

South East Coast Ambulance Service NHS Foundation Trust

Trust Board Meeting, 29 June 2017

Tangmere MRC

Minutes of the meeting, which was held in public.

Present:

Richard Foster	(RF)	Chairman
Daren Mochrie	(DM)	Chief Executive
Alan Rymer	(AR)	Independent Non-Executive Director
Angela Smith	(AS)	Independent Non-Executive Director
David Hammond	(DH)	Executive Director of Finance & Corporate Services
Fionna Moore	(FM)	Executive Medical Director
Graham Colbert	(GC)	Independent Non-Executive Director & Deputy Chair
Jon Amos	(JA)	Acting Executive Director of Strategy & Business Development
Joe Garcia	(JG)	Executive Director of Operations
Lucy Bloem	(LB)	Independent Non-Executive Director
Terry Parkin	(TP)	Independent Non-Executive Director
Tim Howe	(TH)	Independent Non-Executive Director

In attendance:

Janine Compton	(JC)	Head of Communications
Peter Lee	(PL)	Trust Secretary

38/17 Chairman's introductions

RF welcomed members, and staff, governors and members of the public observing the meeting.

39/17 Apologies for absence

Steve Lennox	(SL)	Executive Director of Nursing & Quality
Steve Graham	(SG)	Interim Director of Human Resources

40/17 Declarations of conflicts of interest

The Trust maintains a register of directors' interests. No additional declarations were made in relation to agenda items.

41/17 Minutes of the meeting held in public May 2017

The minutes were approved as a true and accurate record.

42/17 Matters arising (action log)

The progress made with outstanding actions was noted as confirmed in the Action Log and completed actions will now be removed.

43/17 Patient story [10.02 – 10.10]

JC confirmed that the Board receives a patient story at each meeting, alternating between positive and negative experience of our services. The individual in this patient story was the daughter of the patient and

she described the care her mother received. The ambulance crew arrived within 5 minutes and were described as being very responsive, caring and skilled. In particular, they took time to explain during the treatment what was happening and why, acknowledging the daughter was understandably very distressed.

RF reflected that this video illustrated the emotional aspects of the service we provide. DM added that he has experienced much good caring and compassionate care from staff.

44/17 Chief Executive's report [10.10 – 10.16]

DM highlighted the following;

- Changes to the executive team with SL joining the executive team following Emma Wadey's departure and the upcoming interviews for four executive positions.
- HQ/EOC moves. DM confirmed that the majority of staff have now moved to Crawley and thanked staff for all their efforts in making the transition a smooth one.
- The number of thefts targeting medical equipment. DM described the work ongoing with Police to ensure security arrangements are robust.
- CAD. DM reinforced the need to ensure this is implemented safely.
- DM also mentioned the work staff have been doing supporting the changes in East Kent, and the support the Trust offered to our emergency service colleagues following the recent terrorist attacks and fire in London.

RF supported DM's view that safety is of paramount importance in the transition to the new CAD, and so if this means delaying a few days that is the right decision.

Otherwise the Board has no questions for DM.

45/17 Unified Recovery Plan [10.16 – 10.52]

JA reminded the board that the plan was to review the URP after a year, which is now. So we are in process of revising our governance arrangements which support our recovery / improvement, which includes establishing a new culture steering group. JA will update the board more on this in due course.

Recovery:

JA confirmed the good progress and the closure of a number of 999 projects, allowing greater focus on a smaller number of projects, such as hospital handover. ECPR progress has picked up significantly – 75% roll out. The aim is 90% by the end of July as per the revised plan. With regards OU restructure, we are transitioning this project in to business as usual. And CAD sits at amber, given the number of issues to work through ahead of 'go live'.

AS felt that what is missing from the paper is the executive opinion and asked in future we have a clearer steer of where the issues are and, therefore, what the Board needs to focus on.

