South East Coast Ambulance Service NHS
NHS Foundation Trust

Quality Account & Quality Report

2016/17

This document is based on current quality accounts legislation and NHS Improvement's additional requirements for quality reports.

The Quality Account and Quality Report can be accessed via the SECAmb website www.secamb.nhs.uk or alternatively for copies of the document please e-mail enquiries@secamb.nhs.uk

Or write to:

South East Coast Ambulance Service NHS Foundation Trust
Nexus House
4 Gatwick Road
Crawley
RH10 9BG

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Introduction

The purpose of this document is to report on the quality of care provided by South East Coast Ambulance Service (SECAmb) during 2016/17.

Throughout this document you will see how we have performed against a series of measurables and targets. You will also learn about the service improvements which the Trust has committed to implement, both in the short and longer term, learning from the challenges that we have faced this year.

To qualify the information presented in this report, we have a legal requirement to obtain external scrutiny on the content and data that you will find in this document. This scrutiny is provided by the Trust's auditors and follows a framework set out by NHS Improvement (NHSI). In turn this scrutiny offers assurance to our patients on our performance reporting.

The format of the Quality Account and Quality Report is prescribed under regulation and forms three parts which much appear in the following order:

+ **Part 1 – Statement on quality from the Chief Executive of the NHS Foundation Trust**
+ **Part 2 – Priorities for improvement and statements of assurance from the Board**
  – Priorities for improvement
  – Statements of assurance from the Board
  – Reporting against core indicators
+ **Part 3 – Other information; and two annexes:**
  – Annex 1 – Statements from commissioners, local Healthwatch organisations and Overview and Scrutiny Committees
  – Annex 2 – Statement of directors' responsibilities for the quality report

The integrity of the data submitted to the Department of Health has come under scrutiny and the Trust may re-state the data submitted, in line with permitted national reporting timescales, after a thorough review.

Part One

1.0. Chief Executive's Statement on Quality

I am pleased to present South East Coast Ambulance (SECAmb) NHS Foundation Trust's Quality Report for 2016/17. This year has been challenging for the Trust but our staff have worked hard to deliver a good service to our patients, as well as pursuing improvements through our Unified Recovery Plan (URP).

As a Trust, we:

+ Receive and respond to 999 calls from members of the public
+ Respond to urgent calls from healthcare professional e.g. GPs
+ Provide non-emergency patient transport services (up to 31st March 2017)
+ Receive and respond to NHS 111 calls from members of the public

We provide these services to a population of 4.5m across the South East Coast area.

I hope this report demonstrates the areas where we have seen improvements, as well as the areas where we need to do more. There has been much to do doing this year, which has meant we have had to prioritise some areas over others, meaning some are still outstanding.

In last year's report, we stated that 2015/16 was the most difficult year that the Trust had ever faced.

2016/17 has proved to be just as difficult, with the Trust facing a number of internal and external challenges which have impacted on our aim to deliver a high quality and response patient service, including:

+ Challenges in recruiting and retaining sufficient numbers of clinical and non-clinical staff
+ The capacity of the Trust to maintain the pace of improvement required
+ A significant increase in hospital handover delays, which impacts on the availability of crews
+ Sustained high demand which was above contractual levels, as well as our need to improve operational efficiency
+ The need to embed new quality processes

In May 2016 the Trust was inspected by the Care Quality Commission (CQC), who identified a number of issues leading to an overall rating of Inadequate for the Trust, due to specific ratings of Inadequate for the Safe and Well-Led domains.

In response, the Trust developed a specific CQC Action Plan, as part of our boarder, over-arching Unified Recovery Plan (URP) – you can read more about the Trust's response to the CQC visit and the work underway to drive up quality throughout the organisation later on in the Report.

The Trust did not meet its 999 operational performance targets during the year and fell behind where we would want to be on some

of our key clinical indicators. operational response targets and the quality of service for our patients has not always been to the standard we would like or expect.

I am pleased that we are now starting to see a greater level of stability at Board level – this is an area that the newly-appointed Chair and I are keen to address quickly. We are already working hard to make sure that leadership, good governance, systems and processes are embedded throughout every area, as well as working with our commissioners to ensure that the Trust is as supported as possible to respond to rising and changing patient demand.

During the coming year, work will continue in a range of areas that I am confident will see benefits for both patients and staff. As we see the new Staff Health & Wellbeing Strategy rolled out, the increased use of iPADs and the new electronic Patient Care Record (ePCR) and the move to the new Emergency Operations Centre/ HQ and roll out of the new Computer Aided Dispatch (CAD) system at Crawley completed, I am sure this will bring real quality improvements.

To the best of my knowledge, the information contained in this report is accurate.

Daren Mochrie, Chief Executive

Part Two

2.1 Priorities for Improvement 2016/17

How they were developed

In considering which quality measures SECAmb would report on during 2016/17, we held an external workshop in November 2015 and invited Governors, patients, staff, Healthwatch representatives, Health Overview & Scrutiny Committee (HOSC) members and Commissioners to attend.

During the workshop, participants reviewed a selection of suggested quality measures; each was discussed and explored throughout the workshop and the top five were agreed upon by the stakeholders.

Stakeholders were aware that they needed to ensure that at least one quality measure was within each 'quality domain' – clinical effectiveness, patient experience and patient safety.

In January 2016, the chosen five Quality Account measures were agreed by the Trust Board; included within these was one measure carried forward from 2015/16:

Quality domain		
Patient Safety	**Patient Experience**	**Clinical Effectiveness**
Delayed Paramedic Practioner (PP) referrals		
Frequent Caller Identification & Management*		
	999 Call Community First Responder (CFR) Survey	
		Delivery of high quality patient care by enhancing the skills of the Clinical Advisors working in NHS 111
		Using IBIS to assess and monitor whether End of Life Care patients with Preferred Place of Care/ Death documented on IBIS care plans achieved their care goal

*The Council of Governors is required to agree a local quality indicator to be externally audited. The Trust presented a paper to the Governors on the 31 January 2017 and following discussion, the Council of Governors approved a review of Frequent Caller/Identification and Management. This review was undertaken by the Trust's internal auditors and included performing a 'deep dive' review into Frequent Caller/Identification and Management, tracing reported information through from source data to ensure that data collection, validation and reporting processes were robust.

2.1.1 Delayed Paramedic Practitioner (PP) referrals

Quality Domain	Patient Safety
Aim of Priority	+ To measure compliance with the specified time given (1, 2 or 4 hours) to attend a patient by a PP following referral by another clinician
Target measures	+ 85% attendance by a PP within time specified + 95% attendance by a PP within time specified + 1 hour
Performance	+ 72.27% attendance by a PP within time specified + 87.92% attendance by a PP within time specified + 1 hour
Implementation Lead	+ Andy Collen, Consultant Paramedic

Background

One of the care pathways available to SECAmb's front line operational staff is the ability to refer a patient via the PP desk in the EOC. Following this, the patient will be attended by a PP (known as the PP referral system) with the intention being that the patient can be treated at or closer to home, hence avoiding an unnecessary journey to the local A&E department.

Note:

From April 2016 until the introduction of the Ambulance Response Program (ARP) on 18th October 2016, when a referral was made to the PP desk by a front line operational member of staff a time priority was placed on the case depending upon its perceived urgency (i.e. one, two or four hours).

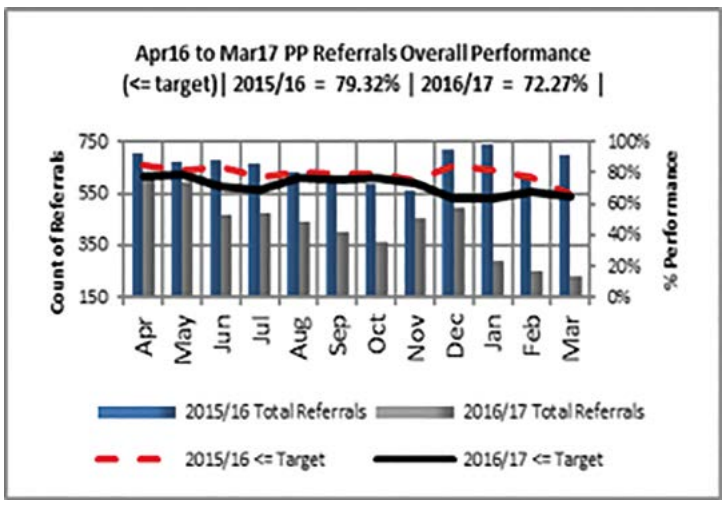
Since the introduction of the ARP, the PP Referral problem text is a without a time limit so the data used within this report from 18th October 2016 onwards uses the priority of the call to determine the urgency of the required response and this data has been added to the data set used prior to the introduction of the ARP.

Performance against targets

Note - there has been a 35.49% decrease in overall PP referrals during 2016/17 compared to 2015/16

Overall compliance with 85% attendance by PP within time specified (across 1, 2 & 4 hour priorities)

Chart 1

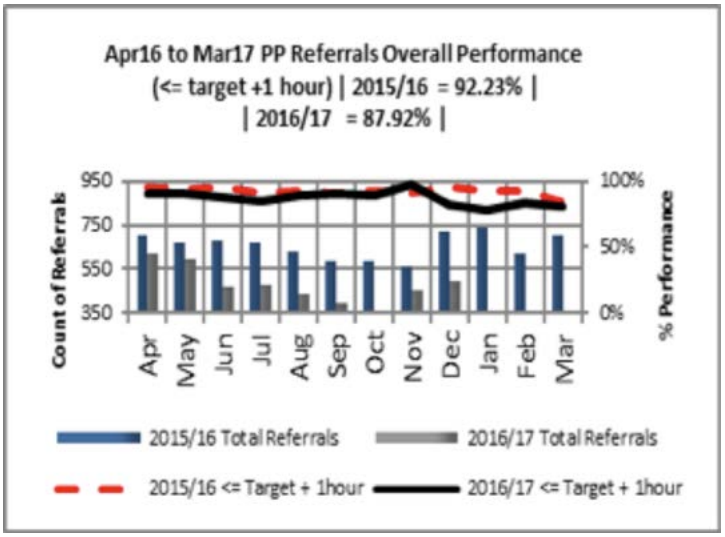


+ Chart 1 shows that the overall performance (72.27%) is under the required target of 85%
+ This also shows a reduction in performance of 7.05% compared to 2015/16 (79.32%)

Part Two

Overall compliance with 95% attendance by PP within time specified + 1 hour (across 1, 2 & 4 hour priorities)

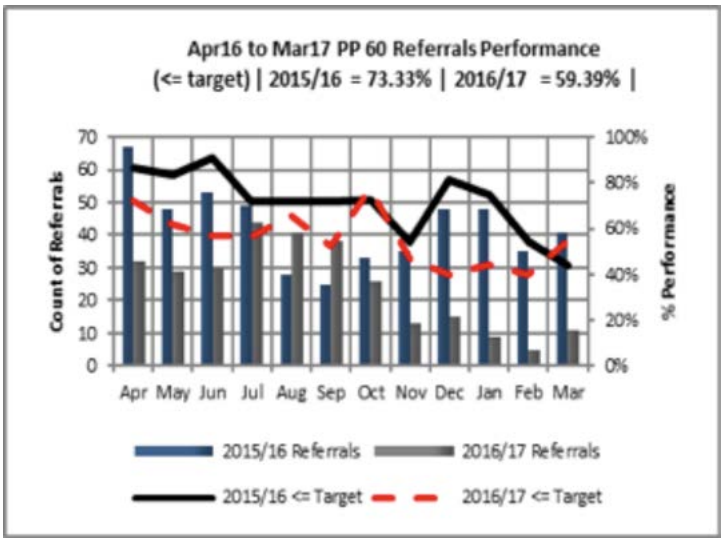
Chart 2



- Chart 2 shows performance of 87.92% is below the target of 95%
- This also shows a reduction in performance of 4.31% compared to 2015/16 (92.23%)

Compliance with 85% attendance by a PP within 1-hour target

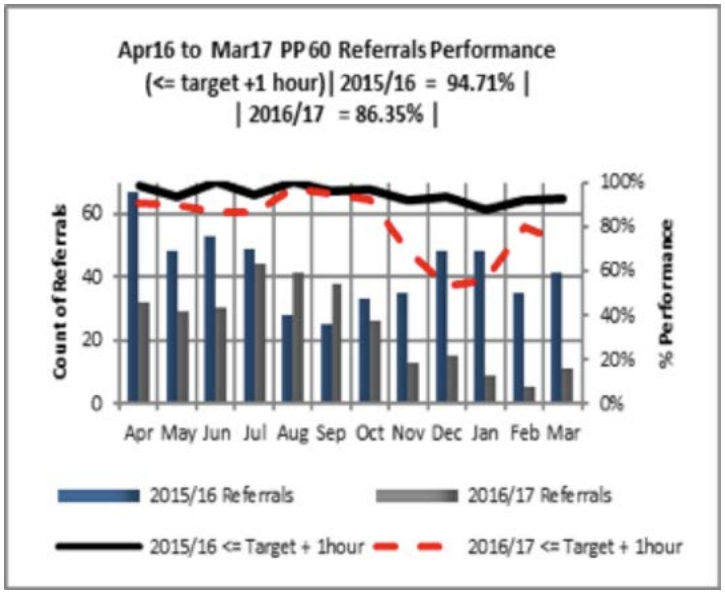
Chart 3



- Chart 3 shows performance of 59.39% is below the target of 85%
- This also shows a reduction in performance of 13.94% compared to 2015/16 (73.33%)

Compliance with 95% attendance by a PP within 1-hour target + 1 hour

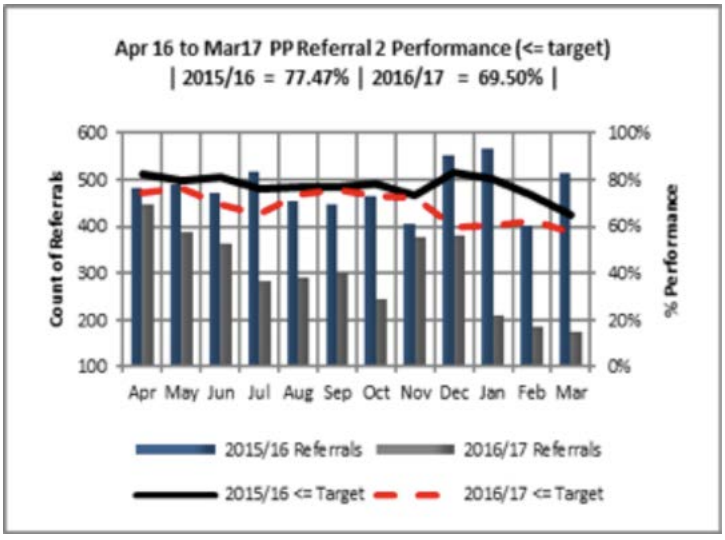
Chart 4



- Chart 4 shows performance of 86.35% below the target of 95%
- This also shows a reduction in performance of 8.36% compared to 2015/16 (94.71%)

Compliance with 85% attendance by a PP within 2-hour target

Chart 5

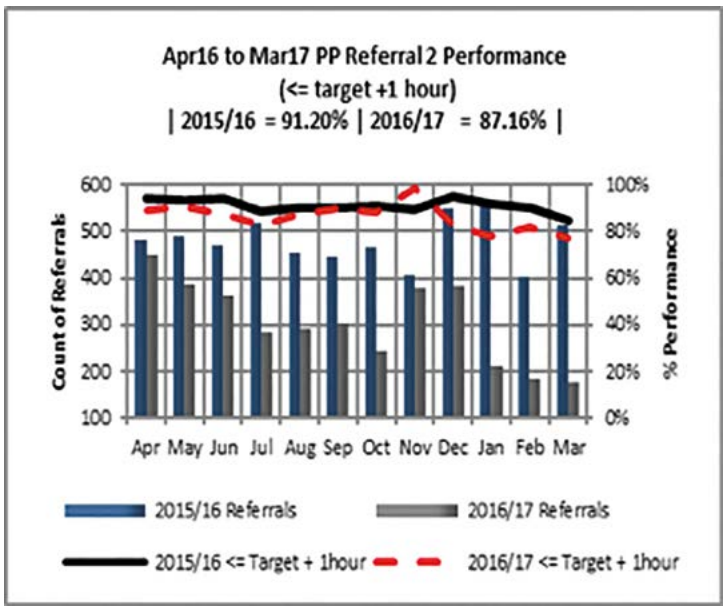


- Chart 5 shows performance of 69.50% below the target of 85%
- This also shows a reduction in performance of 7.97% compared to 2015/16 (77.47%)

Part Two

Compliance with 95% attendance by a PP within 2-hour target + 1 hour

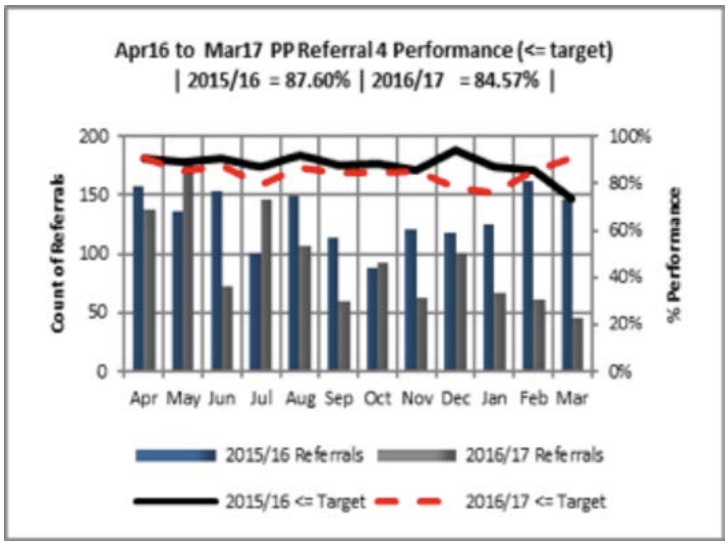
Chart 6



- Chart 6 shows performance of 81.16% below the target of 95%
- This also shows a reduction in performance of 4.04% compared to 2015/16 (91.20%)

Compliance with 85% attendance by a PP within 1-hour target

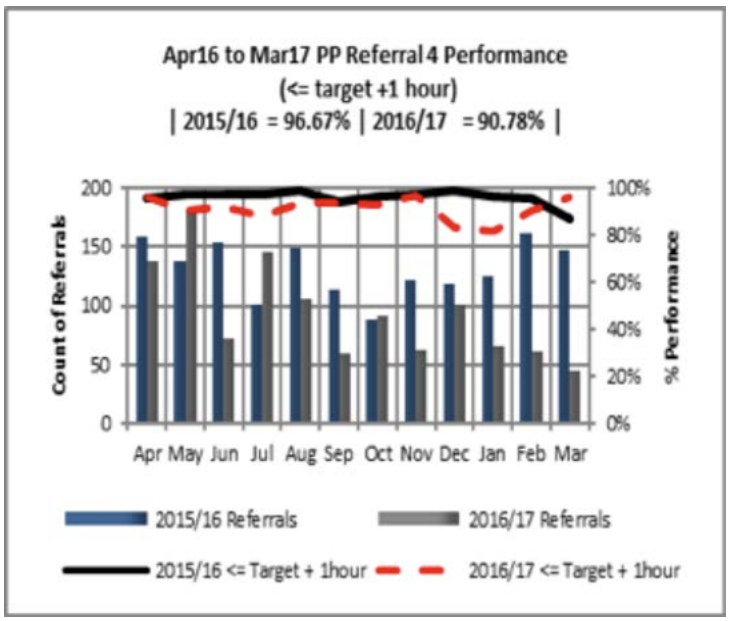
Chart 7



- Chart 7 shows performance of 84.57% below the target of 85%
- This also shows a reduction in performance of 3.03% compared to 2015/16 (87.60%)

Compliance with 95% attendance by a PP within 4-hour target + 1 hour

Chart 8



- Chart 8 shows performance of 90.78% below the target of 95%
- This also shows a reduction in performance of 5.89% compared to 2015/16 (96.67%)

Initiatives

SECAmb is working in a number of ways to ensure that patients who are referred for care by PPs receive their follow up in a timely way.

