South East Coast Ambulance Service NHS Foundation Trust

Trust Board Meeting to be held in public.

29 September 2017

10:00-13:00

Crawley HQ

Agenda

Item No.	Time	Item	Encl.	Purpose	Lead
78/17	10.00	Chairman's introduction	**-**	-	RF
79/17	10.01	Apologies for absence	**-**	-	RF
80/17	10.02	Declarations of interest	**-**	-	RF
81/17	10.03	Minutes of the previous meeting: July 2017	**Y**	Decision	RF
82/17	10.05	Matters arising (Action log)	**Y**	Decision	RF
Organisational culture					
83/17	10.10	Patient story	**-**	Set the tone	
84/17	10.15	Chief Executive's report	**Y**	Information	DM
Trust strategy					
85/17	10.25	Unified Improvement Plan Delivery Progress Update ▪ Organisational Recovery Dashboard ▪ Quality Dashboard ▪ Financial Sustainability Dashboard	**Y** **Y** **Y** **Y**	Assurance	JA JA SL DH
86/17	11.00	Medicines Governance Optimisation Plan	**Y**	Assurance	FM
87/17	11.15	999 Call Recording	**Y**	Assurance	DH
88/17	11.25	Bullying & Harrassment Report Update	**Verbal**	Information	DM
89/17	11.35	STP Update	**Y**	Information	JA
Ten minute Break					
Monitoring performance					
90/17	11.45	Integrated Performance Report	**Y**	Information	DM
91/17	12.25	Serious Incident Annual Report 2016/17	**Y**	Information	FM
92/17	12.35	Clinical Audit Report 2016/17	**Y**	Decision	FM
Holding to account					
93/17	12.45	Escalation report; Workforce Committee	**Y**	Information	TH
94/17	12.50	Escalation report; Quality & Patient Safety Committee	**Y**	Information	LB
95/17	12.55	Escalation report; Audit Committee	**Y**	Information	AS
96/17	13.00	Any other business	**-**	Discussion	RF
97/17	-	Review of meeting effectiveness	**-**	Discussion	ALL
Close of meeting					

Date of next Board meeting: 26 October 2017. After the close of the meeting, questions will be invited from members of the public.

South East Coast Ambulance Service NHS Foundation Trust

Trust Board Meeting, 25 July 2017

Crawley HQ
Minutes of the meeting, which was held in public.

Present:

Graham Colbert	(GC)	Independent Non-Executive Director & Deputy Chair
Daren Mochrie	(DM)	Chief Executive
Alan Rymer	(AR)	Independent Non-Executive Director
David Hammond	(DH)	Executive Director of Finance & Corporate Services
Fionna Moore	(FM)	Executive Medical Director
Jon Amos	(JA)	Acting Executive Director of Strategy & Business Development
Joe Garcia	(JG)	Executive Director of Operations
Lucy Bloem	(LB)	Independent Non-Executive Director
Steve Lennox	(SL)	Executive Director of Nursing & Quality
Steve Graham	(SG)	Interim Director of Human Resources
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

58/17 Chairman's introductions

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

59/17 Apologies for absence

Richard Foster	(RF)	Chairman
Angela Smith	(AS)	Independent Non-Executive Director

60/17 Declarations of conflicts of interest

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

61/17 Minutes of the meeting held in public on 29 June 2017

The minutes were approved as a true and accurate record.

62/17 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.

63/17 Patient story [10.02 – 10.13]

JC explained that following the Board's discussion in June and, as we weren't able to obtain a patient story for this month, we have instead an insight from a member of staff.

DRAFT

The member of staff in the video described pressures on the service and the changing demand to more social and mental health care. He talked about the need to look after staff to ensure they are able to provide good levels of care to patients and improve staff retention.

DM agreed with the insights provided in the video. We definitely need to do more to support staff, which is part of our strategy. JG added that some of the blue-sky thinking referred to in the video includes things like disturbed meal breaks, which we have made good progress on, as well as reducing end of shift overtime. All this helps to improve the working environment.

The Board agreed to intersperse staff insights with patient stories going forward.

64/17 **Chief Executive's report** [10.13 – 10.20]
DM highlighted the following;

- Executive recruitment is underway.
- We have a new CAD now in both Coxheath and Crawley. DM thanked all staff in the successful implementation of this.
- 999 performance dipped in June, which JG will deal with later in the agenda.
- Funding discussions with commissioners are ongoing. DM reflected that 5 of our 22 CCGs are in special measures which highlights the pressure in the system.
- The new ambulance response programme was formally announced since the last Board meeting. We are working up an implementation plan which will come back to the Board in due course.

DM also mentioned the media interviews he gave last week focusing on the future of the Trust and the good work that is ongoing. He confirmed that we have approached Meridian about some inaccuracies they reported. But generally there has been positive feedback from staff regarding the coverage.

There were no questions from the Board.

65/17 **Unified Recovery Plan** [10.20 – 11.03]
JA introduced this item confirming that we are in the process of revising the governance through the PMO. A new culture work-stream has been introduced and this will report through the new delivery plan the Board will receive from September. The governance structure in the paper set outs the emerging thinking and will be developed further.

Recovery:
The continued progress with the projects was noted. JA explained that we are still defining the scope of the Hear and Treat project in light of the new ambulance response programme. Work with the hospital turnaround project, in terms of its specific aim, is progressing well, but we need to revisit the impact on actual delays. In terms of HQ, there are some final actions to work through then it will move in to Phase 2 which will be about the closure of Banstead and plans for Coxheath. Our focus on EPCR has been to roll out ipads. Last week we were at 85% and there is confidence that we will hit our 95% target by the end of July. Our focus will then be to continue getting all hospitals on board by the end of September. In terms of the OU restructure JA confirmed that this is going through the formal closedown process, moving to business as usual. Finally, JA reiterated the success of the CAD moves, as DM mentioned earlier.

GC asked JG how the CAD is bedding down in Coxheath and Crawley. JG explained that it is bedding down well and staff are positive about the new functionalities. The final move will be in the first week in September, from Banstead. In the meantime, we will focus on completing the training. JG added that to aid integration we plan to intermix the dispatch desks. GC confirmed that the Finance Committee looked at this last week and he agreed that the team has managed the new CAD very well.

DRAFT

JG explained ARP will be a significant change, and he outlined some of the new performance targets, which are aimed at helping to ensure more timely response to those in greatest need. DM felt that this will help re-focus on clinical outcomes.

Action:
JG to regularly update the Board on the plan to implement ARP, to include the risks and opportunities

TH referred back to the OU restructure and noted that we have progressed this on time, which is a significant achievement given the previous failed attempts to implement this. He acknowledged the next steps is to deliver the benefits, but felt the Board should acknowledge this achievement, which it did. JG added that some of the feedback is demonstrating a positive impact to-date, but there is a long way to go.

TP asked about the handover project, picking up what JA said about this delivering against the aims of the project but not having any real impact on reducing handover delays. He felt that reporting this as green, while technically correct, is a little misleading and wondered whether we ought to review how this is reported. JA agreed, confirming that the scope of the project is very focused on the process, rather than the patient impact.

Action:
JA to review and refine the handover project to include how we measure the impact on patients.

GC summarised that handover has been an issue for many years and while this project demonstrates what we are doing, the Board needs to continually review this issue until it is fixed.

On the governance structure AR asked whether we should include the cross-cutting nature of ensuring sufficient staff employed, suggesting it is so critical that it ought to be treated as a project in its own right. DM confirmed this will be considered as part of planning for ARP and part of the workforce plan.

Action:
WWC to seek assurance that the workforce plan is established. The plan to come to the Board in October.

Quality:
SL confirmed that the steering group meets weekly. It is in the process of closing down some projects to ensure better focus. There is more green than last month and the main issues continue to relate to:

- Incidents and Sis.
- Medicines Governance
- Patient Care Records
- Clinical Audit

All of these items are under scrutiny by the Quality and Patient Safety Committee.

LB made three points; firstly, with regards the security improvement plan should the extent to which security is where we would want it to be; secondly is it too soon to close down the SI project; and thirdly, some key external deadlines (e.g. medicines optimization action plan) should be included on this dashboard.

DRAFT

Action:
JA to ensure that key external deadlines are included in the dashboard / new delivery plan, for example the deadline for the medicines optimization action plan.

In terms of governance flow, SL explained we will ensure CQC compliance is not lost within the governance structure.

Finance:
DH confirmed that we are on plan at the end of Q1 which is positive given in recent years we have by this time been behind plan. That said, there is significant risk to meeting our control total given the size of the CIP and unresolved negotiations with commissioners. We have £11.2m of fully validated schemes. NHSI are assured with our plans while recognising the size of the task. The QIA process ensures proper consideration to the quality impact, which was considered in July by the Quality & Patient Safety Committee.

LB agreed that the Quality & Patient Safety Committee was assured by a very robust QIA process.

GC reflected that the work we are doing to improve our efficiency demonstrates we are doing our part and noted that the CCGs currently are not.

66/17 **Trust Strategic Plan** [11.03 – 11.10]
DM confirmed this has been to Board a regularly since December 2016 and this is the final draft for approval after 7 months of consultation. JA added that this sets out our five year goals, and our broad direction of travel with greater detail over the next two years. The Delivery Plan is being developed and will come to Board in September. The next steps will be to engage with stakeholders to ensure delivery. It is a live strategic plan not a static strategy, which ensures we are able to respond to the external environment, such as APR.

JC has developed a communication plan which she has shared with the Board and will use this as an opportunity to refresh our corporate branding. The engagement with staff will focus on what this means for staff, patients and our partners.