AR asked about the projects like the OU restructure being moved in to business as usual, and how the Board has visibility on the benefits realisation. JG confirmed that in respect of the OU restructure, efficiency metrics such as cycle time will be included in the Integrated Performance Report. JA confirmed that the project closure process includes handing over ownership of the benefits realisation and confirming the metrics use to monitor this. DH added that more fundamentally, the board has approved the business cases and so the benefits realisation will be overseen by F&I Committee. TH agreed that this would be for board committees to oversee, through their assurance function and then escalate to the Board in usual way.

LB asked about pace and clarity, giving the example of hear and treat. If we are to re-scope this, then the Board should have greater visibility. JA agreed.

GC asked for an update on the iPad roll out and, in particular the interface with hospitals. JA explained that we continue to push this with hospitals. We have 11/22 hospitals connected and is part of the roll out programme. DH confirmed EPCR is a priority given the benefits to patients and staff, especially in the context of the issues currently with paper records. DM is writing to Chief Executives to emphasise the benefits.

GC asked for a review of the business case in the Autumn.

Action:

Ipad business case to be reviewed by Finance and Investment Committee in October 2017.

In summary, RF reminded the Board that we are in much better order than we were. We have better grip which is good news. There is more we can do but the message is that the Board is to judge and decide, not to be assured. The executive need to set out the issues to ensure the Board has its view on what the issues are. As we progress we can work on this subtle balance.

Quality:

FM confirmed that 75% of the actions are completed, but there a number of significant areas at risk, including;

- Incidents/Sis – there is much work ongoing to reduce the backlog. Incident numbers have increased which is positive. We are reviewing the SI policy to ensure we improve timeliness of investigations.
- PCRs – sooner we get ECPR rolled out the better as it will correct much of the paper record issues. We have scoped the issues and so have a better understanding. Internal audit is checking this to ensure we have it right.
- Clinical Audit remains a risk mainly due to staff shortages.

LB asked about serious incidents and within the IPR (later in agenda) it shows that we haven't assigned any in the timeframe; the backlog of incidents is a concern too. FM explained that in the past we investigated SIs a small central team. Going forward we are aiming to devolve this to operational areas, save those incident which require specialist investigation. Instead the professional standards team will provide support. We have an SI review group which meets every week to ensure we have greater visibility and oversight of SI identification and allocation. Also, we are ensuring executive ownership of SIs.

Action:

A paper to the Board in July setting out the changes in arrangements of SI management and the impact of this to date.

Finance:

DH confirmed that the Finance Sustainability Steering Group meets at least twice a week. We currently have £22m worth of schemes under consideration. £10m are fully validated and £10.7m are scoped. The buy-in from staff has been really positive with a good level of understanding of what we need to do and why. The emphasis going forward will focus on schemes in operational services. It is a challenge but we are getting there. NHSI continue to be cautiously satisfied in the context of the target of £15m being extremely difficult.

No questions from the Board.

Comfort break 10.52 – 11.03

46/17 Independent Governance Review [11.03 – 11.05]

PL updated the Board that as part of the undertakings agreed with NHSI (then Monitor) in 2015, we are in the process of procuring an external governance review. This will involve the board and so arrangements will be made in due course to schedule interview etc.

47/17 Certification on Training for Governors [11.05-11.07]

PL outlined the requirement of this self-certification, confirming the views expressed by the Council of Governors.

Decision:

The Board approved this self-certificate which will be published on the Trust website.

48/17 Corporate Governance Statement [11.07-11.17]

PL set out the steps taken by the executive in consideration of this corporate governance statement, and the balance taken in not confirming some statements where not all the elements could be confirmed. The Board discussed this and although it felt overall the statements confirmed and not confirmed were probably right, it asked that we be more explicit where we do not confirm, so that it is clear which elements we are referring to.

Action:

Executive to review the corporate governance statement to give more detailed narrative, especially against the statements we are not confirming. Then share by email with the Board to approve.

[As set out in the actions log this action was completed and, as agreed with the Board, the revised corporate governance statement is annexed to these minutes]

49/17 IPR [11.17-11.49]

DM introduced this report and in SG's absence highlighted the workforce-related issues. No questions from the Board on workforce.