Areas of focus include:

- **Monitoring and Reporting** - there is a standard report being developed by the Clinical Development Team on all the aspects of specialist practice, and this will include a section on performance of the PP referral system
- **Development of the PP desk** (as part of the wider Clinical Hub within EOC) - one of the roles of the Clinical Hub will be to assist monitoring and oversight of PP referrals, which will aid dispatchers in managing their workloads
- **Referral Management** - the Clinical Development Team and EOC Senior Management Team will continue to work together to ensure that referral requests are improved, that patient flow is optimised and that patients' needs are met in the correct part of the health and social care economy. We are working in partnership with commissioners and other providers to ensure that referrals offer the most clinical benefit ['and there is work in progress to ensure all clinicians can confidently refer patients successfully. SECAmb also allows clinicians to discharge patients where appropriate, and we will continue to ensure that staff do not use referrals where safe discharge is appropriate (or vice versa).

2.1.2 Priority 2 - Frequent Caller Identification and Management

Quality Domain	Patient Safety
Aim of Priority	+ To reduce the volume of frequent caller calls
Target measures	+ To reduce the volume of frequent caller calls by 1% compared to 2015/16 (monthly average of 3.79% of total call volume)
Performance	+ Reduction of 4% of calls by identified frequent callers (calls per patient ratio) + Frequent caller calls reduced by 0.12% of all calls

Background

Frequent callers are identified by the Frequent Caller National Network (FreCaNN) as a person aged 18 or over who makes five or more emergency calls related to individual episodes of care in a month, or twelve or more emergency calls related to individual episodes of care in three months from a private dwelling.

Identifying and engaging with patients who are frequent callers to the ambulance service is essential to assisting the individuals to work with their GP and other health care professionals to identify their unmet healthcare needs and get the support they need to reduce their call volume. This subsequently has a positive impact on both the patient, who will no longer rely on the ambulance service for their healthcare needs, and on the wider community by making ambulances available to respond to emergency calls.

SECAmb has followed guidance from FreCaNN and other ambulance trusts with a frequent caller process to create policies and procedures to identify frequent callers, assess their needs and instigate intervention in their care.

Performance against targets

Key Performance Indicator (KPI)

The Trust has set itself a target to reduce the volume of frequent caller calls by 1%. For 2015/2016 the average percentage of call volume from frequent callers per month was 3.79%. Since April 2016 there has been a 0.12% reduction in call volume. It should be noted that prior to this period of measurement, calls from frequent callers were in excess of 5% of all calls, and this compares to the national averages of between 6 and 10% of calls.

The data collected also illustrates a reduction in calls per frequent caller by 4% resulting in a reduction of 99 calls per month, as shown below:

Quality domain	2015/16	2016/17
Number of Frequent Callers Identified	413	444
Number of calls – 1 month*	2793	2899
Frequent Callers 999 Activity	3.79%	3.66%
Frequent Callers on IBIS	31%	41%
Number of calls – 3 month**	6636	6838

*A Frequent Caller making 5 or more 999 calls in one month
**A Frequent Caller making 12 or more 999 calls in three months

+ Reduction in calls per patient
–The number of patients identified as a frequent caller has risen from 413 to 444 (27 additional patients) and the total number of calls from frequent callers has risen from 6636 to 6838 (202 more calls). The average number of calls per patient has fallen from 16.07 to 15.40 – a reduction of 4%. This means the impact of each frequent caller is reduced.

+ Reduction in average monthly call volume
– Based on the 1 month and 3 month figures, the improvements seen in relation to the use of the frequent caller management system has seen a reduction of 99 calls (1 month average) and 92 calls (3 month average).
– While overall the reduction is only 0.12%, this figure is not normalised for growth in 999 activity or fluctuations in the number of individual frequent callers.

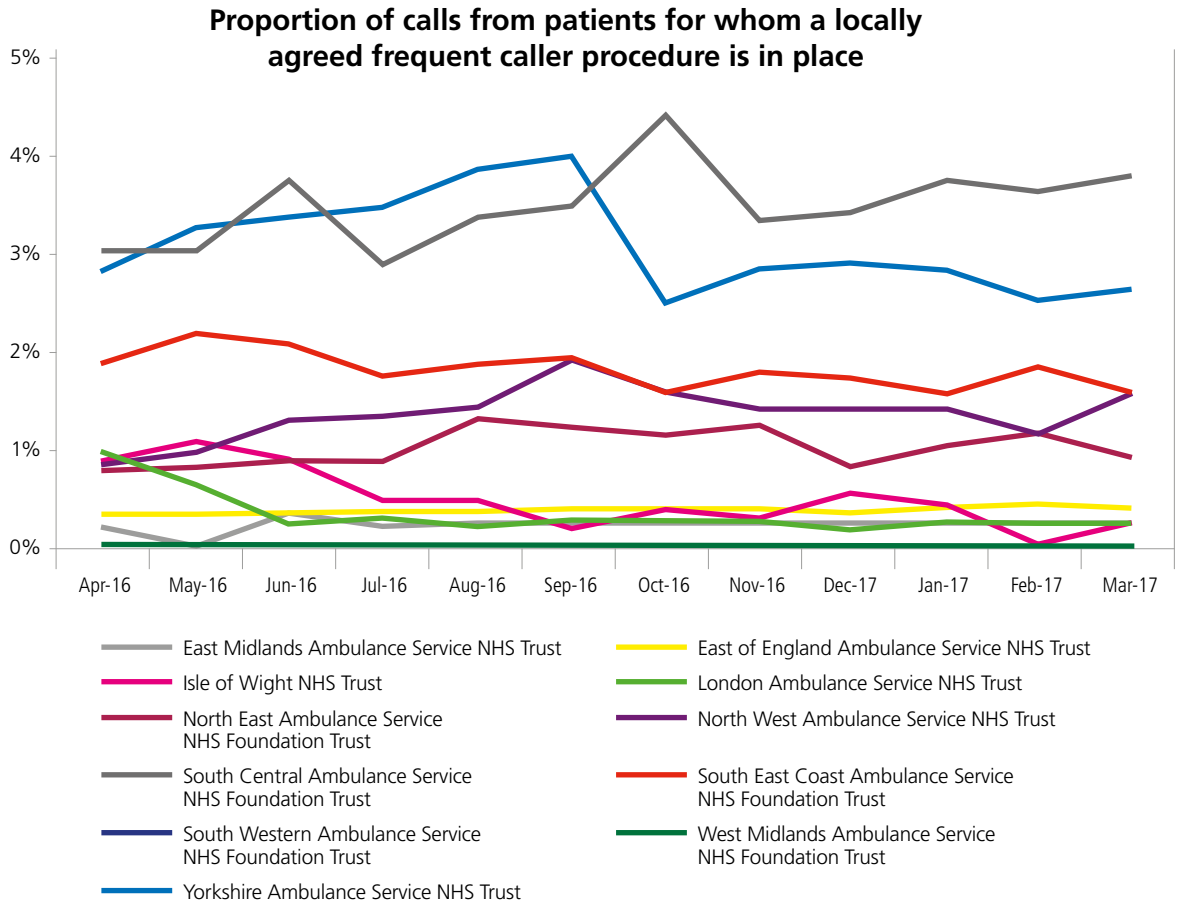
Ambulance Quality Indicator (AQI)

This year the Trust has been in a position to report on the national Frequent Caller AQI: *"Proportion of emergency calls from patients for whom a frequent caller procedure is in place"*, see figure 2. This was part of the Trust's contractual requirements for 2016/17.

Nationally, the AQI reporting has been postponed due to a lack of consistency in reporting across Ambulance Trusts, resulting in difficulty comparing performance. This will be revisited when Trusts are able to match patients to NHS numbers, resulting in more accurate identification of frequent callers.

What the national data does illustrate is that SECAmb (illustrated by the red line in Figure 2 below) has frequent caller procedure in place for 1.8% of patients that call 999 compared to the national average of 1.3% (although this doesn't take into account the differences in call volumes across the ambulance trusts).

Figure 1



Frequent Callers/IBIS

A 999 or 111 call to SECAmb from a Frequent Caller is considered to have a procedure in place if the patient has an IBIS record and the record is linked to the patient at the time of call. IBIS will then signpost clinicians to a care plan, or contact number, for the patient's main care provider (for example GP or Mental Health Service).

In April 2016, it was ensured that the top 10 frequent callers in each Operational Dispatch Area had an IBIS record in place, to aid clinician decision-making.

Initiatives

During the year, excellent progress has been made in working with the Trust's "top ten" Frequent Callers. For example, intervention with two of these patients (who have made 72 and 58 999 calls in three months respectively) has been greatly assisted by the Trust's newly-appointed Consultant Mental Health Nurse.

All four stages of the frequent caller process have now been carried out. The Frequent Caller Team continues to recruit and train local leads to progress patients though stage 2 and 3 of the process and co-ordinate stages 1 and 4.

2.1.3 Priority three – 999 Call Community First Responder Survey

Quality Domain	Patient Experience
Aim of Priority	+ To gauge the level of satisfaction of patients, their families and carers with the customer care provided by Community First Responders (CFRs)
Target measures	+ No specific targets were set however the outcomes have been compared to a survey undertaken in 2015
Performance	+ Positive feedback was received in relation to CFRs demonstrating the 6Cs – Care, Compassion, Competence, Communication, Courage and Commitment (between 93% and 100% satisfaction reported) in 2016
Implementation Lead	+ Karen Ramnauth – Voluntary Services Manager

Background

Measuring success of CFRs has been focussed on the number of volunteers at any given time, their percentage contribution to performance and the number of incidents they attended. These measurements will not change; however, it was identified that what was lacking was information on how patients felt about CFRs. Quantifiable data would justify the continuation of this service, inform the Trust if Community First Responder development was progressing in the right direction, and potentially speak to changes in scope of practice.

In September 2015, the Trust undertook its first patient satisfaction survey to patients who had been seen first by Community First Responders.

A second survey was circulated to patients seen during May 2016. The surveys seek to gauge the level of satisfaction of patients, their families and carers, with the customer care provided by Community First Responders. The survey focusses on the patient's experience of having a CFR attend as a first response, and enquires whether patients found the Trust's CFRs demonstrated compassionate care and adopted the 6Cs – Care, Compassion, Competence, Communication, Courage and Commitment.

The 2015 survey was sent to patients en masse across the area where CFRs work, but the 2016 survey was split by county, so there are now four return entries in the data - September 2015, May 2016 Kent, May 2016 Sussex and

May 2016 Surrey. Later surveys will continue to be analysed by county to enable comparison.

Performance against targets

As stated above, no targets were set as this survey was exploratory and intended to create a baseline for future measurements. The results demonstrate that Community First Responders (CFRs) are tangibly and positively contributing to the patient experience within the Trust's operating area.

The main data collected is detailed in the table below. The percentage shown is the number of recipients who agreed with the domain statements.

The Trust was keen to understand whether respondents were aware or made aware that Community First Responders were volunteers

Domain	Sept 2015	May 2016 - Kent	May 2016 - Surrey	May 2016 - Surrey
CFR listened to them or the patient	98%	98.6%	96.7%	93.5%
CFR respected patients privacy and dignity	99%	100%	100%	97.6%
CFR was kind and caring	100%	100%	100%	97.5%
CFR was calm and confident	100%	100%	100%	98.8%
CFR was reassuring	100%	100%	98.5%	98.7%
Satisfied with response from CFR	100%	100%	100%	100%

in the community. The comments suggested that patients and their families/carers had been too distraught during the incident to be able remember whether the responder identified that they were dispatched by the ambulance service.

In the 2016 survey in each county this sentiment was echoed but there were also many affirmative comments to show that CFRs were known and appreciated in their community.

Population

Data was derived from the Trust's performance reports to identify addresses where CFRs had been dispatched and arrived on scene to patients.

To ensure that the recipients were aware and recognised that a volunteer Community First Responder had been first on scene as opposed to another member of ambulance staff, the data was filtered in the first instance to include those incident addresses where the Community First Responder would have been on scene alone with the patient for at least three minutes before the arrival of crew.

The addresses were then filtered to exclude those calls which had come in from a public place / school / nursing home. The next filter was frequency of attendance, so if a Community First responder had visited the address more than once during the catchment time frame that address was excluded. This was to respect the privacy of the patient and their family depending on the outcome. For the same reason the final filter applied excluded those addresses where the problem nature was cardiac arrest. The result was 373 eligible addresses in the 2015 survey and 529 in 2016.

Research Methodology

The surveys were sent by post to the address where the call originated, with a letter of explanation and a Freepost addressed envelope. The closing date was four weeks after posting, and a reminder letter sent at two weeks.

The data was manually entered onto Survey Monkey to facilitate analysis. The questions are listed in the Appendix. Respondents were given the opportunity to share more details to explain their reasoning for all but the first question.

In the 2015 survey a number of recipients wrote in the additional comments they wanted to express their thanks to the volunteer / crew who attended. It was impossible to act on this as the survey is completely anonymised. This learning was incorporated into the 2016 survey;

recipients were advised that if they wished the Trust to look into any aspect of their experience, or to pass on comments to those who attended them, that contact details would need to be provided. Any details received will have been forwarded to the Patient Experience team for action.

Recommendations for 2017/18

Future surveys will continue to be analysed by county. It would be difficult to improve on these consistently positive results, but it is necessary to maintain regular surveys as CFRs both join and leave the network, and the results can vary.

From this survey there are no immediate identifiable training needs for CFRs. As their scope of practice develops it will be important to continue to assess the satisfaction of our patients and their families/carers.

2.1.4 Priority four - Delivery of high quality patient care by enhancing the skills of the Clinical Advisors working in NHS 111

Quality Domain	Patient Experience
Aim of Priority	+ To enhance the skills of Clinical Advisers in NHS 111 to provide a better service to patients and to improve staff retention
Target measures	+ Improved staff retention rates + Reduced 999/ED/Urgent GP Dispositions (NB - original measures evolved when working in partnership in order to secure funding however these improvements can be demonstrated, if not wholly attributable to this measure)
Performance	+ Health Advisor attrition reduced by 50% + Reduction in referral rates to 999 (from 12.5% to below 11% at year end) + Reduction in referral rates to ED (from in-year peak of 8% to 7% at year end) + Reported improved confidence and competence of clinicians in the management of poisons and medicines, and in the use of specialised support where needed
Implementation Lead	+ Scott Thowney - KMSS111 Clinical Lead + Sue Mitchell - KMSS111 Senior Quality Manager

Background

In 2015, clinicians in Kent, Medway, Surrey, and Sussex NHS 111 (KMS111) were surveyed to explore their personal priorities for additional training and support. The two biggest opportunities were identified as training and support in medicines and mental health.

As a result, KMSS 111 submitted a bid to NHS England (NHSE) for workforce investment funding for a program to provide specialist training for its clinicians, whilst also enabling them to access the right specialist reference sources within the right time frame.

There were two parts of this programme:

+ National Poisons Information Service (NPIS) training in how to use ToxBase correctly and efficiently; and
+ Providing suitable medicines reference sources with the requisite training to maximise the benefits of this expert material.