Action:
Report back to Board in October how the strategy has landed with our internal and external stakeholders.

Decision:
The Board approved the strategy.

67/17 **Board Assurance Framework [**11.10 – 11.17]
PL explained that this version of the Board Assurance Framework (BAF) aligns to the 5-year strategic goals just approved as part of the strategy, and helps the Board understand the risks to achieving those goals. It is considered by the Board every quarter and at each meeting of the Audit Committee and Executive Risk and Assurance Group.

The next step is to review it in more detail at the next Audit Committee and going forward the movement in risk will help the Board to understand the likelihood of the Trust achieving its objectives; to be considered alongside the delivery plan.

DRAFT

TH asked about objective 8 and whether the controls are such that they realistically reduce the risk to 12, especially given the work still outstanding on funding.

Action:
In its review of the BAF the Audit Committee to agree the risk scores.

Comfort break 11.17-11.30

68/17 **Integrated Performance Report** [11.46-12.22]
[taken after item 70/17]

Workforce:
SG took the paper as read, highlighting the increase in vacancy rate and the plans to improve this, as part of the various department restructures. He also confirmed that sickness absence remains under control.

TH asked about the appraisal rate of 4.7% (on the dashboard) and how we can report this more clearly given it only relates to appraisals formally reported on Actus. TH also asked about training figures and SG explained this might be underreporting.

Action:
Workforce and Wellbeing Committee to scrutinise the training figures reported in the IPR and agree how best to report completion of Appraisals

LB raised concern about the vacancy rate in support services. SG explained some of the 25% is covered by interims/agency.

Action:
IPR to include greater detail about vacancy rates, to ensure clarity on the true number, especially if we are reporting a vacancy when it is covered on an interim/agency basis.

LB asked about the balance between having good management grip and control, and being nimble with recruitment. DH explained we have refined the progress again and he and SG meet weekly to review all requests to fill vacancies. If there are urgent vacancies, then we can and do respond outside of the process. This will be kept under review and will release some control when appropriate to do so.

Action:
Workforce & Wellbeing Committee to seek assurance that the process for approving the recruitment of vacancies is sufficiently nimble and not too bureaucratic.

On physical assaults LB noted the trend of increasing numbers and asked is this is being understood. SG confirmed some of this relates to improved reporting.

DRAFT

GC asked whether we should be worried that we aren't getting any whistleblowing cases. SG didn't think so especially in the context of the huge response to the bullying and harassment review and other reporting lines, including 'speak up in confidence'.

Operational Performance:
JG explained that he is extremely disappointed with June's performance, in particular Red 2, despite resourcing to forecasted activity. That said, we did hit commissioned trajectories during Q1. The downward trajectory through June is being monitored closely by the executive; it approved in early July an additional DCA overnight in every dispatch area which is starting to show a benefit.

[FM left the meeting - 12.00]

We are continuing to see improvement in see and treat activity. There are 2000 more incidents than in same period last year. See and convey has levelled-off. We are looking at the impact of introducing more DCAs on conveyance rates. In terms of sickness levels, this has been at a sustained rate since February which is significantly better that in the same period last year. JG noted that this coincides with the improvements in meal breaks and end of shift overtime.

TH asked about performance for July and JG confirmed that it is very similar to June so on downward trajectory. This dip was forecast due to the impact of new CAD (4% dip) and so is consistent and suggests there isn't a different underlying issue.

JG highlighted concern with call answering concern, despite being at establishment. He explained that the impact of the new CAD training has been greater than expected, in large part due to staff not taking up overtime due to longer travel time (of them living further away following the move to Crawley). We are trying to mitigate this as best we can, but against the background of training two cohorts of staff each day. This has a knock-on to Red 1 performance. Average call handling is 10 seconds, but we are seeing an increase in those over two minutes and abandoned calls. JG explained what we have done, including having a dedicated manager in EOC to ensure continued focus, and changing the way we queue the calls. In summary, SG believed that we will start to show improvement after the end of training for new CAD but warned the next risk will be the training needed for ARP.

GC reflected that this is clearly a complicated picture. He felt that the executive need to help the Board understand this; what we have agreed with commissioners and what mitigating steps are being taken. Including helping the Board to understand what is safe. DH agreed and confirmed that we have been explicit with commissioners about our view on what is safe, in context of what trajectories the funding allows.

TP asked about what we are accountable for compared the wider system. He explained that we can't deliver performance if for example handover delays don't improve or get worse.

Action:
Allow more time for the Board to understand the performance issues discussed at the meeting in July.

Quality:
Much of this has been covered already. SL added that we are at 18% for Safeguarding Level 3 training and confirmed that the duty of candour compliance figures set out in the report includes an internal 10-day standard. If we remove this, then we are 100% compliant.

DRAFT

Finance:
DH confirmed that there is good control in matching hours to what we are commissioned to provide. Q1 is on plan. We have delivered the CIP target to-date through really good engagement, which is positive. In terms of sustainability, our capital spend is behind plan due to phasing as described last month. By September we will review the forecast and cash balance. The use of resource rating is on track at level 3 (last year was 4 which is the lowest) which is what we planned for. In summary, DH confirmed that we are cautiously optimistic at the end of Q1 and acknowledge the challenges.

Decision:
Although there is no Board meeting in August, a copy of August's IPR to be circulated to members for information

69/17 Medicines Management Progress Update [11.30-11.37]
[Taken after comfort break]

FM set out the areas we have made progress and highlighted;

- Omnicells we are utilising much better.
- There is much work on controlled drugs, amending policy and with education to help change the culture in managing medicines more generally.
- We have improved how we dispose of controlled drugs and recently was held up as best practice at recent CDLIN meeting.
- PGDs have been reviewed, although some work still to do with PGDs for CCPs.
- Significant issue on temperature control which we are improving.

FM reminded the Board of the issues CQC highlighted following its recent inspection and confirmed that we have developed an action plan to deliver the improvements by 22 September 2017. The executive will be monitoring this closely.

GC asked for further clarity on what the main issues are in the action plan. FM confirmed they include;

- A review a number of policies to ensure proper guidance to staff
- Ensuring we store and secure medical gases is correct
- CDs – how we manage and carry them / reduce breakages
- Temperature monitoring.

LB acknowledged that 22 September 2017 is a challenging timeframe. FM agreed, especially in context of the culture change needed which we are working very closely with operations to resolve. This requires ownership at OU level. JG confirmed we have nominated an OU manager to support this and a team leader at every unit to ensure a consistent approach to managing medicines.

70/17 SI Management Update [11.37-11.46]
FM confirmed that we now have senior SI lead to ensure we take forward the improvement in the management of and learning from SIs. We also have weekly reviews of potential SIs and incidents currently under investigation. The increase in training has been maintained ensuring larger numbers of staff supporting investigations; moving away from just RCA trained staff investigating. The more specialist staff who are RCA trained will act as support to staff staff.

FM explained a change to the paper as there are now 14 investigations with CCGs today for closure.

DRAFT

LB confirmed that the Quality & Patient Safety Committee scrutinises this area and is content that we are moving in the right direction.

AR asked whether the committee looks at the nature of and themes of Sis. LB confirmed it does through the quarterly report, with lessons learnt, although we have now asked for this to include a specific summary of each SI as an appendix. SL added that operationally SIs are looked at every week and FM went on to explain that we now consider mortality and morbidity focusing on specific topics; recently there was a deep dive of incidents involving children under 2 to see what themes could be identified. This is the first of a series of deep dives, bringing together incidents, complaints, operations etc. Having attended this mortality and morbidity meeting, LB reflected her positivity about this approach helping to ensure learning.

GC summarised that the Board expects improvement in the backlog of SIs and general management of incidents. DM agreed that we need to demonstrate the continued improvement we are seeing.

71/17 Infection Prevention and Control Annual Report [12.22. – 12.24]
SL noted the really good progress made over the year as set out in the report. This is much improved since the CQC findings in May 2016. SL did note a dip in Q1 of this year around hand hygiene and this will be closely monitored to establish any trend.

The Board noted the report.

72/17 WRES Annual Report [12.24 – 12.50]
Yvonne Coghill Director of WRES at NHSE, and Habid Naqvi, Policy Lead) joined the meeting for this item. They talked to the power point presentation.

The positive difference in WRES results in 2017 compared to the year before was noted with Yvonne challenging the Trust to seek to understand how this improvement was made. SG agreed that it is good we have made progress and committed to exploring how this was achieved.

DM thanked Yvonne and Habid for their presentation and highlighting the importance of this and the positive impact it can make.

The Board noted the annual report.

Action:
Workforce and Wellbeing Committee to seek assurance that there is sufficient focus and resource to ensure delivery of the objectives in the Workforce Race Equality Standards Action Plan 2017-18.

73/17 WWC
No meeting

74/17 QPS Escalation Report [12.50 – 12.52]
LB highlighted the areas of focus as set out in the report.

75/17 Finance & Investment Committee [12.52 – 12.53]
GC highlighted the change in risk profile relating to consequences of not closing negotiations with CCGs and referred to the other areas listed in the report.

76/17 Any other business [12.53-12.54]

DRAFT

None.

77/17 Review of meeting effectiveness

The Board felt it was an effective meeting. However, it felt more time is needed to ensure fuller discussion and asked that the executive is clearer about the issues and / or what it is recommending to the Board to ensure more focused discussion.