Operations:

JG confirmed that this report now reflects the commissioned targets. We met Red 1, Red 2 and Red 19. JG set out the position with activity, which was slightly below plan. In terms of handover delays, there has been good work with most hospitals despite a rise in number of hours lost. Call answering performance dropped and JG explained that this is due to training extraction for the new CAD.

GC asked whether we are on an improving trajectory. JG explained we aren't although we will meet trajectories agreed with commissioners. He explained the issues impacting, such as weather and abstraction for key skills training. Despite this, we are doing the right things and trajectory for Q2 is realistic and achievable, this factors in handover delays. DH added that we have a mechanism with commissioners to adjust trajectories if there is a significant change in assumptions, such as handover delays.

LB asked whether the CAD go live has been taken account of in the trajectories. JG confirmed it has and the Board acknowledged that there may be a dip in performance when we go live.

DM agreed we are doing the right things; we must ensure staff get breaks, not have shift overruns and give them training etc. We need to strike the balance between doing these things and ensuring responsiveness to patients.

Clinical:

FM reminded the Board that this report is based on data from January. The picture is much the same as reported at the last meeting. We aren't doing as well with patients with elevated myocardial infarction mainly as we don't record a second pain score which we are working on with clinical education. JA updated with regards stroke that our timeliness on getting patients to hospital reflects some of the changes locally resulting in longer journeys.

Quality:

Having discussed much of this already under item 45/17 FM highlighted some of the key findings from the report, including the rise in reported incidents which is positive.

There were no questions from the Board.

Finance:

DH confirmed that month 2 was slightly ahead of plan and YTD we are on plan. The key headlines were that activity was lower than expected, but resource was adjusted accordingly. Non-pay control is good. Capital expenditure was behind plan which DH explained is more a phasing issue, e.g. timing of HQ and fleet business cases (on part 2 agenda) and so it will correct itself over the coming months. We have slightly more cash than expected. In summary, we are there or thereabout, but recognise this will be a tough year.

TP asked whether there is potential for income to come back on track. DH answered that the main issue is matching hours with activity and therefore ensuring income and activity aligns accordingly. If commissioners invest more money, this won't impact on the bottom line as this would be used to increase hours. In terms of our contribution to patient benefit, we have already put in our £15.1m CIP which we are delivering.

RF asked what the proportion of the budget is salary? DH confirmed circa £130m and acknowledged that if the cap in public sector is removed it would have significant impact. In addition, the settlement for paramedic Band 6 is only funded only for this year and so this could be an issue next year when it falls to CCGs.

50/17 Medicines Management [11.49 – 12.10]

FM explains this paper is a stock take on where we are, reflecting the significant work being undertaken. Phase 1 of the external review is complete. This was a retrospective review of medicines governance and the outcome was quite positive. We reviewed the range of drugs we provide and the policies on controlled drugs, in particular around storage, possession and destruction. FM confirmed that she is now the CD accountable officer and has undertaken appropriate training. Staffing in medicines management has improved, both in terms of support to the Chief Pharmacist and from the PMO which has put project structure in this area. All PGDs have been signed off. CCP PGDs are under review with external advice sought. In terms of temperature control, this is a concern across the ambulance sector generally.

FM introduced to the meeting Carol-Anne (CA), Chief Pharmacist.

TP felt this was an excellent report, exposing issues we need to have visibility of. He asked whether we understand why we overspent by 100% last year? CA explained that she has a better picture now; there has been £147k of waste so we are looking at stock-holding. Currently we hold 4 months and most other ambulance trusts hold 1 month, as an example.

RF agreed this is a very frank account. We know what the problems are and we have a plan to address them. He asked when the Board will have assurance that we are doing everything we should be doing. FM explained some things are quicker to fix than others, but certainly within 4-6 months.

RF asked whether this at its root is an issue about sites and systems or about culture and behaviours. FM confirmed it is both. She explained that it is difficult to operate from so many site, but culture is an issue too. Some of the things the Trust has introduced over the years, while might not have been supported by good governance, were introduced to help improve patient care, so the intentions have always been well positioned.