As a result of receiving NHSE funding, KMSS 111 approached the NPIS to develop and deliver specialist training to the clinicians at KMSS 111 with the principal aims to decrease calls to the NPIS helpline, increase the use of the ToxBase website as an alternative to using the helpline and to evaluate the clinicians' confidence with handling calls relating to the ingestion of poisons and/or toxic substances both prior to and after this training was undertaken.

At the same time the service also approached the Pharmaceutical Press (publishing division of the Royal Pharmaceutical Society of Great Britain) to look at reference sources and training support to enable clinicians working in 111 to have the suitable expert knowledge and information available at all times. Given that 111 Clinical Advisors have to be either Paramedics or Nurses, it was felt that a core base of Pharmacy information would be most beneficial. The aim of this work stream was to identify a package of expert information for clinicians, to facilitate easy access (preferably on-line) and to also enable the clinicians to maximise this information by providing training in how to use the expert information.

Project Activity

NPIS Training

The Head of the NPIS agreed to develop a bespoke ToxBase training package for KMSS 111 Clinical Advisors (CAs) and a suite of training packages to be utilised by 111 was developed, including specific packages for Paramedics, Nurses and an advanced "Train the Trainer" module for Clinical Coaches to deliver to colleagues.

Medicines Complete Training

The Pharmaceutical Press provide an on-line portal called MedicinesComplete which allows a subscriber to access a variety of expert reference sources including the BNF amongst others. At the time, only one 111 provider was using the service.

KMSS 111 paid to subsribe, allowing up to 40 clinicians access to the MedicinesComplete portal at any one time.

The training provided for both the NPIS and Medicines Complete was evaluated both quantitatively and qualitatively.

Results

NPIS training

There was a significant difference between the outcomes generated by the pre and post training data that was collated and analysed:

+ In the three months prior to training, Contact Centre A had an average of 62 calls made monthly to the NPIS helpline. In the three months immediately following the training there was a marked drop in average monthly call rate to the NPIS helpline to 40. During the same period of time in the control site of Contact Centre B where the NPIS training was deliberately deferred, the average monthly call rate to the NPIS remained consistent at 61 calls per month. The number of clinicians based across both contact centres is relatively equal
+ In terms of the use of ToxBase there was a step change immediately following the training intervention. The average monthly ToxBase 'hits' on the website during the three months prior to training was 1,330 whereas in the following three months, the average number of monthly ToxBase hits thereafter was 1,915.

When reviewing the pre and post training surveys the greatest movement in terms of survey questions responses was on:

Q3 – Do you feel competent when using ToxBase as a reference source? (moved from 4/10 to 8/10 average score)

Q4 – Do you know when to call the NPIS helpline and when to use the ToxBase website? (moved from 5/10 to 8/10 average score)

Q6 – Do you feel confident about handling calls when there has been the ingestion of poisons or toxic substances? (moved from 4/10 to 7/10 average score)

Medicines Complete Training

+ The number of "hits" for the MedicinesComplete website relates to the number of section requests. Prior to training the monthly average MedicinesComplete "hits" was 1,216 whereas afterwards it rose to 1,637. The majority of this change related to increased access to the BNF section of MedicinesComplete.

The pre and post training surveys also indicated an increase on the response scores for:

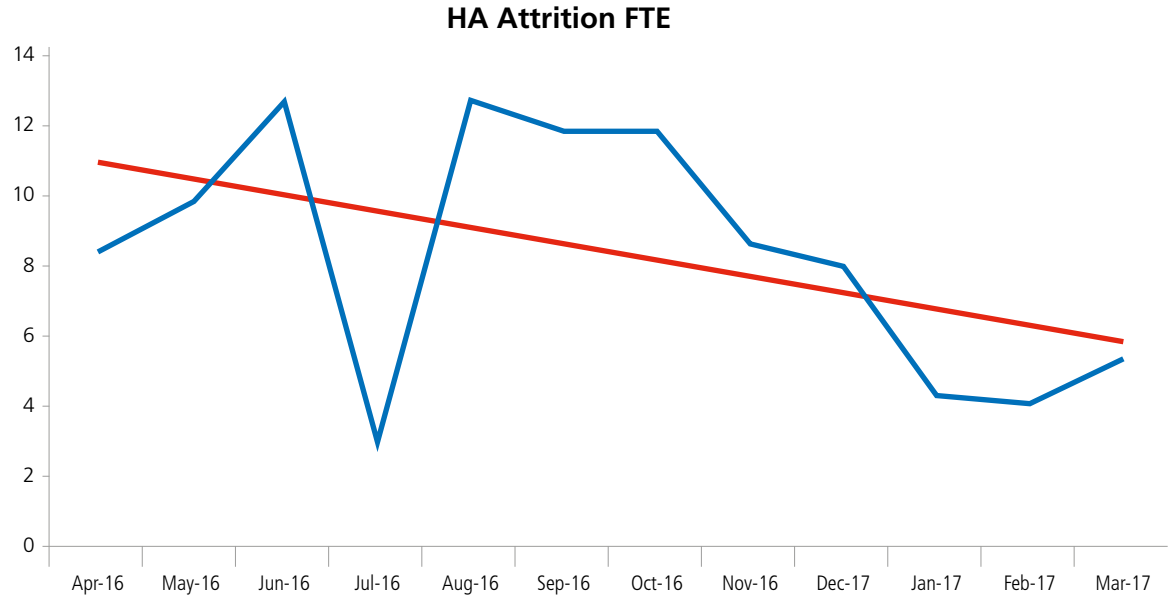
Q2 – Do you feel confident using the BNF as a reference source? (moved from 4/10 to 7/10 average response score)

Q5 – Do you feel confident handling calls with an element relating to medicines? (moved from 5/10 to 7/10 average response score)

Local improvements

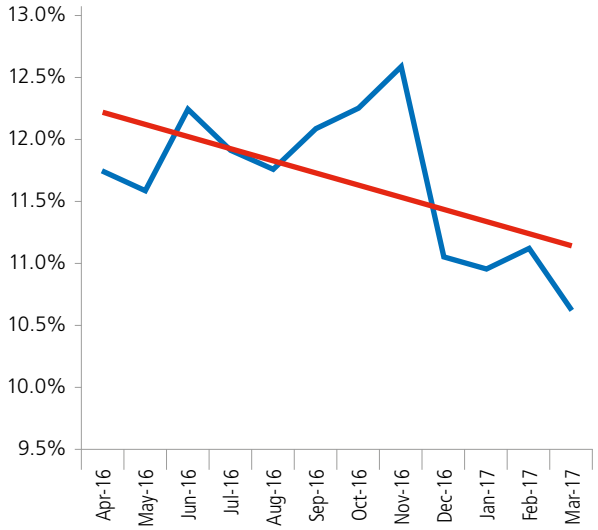
Although as noted above, the targets evolved due to our funding partnership, we in fact saw a reduction in 999/A&E/Urgent GP Dispositions and improved staff retention during the year.

The graph below shows the reduction in Health Advisor staff attrition - reducing by nearly 50% over 12 months, although there will obviously we other factors that have contributed to this:

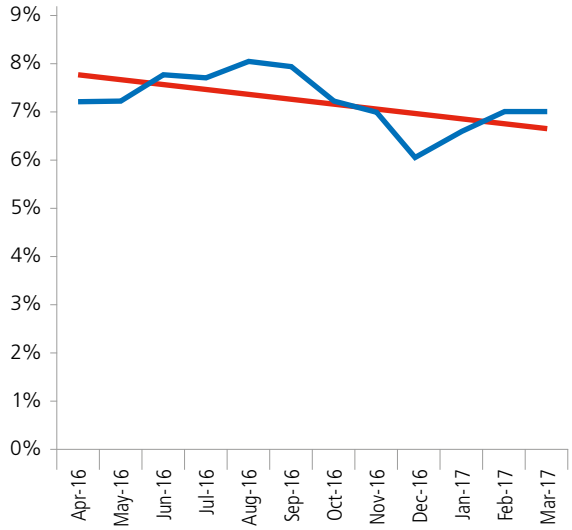


The graphs below show the reduction in referral rates to 999 and A&E Departments; again, there will be other factors that have contributed to this:

Transfer to 999



Transfer to 999



Project Learnings

KMSS 111 is committed to exploring further opportunities to improve the patient experience through the upskilling of clinicians working across the service. This is relevant to all clinical outcomes, not just with regards to Pharmacy and poison's knowledge. This supports the ongoing development of Integrated Urgent Care, and the proposed deployment of local Clinical hubs.

There are several specific learnings and insights to take from both of these training packages:

+ If you listen to staff, they will feel more engaged and clinicians working in KMSS 111 do want to continue their professional development and fill the gaps in their current skill set
+ The NPIS/ToxBase training resulted in a 35% decrease in calls from KMSS 111 to the NPIS helpline
+ The NPIS/ToxBase training resulted in a 30% increase in the number of "hits" to the ToxBase website
+ CAs felt more confident and competent to handle these more complex calls once they had received the appropriate training
+ CAs want to have access to the right reference sources and that training to enable this access results in increased source material utilisation
+ CAs feel more confident when they are shown how to use appropriate reference sources and this manifests itself in greater utilisation of reference sources. The access to MedicinesComplete increased by over 25% as a result of additional training and sign-posting

Recommendations

There is a genuine need for further upskilling of 111 clinicians, especially as we enter a period of transition and the advent of clinical hubs. Further workforce investment programs are required to develop a set of widely acceptable clinician competencies.

There is real merit to the NPIS training package being extended and implemented nationally to improve the level of knowledge and confidence of 111 CAs and also to ease the pressure on the NPIS, allowing them to focus on cases of a higher acuity.

There is a real benefit to encouraging all 111 service providers to subscribe to MedicinesComplete, ensuring that there is a national training program in place to facilitate appropriate utilisation.

Potentially Commissioners could incorporate the need for both NPIS ToxBase training and access to MedicinesComplete as essential when writing the new service specifications.

Further qualitative analysis is required to truly measure the benefits of these training programs prior to a national roll-out.

Conclusion

Both of the training packages developed/ implemented for this program have proved successful and have made a difference to both the competence and confidence of 111 clinicians. There is a definite need to provide more specialist training to our clinicians (and hence non-clinical Health Advisors also) and this is even more important as we enter a period of service transition and the introduction of clinical hubs. The feedback from colleagues throughout the program was incredibly positive and there is a tangible desire for further professional development activity.

2.1.5 Priority four – Using IBIS to assess and monitor whether End of Life Care patients with Preferred Place of Care/Death documented on IBIS care plans achieve their care goals

Quality Domain	Clinical effectiveness
Aim of Priority	+ To enhance the experience of patients with End of Life Care plans and a Preferred Place of Care/Death + To achieve the wishes of more EOLC patients
Target measures	+ Improved adherence to care plans on IBIS relating to preferred place of care/death at end of life + IBIS conveyance rate for patients with End of Life Care Plan
Performance	+ IBIS conveyance rate for patients with End of Life Care advance care plan – 19% (compared to IBIS conveyance rate (37%) & Trust conveyance rate (c.50%) + Of those care plans which specified a preferred place of care/ preferred place of death, the conveyance rate was 0%
Implementation Lead	+ Andy Collen – Consultant Paramedic

Background

When patients have discussed with their care team where they would prefer to be cared for, and to die, the care team often detail this on their personalised IBIS care plan. It is important that the ambulance service integrate with the wider health care team and adhere to the patients' choices – especially when they are no longer able to advocate for themselves.

It was decided that the most appropriate way to collate data which identifies both patients who call 999 who have an IBIS care plan and those that don't was to assess patients End of Life status from their initial caller statement; this identified a reasonable proportion of patients who called 999 at the End of Life.

It was recognised that the methodology used only identified patients identified as being at End of Life from initial 999 call "chief complaint" (the reason for their emergency call).

In order to measure the impact of documented Preferred Place of Care/ death within IBIS care plans on patients achieving their care goals, initial data was gained by assessing received calls. Of 317 calls deemed to be related to terminal/palliative or End of Life care between 01/01/17 and 28/02/17, 78 patients' care plan were on IBIS (25%).

In order to make sure that patients care needs are effectively met we need to improve both the quality of care plans on IBIS (i.e. ensuring that IBIS care plans contain Preferred Place of Care/Death) and by ensuring that crews access any information contained within IBIS care plans to inform their decisions on management of this complex patient group.

Of the total 317, 211 (67%) of the calls related to HCP admissions to Hospices, Wards or acute accident and emergency departments.

In previous audit of the general 999 call activity (non HCP admissions), undertaken during 2015/16, 34 patients were IBIS matched (41% of the total non-HCP admission calls).

In this audit, 16 patients were IBIS matched, 12% of the total non HCP admission.

On the previous audit of those 34 matched, 19 care plans had a reported PPC/D on the IBIS care plan.

In this Audit, of the 16 matched, one care plan had a reported PPC/D on their IBIS care plan.

This section of the report provides information for the EoLC patients who call 999 and have a care plan recorded in IBIS and that continue to go to or stay in their preferred place of care.

Of the 16 patients with IBIS care plans, one IBIS Care Plans identifies a Preferred Place of Care/Death. In this case the patient was enabled to remain at home as was their declared Preferred Place of Care.

Of these 16 IBIS matches, four were DNACPR records only.

Despite there being no Preferred Place of care/ death on the majority of these records in 13 of the 16 cases, the patients were treated at home, making a conveyance rate of 19%

Therefore, in this audit, EoLC patients with IBIS records without a pre-agreed destination, attended by the ambulance service, had a conveyance rate of 19%.

Local improvement plans

In addition to the quality measures, reviewed above, there have been a number of further areas that have been identified during the year as key issues for the Trust to tackle and these are identified below.

In this section, we will also provide an up-date on a number of external reviews undertaken during the year.

Through the development and delivery of the Unified Recovery Plan (URP) and significant changes to our governance processes, the Trust has worked hard to improve the safety of the services we provide to patients. The Trust was not part of the Sign Up To Safety campaign during the year, although has committed to signing up during 2017/18.

Duty of Candour

Since 2015, Duty of Candour has been a legal duty applied to all NHS Trusts to be open and honest with patients and their families when things go wrong. Section 20 of the Health and Social Care act sets out the specific requirements for written and face to face communication with patients and their families where the 'harm' that has occurred is considered moderate, severe or has directly resulted in death.

In response to the new legislative requirements, SECAmb made a commitment to update its Being Open and Duty of Candour Policy and Procedure to reflect the changes. This work was completed in June 2015.

Part Two

The inspection by the CQC in May 2016 highlighted that we needed to do further work to ensure that all staff understood the Duty of Candour and their responsibilities under it.

In response to the CQC recommendation:

+ A new CQC Fundamental Standards Staff Handbook was designed and issued Trust-wide in February 2017
+ SECAmb also delivered Human Factors Duty of Candour training to a range of senior managers, delivered in February 2017
+ The Serious Incident process was amended to tracks Duty of Candour as of April 2017, as was the incident reporting system, Datix
+ All patients involved in a complaint or serious incident now receive a CQC-endorsed leaflet explaining Duty of Candour from the Trust
+ The Trust has updated its Incident & Serious Incident Policy, Complaints Policy and Being Open Duty of Candour Policy.

However, we do recognise that there are still many significant improvements to be made in how we embed Duty of Candour at SECAmb.

NHS National Staff Survey 2016

The NHS Staff Survey is undertaken annually and covers all staff who work for the NHS. It provides a valuable opportunity for staff to provide feedback anonymously, on a number of important areas included the care provided by their Trust, training, engagement and personal development.

The 2016/17 survey was undertaken between 10th October and 9th December 2016 by Quality Health, an independent organisation on behalf of SECAmb and the results were published in March 2017. SECAmb opted to survey all eligible staff (3,168) and 1,278 completed the survey – a return rate of 40%.

SECAmb's results show there has been a deterioration in most areas compared to last year. As mentioned already, 2016/17 has been a particularly challenging year for the Trust and operational pressures and wide-ranging demands placed on the Trust has slowed the pace of change in many areas.

However, lots of work has been put into building the foundations of a number of initiatives that will lead to improved staff satisfaction and it is hoped that this will be reflected in future surveys.

As required, we will now look more closely at two areas of the Staff Survey in more detail:

+ Bullying
+ Equal opportunities for career progression

Bullying

The table below shows the Trust's performance against indicator KF26 *'Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months':*

	Managers	Other Colleagues
Never	76%	82%
1-2	15%	13%
3-5	6%	4%
6-10	2%	1%
More than 10	1%	0%

Although not surprising, these results were obviously extremely disappointing for the Trust.

Alongside a range of initiatives being undertaken to improve engagement and support to staff, the Trust is also undertaking a significant piece of work to address concerns raised by staff around bullying, whilst recognising that this is also a cultural issue that will take time to change.

The Trust has commissioned Professor Duncan Lewis of Plymouth University, who has worked with a number of other NHS Trusts previously, to engage with staff and undertake a diagnostic review of the issue of the culture.

The review, which started in February 2017, has four phases:

+ A survey of all staff
+ Staff focus groups
+ 1 to 1 interviews with staff who have asked for an interview
+ Sharing of the summary report outlining the background information, findings of the research, methodology and data analytics, as well as conclusions and recommendations on actions

The Trust is due to receive Professor Lewis's report in Summer 2017 and will then be able to build a specific action plan, in response to the issues identified.

Equal opportunities for career progression

The table below shows the Trust's performance against indicator KF21 *'Percentage believing that Trust provides equal opportunities for career progression or promotion'* (the Workforce Race Equality Standard):

Yes	66%
No	34%
Don't know	29%

Compared to figures published for 2015, the Trust reported a decline in the number of staff feeling as though there were equal opportunities for progression.