Questions from observers

Question 1
From a Trust Member:
Last week I watched the KCC HOSC meeting. It was stated that £450k per month extra had been made available to SECAmb to provide for the additional 999 services (not G4s) that this change will incur.

Q1 -Will G4S will still provide inter hospital transfers?
JA explained the split between PTS confirming that we attend the more clinically unwell for those needing emergency transport.

Q2 - Is this to cover the longer journey times for new critically ill patients?
JA confirmed it is and the funding recognises the increased journey times.

Q3 - Will ARP reduce the number of multiple attendances? Will the above sum be revised?
JA confirmed this is still to be decided.

Q4 - Will this additional time requirement mean that more PP's and CCP's (or similar grade) be deployed in East Kent?
JA explained that it is a mix of staff.

Q5 - If so how many by grade?
As Q4 above

Q6 - Likewise, SECAmb vehicles?
JA confirmed it will be a mix with PAPS

Q7 - Will this in the light of recruitment /retention mean greater use of agency vehicles and crew across SECAmb?
As above

Q8 - Has there been any improvement in Handover times at the EKUFT Hospitals?
Some improvement in lead up to change but not sustained.

Question 2
It is my understanding from this financial year, Ambulance Paramedic and Technician (Associate Practioner) Training has been standardised and financed through the National Apprenticeship Scheme (NAS). Can you confirm you have you advised your education providers of the schemes requirements in accordance with guidelines (attached) issued by the external auditor Health Care Professionals' Council (HCPC)? Failure could mean central NHS funding could be withdrawn.

DRAFT

SG explained that he Trust will be providing the Apprenticeship for the Level 4 AAP course under the FutureQual standards and framework, starting in October. We have been working with colleagues from other Trusts and the College of Paramedics to ensure the qualification is fair, robust and of a standard acceptable to our HEI providers. We are also exploring the RPEL route for our existing Technicians, in order for them to achieve the Level 4 AAP qualification, as an entry route to university. We anticipate that this will mean a course of approximately 10 weeks for this group of staff and hopefully we will be able to run the first cohort this year. Staff will need the minimum GCSEs in English and maths and potentially 3 other subjects depending on the university.

There being no further business, the meeting closed at 13.01pm

Signed as a true and accurate record by the Chair: ___________________________

Date ___________________________

DRAFT

South East Coast Ambulance Service NHS FT action log

Meeting Date	Agenda item	Action Point	Owner	Target Completion Date	Report to:	Status: (C, IP, R)	Comments / Update
30.05.2017	31 17	A report to the Board in Autumn setting out how the Trust is ensuring learning from complaints, incidents, SIs etc.	SL / FM	26.10.2017	Board	IP	
29.06.2017	45 17	Ipad business case to be reviewed by Finance and Investment Committee in October 2017.	DH	26.10.2017	FIC	IP	
29.06.2017	51 17	To bring back a deep dive in to clinical outcomes to the Board in November 2017	FM	29.11.2017	Board	IP	**25.07.17: GC asked if this could be brought to the Board earlier than November. FM confirmed potentially in September.**
25.07.2017	65 17	JG to regularly update the Board on the plan to implement ARP, to include the risks and opportunities	JG	29.09.2017	Board	C	**ARP is part of the Unified Improvement Plan (under Service Transformation) and so will be picked up under this item**
25.07.2017	65 17	JA to review and refine the handover project to include how we measure the impact on patients.	JA	29.09.2017		IP	**System working group has been established to review quality metrics and resulting actions. Daily, weekly and monthly metrics are being provided to CCGs and regulators**
25.07.2017	65 17	WWC to seek assurance that the workforce plan is established. The plan to come to the Board in October.	SG	26.10.2017		IP	
25.07.2017	65 17	JA to ensure that key external deadlines are included in the dashboard / new delivery plan, for example the deadline for the medicines optimization action plan.	JA	26.10.2017		IP	
25.07.2017	66 17	Report back to Board in October how the strategy has landed with our internal and external stakeholders.	JA	26.10.2017		IP	
25.07.2017	67 17	In its review of the BAF the Audit Committee to agree the risk scores.	PL	29.09.2017		C	**The BAF was reviewed by the Audit Committee at its meeting in Sept.**
25.07.2017	68 17	Workforce and Wellbeing Committee to scrutinise the training figures reported in the IPR and agree how best to report completion of Appraisals	SG	26.10.2017		IP	
25.07.2017	68 17	IPR to include greater detail about vacancy rates, to ensure clarity on the true number, especially if we are reporting a vacancy when it is covered on an interim/agency basis.	SG	26.10.2017		IP	
25.07.2017	68 17	Workforce & Wellbeing Committee to seek assurance that the process for approving the recruitment of vacancies is sufficiently nimble and not too bureaucratic.	SG	26.10.2017		IP	
25.07.2017	68 17	Allow more time for the Board to understand the performance issues discussed at the meeting in July.	PL	29.09.2017		C	**Scheduled agenda to allow 40 minutes**
25.07.2017	72 17	Workforce and Wellbeing Committee to seek assurance that there is sufficient focus and resource to ensure delivery of the objectives in the Workforce Race Equality Standards Action Plan 2017-18.	SG	29.09.2017		C	**Added to forward plan**

South East Coast Ambulance Service NHS
NHS Foundation Trust

		Item No	84/17
Name of meeting	Trust Board		
Date	29.09.2017		
Name of paper	Chief Executive's Report		
Executive sponsor	Chief Executive		
Author name and role	Daren Mochrie		
Synopsis (up to 120 words)	The Chief Executive's Report provides an overview of the key local, regional and national issues involving and impacting on the Trust and the wider ambulance sector.		
Recommendations, decisions or actions sought	The Board is asked to note the content of the Report.		
Does this paper, or the subject of this paper, require an equality analysis ('EA')? (EAs are required for all strategies, policies, procedures, guidelines, plans and business cases).	Yes / **No**		

SOUTH EAST COAST AMBULANCE SERVICE NHS FOUNDATION TRUST

CHIEF EXECUTIVE'S REPORT TO THE TRUST BOARD

August & September 2017

1. Introduction

1.1 This report seeks to provide a summary of the key activities undertaken by the Chief Executive and the local, regional and national issues of note in relation to the Trust.

2. Local issues

2.1 Recruitment to the Executive Team

2.1.1 During late July and early August, interviews took place for the substantive posts of Director of Operations, Director of HR & OD, Director of Nursing & Quality and Director of Strategy & Business Development.

2.1.2 Unfortunately, we were not able to make appointments to either the Director of HR & OD and Director of Nursing & Quality roles. We were also unable to make a substantive appointment to the Director of Strategy & Business Development position, as we did not find a candidate with the right level and breadth of experience. However, recognising the good job that he has been doing for us during the past 16 months, I asked Jon Amos to continue in the role of Interim Director of Strategy & Business Development. Steve Lennox Interim Director of Nursing & Quality and Steve Graham Interim Director of HR & OD will continue in these roles.

2.1.3 I am pleased to report that, following the interview and assessment process, the appointment of Joe Garcia into the substantive role of Director of Operations was announced on 3rd August 2017.

2.1.4 Whilst disappointing that we were not able to make appointments into all roles, it was most important for us to have the right people in terms of skills and experience in these key roles.

2.1.5 The roles of Director of HR, Director of Quality and Director of Strategy & Business Development are currently being re-advertised. The closing date for these roles is 1st October 2017 and we will be looking to hold interviews in late October/early November.

2.2 Banstead EOC move to Crawley

2.2.1 On 5th September 2017, Emergency Operations Centre (EOC) staff from Banstead re-located into the new EOC West at Crawley to join their colleagues from Lewes EOC.

2.2.2 The move went very smoothly, which was down to a great deal of hard work by all of the staff involved.

2.2.3 This move marked the final phase of not only the physical EOC move but also the transition to the new CAD system. This has been a massive undertaking, including training more than 500 staff on the new CAD but it is a real credit to everyone involved that it has been accomplished safely and on time, whilst continuing to deliver a service to our patients.

2.2.4 A small number of staff, including Clinical Education and Fleet & Logistics, are currently continuing to operate out of the Banstead site.

2.3 Response to Professor Duncan Lewis report

2.3.1 On 4th August 2017 the Trust published the full and summary reports into bullying and harassment within SECAmb that we had commissioned from Professor Duncan Lewis, a recognised expert in this area. The publication led to some difficult media coverage for the Trust.

2.3.2 Around 2,000 staff participated in the research undertaken by Professor Lewis, with more than 40% of those who responded reporting some experience of bullying in the last 12 months. The report also included a range of poor behaviours and cultural issues experienced by staff.

2.3.3 Following publication, staff attended 58 focus groups during August and early September 2017, led by Exec Directors, to discuss the themes identified in the report and suggest actions to be taken in response. The input from staff through the focus groups has been tremendous and a whole raft of suggestions have been made as to how we tackle the issues raised in the report.

2.3.4 This feedback is being developed into an action plan, which will be presented to the October Trust Board meeting.

2.4 CQC

2.4.1 The draft CQC inspection report into the KMS111 service was received by the Trust on 26th July 2017. The Factual Accuracy check has been completed on this report and was returned to the CQC on 8th August 2017.

2.4.2 The draft CQC inspection report into the wider Trust was received by the Trust on 31st August 2017. The Factual Accuracy check has been completed and was returned to the CQC on 12th September 2017.

2.4.3 Both reports are likely to be published by the CQC in early October 2017.

2.5 Operational Performance

2.5.1 The Executive Team are continuing to closely monitor 999 performance on a weekly basis. The Director of Operations has brought in additional expertise under the auspices of the Association of Ambulance Chief Executives to review our EOC working practises and operating model now that we have made the changes to EOC configuration. We have also engaged expertise from other Ambulance Trusts to assist us with our forecasting and resource modelling.

