 triage [next to each other in any order]</td>
<td>(&quot;111 Triage” or &quot;triage 111”)</td>
</tr>
<tr>
<td>17 111 triaging [next to each other in any order]</td>
<td>(&quot;111 Triaging” or &quot;triaging 111”)</td>
</tr>
<tr>
<td>18 Project intercept</td>
<td>&quot;Project intercept&quot;</td>
</tr>
<tr>
<td>19 R3G5</td>
<td>&quot;R3G5&quot;</td>
</tr>
<tr>
<td>20 ODSG</td>
<td>&quot;ODSG&quot;</td>
</tr>
<tr>
<td>21 project 70</td>
<td>&quot;project 70&quot;</td>
</tr>
</tbody>
</table>
# Appendix 3

**Members of the Project Board for the ODSG**

<table>
<thead>
<tr>
<th>Individual</th>
<th>Role within SECAmb at the time of the Pilot</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paul Sutton</td>
<td>CEO</td>
</tr>
<tr>
<td>Sue Skelton</td>
<td>Acting Associate Director of Clinical Operations</td>
</tr>
<tr>
<td>Greg Timmins</td>
<td>Head of Operational Finance and Resources</td>
</tr>
<tr>
<td>Rob Mason</td>
<td>Head of PTS</td>
</tr>
<tr>
<td>Jane Pateman</td>
<td>Medical Director</td>
</tr>
<tr>
<td>Geraint Davies</td>
<td>Director of Commercial Services</td>
</tr>
<tr>
<td>Dave Hawkins</td>
<td>Senior Operations Manager - Distribution</td>
</tr>
<tr>
<td>Justin Wand</td>
<td>Head of Fleet</td>
</tr>
<tr>
<td>James Kennedy</td>
<td>Director of Finance</td>
</tr>
<tr>
<td>Andy Newton</td>
<td>Director of Clinical Operations</td>
</tr>
<tr>
<td>Kath Start</td>
<td>Director of Nursing</td>
</tr>
</tbody>
</table>

*Source: ODSG Project Brief (version 5)*
Appendix 4

Methodology and limitations of the performance indicators’ review

1.1 To recalculate the AQIs and the Green indicators, data at call level was sourced from SECAmb. The unique Incident ID was used to aggregate a number of datasets provided by SECAmb.

1.2 The first step of the analysis was identifying all valid calls, i.e. all calls for which an emergency vehicle arrived at the scene. All calls for which the time of arrival of first vehicle at the scene was reported as ‘Null’ were considered not valid. This was agreed with SECAmb.

1.3 For all valid calls, a clock start and a clock stop were detailed, according to NHSE 2013 guidelines and SECAmb’s local contracts. For those calls for which the Pathways Initial DX Code time was recorded was available, the Pathways Initial DX Code time was included in the clock start calculation.

1.4 In line with NHSE 2013 guidelines, in the calculation of the R-19 AQI the clock stop was defined to be the time of arrival of the first vehicle on the scene for all but for Category A calls. According to NHSE, for R-19 AQI the start of the clock should be when a transport vehicle is requested, and the stop of the clock should be when a transport vehicle arrives on the scene.

1.5 The table below shows the calls included in each indicator’s calculations, the criteria used to set the start of the clock, and the criteria used to set the stop of the clock.

Table 6: Start of the clock and stop of the clock for all indicators used in this review

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Incidents included (by final priority)</th>
<th>Clock Start</th>
<th>Clock Stop</th>
</tr>
</thead>
<tbody>
<tr>
<td>R1-8</td>
<td>R1</td>
<td>Call Connect</td>
<td>Arrival of the first vehicle on the scene</td>
</tr>
<tr>
<td>R2-8</td>
<td>R2</td>
<td>Earliest of:</td>
<td>Arrival of the first vehicle on the scene</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Pathways Initial DX Code Information is obtained - if available</td>
<td></td>
</tr>
<tr>
<td>R-19</td>
<td>R1 and R2</td>
<td>If the first vehicle on the scene is a transport vehicle, the earliest of:</td>
<td>If the first vehicle on the scene is a transport vehicle:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Pathways Initial DX Code Information is obtained - if available</td>
<td>• Arrival of the first vehicle on the scene</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• First vehicle assigned</td>
<td></td>
</tr>
<tr>
<td>G2-30</td>
<td>G2</td>
<td>Earliest of:</td>
<td>Arrival of the first vehicle on the scene</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Pathways Initial DX Code Information is obtained - if available</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• First vehicle assigned</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• 60 seconds after Call Connect</td>
<td></td>
</tr>
</tbody>
</table>
1.6 The response time was calculated as the difference between the clock stop and the clock start.

1.7 For those calls for which the time of the first unit on the scene is earlier than the clock start, response time is assumed to be zero. For two of these calls in February 2015 it was found that the year of the time the first ambulance arrived on the scene was incorrectly entered as 2014. For these two calls only, the year was manually corrected to 2015, this was agreed with SECAmb.

1.8 The incidents were assigned to different codes on the basis of their final priority. Each indicator was calculated as the number of valid calls respecting the indicators’ condition over the total number of valid calls.

1.9 The methodology was based on NHSE 2013 guidelines and its interpretation was discussed with SECAmb.

1.10 The analysis relies on the data and information provided by SECAmb. It is therefore limited by the completeness of the data provided by SECAmb and its accuracy. For example, only partial information was available for Pathways Initial DX Code time.

1.11 The interpretation of the data was discussed and agreed with SECAmb and the information received was verified when possible. However, a detailed review of the accuracy of the raw data captured and information provided by SECAmb was not in the scope of the review.

1.12 In the review raw data was assumed to be accurate. Any manipulation of the Computer Aided Dispatch (CAD) data that may have occurred at the time of registration of the data has not been investigated. This review does not express a view as to whether such manipulation may or may not have occurred.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Incidents included (by final priority)</th>
<th>Clock Start</th>
<th>Clock Stop</th>
</tr>
</thead>
<tbody>
<tr>
<td>G4-60</td>
<td>G4</td>
<td>Earliest of:</td>
<td>Arrival of the first vehicle on the scene</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Pathways Initial DX Code Information is obtained - if available</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• First vehicle assigned</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• 60 seconds after Call Connect</td>
<td></td>
</tr>
</tbody>
</table>