The Trust is tackling this from a number of angles:

+ We are working to increase the diversity in our recruitment of candidates by engaging with diverse communities in our regions and encouraging applications from under-represented groups. We will also monitor the attrition rate of candidates through our recruitment processes and report these statistics through the internal HR Group
+ In addition, we have amended our Acting Up and Secondment processes to ensure appointments are made in a fair and transparent manner and shared across the workforce. These appointments will also be monitored and reported on a regular basis. We are also working hard to support individual members of staff from BME backgrounds as opportunities for internal promotion arise
+ Our newly-established team of staff Diversity Champions also work hard within their workplaces to promote a culture of inclusion and respect

Care Quality Commission (CQC) Inspection

As reported in the Chief Executive's statement above, the CQC inspected SECAmb in May 2016. There were two inspections undertaken:

+ An inspection of four of our core services:
  – Emergency & Urgent Care
  – Patient Transport Service
  – Emergency Operations Centre
  – Resilience and our Hazardous Area Response Teams (HART)
+ A separate inspection of the NHS 111 service

Part Two

The CQC ratings for each domain are shown below:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Emergency & urgent care	Inadequate	Requires Improvement	Good	Requires Improvement	Inadequate	Inadequate
Patient transport services	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement	Requires Improvement
Emergency operations centre	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement
NHS 111 service	Inadequate	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement
Overall	Inadequate	Requires Improvement	Good	Requires Improvement	Inadequate	Inadequate

Following the inspection and report, the CQC formally issued a Section 29 warning Notice (Health and Social Care Act 2008) detailing the required improvement, compliance actions and 'Must dos' which the trust has accepted. It also recommended that NHS Improvement (NHSI) place the Trust in Special Measures. NHSI agreed to uphold that recommendation and, on 29 September 2016 placed the Trust in Special Measures

In order to address the significant issues identified through the CQC inspection, the Trust has devised an improvement action plan; this forms a key part of the Trust's over-arching Unified Recovery Plan (URP) and covers all the issues identified by the CQC (the 'must dos' and 'should dos').

Progress in delivering the URP, and the specific CQC Action Plan is monitored by our Board, the CQC, NHS Improvement (NHSI) and our commissioners.

The specific areas covered by the CQC in the Warning Notice were grouped into six main themes:

+ Governance
+ Staffing
+ Call handling times in 111
+ Equipment
+ Safeguarding
+ Medicines management

Much work has been undertaken in each area since the Trust received the CQC's report – you can see a summary of actions taken in each area below and also read about the progress of external reviews that the Trust has commissioned in some areas.

Area of concern	2015/16
Governance	+ Implemented revised Board, committee and executive governance arrangements + Introduced a programme of unannounced Quality Assurance Visits (QAV) + Significant progress in Infection Prevention & Control, including appointing staff champions & programme of training, audits & inspections + Revised complaints process + Reduced incident backlog + Better use of Datix system
Staffing	+ Significant programme of recruitment undertaken – closed gaps in front-line & EOC staffing + Ensuring we give staff a timely break + Reducing shift-overruns
Call handling times in 111	+ Increased call-taker numbers + Reduced use of agency staff + Better matching of rotas v demand
Equipment	+ Moved all medical devices across to the Fleetman asset management system, where they are now managed including repairs & service dates + All repairs on medical equipment are carried out by the Trust's trained & certificated Equipment Officers or by the manufacturers on site
Safeguarding	+ Capacity increased in team + Increased Board oversight + On-line & face to face Mental Capacity Act (MCA) training + Developed & implemented Level 3 training + Engaged with external safeguarding boards
Medicines Management	+ Security on vehicles improved + Externally-led review commissioned + Lock down of procurement process + Guidance issued to all staff + Medicines' Optimisation Strategy drafted

The actions listed above were all completed by the end of the year. The Trust does recognise however that more work still needs to be completed in some areas and will be working hard to meet any outstanding 'must do' and 'should do' actions, within the timescales specified by the CQC (six months and twelve months respectively from publication of their report).

At the time of writing, the Trust is currently being re-inspected by the CQC. Once the report is received, this will provide a robust assessment of where progress has been made and where further work needs to be undertaken.

Reviews and external oversight

As mentioned above, to help the Trust to address key areas of concern, a number of reviews, often including external bodies, have been commissioned or completed during the year:

Patient Impact Review – Defibrillators

An internal review was undertaken during the year to understand the impact on patients of the Trust's use of the 'Webdefib' call-sign in reporting 999 performance.

The review, which has included in-put from NHS I, looked at two specific areas:

+ The use of the 'Webdefib' call sign to 'stop the clock' and how appropriately this was applied
+ The inability of the Trust's current Computer Aided Dispatch (CAD) system to consistently record the location of the nearest Public Access Defibrillator (PAD)

The findings of the review will be reported to the Trust's Quality & Patient Safety Committee during the Summer of 2017.

Independent Medicines Review

As reported elsewhere in the Report, medicines management has been a key area of concern for the Trust during the year.

To provide an external view, an Idependent Review of medicines management processes was commissioned by the Trust in March 2017 and is chaired by Professor Ann Jacklin, supported by a team of internal Trust staff.

The scope of the Review includes:

+ Governance structures
+ Compliance with the relevant regulatory and legal requirements
+ The roles and responsibilities of staff at all levels in the Trust who have any element of medicine management included in their job description

At the end of the Review it is expected there will be four outputs:

+ A report identifying the root cause(s) of the failings in governance of medicines management including omissions in adherence to legislation, regulation, best practice and professional standards
+ A report that establishes that actions taken in response to identified failings have been appropriate and implemented
+ A report that identifies any good practice or areas for development in relation to the Trust's assurance framework
+ A set of recommendations including guidance on the actions or mitigation necessary to complete those recommendations

The Review is expected to conclude during 2017/18.

Patient Impact Review into the Red 3 Pilot

As reported in last year's Annual Report, 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 – this was known locally as the Red 3 Pilot.

Following an initial Trust-led investigation, NHS England opened a separate investigation in March 2015, which was shared with stakeholders including Monitor (now NHS I) in August 2015.

On the basis of these reviews, Monitor decided to take enforcement action against the Trust, which included a requirement for the Trust to commission three reviews:

+ A 'forensic' review into the Pilot project – this was undertaken by Deloitte and reported in February 2016
+ A governance review – this was postponed previously, with the agreement of NHS I but will now be undertaken during 2017
+ An externally-led review into the Patient Impact of the Pilot – published in October 2016

The Patient Impact Review looked at 185,000 calls and identified no evidence of patient harm attributable to the Pilot, although the Trust recognises that there were significant governance and other failings around it.

Safeguarding Review

Another key area of concern, highlighted by the CQC and also by the Trust's own internal governance processes during the year, was safeguarding.

An externally-led review was commissioned during the year – the findings of which have fed into the Trust's Unified Recovery Plan.

Review into misuse of the Mobile Data Terminal (MDT) system

During the summer of 2014, concerns were raised internally regarding the potential misuse of the MDT system by staff.

The MDT system allows our control staff to track where emergency vehicles are and this misuse meant that our control staff were not aware of the location and availability of these vehicles.

SECAmb carried out an internal investigation, which resulted in six members of staff being investigated and disciplined for their actions.

During 2016/17, a further review was undertaken into the patient impact of the MDT misuse – the findings of this review will be reported to the Trust's Quality & Patient Safety Committee in the Summer of 2017.

Priorities for Improvement 2017-18

The following three priorities for Improvement have been agreed for 2017/18, with one being under each key area of Clinical Effectiveness, Patient Experience and Patient Safety.

The priorities were chosen following the outcomes of a workshop involving the Trust's key stakeholders, including Governors, patient and public representatives, Scrutiny Committee members and Healthwatch representatives.

Part Two

Improving outcomes from Out of Hospital Cardiac Arrests (OHCA) – Clinical Effectiveness

Background on the proposed quality measure	+ Patient outcomes from OHCA are below the national average when compared to the other Ambulance Trusts in England + The Trust's performance in this Clinical Outcome Indicator (COI) over the past two years has deteriorated + This measure will focus the Trust on delivering high- quality care for those patients experiencing OHCA, giving them the most appropriate resource to better improve their outcomes
Aims of the Quality Measure	+ Early Identification of Cardiac Arrest calls + Appropriate dispatch of resources to incidents + Adherence to JRCALC guidelines + Improve Return of Spontaneous Circulation (ROSC) + Improve Survival to Discharge (StD)
Initiatives	+ To develop and implement a trust-wide Cardiac Arrest Strategy + To develop and implement a "PITSTOP" model + To implement a clinical partnership model working locally with the Operating Units to improve health outcomes for patients
How will we know if we have achieved the quality measure?	+ **Specific** - national COI data is available through NHS England three months in arrears, this allows for StD data to be collected + **Measureable** - early recognition of Cardiac the Ambulance Response Programme which will ensure that the Nature of Call (NOC) is identified early by using pre-triage questions which will enable faster dispatch + **Achievable** - good clinical governance supporting clinical key skills training in BLS/ALS; implementing the "PITSTOP" model + **Realistic** - supporting clinical effectiveness which will in turn improve clinical outcomes + **Timely/Time Bound** - this will support the right resource at the right time in the right place, supporting patient outcomes
Infrastructure Requirements and associated costs (if any)	+ Performance reports are already included within the scope of the Performance and Information team and will be managed locally by the Operating Unit Managers supported by the clinical partnership model
Implementation Lead(s) (Name/s)	+ Andy Collen - Consultant Paramedic/Head of Clinical Development + Fiona Wray - Associate Director, Medical
Exec Lead (Name)	+ Fionna Moore - Medical Director

Patient & Family involvement in investigating incidents – Patient Experience

Background on the proposed quality measure	+ The Trust is required to comply with Duty of Candour regulation + Currently the Trust has insufficient data quality to accurately report the number of cases where duty of candour is applicable or measure compliance with the regulation
Aims of the Quality Measure	+ To improve compliance with the Duty of Candour requirements placed on the Trust following severe harm being caused to a patient.
Initiatives	+ Improved management and reporting of incidents within Datix, enabling the identification of incidents meeting Duty of Candour Requirements.
How will we know if we have achieved the quality measure?	+ Introduction of a process to monitor and report the number of incidents meeting Duty of Candour Requirements + Upward trajectory of compliance to the Duty of Candour requirements across the year, particularly with regard to timescales for informing patients that we have caused harm
Infrastructure Requirements and associated costs (if any)	+ Improvements to the Datix System have already been costed in the Recovery Plan
Implementation Lead(s) (Name/s)	Jo Habben
Exec Lead (Name)	Emma Wadey - Director of Quality and Safety / Chief Nurse.

Part Two

Learn from incidents and improve patient safety - Patient Safety

Background on the proposed quality measure	+ Reporting of near miss and low harm incidents is indicative of reporting culture, and can prevent the reoccurrence of incidents, with the potential to reduce the likelihood of more serious incidents occurring
Aims of the Quality Measure	+ To improve patient safety by reducing harm
Initiatives	+ Improved user experience in reporting incidents via the Datix System with an enhanced/streamlined IRW1 form + Introduction of staff feedback loop following incident reporting, and lessons identified + Improve local oversight of reporting metrics across Operating Units
How will we know if we have achieved the quality measure?	+ 10% increase (with previous year comparison) in near miss reporting by Q4 + 10% increase (with previous year comparison) in low harm reporting by Q4 + Compliance with CQC fundamental standards
Infrastructure Requirements and associated costs (if any)	+ Improvements to the Datix System have already been costed in the Recovery Plan
Implementation Lead(s) (Name/s)	Sarah Songhurst - AD Quality & Safety
Exec Lead (Name)	Emma Wadey - Director of Quality and Safety / Chief Nurse.

2.2 Trust Board Statements of Assurance

This section of the quality report includes a series of statements of assurance from the board of the NHS foundation trust on particular points. The exact form of each of these statements is specified by the Quality Accounts Regulations and is laid out below.

Information on the Review of Services

During 2016/27, South East Coast Ambulance Service NHS Foundation Trust (SECAmb) provided and/or sub-contracted three relevant health services:

+ PTS contract
+ A&E contract
+ NHS 111 contract (with Care UK)

SECAmb has reviewed all the data available to them on the quality of care in three of these relevant health services.

The income generated by the relevant health services reviewed in 2016/17 represents 70% of the total income generated from the provision by SECAmb for 2016/17:

Total Trust income	66%
Total A&E income	£181m
Total PTS income	£6m
Total NHS 111 income	£7m

Clinical Audits

During 2016-17 nine national clinical audits and no national confidential enquiries covered relevant health services that SECAmb provides.

During that period, SECAmb participated in

100% of national clinical audits and 100% of national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that SECamb was eligible to participate in during 2016-17 are as follows:

+ Ambulance Service Clinical Outcome Indicators
+ Out of Hospital Cardiac Arrest Outcomes

The national clinical audits and national confidential enquires that SECAmb participated in, and for which data collection was completed during 201617, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry:

Clinical Outcome Indicator

+ **Cardiac Arrest** - Return of Spontaneous Circulation at Hospital (all cases)
  Total: 2871 cases submitted.
  761 confirmed as ROSC at Hospital.
  26.5% compliance for this National Audit
+ **Cardiac Arrest** - Return of Spontaneous Circulation at Hospital (Utstein Group)
  Total: 382 cases submitted. 190 confirmed as ROSC at Hospital.
  49.7% compliance for this National Audit
+ **Cardiac Arrest** – Survival to Discharge
  Total: 2721 cases submitted. 188 confirmed as Survival to Discharge.
  6.9% compliance for this National Audit.
+ **Cardiac Arrest** – Survival to Discharge (Utstein)
  Total: 348 cases submitted. 84 confirmed as Survival to Discharge.
  24.1% compliance for this National Audit
+ **ST Elevation Myocardial Infarction (STEMI)** – Care Bundle
  Total: 1370 cases submitted.
  928 confirmed as STEMI
  67.7% compliance for this National Audit
+ **ST Elevation Myocardial Infarction (STEMI)** – Time to hospital in 150 minutes
  Total: 1117 cases submitted. 1026 confirmed within time frame.
  91.9% compliance for this National Audit
+ **Stroke** – Care Bundle
  Total: 6034 cases submitted.
  5793 confirmed as full Stroke care bundle
  96.0% compliance for this National Audit
+ **Stroke** – Time to hospital within 60 minutes
  Total: 4823 cases submitted
  3045 confirmed within time frame
  63.1% compliance for this National Audit

The Trust has also reported on the national Out of Hospital Cardiac Arrest Outcomes Project but they have not yet published their report.

The reports of eight national clinical audits were reviewed by the provider in 2016/17 and SECAmb intends to take the following actions to improve the quality of healthcare provided - implementation of the COI Performance Dashboard giving performance to OU level.

The reports of five local clinical audits were reviewed by the provider in 2016/17 and SECAmb intends to take the following actions to improve the quality of healthcare provided:

Feverishness Illness in Children under 5 (CA16-17/2f) recommended that:

+ Review guidance on administration of anti-pyretic medication for children with a fever of >38Oc
+ Consider re-distribution of guidance on the importance of recording blood pressures for unwell children using the paediatric observations kit

Transportation in Cardiac Arrest recommended that:

+ Formally review circumstances where transport may be appropriate as part of the cardiac arrest strategy, and subsequently clarify

guidance to all crews. This must include consideration to the outcomes of patients that are transported and clearly outline the interventions that are available to patients to manage reversible causes at scene

+ Review and reissue a clinical instruction regarding the transport of adult patients in cardiac arrest with manual compressions on-going
+ Provide clarification to critical care paramedics on the documentation of LUCAS as an intervention and the rationale they should record for its use

Airways Management of Patients in Cardiac Arrest recommended that:

+ Audit findings to be shared with Professional Practice Group (PPG) for consideration of all recommendations
+ The Professional Practice Group should clarify the trusts adherence to the JRCALC (2016) airway management guidelines, in particular the stepwise approach, issuing justification and formal clinical instruction for deviation if required
+ A clinical instruction should be considered that reiterates the expectation that intubation is only attempted with capnography, and that all staff should be comfortable prompting its use.
+ The conclusions of this audit should be reviewed by learning and development, specifically considering inclusion of the audit results and 'step-wise approach' guidance in the advanced life support (ALS) section of key-skills training
+ The Clinical Equipment and Consumables Sub Group should review the airway equipment provided to all crews, considering:
  – bougie and stylet availability/training
  – availability and efficacy of paediatric supraglottic airway devices.

Documentation Completion Audit recommended:

+ Publicise key findings from this audit in relevant staff newsletters to promote greater understanding of the importance of accurate and complete PCR completion
+ Issue an interim 'Quick Reference' guide to crews whilst awaiting the electronic PCR rollout to facilitate PCR completion
+ Consider issuing guidance to crews about the importance of documenting a decision not to take or repeat an observation
+ Re-audit overall documentation compliance from a sample of all incidents
+ Request inclusion of PCR completion and its importance to the 2017/18 Key Skills training

Appropriate and Effective use of Activated Charcoal audit recommended:

+ Continue usage of activated charcoal
+ Crews to ensure times for overdose are accurately recorded on the PCR whenever possible
+ Crews to ensure time of administration of activated charcoal is recorded.

Research and Development

The number of patients receiving relevant health services provided or subcontracted by SECAmb in 2016/17 that were recruited during that period to participate in research approved by a research ethics committee was two.

CQUIN

A proportion of SECAmb's income in 2016/17 was conditional on achieving quality improvement and innovation goals agreed SECAmb and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for

Quality and Innovation payment framework.

In 2015/16, SECAmb received £2,749k, 1.7% of the contract income (£162,618k) for its CQUIN payment. For 2016/17, the monetary total for income condition on achieving quality improvement and innovation goals is £4,065k – 2.5% of the contract income.