2.5.2 In addition to this we are continuing to work with the rest of the system to see how we can make existing referral pathways more robust and open up more referral pathways to reduce the time crews spend on scene undertaking a see and treat and we are also working on ways to reduce handover delays at Emergency Departments. In addition to this we have agreed additional funding with commissioners and this will be targeted at periods of high demand; all of which will mean more available ambulances to respond to calls and improve performance.

2.6 Ambulance Response Programme (ARP) up-date

2.6.1 On 11th July the Trust took a big step forwards in preparing for the go-live of the Ambulance Response Programme in SECAmb when we started training for EOC staff on 13th September 2017 in preparation for the go live of the final phase of ARP on 22nd November.

2.6.2 Between 13th September and 17th November we are training 430 EOC staff, as well as a small number of other staff; this involves one day's training for Dispatchers, whilst the training for EMAs is being delivered with training for the upgrade of NHS Pathways.

2.6.3 The go-live of ARP will see a reclassification of some emergency calls and the introduction of new response time standards, as below:

- Category One – 7-minute response in 50% of incidents and 15 minutes in 9 out of 10 cases for transport
- Category Two – 18-minute response in 50% of incidents and a 40-minute response in 9 out of 10 cases for transport
- Category Three – 120-minute response for 9 out of 10 cases for transport
- Category Four – 180-minute response for 9 out of 10 cases for transport

2.6.4 Further modelling will take place in the Spring once a full set of national data is available to establish how the system can be improved even further through targeted See and Treat and Hear and Treat activities as opposed to just transportation.

2.6.5 The findings from the national pilot undertaken by six ambulance Trusts has indicated that the move to ARP will help us to get the right resource to our patients to meet their clinical need, in a timeframe that is appropriate to their condition; this will require a different operational response model in the future.

2.6.6 We have agreed £1m of additional funding with our local Clinical Commissioning Groups (CCGs) to support changes required in the preparation for go-live.

2.6.7 The Trust has already started to deliver a comprehensive internal and external communications plan to support the go-live of ARP, to ensure that key stakeholders are well sited on the changes.

2.7 Changes to Senior Operational Leadership team

2.7.1 On 12th September 2017, Director of Operations, Joe Garcia, announced that further to the re-location of Banstead EOC staff into Crawley, we would also now reflect the East and West configuration in our operational management structure.

2.7.2 Ahead of a full restructure likely to take place next year, the Trust moved to the following structure as of 18th September 2017 in a move away from the historical, county structures to a SECAmb East and West model.

2.7.3 This required some re-shaping of the previous operational areas, as below:

SECAmb East	SECAmb West
• Medway & Dartford • Paddock Wood • Ashford • Thanet • Polegate & Hastings	• Chertsey • Guildford • Gatwick & Redhill • Brighton • Tangmere & Worthing

2.7.4 Changes have also been made to the senior operational management structure to support this move.

3. Regional issues

3.1 Withdrawal of Fire & Rescue Services from co-responding pilot

3.1.1 On 18th September 2017, the Trust was informed that fire service personnel would be withdrawing from co-responding pilots in West Sussex and Surrey. Kent would continue with the pilot, albeit in a potentially reduced capacity. This was due to the Fire Brigade Union (FBU) withdrawing its support nationally from co-responding pilots.

3.1.2 The Trust is continuing to monitor the impact locally.

3.2 Sustainability and Transformation Partnership (STP) up-date

3.2.1 The Trust is continuing to participate in the four STPs within our region. As part of this, we are working with the STPs on transformation funding, as well as with our regional CCGs on a demand and capacity review to secure longer- term agreement on the model of care and appropriate funding to support this.

4. National issues

4.1 Change to national threat level

4.1.1 On 15th September 2017, the Government announced that the national threat level was increasing to Critical, following the terrorist attack at Parsons Green Station in London; this was communicated to all staff.

4.1.2 The threat level was subsequently lowered to Severe on 17th September 2017, although we are continuing to remind all staff of the need to remain vigilant and take all necessary precautions.

5. Recommendation

5.1 The Board is asked to note the contents of this Report.

Daren Mochrie QAM, Chief Executive

19th September 2017

South East Coast Ambulance Service NHS
NHS Foundation Trust

	Agenda No	85/17

Name of meeting	Trust Board
Date	29 September 2017
Name of paper	Unified Improvement Plan Delivery Progress
Responsible Executive	Jon Amos, Acting Director of Strategy and Business Development
Author	Eileen Sanderson, Head of PMO
Synopsis	This paper provides an update on the Unified Improvement Plan, including progress made in relation to how this is supported and changes to the governance structure to oversee programme delivery.
Recommendations, decisions or actions sought	• To note the continued progress made in relation to the PMO improvements • To note the proposed programme information flow • To review the dashboards to be fully sighted on the current progress of the UIP • To note the re-framing of the Unified Recovery Plan to Unified Improvement Plan (UIP)

Does this paper, or the subject of this paper, require an equality impact analysis ('EIA')? (EIAs are required for all strategies, policies, procedures, guidelines, plans and business cases).	**No**

Unified Recovery Plan Delivery Progress

1. Introduction

1.1 This paper provides the Board with a summary of the progress of the Programme Management Office (PMO) and highlights a number of updates in relation to governance.

1.2 The purpose of the paper is to ensure the Trust Board is sighted on a number of key governance updates, the progress against the various work-streams and, in particular, notable risk areas.

2.0 PMO and Governance update

2.1 The PMO until recently has been focused on the delivery of the Unified Recovery Pan which sets out the recovery trajectory for the Trust. The Five Year Strategic Plan (2017 – 2022) has now been developed to build on this work to ensure that the Trust continues to improve quality for patients, deliver improved performance and to meet financial targets. The impact this has on the PMO programme information flow is that the existing steering groups will be amended to reflect the refreshed strategy (see appendix A)

2.2 There will now be four Steering Groups that the PMO will support; Compliance Steering Group, Service Transformation & Delivery Steering Group, Culture and Organisational Development Steering Group and Sustainability Steering Group. Over the coming weeks, work will continue to align the existing projects to this new governance structure. To ensure that visibility and grip on the project continues, each Steering Group will continue to have an Executive Sponsor which will feed into Turnaround Executive on a weekly basis.

2.3 Programme Risks for all the URP programmes will continue to be monitored through the Trust Risk Management system Datix with the Executives having sight of the top risks on a monthly basis.

3.0 URP Progress and Risks

Organisational Recovery Programme

3.1 The Organisational Recovery Steering Group has now been disbanded and the projects that were aligned to this group have now been mapped across to the newly established Steering Groups.

3.2 The Electronic Clinical Patient Record project (ePCR) will now be reporting into the Digital Project Board which will feed into the Sustainability Steering Group. Hear and Treat, Ambulance Response Programme (ARP) and Hospital Handover will feed into the Service Transformation & Delivery Steering Group.

3.3 Project Boards have now been established for the Increased Hear and Treat and ARP projects to ensure that key milestones are achieved and progress is closely monitored. Project mandates has now been developed and awaiting sign off.

3.4 All three CQC 'Must and Should Do's' projects; Security Improvement Plan, Safe Resource Dispatch and Staff and Resourcing Improvement Plan have now been formally closed.

3.5 Good progress continues to be made with the on-boarding of ipads. Currently, 92% of users have on-boarded. Focus continues on working with the hospitals who have not yet accepted ePCR.

3.6 *CAD*

Each of the three-phased go lives have now been completed with the users from Banstead EOC relocating to Crawley on Tuesday 5th September and switching over to the new Cleric CAD system. As part of the switchover, testing and switchover of the with the final NHS 111 provider (South Central Ambulance Service) was completed.
The migration onto Cleric has been very smooth during each go live with only a small number of issues being reported, which Cleric have been investigating and resolving. Feedback from staff has been very positive with users being enthused about the new system and ICT staff commenting that this has been one of the smoothest go lives that they have been involved with.

Next steps for the Project team is the decommissioning of the VisiCAD system; following this, several servers will be re-commissioned to provide additional levels of resilience for the new Cleric platform. The existing Infrastructure at Banstead will then be relocated to Crawley and a full system (site) failover will be conducted.

Quality Programme

3.7 Over the coming weeks, the PMO will be establishing task and finish groups to ensure pace and traction is maintained to address the CQC actions. Each group will be led by an Executive. See below the breakdown of the groups with associated leads:

Theme	Director Lead
Incidents (Incidents, Datix, Serious Incidents, Duty of Candour)	Steve Lennox
Medicines Management	Fionna Moore
999 Call Recording	David Hammond
Safeguarding	Steve Lennox
Risk	Steve Lennox
Clinical Records & Clinical Audit	Fionna Moore
EOC	Joe Garcia
Performance & AQIs	Joe Garcia & Fionna Moore
Complaints	Steve Lennox
Policies	Daren Mochrie

3.8 Each Task and Finish group will report weekly to the Compliance Steering Group to ensure pace and traction. Any escalations will be fed into the weekly Turnaround Executive meeting.

Financial Sustainability

3.9 The CIPs Team, in discussions with Execs/Budget Holders/CIP Project Leads, have now identified £14.7m of fully validated CIPs schemes against the target of £15.1m. Further potential schemes have been identified and are in the course of development.

The Team is now starting to focus on CIPs for 2018/19 and have outlined a plan to the Turnaround Executive Committee.