DM added that the work needed requires resourcing, to ensure good staff development. We are therefore ensuring as part of the medicines optimization action plan a dedicated OUM who will act as medicines champion to help drive good governance and practice.

AR was assured that we are moving at pace to ensure PGDs are in place, but for CCPs he asked when these will be complete. FM confirmed the aim was to complete these by the end of July. She added that there are no concerns about the way CCPS are operating, although some areas we need to tighten up on.

In summary RF confirmed the Board was impressed with the candour in this report and was assured by the grip there appears to be, and in the way the executive is approaching this as a team; not just with regards medicines but also performance and finance.

51/17 Clinical Outcomes Deep Dive [12.10 – 12.21]

FM confirmed that we are still in the process of analysing clinical outcomes. This paper is therefore a stock take and shows the progress against the AQIs over last 15 months. We are exploring the data and will be in a much better position to identify areas we are doing well.

TP felt that this helps us to begin to understand our data. However, as it is presented in percentages it is difficult to know how to focus resources, so it would help to show numbers of patients too.

TH felt that one of the difficulties is making a judgment based on data 6 months old. He asked if we can see more up to date data so we can see what is happening currently. FM explained the reason why it is 6 months old relates to survival to discharge and so there will always be a time-lag. But going forward we can download defibs to give more real-time data.

AR asked about the second pain score and whether this is a data quality issue or a patient care issue. FM explained that it helps establish the impact of the pain relief given. So is good practice. JG added that this is a culture issue; if we haven't in the past been explicit about the need to record a second pain score then we need to do this so staff know what is expected of them.

LB commented that it has been a very long time since we have been able to have a meaningful discussion about clinical outcomes so this is a positive step forward.

Action:

To bring back a deep dive in to clinical outcomes to the Board in November 2017

52/17 Defib Patient Impact Review [12.21 – 12.22]

JG explained this draws to a conclusion the review as set out in the paper.

The Board noted the paper.

53/17 Audit Committee Escalation Report [12.21 – 12.26]

AS highlighted from the report risk management, commending the progress but noting we still have a way to go to bring about the improvement in the way we manage risk. AS also referred to the IPR confirming that the executive will lead a discussion on IPR at the next meeting, describing what should be included for the Board and what aspects are for Board committees. This will give the Board control over the way the IPR changes.

54/17 QPS Escalation Report [12.26 – 12.29]

LB referred to the management responses where additional assurance was provided.

With regards defibs, LB noted the need for a strategy. Clinical audit continues to be a concern but with FM leadership there is confidence this will be improved.

55/17 Finance & Investment Committee [12.29 – 12.30]

GC confirmed the consideration of the fleet business cases which is on the part 2 agenda. He also fed back that the review of datix was helpful exercise and that the committee had a good discussion on CAD, with assurance on the plans in place.

56/17 Any other business [12.30-12.32]

DH explained each year FTs need to submit their reference costs and the Board needs to approve these. He asked the Board to delegate this authority to the Finance and Investment Committee as in previous years. The Board agreed.

57/17 Review of meeting effectiveness

The Board felt it was an effective meeting.

Questions from observers

Question 1

What is the trust's policy regarding the renewal of older vehicles? I ask this as I was in Burgess Hill on the 3rd June and inspected an older vehicle parked by the Marletts (Burgess Hill). This vehicle reg RJ06 showed extensive minor, long term accident damage and extensive wear and tear with parts of the vehicle held together by duct tape. Surely vehicles of this age and poor state should have been replaced?

I trust that this request is in order. Many thanks.

Foundation Trust Member

JG answered;

The Trust had a replacement policy of 40 cars and 40 DCAs each year. This was paused. But we have in part 2 a business case to replace 42 DCAs. Plus, an additional 53 which are at the end of lease. This puts us with 113 vehicles older than 7 years and a strategy will be developed to ensure vehicles no older than 7 years.

There being no further business, the meeting closed at 12.35pm

Signed as a true and accurate record by the Chair:

Date

DRAFT