Further details of the agreed goals for 2016/17 and for the following 12-month period are available electronically at http://www.secamb.nhs.uk/about_us/our_performance/quality_account.aspx.

Details of SECAmb's local 999 CQUINs are available at http://www.secamb.nhs.uk/about_us/our_performance/idoc.ashx?docid=a81fe8cf-c42a-4bbb-b528-84eaf82a5511&version=-1

CQC

SECAmb is required to register with the Care Quality Commission and its current registration status is that there are no conditions to current registration.

The Care Quality Commission has taken no enforcement action against South East Coast Ambulance Service NHS Foundation Trust during 2016-17. However, a CQC inspection was completed in May 2016 and the overall rating for the Trust was scored as 'Inadequate'. Following the inspection and report the CQC formally issued a Section 29 warning Notice (Health and Social Care Act 2008) detailing the required improvement, compliance actions and 'Must dos'. The Trust was subsequently placed in 'Special Measures' in September 2016 by NHS Improvement.

You can read more about the findings of the CQC Inspection and how the Trust has responded to this in section 2.1 above.

SECAmb has not participated in any special reviews or investigations by the CQC during the reporting period.

Quality of Data

SECAmb did not submit records during 2016/17 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

SECAmb's Information Governance Assessment Report overall score for April 2016 to March 2017 was 66% and was graded at a level 2.

SECAmb was not subject to the Payment by Results clinical coding audit during 2016/17 by the Audit Commission.

SECAmb will be taking the following actions to improve data quality:

+ The Trust will seek internal and external audits to continually assess and improve data quality
+ Implement the Computer Aided Dispatch (CAD) System and Electronic Patient Records
+ Further develop and improve our Business Intelligence Service
+ Work with commissioners and other partners to deliver digital agenda and contractual data quality improvement requirements
+ Up-grading the DATIX system

2.3 Reporting against Core Indicators

SECAmb has undertaken a comprehensive and robust review of its core performance targets and has developed a robust Unified Recovery Plan (URP) which was developed in 2016 in response to a number of key concerns raised during the CQC inspection in May.

The report clearly highlighted a range of areas that were inadequate. The aim of the URP was to create a comprehensive plan to ensure remedial action was undertaken. A robust PMO was fully established at the beginning of the year following recognition that there was limited grip as to progress being made

against priority areas and there was no regular reporting being provided at the time.

Since the establishment of the PMO, the URP comprising of eight work streams has been grouped to three steering groups - Quality, Organisational Recovery and Financial Recovery. Through the steering groups, which are each chaired by execs, projects are closely monitored using highlight reports and project plans. Issues and risks are discussed in a timely manner and escalations raised on a weekly basis to an executive attended 'Turnaround' meeting for immediate resolve.

Comprehensive dashboards and exception reports are produced on a monthly basis and are received by the executive team, Trust board and sub committees of the board. These governance structures, now embedded, are enabling much faster progress and visibility of potential risks to delivery. The organisation is much more sighted on the issues and there is a more streamlined flow of information ensuring rapid escalation as required.

	Prescribed information	Type of Trust	Comment
14 & 14.1	The percentage of Category A telephone calls (Red 1 and Red 2 calls) resulting in an emergency response by the trust at the scene of the emergency within 8 minutes of receipt of that call during the reporting period.	Ambulance Trusts	+ Red 1 (75% within eight minutes) – 65.1% + Red 2 (75% within eight minutes) – 52.5% + Red 19-minute standard (95%) – 89.2%

SECAmb considers that this data is as described for the following reasons:

In terms of the data, the Trust has undertaken the following to assure itself of the data quality:

+ External performance data monitoring and reporting system developed by Lightfoot. This has been a key aspect of our ability to scrutinise performance on a daily basis and support our clinical staff in the implementation of continuous improvement projects
+ Internal audit review of clinical outcomes
+ Internal scrutiny of all data areas

SECAmb has taken the following actions to improve 999 response times and so the quality of its services:

+ Inclusion of a 999 performance improvement plan within the Trust's Unified Recovery Plan (URP) and monitoring of delivery through the PMO
+ Sustained recruitment campaign for both front-line clinical staff and EOC staff
+ Engagement with commissioners regarding contractual funding levels
+ More efficient use of clinician resources, including reducing 'job-cycle' time, reducing shift over-runs and better management of staff rest breaks
+ Changed the ratio of ambulances to response cars
+ Closer working with Community First Responders, leading to increased contribution to performance
+ More efficient use of private providers
+ Improved 999 call answer times

However, 999 response times continue to fall below where they need to be and will need to continue to be a key area of focus during 2017/18.

	Prescribed information	Type of Trust	Comment
15	The percentage of patients with a pre-existing diagnosis of suspected ST elevation myocardial infarction who received an appropriate care bundle from The trust during the reporting period.	Ambulance Trusts	SECAmb performance = 68.1% The National Average = 78.3% (up to Nov 2015) Highest and Lowest = 88.4% and 62.5%

SECAmb considers that this data is as described for the following reasons:

In terms of the data, the Trust has undertaken the following to assure itself of the data quality:

+ Internal audit review of clinical outcomes
+ Internal scrutiny of all data areas

SECAmb has taken the following actions to improve performance against this indicator and so the quality of its services:

The Trust is aware of the below standard performance in relation to the STEMI care bundle which is mainly attributable to missing documentation in relation to the second pain scores and addressing appropriate analgesia. To rectify this, an update to the reporting requirement is being distributed across the Trust, supported by review by local operating units of their own clinical performance. The team are in the process of discussing these with the Clinical Education team for inclusion in the key skills training programme for 2017/18.

The Trust's Clinical Audit Lead has also undertaken a comprehensive and robust review of the current reporting processes which has been matched against the Department of Health's national technical guidance. In line with this programme of work, the Clinical Audit function has undergone a comprehensive review of all areas of its core business which includes local level reporting to the Operational Units for local level Quality Improvements. The performance of the suspected ST elevation myocardial infarction care bundle is hoped to increase above the national average following this programme of work.

	Prescribed information	Type of Trust	Comment
16	The percentage of patients with suspected stroke assessed face to face who received an appropriate care bundle from the trust during the reporting period.	Ambulance Trusts.	SECAmb performance = 95.5% The National Average = 97.6% Highest and Lowest = 100% - 90.1% (Nov 15).

SECAmb considers that this data is as described for the following reasons:

In terms of the data, the Trust has undertaken the following to assure itself of the data quality:

+ Internal audit review of clinical outcomes
+ Internal scrutiny of all data areas

SECAmb has taken the following actions to improve performance against this indicator and so the quality of its services:

The Trust is aware of the below-standard performance in the Stroke care bundles which is largely attributable to the lack of blood glucose monitoring recording on the clinical record. To rectify this, an update to the reporting requirement is being distributed across the Trust, supported by review by local operating units of their own clinical performance. The team are in the process of discussing these with the Clinical Education team for inclusion in the key skills training programme for 2017/18.

The Trust's Clinical Audit Lead has undertaken a comprehensive and robust review of its current reporting processes, which has been matched against the Department of Health's national technical guidance. In line with this programme of work, the Clinical Audit function has undergone a comprehensive review of all areas of its core business which includes local level reporting to the Operational Units for local level Quality Improvements. The performance of the patients with suspected stroke assessed face to face who received an appropriate care bundle is hoped to increase above the national average following this programme of work.

	Prescribed information	Type of Trust	Comment
20	The trust's responsiveness to the personal needs of its patients during the reporting period.	Trusts providing relevant acute services.	At the time of publication, the data dictionary for Quality Accounts on the NHS Choices website refers to this relating to all trusts, but NHS Improvement has confirmed this indicator only relates to trusts providing acute services.

	Prescribed information	Type of Trust	Comment
21	The percentage of staff employed by, or under contract to, the trust during the reporting period who would recommend the trust as a provider of care to their family or friends.	Trusts providing relevant acute services.	***"How likely are you to recommend the care SECAmb provides to your friends & family if they needed it?"*** Quarter 2 + Likely = 85.84% + Unlikely = 7.07% Quarter 4 + Likely = 79.47% + Unlikely = 9.27% ***"How likely are you to recommend SECAmb as a place to work?"*** Quarter 2 + Likely = 42.77% + Unlikely = 38.15% Quarter 4 + Likely = 27.49% + Unlikely = 59.6%

SECAmb considers that this data is as described for the following reasons:

In terms of the data, the Trust has undertaken the following to assure itself of the data quality:

+ Internal scrutiny of all data areas

SECAmb has taken the following actions to improve performance against this indicator and so the quality of its services:

The Friends and Family test is currently being completed by a tiny percentage of staff (less than 2%). However, those who do complete the test show increasing dissatisfaction with the organisation.

The Trust is aiming to increase participation to a target of 20% by the end of 2017/18 and also gain a 20% improvement on positivity scores at the end of the same period.

In order to make these improvements, there are three specific actions proposed:

+ The recruitment of a dedicated staff engagement team who will have responsibility for incorporating the F&F Test within a wider quarterly survey, related to the Staff Survey, in which staff should have more interest in and see it as more relevant
+ More feedback and actions emanating from the survey

+ The implementation of organisation development plans relating to leadership and management development, staff engagement, performance management and appraisal, succession planning and talent management, all of which should lead to a more satisfied workforce as measured through the annual Staff Survey, quarterly surveys and the Friends & Family Test

	Prescribed information	Type of Trust	Comment
25	The number and, where available, rate of patient safety incidents reported within the Trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death.	All trusts	There were 205 patient safety incidents for this period, 75 (37%) of which resulted in death or serious harm.

SECAmb considers that this data is as described for the following reasons:

In terms of the data, the Trust has undertaken the following to assure itself of the data quality:

+ Internal scrutiny of all data areas

SECAmb has taken the following actions to improve performance against this indicator and so the quality of its services:

The National Reporting and Learning System (NRLS) have confirmed that directly comparing the number of reports received from organisations can be misleading as ambulance organisations can vary in size and activity. The NRLS are currently looking into ways to make comparisons across this cluster more effective. It is therefore advised that comparisons drawn within this report should not be used as a basis for assurance.

SECAmb has reviewed its governance process in respect of incident reporting through the re-design of the incident reporting system, more recently ensuring the "harm" descriptor on the incident form is a mandatory field; this is supported with the introduction of weekly serious incident decision and mortality reviews, which are escalated as needed. Increased incident reporting, including no and low harm, improves each quarter with serious incident reporting remaining consistent.

In terms of making improvements going forwards, the Trust has listened to staff to identify areas where the system and process could be improved to increase our reporting. As a result, we have rewritten our policy, streamlined the reporting process, raised awareness of what an incident is and how to report, provided feedback to staff and shared learning in a timelier and more consistent manner.

Part Three

3. Other Information

The Risk Assessment Framework was replaced with the Single Oversight Framework during the year and the information regarding it appears below.

Single Oversight Framework

NHS Improvement's Single Oversight Framework provides the framework for overseeing providers and identifying potential support needs. The framework looks at five themes:

1. Quality of care

2. Finance and use of resources

3. Operational performance

4. Strategic change

5. Leadership and improvement capability (well-led)

Based on information from these themes, providers are segmented from 1 to 4, where '4' reflects providers receiving the most support, and '1' reflects providers with maximum autonomy. A foundation trust will only be in segments 3 or 4 where it has been found to be in breach or suspected breach of its licence.

The Single Oversight Framework applied from Quarter 3 of 2016/17. Prior to this, Monitor's *Risk Assessment Framework* (RAF) was in place. Information for the prior year and first two quarters relating to the RAF has not been presented as the basis of accountability was different. This is in line with NHS Improvement's guidance for annual reports.

Segmentation

NHS Improvement has placed South East Coast Ambulance NHS Foundation Trust in segment 4 (special measures). The Trust has taken a number of steps to ensure improvement, all of which is set out in the Unified Recovery Plan, information of which appears earlier in this report.

This segmentation information is the trust's position as at May 2017. Current segmentation information for NHS trusts and foundation trusts is published on the NHS Improvement website.

Finance and use of resources

The finance and use of resources theme is based on the scoring of five measures, from '1' to '4' where '1' reflects the strongest performance. These scores are then weighted to give an overall score. Given that finance and use of resources is only one of the five themes feeding into the Single Oversight Framework, the segmentation of the Trust, disclosed above, might not be the same as the overall finance score here.

Area	Metric	2016/17 Q3 score	2016/17 Q4 score
Financial sustainability	Capital service capacity	4	4
	Liquidity	2	1
Financial efficiency	I&E Margin	4	4
Financial controls	Distance from financial plan	4	4
	Agency spend	4	4
Overall scoring		**4**	**3**

The Trust has refreshed and revised its approach to patient safety and patient experience and has committed to becoming a safe, open and transparent care provider.

In the last year, a new Quality and Safety Directorate has been established to bring together, for the first time, all aspects of clinical governance and quality into one core central team. Led by the Chief Nurse and Director of Quality and Safety the team have worked in partnership with colleagues and other external key stakeholders to review and improve our policies, processes and practice. We remain on a journey of continual improvement and the focus on good governance supported by authentic patient and staff engagement will continue throughout the next year.

CQC Fundamental Standards of Care

The duty to ensure that each of the CQC Fundamental Standards of care is met rests with the organisation.

The Board continues to assure itself that the systems in place provide robust evidence of compliance. Using a triangulation approach to correlate the information and intelligence data reported via the Operational Unit (OU) dashboard, the Section 29A Warning Notice issued to the Trust by the CQC, the SECAmb corporate action plan (must do improvement plan); and feedback from the staff survey, a quality assurance template using the CQC 13 Fundamental Standards of Care as the quality baseline, has been developed.

The developed tool assesses the 13 CQC Fundamental Standards of Care to form the evidence to appraise and inform the Trusts self-assessment of the CQC Key Lines of Enquiry (KLOEs).

Currently the evidence is tested and internally assured by a new programme of unannounced inspection visits undertaken by a quorate specialist team led by the Deputy Director of Nursing and the Lead Clinician of Quality & Compliance.

In the interests of openness, transparency and provision of an independent viewpoint, external stakeholders such as Quality Leads from the Clinical Commissioning Groups and Health watch are also invited to attend in an observational capacity. Feedback from the visits has been extremely positive with external representatives rating the domain of 'Caring' as outstanding.

To date, one pilot announced and seven unannounced Quality Assurance Visits have been completed. A calendar of planned visits has been diarised for 2017/18. This calendar has been shared with NHS Improvement, the Clinical Commissioning Groups and Healthwatch.

In order to assess the services accurately and consistently, the quorate inspection group rate the services from the documentation and evidence provided, and the observations and interviews/ discussions experienced on the day of the visit. This rating with be service specific, and not necessarily reflect or match what the overall CQC rating of the organisation would achieve. For example, *'well-led'* will represent the exclusive service team leadership only, not the senior management, corporate or executive responsibility or accountability.

Review of 2016/17 Quality Performance

This section provides an overview of the quality of care offered by SECAmb on performance in 2016/17 against the indicators previously selected by the Board and published in last year's Quality Account.

Patient Safety Indicators

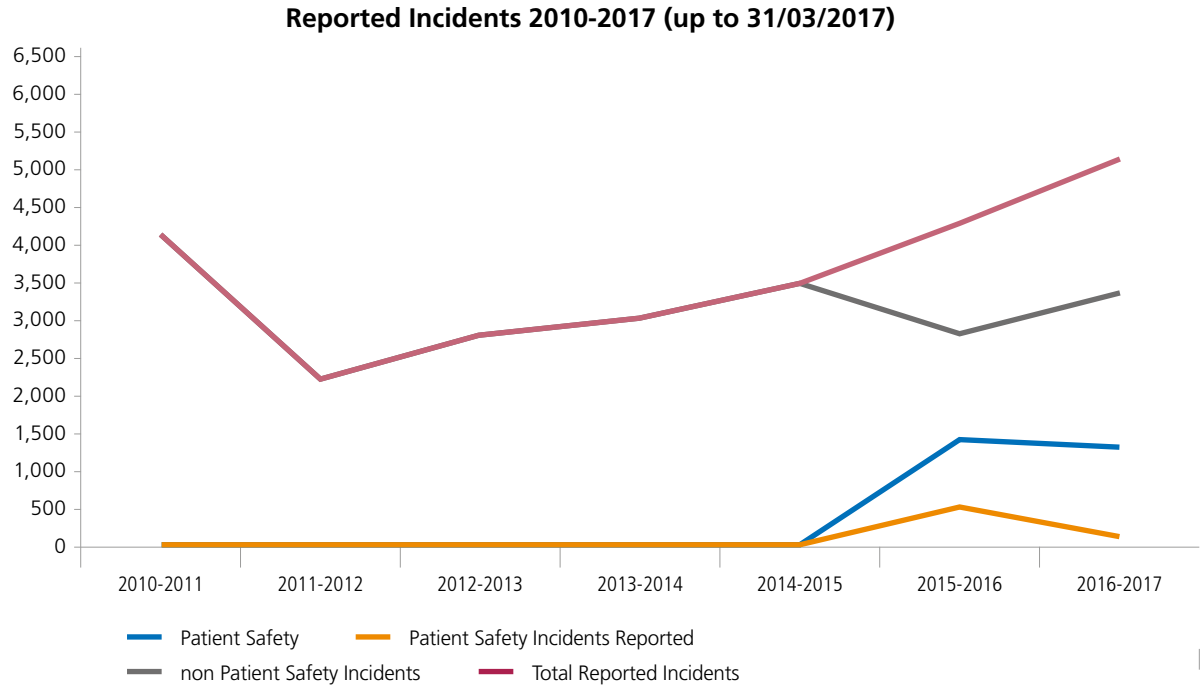
The Trust has refreshed and revised its approach to patient safety and patient experience and

has committed to becoming a safe, open and transparent care provider. In the last year a new Quality and Safety Directorate has been established to bring together for the first time all aspects of clinical governance and quality into one core central team. Led by the Chief Nurse and Director of Quality and Safety the team have worked in partnership with colleagues and other external key stakeholders to review and improve our policies, processes and practice. We remain on a journey of continual improvement and the focus on good governance supported by authentic patient and staff engagement will continue throughout the next year.