Culture and Organisational Development

4.0 In light of Duncan Lewis' report, focus groups are being delivered across the region with a report on the thematic analysis of the key themes to be produced at the end of the month.

An action plan is being developed which will highlight the areas of focus. To support effective project management and assurances, a Culture and Organisational Steering group will be re-established (it is currently paused) once priorities have been re-aligned.

5.0 URP Dashboards

5.1 A series of Dashboards / exception reports are provided;

Appendix B Compliance (CQC Must Dos)

Appendix C Service Transformation & Sustainability

Appendix D Cost Improvement Programme

6.0 Summary

6.1 This paper provides the Board with a summary of notable updates in relation to the PMO and progress against the URP. Progress continues to be made with increased control and grip over delivery.

7.0 Recommendation

7.1 The Board is asked to note the paper and discuss the appendices with specific attention to the Dashboards and Exception Reports.

7.2 The Board is asked to continue to support the programme governance and controls introduced to provide enhanced grip and provide assurance on delivery.

7.3 Following the developments outlined in this paper, the Trust's URP will now be the Unified Improvement Plan to reflect the programmes of improvement within our refreshed five-year strategy.

South East Coast Ambulance Service NHS
NHS Foundation Trust

Proposed Programme Information Flow

External Groups

- CQC
- NHSI
- Partnerships
- Single Oversight Group

CQC
Frequency: Monthly
Document requirements:
- CQC Dashboard and QSG Risk Register
- CQC Must / Should Do Action Plans
- Exception Report (as required)

NHSI, Partnerships & Single Oversight Groups
Frequency: Monthly
Document requirements:
- Programme Dashboard
- Programme Risk Log
- Exception Report (if required)

Internal Groups

- Trust Board
- Board Committees
- Risk and Assurance Executive Management Board
- Turnaround Executive

Board Committees
Frequency: Bi-monthly
Document requirements:
- See next page

Trust Board
Frequency: Monthly
Chair: Richard Foster
Document requirements:
- Programme Dashboard
- Programme Risk Log
- Summary / Exception Report

Risk and Assurance Executive Management Board
Frequency: Monthly
Chair: Daren Mochrie
Document requirements:
- Programme Dashboard
- Programme Risk Log
- Summary / Exception Report

Turnaround Executive
Frequency: Weekly
Chair: Daren Mochrie
Document requirements:
- Escalation Logs from Steering Groups
- Programme Risk Log
- Steering Group Dashboards

Steering Groups
Frequency: Weekly
Document requirements:
- Dashboards
- Highlight reports
- Steering Group Risk Logs
- Action Plans and Action Logs

Programme workstreams

Compliance Steering Group Patients
- CQC Must & Should Dos
- Infection Control
- First Responders- Public Access Defibrillators (PAD)
- Health, Safety & Welfare

Service Transformation & Delivery Steering Group Patients
- Increased Hear & Treat *Project Board*
- Demand & Capacity Review
- Hospital Handover (enabling) *Project Board*
- Ambulance Response Programme *Project Board*
- 999/111 Integration

Culture and Organisational Development Steering Group People
- Engagement Values and Behaviours
- Effective Leadership and Management
- Appraisals
- Health and Wellbeing
- Clinical Education

Sustainability Steering Group Enablers
- Financial Sustainability
- Digital
- Fleet
- Estates

Your service, your call

DRAFT

South East Coast Ambulance Service NHS
NHS Foundation Trust

Governance

The below structure illustrates how the proposed Steering Groups will align to the Committees

Committees

Audit Committee
- *Governance and Quality Systems*

Quality and Patient Safety Committee (Patients)
- *Governance and Quality Systems*
- *Integrated Urgent Care*
- *Clinical Service Model*
- *Clinical Outcomes and Performance*

Workforce and Wellbeing Committee (People)
- *Engagement Values and Behaviours*
- *Effective Leadership and Management*
- *Appraisals*
- *Health and Wellbeing*

Finance and Investment Committee (Enablers)
- *Financial Sustainability*
- *Digital*
- *Fleet*
- *Estates*

Steering Groups

- *Compliance Steering Group Patients*
- *Service Transformation & Delivery Steering Group Patients*
- *Culture and Organisational Development Steering Group People*
- *Sustainability Steering Group Enablers*

Workstreams

Compliance Steering Group:
- *CQC Must Dos*
- Infection Control
- Health, Safety & Welfare
- First Responders/ Public Access Defibrillators (PAD)

Service Transformation & Delivery Steering Group:
- Increased Hear & Treat *Project Board*
- Demand & Capacity Review
- Hospital Handover (enabling) *Project Board*
- Ambulance Response Programme *Project Board*
- 999/111 Integration

Culture and Organisational Development Steering Group:
- *Engagement Values and Behaviours*
- *Effective Leadership and Management*
- *Appraisals*
- *Health and Wellbeing*
- *Clinical Education*

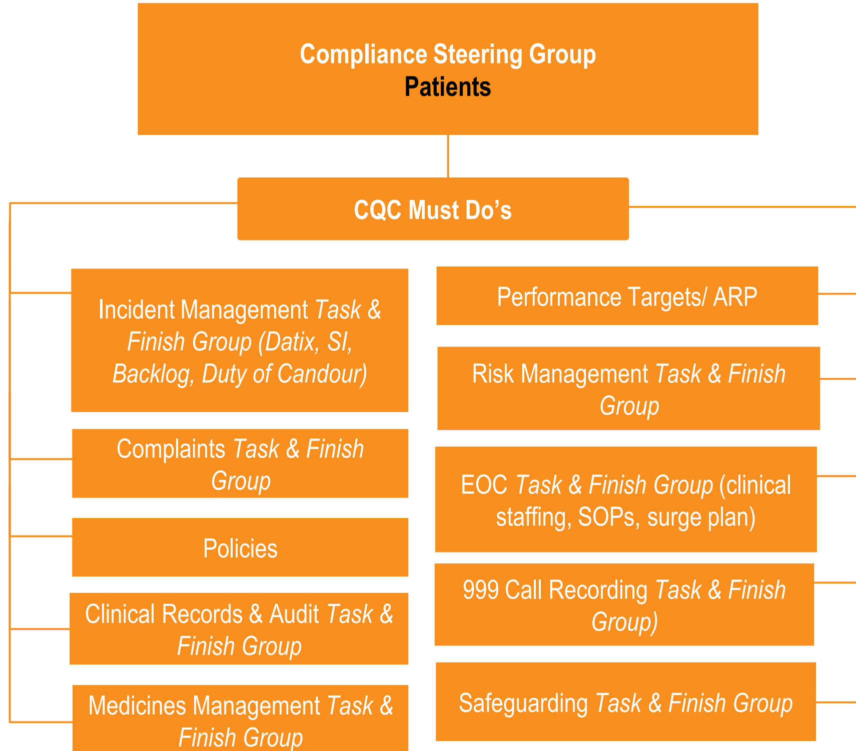
Sustainability Steering Group:
- *Financial Sustainability*
- *Digital*
- *Fleet*
- *Estates*

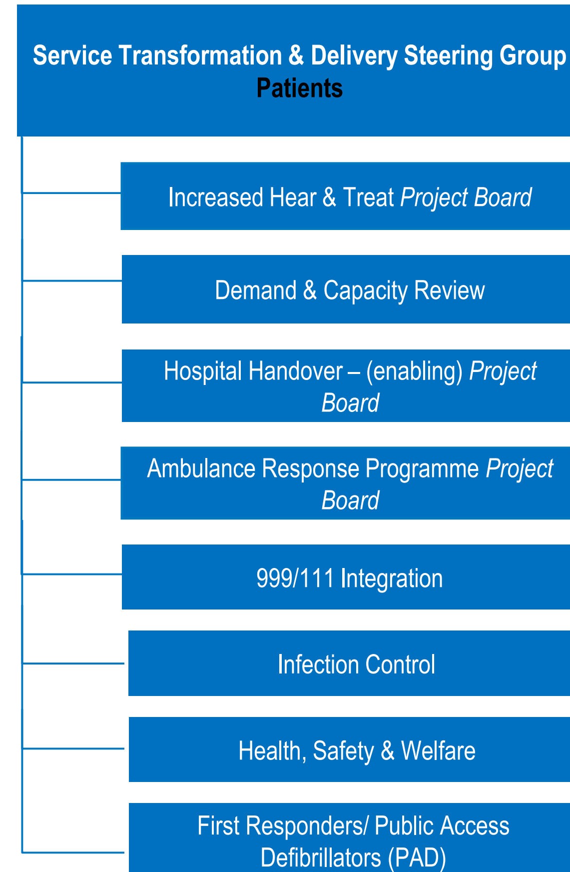
Your service, your call

South East Coast Ambulance Service

NHS Foundation Trust

Project Level Governance





Your service, your call

Project Level Governance (Cont'd)

Culture and Organisational Development Steering Group
People

- Engagement Values and Behaviours
- Effective Leadership and Management
- Appraisals (PDR, Key Skills, Statutory and Mandatory training)
- Health and Wellbeing
- Clinical Education

Sustainability Steering Group
Enablers

- **Estates**
  - Trust HQ (Phase 2) *Project Board*
- **Fleet**
- **Financial Sustainability**
  - Cost Improvement Programme
- **Digital**
  - Electronic Patient Clinical Record (ePCR) *Project Board*
  - Informatics/ CAD
  - Emergency Services Mobile Communications Programme (ESMCP) *Project Board*

Objectives

South East Coast Ambulance Service NHS
NHS Foundation Trust

	Our People	Our Patients	Our Enablers	Our Partners
Our two year objectives	With the support and engagement of staff and volunteers, refresh the Trust values and behaviours.	Develop and deliver a clinically led process to prioritise patient need at the point of call, increasing referral to alternative services where clinically appropriate.	Ensure our services are efficient and sustainable and that they are supported by appropriate levels of funding.	Work with STPs to achieve the best care for our patients through emerging local out of hospital care systems
	Develop effective leadership and management at all levels, through our new selection, assessment and development processes.	Further integrate and share best practice between NHS 111 and 999 services, striving for Integrated Urgent Care service where this is considered viable.	Develop and deliver a digital plan which supports integration with the health system and enables the clinical model and our approach to continuous improvement.	Work with STPs to design and deliver generalists and specialist care pathways for patients requiring an acute hospital attendance
	Ensure all staff and volunteers have clear objectives, and a plan for their development, set through regular appraisal.	Further improve and embed governance and quality systems across the organisation, building capacity and capability for continuous improvement.	Ensure that our fleet is fit for purpose and supports the clinical model.	Work with education and STP partners to develop career pathways that support our staff to make effective clinician decision making
	Improve staff and volunteer health and wellbeing.	Improve clinical outcomes and operational performance, with a particular focus on life threatening emergencies.	Ensure that our estate is fit for purpose and supports the clinical model.	Work with blue light partners to ensure collaboration supports patients outcomes and efficient service delivery

Your service, your call

South East Coast Ambulance Service

CQC Dashboard - September 2017

Domain	CQC Work stream	CQC Must Do	Confidence of delivery on time and realising benefits	Project lead	Executive lead	Progress summary	Project completion date
Safe	Incidents	7. Incident and SI Reporting Improvement Plan	On Target	Samantha Gradwell	Steve Lennox	The new Head of Risk joined the Trust in July 2017 and has taken on the lead role for the project. Priorities for the month of August have involved gaining a comprehensive understanding of the incidents and SIs process and the challenges that currently exist. A number of key changes have been implemented to the incident reporting timeframes to assist with understanding how many incidents are actually considered overdue and to align with leading incident processing practice from other Trusts. Priorities for the next period remain focused on resolving the backlog of both incidents and SIs, and developing a work programme to establish a reporting culture within the Trust, starting from the Board and cascading throughout the organisation	Undergoing re-scoping, timeframes to be confirmed
	Medicines	14.0 Medicines Management Improvement Plan	At Risk	Carol-Anne Davis-Jones	Fionna Moore	There has been a significant investment in resources to drive the improvements required around the management of medicines within the Trust. Progress against the project plan remains on track with key systems to govern the storage and handling of medicines being implemented and monitored. More detail on each workstream is provided on the medicines project summary document. A key risk for the project is the level of culture change required from operational staff within the timeframes set out. This risk is being closely monitored and mitigated through a strong assurance framework, which is discussed in more detail below	22/09/2017
	Patient records	15.0 Patient Records Improvement Plan	On Target	Kirsty Booth	Fionna Moore	This project has successfully addressed the concerns identified around the storage and security of PCRs through the implementation of the shift incident log and monitoring compliance with the use of PCR boxes. The focus has now shifted to enhancing the quality of PCR completion by operational staff. To address this, the project team is progressing with an IT solution to identify where the minimum dataset of PCRs is inaccurately completed. This will enable the health records team to liaise with stations with PCR quality concerns and work towards improvement. The cost of this solution will require approval prior to implementation, and alternative options are being considered at the same time	01/05/2017 *Estimated to now be complete by 30/09/2017*
	Safeguarding	1. Safeguarding Improvement Plan	Parked	Sara Songhurst	Steve Lennox	Following the development and approval of the work plan to implement the Safeguarding Strategy, the majority of actions within the original project plan had been delivered. However, with the recent appointment of the Safeguarding Consultant, this project is being re-scoped with a key focus on establishing an effective safeguarding culture. A key priority for the next period will be to develop supporting project documentation that explicitly outlines the objectives and milestones to be achieved	Undergoing re-scoping, timeframes to be confirmed
Effective	Outcomes	9.0 Outcomes Improvement Plan - Take action to improve outcomes for patients who receive care and treatment	On Target	Andy Collen	Fionna Moore	The clinical outcomes workstream continues to progress with the three priority projects: - The ASHICE process has been implemented and is undergoing a review for effectiveness with the view to close the project if no concerns are raised. - Following the commencement of the new frequent caller lead, the project is being re-scoped to support the realisation of more tangible benefits to patients and the Trust. - The cardiac arrest consultant paramedic has submitted a paper to the Executive outlining the proposed strategy to improve outcomes for cardiac arrest patients. Approval to proceed with implementing the recommendations was received and is underway. This will have a direct impact on the AQIs relating to cardiac arrest	30/03/2018
Well-led	Governance	6.0A Corporate Governance	Complete	Peter Lee	Daren Mochrie	This project has been formally closed following the achievement of its original objectives as set out within the closure section below. However, it is important to note that further work is still required to ensure effective governance systems are in place to assess, monitor and improve the quality and safety of services. Specifically this includes: - The implementation of the Risk Management Strategy and Policy, and ensuring the required systems are in place to enable timely maintenance and monitoring of risks. - The timely management of all out of date policies and procedures, with the backlog of policies continuing to be an ongoing issue despite the establishment of a revised process to ensure these documents are regularly reviewed and maintained up to date. To address this, a new project has been established and is being monitored through the Compliance Steering Group	31/03/2018
		6.0B Clinical Audit	On Target	Fiona Wray	Fionna Moore	Progress has been made with the delivery of the Clinical Audit improvement plan. The interim Head of Clinical Audit has been appointed and has commenced with the Trust. Priorities have been focused on developing the 2016/17 Annual Audit Report, and submitting the 2017/18 Audit Programme for final approval. With these complete, the focus will shift onto ensuring accuracy of nationally reported data, and work planning for the 2017/18 year to enable the successful delivery of the Audit Programme	31/12/2017

Summary exception report

Domain	CQC Work stream	Risk Description	Current RAG	Previous RAG	Mitigating action	Risk after mitigation	Owner	Date for resolution
Safe	Medicines Management	A key risk for the project is the level of culture change required from operational staff within the timeframes set out	Red	NA	A robust assurance framework has been implemented across the operations to ensure changes implemented within the medicines project are adhered to. This involves a rigorous audit programme consisting of daily, weekly and monthly audits conducted by operational managers and reported to the project team, a series of unannounced medicines spot checks conducted by the Medical Directorate, and quarterly medicines governance audits conducted by the medicines team. To support feedback and cascade actions and learnings throughout the operational teams, daily operational assurance meetings have been established consisting of the Director of Operations, Regional Operations Managers, all OUMs and the Deputy Clinical Director. The purpose of this meeting is to discuss the responses of the manager daily medicines audits, issues identified during unannounced medicines spot audits, and progress with actions assigned to the operations team. This meeting enables a two way dialogue between the medicines and operations team	Red	Fionna Moore	22/09/2017

Summary of project closures

Domain	CQC Work stream	Executive sponsor	Project lead	Date of closure	CQC findings	Rationale for closure	Handover plan to BAU	Next review date
Well-led	Corporate Governance	Daren Mochrie	Peter Lee	18/07/2017	Ensure that governance systems are effective and fit for purpose, including systems to assess, monitor and improve the quality and safety of services	In response to the CQC findings, a programme of work was developed to improve governance systems across the Trust, which included the following key areas: - Developing a clear strategy and vision with values to support and prioritise quality and safety - The trust's 5 year strategy was approved by the Board in June 2017 - Establishing a governance framework that is clear on roles and responsibilities and where quality, performance and risks are understood and managed - Executive portfolios and supporting meeting structures have been refreshed to manage organisational priorities, clearly distinguishing between performance management, risk and assurance, and strategy - Implementing an effective and appropriate governance structure - the revised Risk Management Strategy and Policy was approved by the Board in March and via its Audit Committee is overseeing implementation - Ensuring all policies and standard operating procedures are regularly reviewed and maintained up to date - Policy management is now centralised through the Company Secretary. SMT is the policy review group and has a section within each meeting to review / approve policies	The implementation of the Trust Strategy will be overseen by the Board and the risks to achieving the strategic goals will be managed and monitored via the new Board Assurance Framework The Head of Risk is leading the implementation of the new Risk Management Strategy and Policy To ensure all policies and procedures are updated as a matter of priority, a new project has been established focusing specifically on supporting directorates with updating out of date policies and procedures	31/03/2018

Unified Recovery Plan Dashboard

15th September 2017

Key:
- Red
- Amber
- Green
- Blue (Project closed)

South East Coast Ambulance Service NHS Foundation Trust

Programme Summary:

• Good engagement at Project Boards for both Increased Hear and Treat and Ambulance Turnaround Projects.
• Trust HQ project is on track to deliver expected milestones
• ePCR is on track to achieved target of 98% of users onboarded by mid November 2017