Incidents

Our approach to incident management has been reviewed and refreshed in response to shortfalls in our previous systems and practices. Historically a low reporter of incidents we listened to staff to identify areas of how the system and process could be improved to increase our reporting. As a result, we have rewritten our policy, streamlined the reporting process, raised awareness of what an incident is and how to report, provided feedback to staff and shared learning in a timelier and consistent way.

Figure 1: Overall incident reporting 2010 to 2017



Between 1st April 2016 and 31st March 2017 there had been an 18% increase in the reported figures related to patient safety incidents compared to the same period for 2015/16.

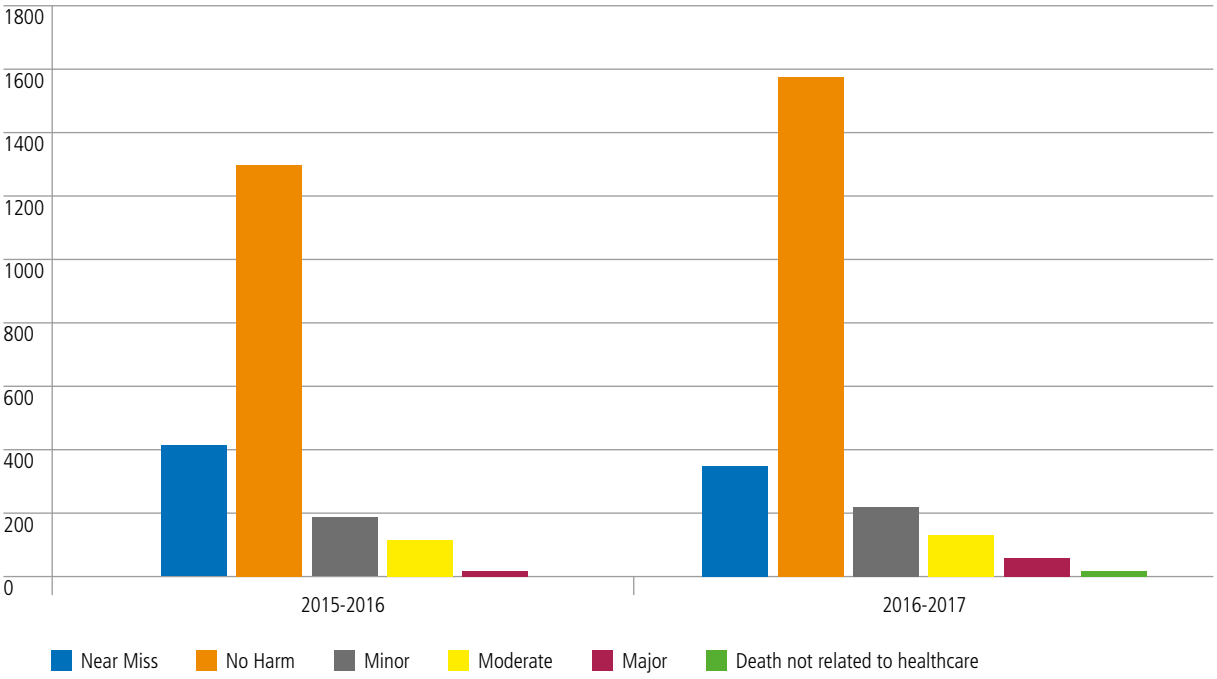
Of the 2,032 reported incidents, there were 205 patient safety incidents for this period, 75 (37%) of which resulted in death or harm.

	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 16	Feb 16	Mar 16	TOTAL
Incident affecting patient/service user	174	162	156	164	147	135	164	181	211	212	160	166	**2032**
Grade of Harm													
Death (caused as direct result of incident)	0	2	1	1	0	0	0	0	1	9	7	1	**22**
Low (minimal harm)	20	13	15	19	14	21	16	21	32	25	21	13	**230**
Moderate (short-term harm)	6	7	12	17	8	7	5	13	14	16	8	18	**131**
No known harm	141	139	124	122	123	105	140	146	159	150	118	127	**1594**
Severe (permanent or long-term harm)	7	1	4	5	2	2	3	1	5	12	6	7	**55**
TOTAL	**174**	**162**	**156**	**164**	**147**	**135**	**164**	**181**	**211**	**212**	**160**	**166**	2032

This is an increase of 350 (19%) compared to 2015/16 (1682).

As shown in Figure 2 below and above, the majority of incidents result in no harm.

Figure 2: Actual Harm from Patient Safety Incidents 2015/16 to 2016/17



National Reporting and Learning System (NRLS) Data

The Organisation Patient Safety Incident Reports (September 2016) were published by NHS Improvement via their website https://improvement.nhs.uk/uploads/documents/5._Ambulance.csv

The data for the reporting period shows that the Trust is above the national percentage for all Ambulance Trust severe harms at 3.4% (compared to 1%) and deaths- 1.9% (compared to 0.9%).

Part Three

Trust level data for the 6-month period, 1st October 2015 - 31st March 2016

Based on occurring d Degree of harm

		No Harm		Low Harm		Moderate Harm		Severe Harm		Death	
Trust	**Number of incidents occuring**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
London Ambulance Service NHS Trust	1,187	945	79.6	183	15.4	53	4.5	3	0.3	3	0.3
Welsh Ambulance Service NHS Trust	514	367	71.4	137	26.7	6	1.2	0	–	4	0.8
North East Ambulance Service NHS Foundation Trust	1,059	851	80.4	183	17.3	8	0.8	1	0.1	16	1.5
North West Ambulance Service NHS Trust	570	508	89.1	51	8.9	4	0.7	3	0.5	4	0.7
Yorkshire Ambulance Service NHS Trust	848	623	73.5	136	16	51	6	21	2.5	17	2
East Midlands Ambulance Service NHS Trust	362	261	72.1	60	16.6	12	3.3	11	3	18	5
West Midlands Ambulance Service NHS Foundation Trust	314	267	85	39	12.4	3	1	3	1	2	0.6
East of England Ambulance Service NHS Trust	1,016	804	79.1	142	14	70	6.9	0	–	0	–
South East Coast Ambulance Service NHS Foundation Trust	267	158	59.2	58	21.7	37	13.9	9	3.4	5	1.9
South Central Ambulance Service NHS Foundation Trust	415	307	74	95	22.9	7	1.7	6	1.4	0	–
South Western Ambulance Service NHS Foundation Trust	1,530	5	0.3	1,501	98.1	4	0.3	20	1.3	0	–
All Ambulance trusts	**8,082**	**5,096**	**63.1**	**2,585**	**32**	**255**	**3.2**	**77**	**1**	**69**	**0.9**

Footnotes:
Ambulance organisations have no reporting rate calculated for them as there currently is no suitable denominator data for them.

* Reporting dataset - incidents reported to the NRLS between 1st October 2015 and 31st March 2016.These data are used for statistics based on reporting and are used for data quality.

** Occurring dataset - incidents occurring between 1st October 2015 and 31st March 2016 and reported to the NRLS by 31st May 2016.

The following notations are used in the tables:
'#' is used when the base number is deemed too small to provide meaningful statistics;
'0' is used for percentages that are rounded down to zero;
'-' is used for a true zero in cell showing percent, i.e. where there are no cases in a category

Since the beginning of the year the Trust has invested in improving its incident systems. The first part of 2017 saw the redevelopment of Datix to encourage reporting and to monitoring functionality including:

+ Shortened IRW1 form to improve end-user reporting by making the process of reporting an incident faster and more streamlined
+ Automatic feedback to staff raising incidents, once an incident has been closed by an administrator in Datix
+ Addition of a History Mark tick box, with the intention that once permissions have been reviewed, the History Marking Lead will receive notification of any incidents requiring a marker on the CAD record
+ Option to identify potential Serious Incidents
+ Duty of Candour checklist

Improvements to the Datix system continue and include updates to enable thematic analysis and data abstraction at a local level. More training and learning events will continue throughout 2017/18 to share changes to practice as a result of incidents and to embed further a culture of no blame and openness.

Duty of Candour

Since 2015, Duty of Candour has been a legal duty applied to all NHS Trusts to be open and honest with patients and their families.

You can read more about how the Trust has applied Duty of Candour in section 2.1 above.

Serious Incidents (SIs) reporting and management

Following our CQC inspection last year we took the opportunity to carry out a complete review of our Serious Incident (SI) investigation process.

All incidents which may be deemed serious incidents according to the updated serious incident reporting framework are referred for urgent review and are discussed weekly at a multidisciplinary Serious Incident Decision Group (SID). At this meeting immediate actions taken are reviewed and any additional actions cascaded to all staff. Duty of candour compliance is checked and agreement made on who will be the investigator.

The new process is now inclusive of Regional Operational managers and clinicians involved in the incident from the investigations process, Root Cause Analysis (RCA) and also presenting the case to the Serious Incident Review Group (SIRG). Serious incident reviews are undertaken by a central team led by the Paramedic Consultant are reviewed by a multidisciplinary group prior to submission.

Following consideration at RCA the cases are then presented at the Trust's Serious Incident Review Group (SIRG), which is chaired by the Chief Nurse/Director of Quality & Safety (Medical Director is vice chair.). It is here that action plans are agreed and the format to communicate lessons learned are discussed. Attendance at this meeting has been sporadic and will be an area to much improve going forward.

The SI Policy will continue to be subject to ongoing review as the new process becomes embedded.

The next step is to further improve the audit of actions taken to provide assurance that they have been effective.

All SIs are also recorded and managed within the Trust's integrated risk management system, Datix. This facilitates the recording of evidence, developments and monitoring proving greater assurance and facilitates monitoring and management pf the Serious Incident process.

Themes from serious incidents are produced and presented internally at our and safety working group, Quality Committee and externally at the Quality Review Group (attended by CCGs and NECS). SI detail is also included in the integrated governance report to the Board

To enable reporting trends, the Trust measures the Reporting Reason for SIs rather than using the STEIS categories used in previous years. This allows

the trust an improved picture of the causes of our SI reporting. STEIS categories changed in the new Framework and do not reflect ambulance service activity well. The following information has been collated from our SI management database and our current incident reporting system (Datix).

1 April 2016 - 31 March 2017	
Child-related / Unexpected Child Death	5
Delayed Dispatch / Attendance	12
Green 5 Process	2
Handover Delay	3
Information Governance Breach	1
Medication Incident	1
Non-Conveyance / Condition deteriorated	3
Other	2
Patient / Third Party Injury	4
Power/Systems Failure	2
Red 3 Process	1
RTC/RTA	3
Staff Conduct	2
Treatment / Care	4
Triage / Call Management	10
TOTAL	**55**

The number of SIs reported has remained the same between the above two comparative years. This confirms the positive reporting culture within the Trust, although we recognise this is an area where more work needs to done in terms of low-level reporting. We also recognise that we need to improve the sharing of learning from incidents and feedback to staff.

Learning from Incidents, serious Incidents safeguarding and complaints

We share learning in many different ways including;

+ Immediate feedback to staff in person and via our Datix system
+ Distribution of Patient Care Updates by the Clinical Care and Patient Safety team
+ Issue of the Clinical News Letter- Reflections
+ Quality Matters Newsletter
+ Use of our internet and intranet sites
+ Use of the staff magazine
+ Topics shared for inclusion in clinical skills updates
+ Revised corporate induction and transition to practice courses
+ Coaching and mentoring
+ Learning shared at Governance Meetings
+ Trust wide learning events

Serious Incident and Duty of Candour Training

In late 2016, the Kent Surrey and Sussex Quality and Patient Safety Collaborative (QPSC) formed a regional Serious Incident (SI) Communities of Practice (CoP).

From inception, the primary remit of the focus group was to develop a Continuous Professional Development (CPD) accredited training course incorporating a human factors approach to SI investigations and experiential Duty of Candour training.

The aim of the training was to develop a very collaborative approach, joining NHS providers and commissioners alike to share learning, ideas and concept, and focus together on a more innovative quality improvement methodology. The training was delivered as a pilot programme in February 2017 to SECAmb staff.

In total 17 SECAmb staff were trained, and the evaluation was very favourable, leading to a transformation in the methodology of SI investigation. Further training will be provided for SECAmb staff in 2017.

In addition, the course has been accredited by the Royal College of Physicians (12 Continual Professional Development/CPD points) and is

supported by both the Kent Surrey and Sussex Patient Safety Collaborative SI CoP and the Health Foundation Q Initiative of which the course facilitator and SECAmb Lead Clinician for Quality and Compliance is a cohort founding member.

Duty of Candour and the role of the Freedom to Speak Up Guardian has now been incorporated into the Trust Corporate Induction for all new staff, in addition a new Duty of Candour information page has been added to both the SECAmb public and staff website.

The AVMA Duty of Candour patient information leaflet is now sent to all service users/families who raise a complaint, and is provided as part of the Duty of Candour process with Serious Incident investigation.

When a notifiable patient safety incident is reported, the Datix electronic incident reporting system has a new Duty of Candour menu, the incident cannot be finally approved and closed until this additional information has been added and documented and the completed investigation report uploaded.

Medication Errors

Effective medicine management is an essential element of ensuring patient safety and wellbeing. This includes the administration of the correct drug type, dosage and method of administration, as well as ensuring staff are trained and competent to identify and recognise any contra-indications associated with drugs. The administration of drug types is documented in the scope of practice for each operational role and is reflective of the clinical experience of that role.

The 2016 Care Quality Commission (CQC) inspection highlighted non-compliance with medicine management processes. Despite the Trust investing over £1 million in the installation of a new medicines management system enabling medicines to be stored securely with the ability to track staff removing drugs, medicines management continues to be a challenging and high risk for the Trust.

Where medication errors do occur there are slightly more incorrect drug doses than incorrect drug types with an average of three incidents per month for incorrect drug doses and two incidents per month for incorrect drug type. SECAmb monitors both of these types of incident to ensure that mitigation is enabled before trends begin to develop. We have promoted a no blame culture in relation to incident reporting throughout the year and this may explain the slight rise in reported incidents relating to incorrect drug doses. The table below highlights the number of drug incidents

	Incorrect drug dose administered	Incorrect drug type administered	TOTAL
Apr 16	2	1	**3**
May 16	1	2	**3**
Jun 16	1	2	**3**
Jul 16	8	3	**11**
Aug 16	1	7	**8**
Sep 16	1	1	**2**
Oct 16	2	1	**3**
Nov 16	3	2	**5**
Dec 16	3	2	**5**
Jan 17	6	0	**6**
Feb 17	1	3	**4**
Mar 17	3	1	**4**
TOTAL	**32**	**25**	**57**

Part Three

Clinical Effectiveness Indicators

Clinical Performance Indicators are monitored by all national ambulance services in England on a rolling cycle with each indicator being measured twice a year. The performance for each trust is compared and benchmarked before the findings are submitted to the National Ambulance Service Clinical Quality Group (NASCQG) and the National Ambulance Services Medical Directors (NASMeD). National CPI reports are produced in two formats. The first relates specifically to each monitored condition within the agreed cycle and is circulated shortly after the submission date. A subsequent report is published bi-annually following the completion of each full cycle. This contains the results for all indicators, qualitative information around variations in results, exception rates etc. and information on quality improvement work which has been undertaken by individual Trusts.

The data samples are obtained through a mixture of automated reporting and manual interrogation of individual patient clinical records by SECAmb's Clinical Audit Department to ensure accuracy of data. The sample size for each indicator is 300 cases. However, as not all participating trusts always reach this number of cases the comparative data is adjusted to accommodate this.

For 2016/17, the Trust reported on the following CPIs:

+ Cycle 16 Mental Health (April 16 Data)
+ Cycle 17 Asthma (June 2016 Data)
+ Single Limb Fracture (July 2016 Data)
+ Febrile Convulsion (August 2016 Data).

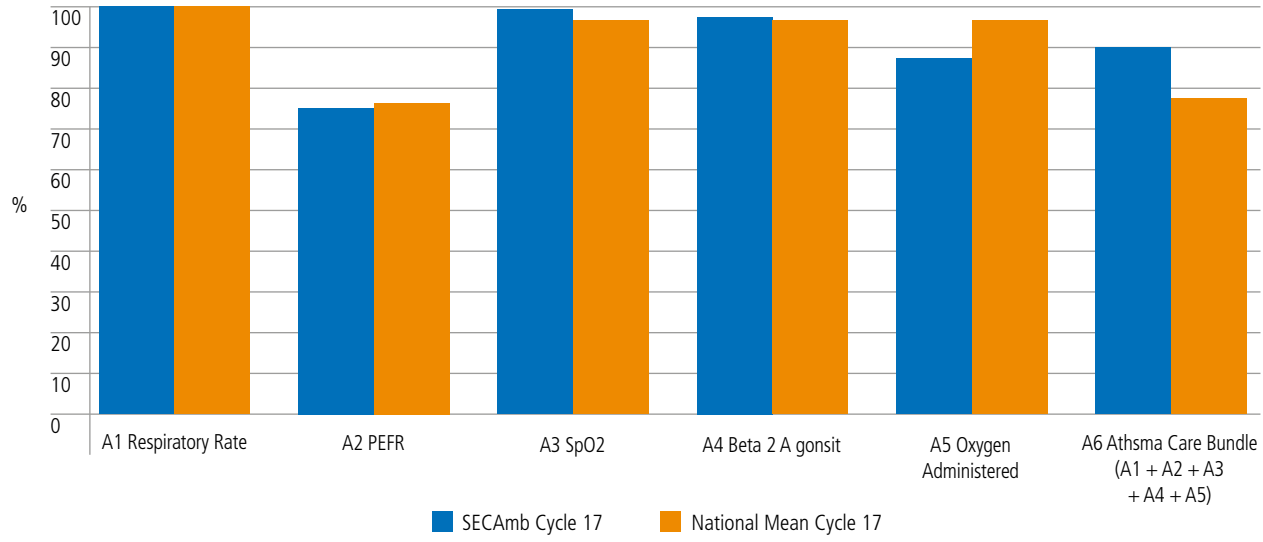
In September 2016, SECAmb was advised of the decision to suspend the CPIs pending further discussions between NASMED, NASCQG and Ambulance Leading Paramedic Group (ALPG) into the future of Ambulance Quality Indicators. Results from subsequent meetings were then taken forward for further consultation with NHS England and the Ambulance Response Programme.