Work stream	Project Name	Project RAG Current Period	Project RAG Previous Period	Project Lead	Executive lead	Completion date	High-level Commentary
Service Transformation & Delivery Steering Group	Increased Hear and Treat Project	Amber	Amber	Scott Thorney	Joe Garcia	31/10/2017	Project mandate approved by Director of Operations and Strategy & Business Development on 10 August 2017. The Project Board meets fortnightly chaired by Head of 111. Quality Impact Assessment is currently being developed with KPI's drafted.
	Hospital Handover Governance Process	Green	Green	Richard Harker	Joe Garcia	29/09/2017	Performance monitoring continues to provide assurance that Acute Trusts and A&E's are using the new conveyance, Handover and Transfers of Care Procedure by 29 September 2017.
	OU Restructure (formally OU Leadership)	Green	Green	Sue Skelton	Joe Garcia	31/07/2017	A change control process is currently being completed to move this project to BAU
	Ambulance Response Programme	Green	First reporting period so no previous RAG	Sue Skelton	Joe Garcia	22/11/2017	A Project Board has now been established which meets weekly which is chaired by Associate Director of Operations. A Project Mandate and Quality Impact Assesement is currently in development.
Sustainability Steering Group (see separate Dashboard for Cost Improvement Programme)	HQ Phase 2	Green	First reporting period so no previous RAG	Ibrahim Razak	David Hammond	28/09/2018	A proposal to expand Coxheath EOC by mid November 2017 to provide resilience for Crawley EOC has been approved.
	Electronic Patient Clinical Records ("EPCR").	Amber	Amber	Edyta Suszek	Jon Amos	29/03/2018	92% of iPads have been onboarded to users with the target of 98% by 30/11/2017. Currently this is on track. Project is flagged Amber as difficulties faced in updating the ePCR application is affecting delivery of project milestones. However, project completion scheduled for 29/03/2018 is still on track.
	Implementation of new CAD	Green	Amber	Phil Smith	Jon Amos	01/10/2017	The EOC move from Banstead to Crawley on 5th September 2017 went live with no issues. Each of the three-phased go lives have now been completed with the users from Banstead EOC relocating to Crawley on Tuesday 5th September and switching over to the new Cleric CAD system.

Closure Reporting

Workstream	Review date	Rationale for closure	Handover to BAU
HQ	02/01/2018	This project has now been closed as it has achieved the following objectives; • Relocated Lewes EOC to Crawley Nexus House • Relocated Corporates Teams from Lewes, Banstead and Coxheath into new Trust HQ • Decomission of Lewis site • Business Continuity Plans reviewed and revised to ensure fit for purpose	Trust Resilience Group will continue to review the Business Continuity plans and the on going management of the building forms part of the remit of Estates and the Person in Charge within HR

South East Coast Ambulance Service: CIP Workstream

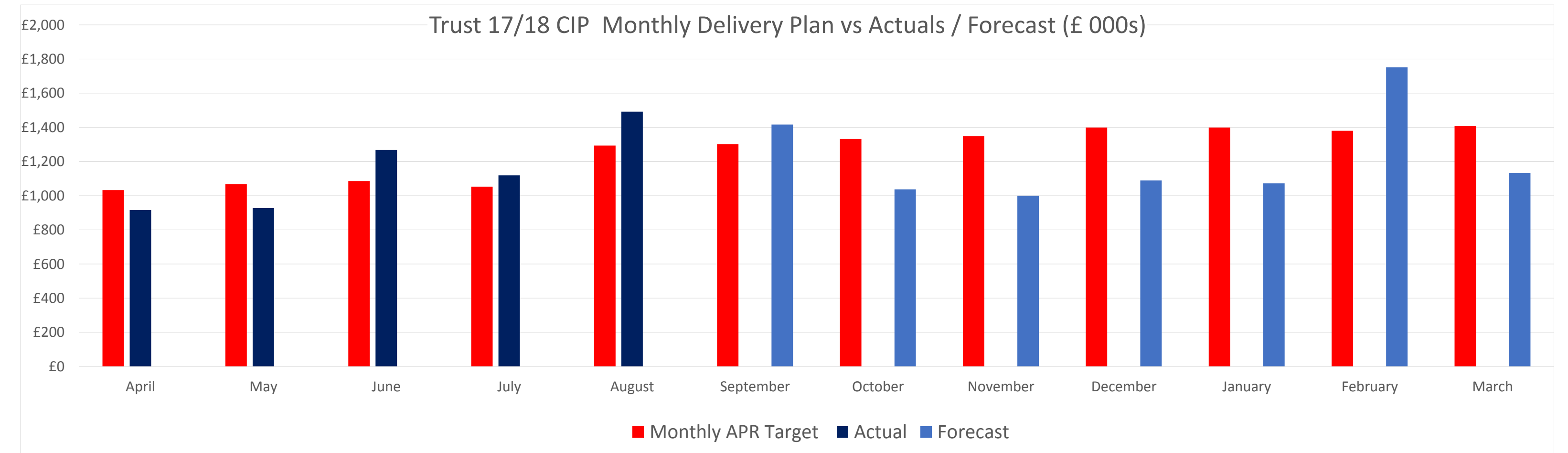
CIP Delivery Dashboard

Reporting Month Aug-17

Programme for 2017/18 to deliver a minimum of £15.1m savings to achieve the planned £1m control total

1. Monthly CIP Trust Profile - Month 5 August 17

CIP Target for 17/18 £000's	Total planned savings on delivery tracker £000's - as at 11 September	Total forecast savings on delivery tracker £000's - as at 11 September	YTD Aug '17 - Target Savings £000's	YTD Aug '17 - Actual Savings £000's	YTD Aug '17 - variance £000's
15,100	14,728	14,219	5,530	5,722	192



Programme Summary: (See Pipeline Tracker for Risks and Issues)

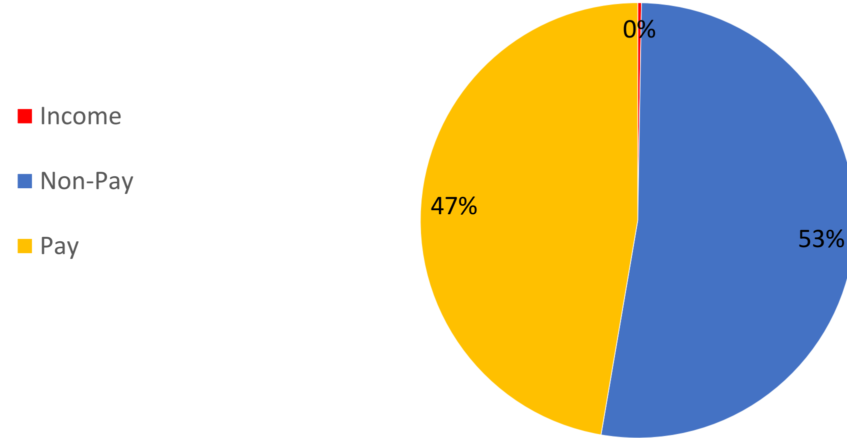
1. Achieved YTD Month 5 delivery of £5.7m CIP savings - £0.2m ahead of the NHSI plan.

2. £14.7m of fully validated savings transferred to delivery tracker as at 13 September 2017. This is £0.4m or 3% below the 2017/18 target of £15.1m but an improvement of of £3.5m compared to figures reported on 12 July 2017 (quarter 1).

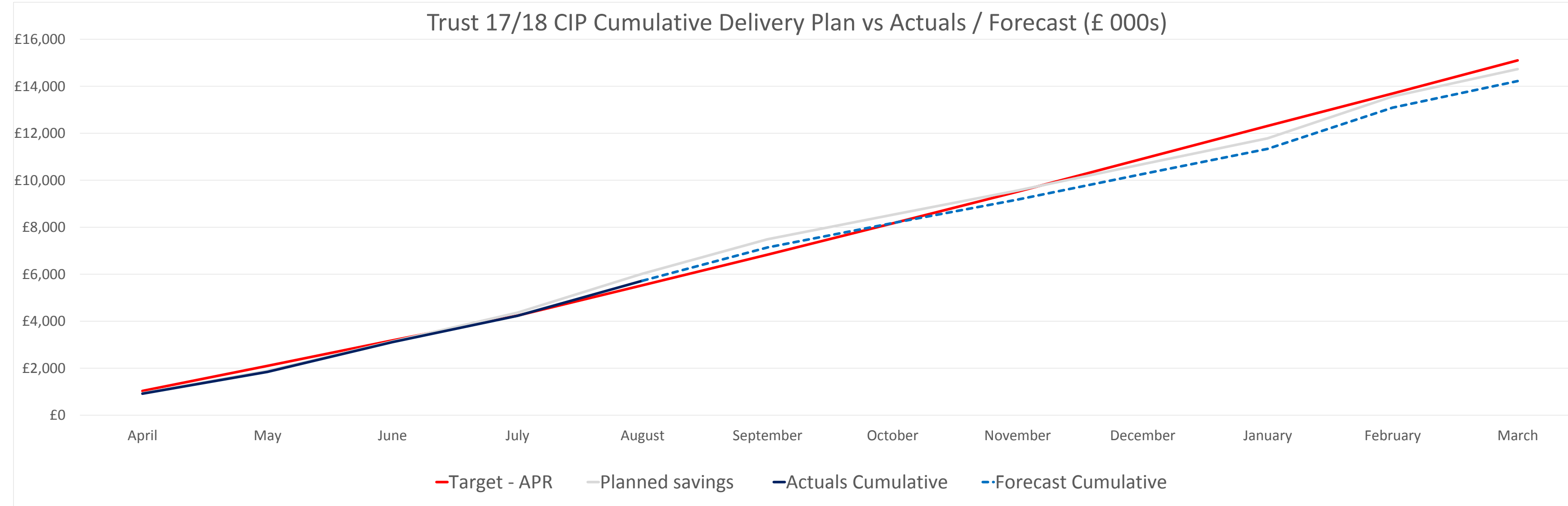
3. Projection for full year forecast of £14.2m is a shortfall of £0.5m compared to plan. The main driver is underachiement in Agency premium scheme due to engagement of Interims staff to cover essential established posts to ensure effective service delivery while restructures are undertaken in various departments across the Trust.