Asthma

Asthma is a chronic disease with a significant impact on the predominantly younger population affecting their quality of life; rapid and appropriate treatment can ensure the patient can safely remain in the community and/or be rapidly transferred to secondary care where appropriate.

SECAmb performance in June 2016 is 74% for the full care bundle and whilst above the national mean of 70.9%, shows a 5% downward trend compared to the previous cycle. The Trust is also above the national mean in three of the five data elements of care delivered for patients suffering from asthma.

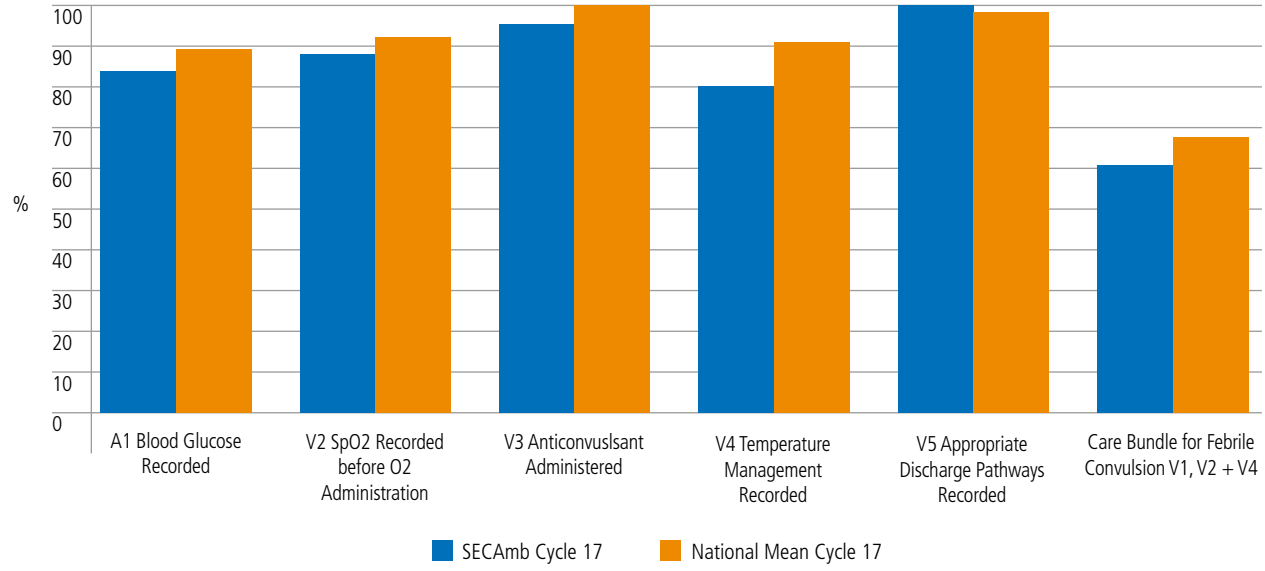
Asthma – June 2016



Febrile Convulsions

In August 2016 the Trust was monitored for the care of febrile convulsions. SECAmb performance against each of the elements is detailed below. The Trust is currently below the national mean for the full care bundle. An increased performance of 96% was recorded was recorded for the administration of anti-Convulsant compared to cycle 16 when this stood at 93.7%.

Febrile Convulsion – August 2016

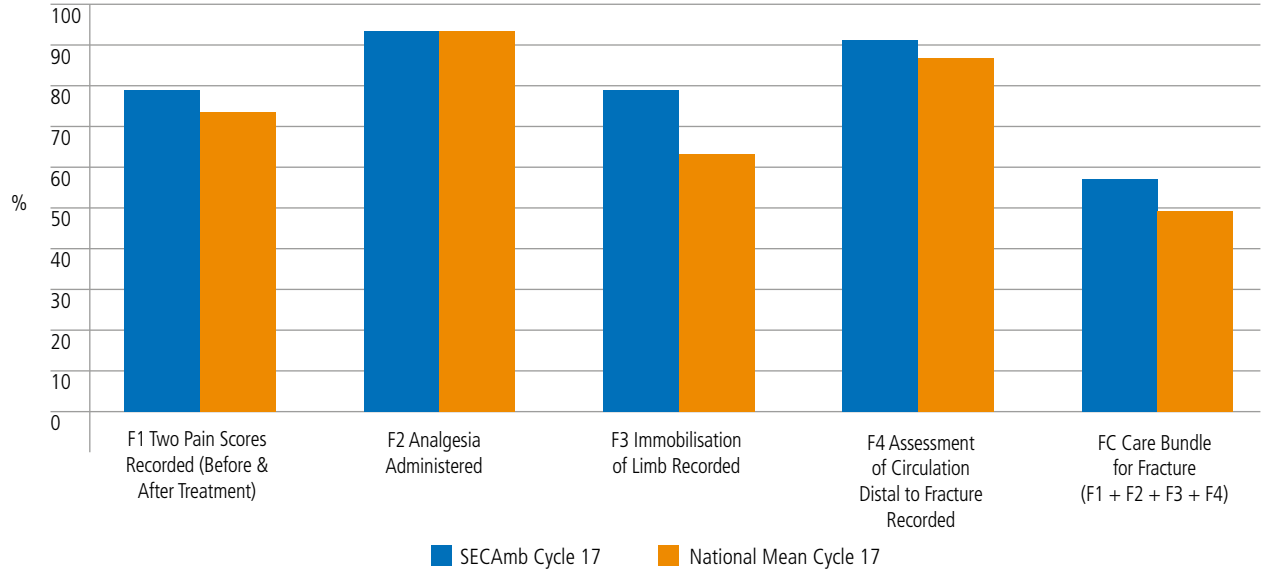


Part Three

Single Limb Fractures

In July 2016 the Trust was assessed for the care of patients experiencing a single limb fracture. SECAmb performance against all four elements and the care bundle is above the national mean as detailed below. For the care bundle the Trust shows an upward trend with an increased performance from 51.0% for the previous cycle to 54.3%.

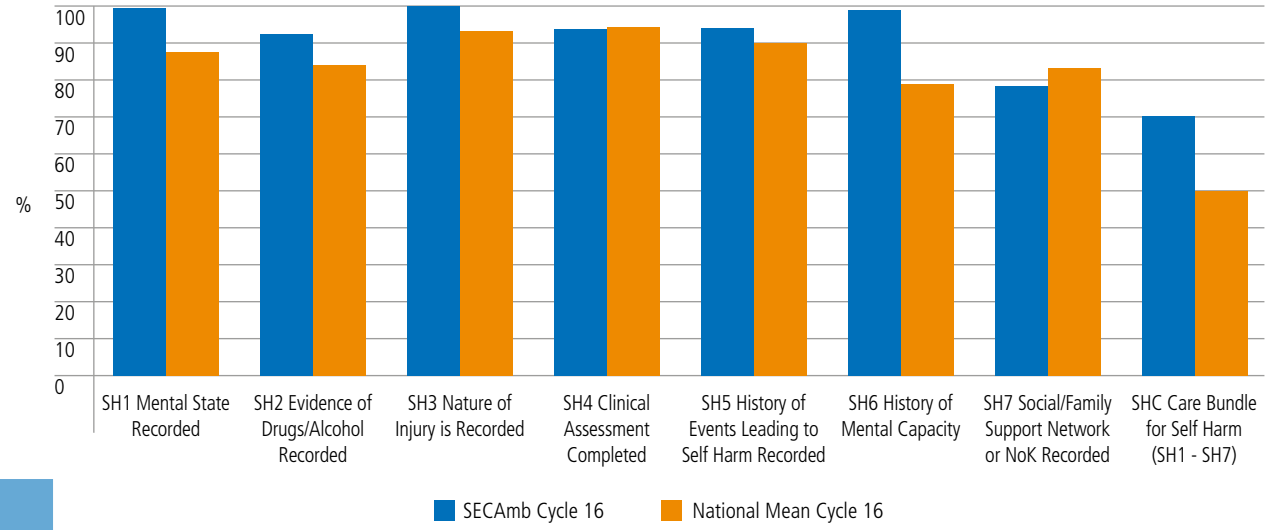
Single Limb Fracture – July 2016



Mental Health

In April 2016 the Trust was assessed for the care of patients experiencing mental health difficulties. The chart below demonstrates how SECAmb performed in the second pilot audit for this condition. The Trust is above the national mean for the full care bundle recording a performance of 69.7% being the second highest in the country.

Mental Health – April 2016



Patient Experience Indicators

Patient Experience Quality Data

The Patient Experience Team manages all complaints that are made to the Trust. The team also delivers SECAmb's Patient Advice and Liaison Service (PALS), providing help to patients, their carers and relatives, other NHS organisations and the general public who have queries or require information about our services, as well as signposting people to other services appropriate to their needs. Last year the Trust received 1,394 complaints. These include:

+ Statutory complaints (those from patients or their direct representatives)
+ Non-statutory complaints (those from other responsible bodies)

This classification has replaced the formal/informal/HCP classifications in order to ensure that complaint handling is compliant with the NHS Regulations. PALS concerns have also been reintroduced and in 2016/2017 the Trust processed 69 such enquiries.

Complaints by service area 2016/17

Service area	Number
PTS	135
EOC	426
A&E	555
NHS 111	271
Non - operational	7
TOTAL	**1394**

Complaints by subject 2016/17

Administration	22
Communication issues	73
History marking issue	9
Miscellaneous	24
Patient care	523
Concern about staff	357
Timeliness	325
Transport	61
TOTAL	**1394**

Complaints may raise more than one issue, hence there being a greater number of subjects than complaints. When running the report by subject and service area, all of the subjects are included, rather than just the primary subject as in the simple table above.

Complaints by subject and service area, 2016/17

Subject	PTS	EOC	A&E	NHS 111	Other	TOTAL
Administration Issues	0	6	4	12	3	**25**
Communication	0	25	9	36	1	**71**
Concern about Staff	27	19	274	35	3	**358**
History Marking Issue	0	5	3	0	0	**8**
Miscellaneous	0	5	19	0	0	**24**
Patient Care	12	132	232	147	0	**523**
Timeliness	45	232	110	41	0	**428**
Transport Issues	51	3	4	0	0	**58**
TOTAL	**135**	**427**	**655**	**271**	**7**	**1495**

Complaints by subject for 2015/16 were as follows:

Administration	27
Communication issues	65
History marking issue	10
Miscellaneous	40
Patient care	495
Concern about staff	551
Timeliness	627
Transport	329
TOTAL	**2144**

Complaints by Outcome

The Trust aims to respond to all complaints within 25 working days. Extensions to this timeframe are granted for specified reasons and the extended timescale is agreed with the complainant. The investigating manager decides, based on their findings, whether the complaint is Upheld, Partly Upheld or Not Upheld, and the Patient Experience Team will challenge the decision should it be felt necessary. The former category of 'Unproven' has been removed as an option.

Below is the outcome of the complaints that had been closed at the time of writing:

Subject	PTS	EOC	A&E	NHS 111	Other	TOTAL
Not Upheld	27	94	280	94	2	**497**
Partly Upheld	20	72	120	40	1	**253**
Upheld	76	221	117	121	1	**536**
Withdrawn	1	1	1	3	0	**6**
TOTAL	**124**	**389**	**519**	**258**	**4**	**1294**

Once an investigation is complete, feedback is provided to the complainant in the manner that they have requested. This may be verbal, in writing or at a resolution meeting. In all cases a full explanation of SECAmb's actions is given, along with a further apology and, where appropriate, an explanation of the actions the Trust will take in order to mitigate against a recurrence.

All complaints that are of a serious, complex nature are responded to by the Chief Executive, with less complex matters being managed to completion by the Patient Experience Team.

Complaints and concerns help us to identify areas where improvements to quality and services can be made and, wherever possible, steps are taken to implement changes as a result. We also ensure that this learning is disseminated throughout SECAmb using a range of mechanisms, reflective practice, peer reviews and the issuing of clinical/operational instructions etc. We place great emphasis on learning from complaints and every effort is made to take all the steps necessary to help prevent similar situations recurring.

Compliments

Each year SECAmb receives an ever-increasing number of "compliments" - letters, calls, cards and e-mails - thanking our staff for the wonderful work they do.

Compliments are recorded on SECAmb's Datix database, alongside complaints, ensuring both

positive and negative feedback is captured and reported. All staff involved receive a letter from SECAmb's Chief Executive, thanking them for their dedication and for the care they provide to our patients.

This data forms part of the report provided every two months to the Quality & Patient Safety Committee, the Board and to the commissioners' quality review group meetings.

During 2016/17 SECAmb received 2,350 compliments (an increase from 2,327 in 2015/16), thanking our staff for the treatment and care they provide.

Annex 1

Statements from external stakeholders

It should be noted that the commissioners have a legal obligation to review and comment, while local Healthwatch organisations and OSCs have been offered the opportunity to comment on a voluntary basis. The Clinical Commissioning Group, which has responsibility for the largest number of people to whom the trust has provided relevant health services during the reporting period, has responded on behalf of the commissioners.

Healthwatch West Sussex response to South East Coast Ambulance NHS Foundation Trust's Quality Account

As the independent voice for patients, Healthwatch West Sussex is committed to ensuring local people are involved in the improvement and development of health and social care services.

For several years now, local Healthwatch across the country have been asked to read, digest and comment on the Quality Accounts, which are produced by every NHS Provider (excluding primary care and Continuing Healthcare providers). In West Sussex this translates to seven Quality Accounts from NHS Trusts. Each document is usually over 50 pages long and contains lengthy detailed accounts of how the Trust feels it has listened and engaged with patients to improve services.

Each year, we spend many hours of valuable time reading the draft accounts and giving clear guidance on how they could be improved to make them meaningful for the public. Each year we also state that each and every Trust could, and should, be doing more to proactively engage and listen to all the communities it serves.

Whilst we appreciate that the process of Quality Accounts is imposed on Trusts, we do not believe it is a process that benefits patients or family and friend carers, in its current format.

This format has remained the same despite Healthwatch working strategically on this for over two years. We have reducing resources and we want to focus our effort where it has the most effect on patient care and we do not believe quality accounts have this impact.

This year we have been more proactive in our own engagement with local people in their communities, more direct in our influencing work and more critical of how commissioners and providers are communicating with local people. These activities have been a positive process and we feel a better use of our resource.

We remain committed to providing feedback to the Trust through a variety of channels to improve the quality, experience and safety of its patients.

Kent HOSC response

The Kent HOSC will not be providing a statement this year as the Committee has not been reconstituted following the election on 4 May; it will be reconstituted on 25 May which is after the deadline for comments.

Medway Council's Health and Adult Social Care Overview and Scrutiny Committee response

The Acting Chief Executive of SECAmb attended the Committee in November 2016 to provide an update on the Trust's improvement journey following the publication of the Care Quality Commission's (CQC) inspection findings in September 2016, which had given the Trust an overall rating of inadequate. The Committee was advised that the Trust had been placed in special measures as a result.

SECAmb recognised its shortcomings and was delivering a Recovery Plan, which it was anticipated would address the issues that been identified by the CQC. The Plan had been submitted to NHS Improvement and had been endorsed by the CQC. The Trust would be re-

inspected within six months. The Acting Chief Executive considered that a realistic target was for this to give the Trust a rating of 'requires improvement.' The expectation was that SECAmb

would be able to come out of special measures within 12 months. It was noted that the Trust had agreed an overall budget deficit of £7.1 million. SECAmb's contract for the current year only provided 75% of what was considered to be the required level of funding for red 1 responses and 70% of the required level for red 2 responses. The presentation given to the Committee also acknowledged concerns about the ability of services to manage winter pressures.

The Committee was informed that a Patient Impact Review published in relation to a Red 3 Pilot had found no evidence of patient harm which could be attributed to the pilot.

The Acting Chief Executive of SECAmb considered that the Trust had got into difficulties due to it having focused on innovation, as opposed to getting the day job right, although a Member of the Committee was not convinced that there had been significant innovation.

Committee Members were concerned about the high staff turnover and retention at SECAmb and the low rate of staff appraisal completions. The Committee was assured that steps were being taken to address these issues, although staff retention was likely to remain problematic for the foreseeable future. Bullying and harassment of staff was also raised as a concern, with the Acting Chief Executive acknowledging the issue.

The Committee noted that some statistics presented a more encouraging picture of service provision. These included relatively low patient conveyancing rates (50%) and patient satisfaction levels of over 90%

General Comments:

+ The Committee notes that SECAmb is due to be re-inspected during May 2017 and anticipates that this will show that measures are being put in place as part of SECAMB's Improvement Plan to address its inadequate rating and concerns raised by the previous inspection and by Committee Members, such as staff retention and the Trust's financial situation. The Committee is concerned that the percentage of staff who have experienced harassment, bullying or abuse had increased in 2016 compared to 2015
+ The Committee is also particularly concerned that safety has been rated as inadequate, both overall and for the NHS 111 service and that only 65.1% of red 1 responses reached the patient within eight minutes, compared to the Department for Health requirement of 75%
+ The Committee is supportive of the Sub-Group, established by the South East Regional Health Scrutiny Network to undertake scrutiny of SECAmb and to support its improvement journey. However, the Committee wishes to emphasise that it does not see the Sub-Group as a replacement for scrutiny of SECAmb undertaken by individual local authority health scrutiny committees and looks forward to SECAmb attending the Committee once again in June 2017 and subsequently during 2017/18
+ The Committee relies on Healthwatch Medway, which is a non-voting committee member, to feedback patient views and experiences.

Councillor David Wildey, Chairman of Medway Health and Adult Social Care Overview and Scrutiny Committee, 2016/17

This response to the Quality Account has been submitted by officers, in consultation with the Committee Chairman, Vice-Chairman and Opposition Spokesperson, under delegation from the Medway Health and Adult Social Care Overview and Scrutiny Committee.

Annex 1

Surrey Wellbeing and Health Scrutiny Board

The Wellbeing and Health Scrutiny Board welcomes the opportunity to comment on the South East Coast Ambulance Trust Quality Account. It has worked closely with the Trust through the South-East Coast Ambulance Regional Scrutiny Sub-group. This group is constituted of representatives from each of the health and overview scrutiny committees covering the region. The Board has seen a good level of engagement from Trust representatives through this sub-group, and feels it represents a coordinated and proportionate scrutiny arrangement.

The Board commends the Trust's candour in highlighting the challenges it continues to face. It would, however, also add that it is difficult to ascertain the impact for people that use the services from the Trust's Quality Account. The Trust could present its information in a more accessible way, with clearer links articulated between its core indicators, priorities and how care is delivered for people that use its services.

The Board notes the implementation of a number of actions following the issue of the Section 29 notice by the CQC, and welcomes steps taken to put a Project Management Office in place to oversee the required improvements. It awaits the outcome of CQC's follow up visit to ascertain the extent to which progress has been made.

The Board notes that anecdotal patient feedback remains positive, and is reflective to the commitment and energy of front-line staff. It is concerned that staff report experiencing bullying, harassment and abuse, and that the figures have risen when compared to 2015. It is hoped that the newly appointed Chief Executive will take action to address issues in workplace culture, for the benefit of the staff and patients.

The Board recognises there are some positive examples of the Trust's work, for example in its use of Community First Responders, and the management of frequent callers. It commends the Trust on the feedback it has received with regard to the Community First Responders, a clear demonstration of the valued role the community can play in supporting patients.

The Board recognises that there are continued challenges for the Trust in the year ahead, and will work with its regional counterparts to ensure these challenges are given due consideration across the whole system. It is clear that partnership working has a vital role to play in supporting the Trust to make its required improvements, and the Board will take this into consideration in its scrutiny over 2017/18

Statement from East Sussex Health Overview and Scrutiny Committee (HOSC)

It is clear from the Quality Account, and from HOSC's own scrutiny of the Trust, that 2016/17 has been another difficult year for the Trust. Demand for services (ambulance, 111, and related services provided by other Trusts) has increased. A number of targets have been missed and it is clear that the Trust's capacity has been stretched.

HOSC is concerned about the findings of the Care Quality Commission (CQC) inspection, which rated SECAmb as inadequate and recommended that it be placed in special measures.

Following the publication of the CQC report, the health scrutiny committees within SECAmb's area of operation have set up a joint liaison meeting in order to monitor the implementation of the Trust's quality improvement plan. The Trust's commitment to this meeting has been evidenced through the senior representation at meetings. SECAmb has been providing evidence of improvement in performance during these meetings in regards to response times, staffing, and organisational

culture, but there is a considerable way still to go.

HOSC also has ongoing concerns about the impact of delays in the handover of patients at hospital A&E departments. The 15 minute recommended handover standard is frequently exceeded, and it is not unusual for ambulance crews to experience delays of up to 45 minutes or more. This inevitably impacts on SECAmb's performance and therefore on the Trust's ability to provide a timely response to other calls. HOSC has investigated this issue during the past year but it continues to be a cause of concern.

The Committee welcomes the appointment of the new Chairman and Chief Executive and is glad to hear their commitment to recruiting a new Executive Leadership team. HOSC hopes that this will enable the Trust to focus on addressing key challenges. The Committee recognises that the Trust has been open in acknowledging the quality challenges that exist and welcomes this approach.

The Committee continues to believe that patient and staff satisfaction are intrinsically linked and a key aspect of moving forward will be addressing staff concerns, ensuring staff feel supported and more positive about the organisation. However, HOSC is disappointed to note that the NHS Staff Survey results showed more staff had experienced harassment and bullying than in 2016 than in the previous year. HOSC believes that SECAmb must show improvements in this year's survey.

2016/17 Quality Priorities

HOSC welcomes the progress made but it is clear that further work is needed on a number of 2016/17 quality priorities, especially those that have decreased in performance compared with the same period in 2015/16.

2017/18 Quality Priorities

It is good to see that patient & family involvement in investigating incidents is being prioritised, as well as the aim to improve patient safety by learning from incidents.

HOSC notes that both were recommendations of the CQC in its September 2016 report.

HOSC looks forward to working with the Trust to monitor progress on the priority areas, and overall performance, over the coming year. HOSC will particularly look to ensure that any areas for improvement highlighted by CQC are fully and actively addressed by the Trust leadership.

Statement from West Sussex HASC

This year it is difficult for the Health and Adult Social Care Select Committee (HASC) to provide any commentary for your Trust's Quality Account as there have recently been County Council elections and the Committee has not held any meetings since mid-March. Two thirds of the county councillors on the Committee are new and therefore it is a difficult time for us to provide a comment.

Brian Rockell, Lead Governor

Patients want to know they are receiving the best quality care. SECAmb has had a very difficult year but with a new Chair and Chief Executive now in place, we shall be looking for a renewed vigour and quality improvements which are embedded in the Trust's approach to performance and patient care.

The Quality Account reflects the Trust's ambitions in a significant number of areas. Successes are positively highlighted but there remains challenges where further progress is needed.

Response from Kent, Surrey and Sussex Clinical Commissioning Group

In response to the draft South East Coast Ambulance NHS Foundation Trust (SECAmb) Quality Account & Quality Report 2016-17 submitted to Kent, Surrey and Sussex Clinial Commissioning Groups (CCGs) for review, please find attached the CCGs statement in accordance with the National Health Service (Quality Account) Amendment Regulations 2012.

Kent, Surrey and Sussex CCGs acknowledge

Annex 1

the 2016/17 draft Quality Account submitted by SECAmb to commissioners. One version was received on 2 May 2017 and circulated for commissioner review on the 3 May 2017. A further draft of the Quality Account was submitted to commissioners on the 11 May 2017. We also acknowledge that a further version was circulated on the 19 May 2017, however this document has not been reviewed as it was received after the timeframe agreed for commissioner review.

The detail of the letter below and the comments on the Quality Account Checklist and draft Quality Account document are based on the version received on the 11 May 2017.

Kent, Surrey and Sussex CCGs can confirm that the documnent has been reviewed against the Department of Health reporting requirements. (See attached quality account checklist). Some comments have also been recorded on the draft document that we hope will be of use in compiling your final Quality Account.

Over the year SECAmb and Commissioners have jointly focused on both the development and implementation of a remedial action plan – the Unified Recovery Plan (URP) – which was initially agreed to address and mitigate operational shortfalls and the wider organisational governance issues and was later expanded in purpose to incorporate the actions identified from the CQC inspection undertaken in May 2016. However there remain concerns between us and our associate commissioners with regard to the on-going financial challenges, performance against constitutional standards and future sustainability.

During the contract negotiations for 2017/18 and 2018/19, SECamb raised concerns about the perceived structural gap required to support their delivery of the national performance standards. As part of these negotiations it was agreed that a piece of work would be commissioned and subsequently carried out by Deloitte to review the financial and performance gap and offer an evidence based position. The final report from this review has proposed a number of scenarios and recommendations that will be considered and will also take into consideration future changes such as the Ambulance Response Programme. It should be noted that in recent years Commissioners have contractually funded outturn plus growth.

CCGs note the Quality Account contains a clear reflection of the outcomes from the CQC organisational assessment in May 2016 and note that reference is also made to the re-inspection scheduled for May 2017. Commissioners acknowledge the work that has been undertaken towards addressing the concerns raised by CQC but would also like to see increased momentum in change over the coming year. We also look forward to support the planned Quality Assurance visits across the year.

The Quality Account provides a summary of progress agains the 2016/17 quality priorities and while it recognises that some of the 2016/17 priorities were not achieved commissioners feel it would be helpful to add some detail on how these priorities will continue to be monitored and reported on moving forward.

The draft report shared with commissioners on the 11 May 2017 included a section describing the 3 priority areas for improvement in 2017/18 which are:

1) Improving outcomes from Out of Hospital Cardiac Arrests (OHCA) – Clinical Effectiveness

2) Patient & Family involvement in investigating incidents – Patient Experience

3) Learning from incidents and improving patient safety – Patient Safety

Whilst Commissioners to support these areas

as prioirities for quality improvement as they align with areas outlined in the Unified Recovery Plan and CQC inspection report, commissioners would like to see clear targets, milestones and measures of improvement metrics set and we would like to see these metrics included in the final published report.

It is expected that SECAmb will require the majority of 2017/18 in order to make a full recovery against the elements identified in the unified recovery plan, and th CCGs have been working jointly with NHS England and NHS Improvement, and working closely with the Trust to support them in further development and implementation of their overarching recovery.

Data Quality

Commissionmers are satisfied with the accuracy of the data contained in the Account pending completion of final validation by auditors. We will continue to work with the SECAmb to ensure that quality data is reported in a timely manner through clear information schedules.

Overall the Kent, Surrey and Sussex CCGs acknowledge the significant challenges the Trust has faced over the past year and we look forward to working closely to support the Trust in delivering and sustaining improvements set out in this plan going forward in to 2017/18, and Commissioners are keen to see improvements in all aspects of the services delivered by the Trust, not only in terms of performance but importantly in the quality aspects of the services delivered and the governance that supports them. As commissioners, we welcome the steps being taken by SECAmb to stabilise the executive team and also note the development of the new programme office.

We look forward to receiving your final document.

If you have any queries, please contact clare.stone@nwsurreyccg.nhs.uk in the first instance.

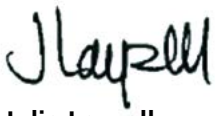
Yours sincerely

Gail Locock
Chief Nurse

For and on behalf of Swale CCG and Associate Commissioners

Clare Stone
Chief Nurse

For and on behalf of North West Surrey CCG and Associate Commissioners



Julia Layzell
Chief Nurse and Head of Quality

For and on behalf of Crawley, Horsham and Mid Sussex CCGs and Associate Commissioners

Annex 2

Statement of Directors' Responsibilities for the Quality Report

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

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

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

+ The content of the Quality Report meets the requirements set out in the NHS foundation trust annual reporting manual 2016/17 and supporting guidance
+ The content of the Quality Report is not inconsistent with internal and external sources of information including:
  - Board minutes and papers for the period April 2016 to May 2017
  - Papers relating to quality reported to the board over the period April 2016 to May 2017
  - Feedback from commissioners dated 26/05/17
  - Feedback from governors dated 26/05/17
  - Feedback from local Healthwatch organisations dated 07/05/2017
  - Feedback from Overview and Scrutiny Committee dated 10/05/2017
  - The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 31/05/2017
  - There is no national patient survey to refer to
  - The latest national staff survey 07/03/2017
  - The Head of Internal Audit's annual opinion of the trust's control environment dated 12/05/2017
  - CQC inspection report dated 29/09/2016
+ The Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered
+ The performance information reported in the Quality Report is reliable and accurate
+ There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
+ The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and
+ The Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

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

By order of the board

30 May 2017 ..... **Date**

R. D. Hoste ..... **Chair**

30 May 2017 ..... **Date**

D S Mackie ..... **Chief Executive**

Annex 3

Independent Practitioner's Limited Assurance Report to the Board of Governors of South East Coast Ambulance Service NHS Foundation Trust on the Quality Report

We have been engaged by the board of governors of South East Coast Ambulance Service NHS Foundation Trust to perform an independent limited assurance engagement in respect of South East Coast Ambulance Service NHS Foundation Trust's Quality Report for the year ended 31 March 2017 (the " Quality Report") and certain performance indicators contained therein against the criteria set out in the 'NHS' foundation trust annual reporting manual 2016/17' and additional supporting guidance in the 'Detailed requirements for quality reports for foundation trusts 2016/17' (the 'Criteria').

Scope and subject matter

The indicators for the year ended 31 March 2017 subject to the limited assurance engagement consist of the national priority indicators mandated by NHS Improvement:

+ Category A call – Emergency response within 8 minutes; and
+ Category A call – ambulance vehicle arrival within 19 minutes

We refer to these national priority indicators collectively as the 'Indicators'.

Respective responsibilities of the directors and Practitioner

The directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the 'NHS foundation trust annual reporting manual 2016/17' and supporting guidance issued by NHS Improvement.

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

+ The Quality Report is not prepared in all material respects in line with the Criteria set out in the NHS foundation trust annual reporting manual 2016/17 and supporting guidance;
+ The Quality Report is not consistent in all material respects with the sources specified in NHS Improvement's 'Detailed requirements for external assurance for quality reports for foundation trusts 2016/17'; and
+ The indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated on all material respects in accordance with the 'NHS foundation trust annual 2016/17' and supporting guidance and the six dimensions of data quality set out in the 'Detailed requirements for external assurance for quality reports for foundation trusts 2016/17.

We read the Quality Report and consider whether it addresses the content requirements of the 'NHS foundation trust annual reporting manual 2016/17' and supporting guidance, and consider the implications for our report if we become aware of any material omissions.

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

+ Board minutes for the period 1 April 2016 to 26 May 2017;
+ Papers relating to quality reported to the Board over the period 1 April 2016 to 26 May 2017;
+ Feedback from Commissioners dated 26 May 2017;
+ Feedback from Governors dated 26 may 2017;
+ Feedback from local Healthwatch organisations dated 7 May 2017;
+ Feedback from Overview and Scrutiny Committee dated 10 May 2017;
+ The Trust's complaints report published under regulation 18 of the Local Authority

Social Services and NHS Complaints Regulations 2009, dated 31 May 2017;

+ The national staff survey dated 7 March 2017;
+ The Care Quality Commission inspection report dated 29 September 2016;
+ The Head of Internal Audit's annual opinion over the Trust's control environment dated 12 May 2017; and
+ Any other information obtained during our limited assurance engagement.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively, the "documents"). Our responsibilities do not extend to any other information.

The firm applies International Standard on Quality Control 1 and accordingly maintains a comprehensive system of quality control including documented policies and procedures regarding compliance with ethical requirements, professional standards and applicable legal and regulatory requirements.

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

This report, including the conclusion, has been prepared solely for the Board of Governors of South East Coast Ambulance Service NHS Foundation Trust as a body, to assist the Board of Governors in reporting South East Coast Ambulance Service NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual report for the year ended 31 March 2017, to enable the Board of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law we do not accept or assume responsibility to anyone other than the board of Governors as a body, and South East Coast Ambulance Service NHS Foundation Trust for our work on this report, except where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

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

+ Evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
+ Making enquires of management;
+ Limited testing, on a selective basis, of the data used to calculate indicators tested back to supporting documentation;
+ Comparing the content requirements of the 'NHS foundation trust annual reporting manual 2016/17' and supporting guidance to the categories reported in the Quality Report; and
+ Reading the documents.

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

Limitations

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

used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques, which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the Quality Report in the context of the criteria set out in the 'NHS foundation trust annual reporting manual 2016/17' and supporting guidance.

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

Our audit work on the financial statements of South East Coast Ambulance Service NHS Foundation trust is carried out in accordance with out statutory obligations and is subject to separate terms and conditions. This engagement will not be treated as having any effect on our separate duties and responsibilities as South East Coast Ambulance Service NHS Foundation Trust's external auditors' Our audit reports on the financial statements are made solely to South East Coast Ambulance Service NHS Foundation Trust's members, as a body, in accordance with paragraph 24(5) of Schedule 7 of the National Health Service Act 2006. Our audit work is undertaken so that we might state to South East Coast Ambulance Service NHS Foundation Trust's members those matters we required to state to them in an auditor's report and for no other purpose. Our audits of South East Coast Ambulance Service NHS Foundation Trust's financial statements are not planned of conducted to address or reflect matters in which anyone other than such members as a body may be interested for such purpose. In these circumstances, to the fullest extent permitted by law, we do not accept or assume any responsibility to anyone other than South East Coast Ambulance Service NHS Foundation Trust and South East Coast Ambulance Service NHS Foundation Trust's members as a body, for our audit work, for our audit reports, or for the opinions we have formed in respect of those audits.

Conclusion

Based on the work described in this report, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2017:

+ The Quality Report is not prepared in all material respects in line with the Criteria set out in the NHS foundation trust annual reporting manual 2016/17 and supporting guidance;
+ The Quality Report is not consistent in all material respects with the sources specified in NHS Improvement's 'Detailed reuirements for external assurance for quality reports for foundation trusts 2016/17'; and
+ The indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report have not been reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual 2016/17' and supporting guidance.

Grant Thornton UK LLP

Grant Thornton UK LLP

Grant Thornton house
Melton Street
Euston Square
London

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