4. Monthly review with Budget leads and Finance Business Partners are in progress to formulate corrective actions required for CIPs with YTD underachievement and to identify new schemes.

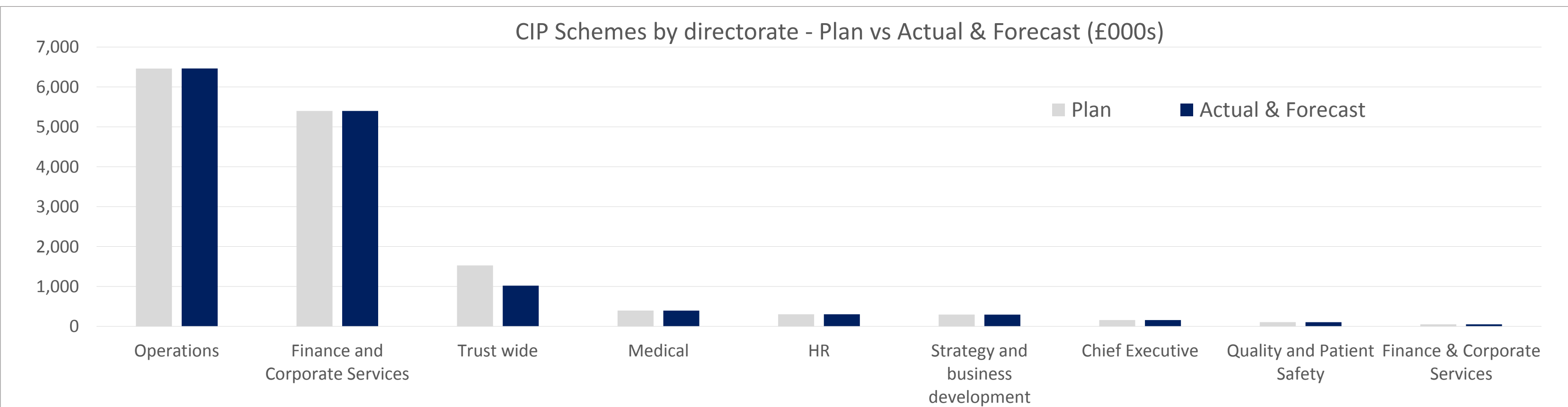
2. CIP - Planned savings split by income, pay and non-pay: Month 5 August



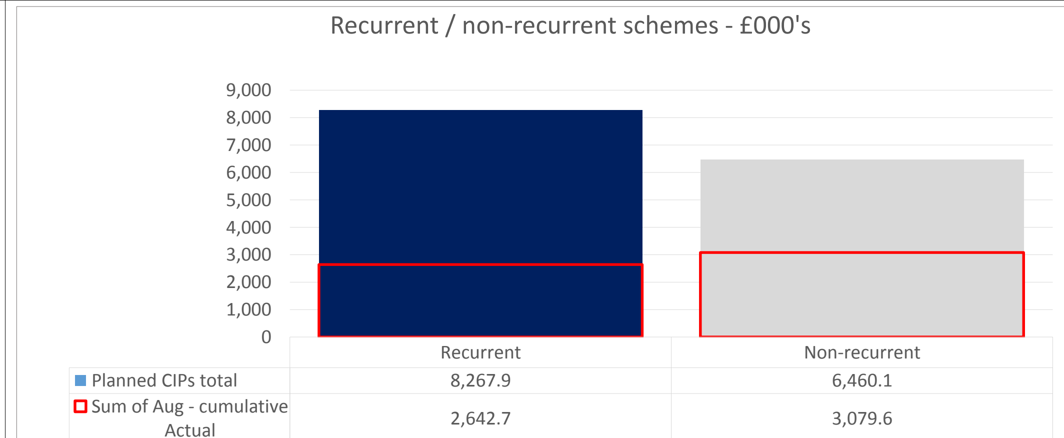
3. Cumulative CIPs - Target Plan & Actual / Forecast savings 2017/18



4. CIP schemes by directorate - Plan vs Actual & Forecast 2017/18

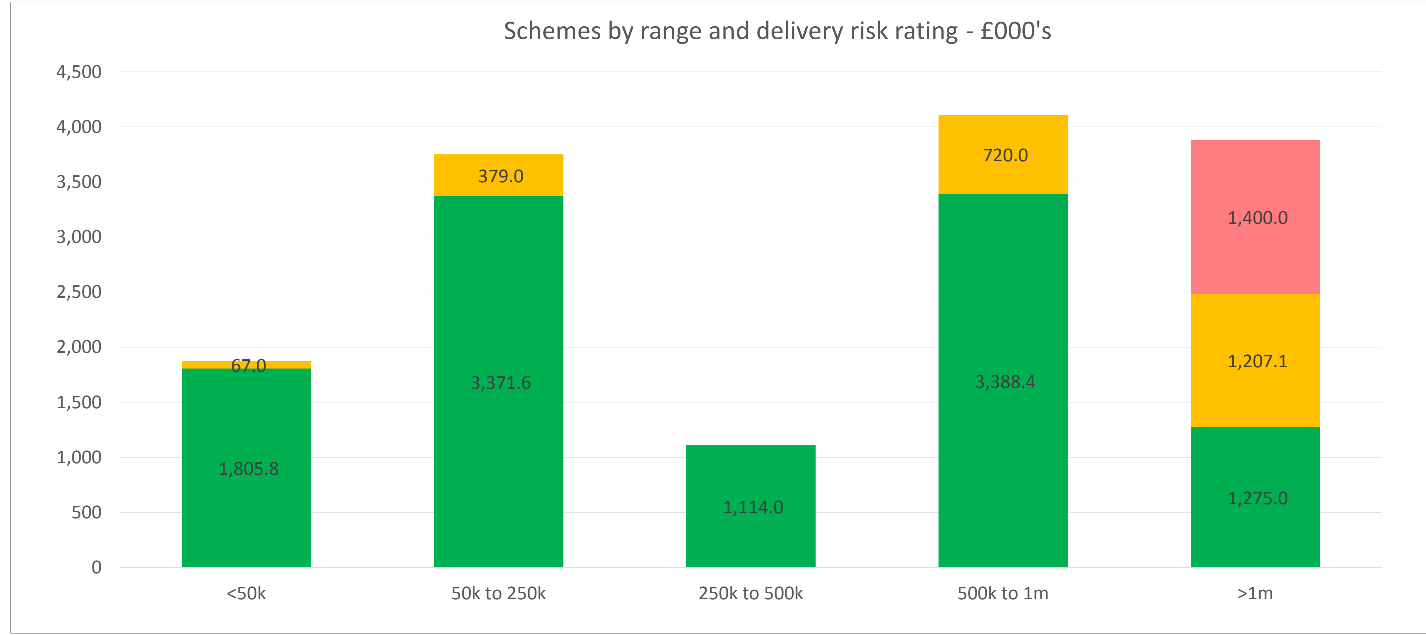


5. Value of planned recurrent and non-recurrent savings - as at 5 July



	Recurrent	Non-recurrent
Planned CIPs total	8,267.9	6,460.1
Sum of Aug - cumulative Actual	2,642.7	3,079.6

6. Planned savings by scheme size and delivery risk rating £000's



7. Operations Hours CIP: Effective from September

Forecast	YTD Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Total
Planned Staff Hours	1,257,910	245,612	259,121	257,441	266,650	253,839	229,600	258,767	**4,034,153**
Planned Staff Hours Reduction (Task Cycle Time)	-	1,662	3,244	4,812	8,624	8,056	8,078	10,066	**44,542**
Cost Saving	-	£45,051	£87,912	£130,409	£233,703	£218,313	£218,902	£272,799	**1,207,090**
Cost Saving Running Total	**-**	**£45,051**	**£132,964**	**£263,373**	**£497,076**	**£715,389**	**£934,291**	**£1,207,090**	

Actuals	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Total
Staff Hours Saved	-								
Cost Saving	-								
Cost Saving Running Total									

8. YTD Identified CIPs to Date and Savings - August Reporting Period

Scheme Category	2017/18 Value of Identified Schemes - £000	2017/18 Forecast Value £000	YTD Planned / Identified Savings (Month 5): £000	YTD Actuals (Month 5): £000	Variance	Comments (+/- £20k variance)
Accounting efficiency	£4,169	£4,169	£1,747	£1,747	£0	-
Meal break payment	£1,834	£1,834	£879	£879	£0	-
Agency Premiums	£1,510	£1,001	£630	£370	(£260)	YTD Underachievement - ongoing monitoring and corrective action in progress
Operations Efficiency	£1,485	£1,485	£51	£51	£0	-
Vacancies - non clinical	£1,000	£1,000	£645	£624	(£21)	Under investigation
Vacancies - clinical	£833	£833	£653	£653	£0	-
Fleet - Fuel: Telematics, Bunkered Fuel & Price Differential	£700	£700	£279	£279	£0	-
External consultancy & contractors	£565	£565	£238	£232	(£6)	Timing - expected to deliver
MRC efficiency	£494	£494	£122	£122	£0	-
Estates and Facilities management	£409	£409	£87	£87	£0	-
EPCR efficiency	£310	£310	£129	£129	£0	-
Staff Uniform	£203	£202	£64	£63	(£1)	-
111 Efficiency	£200	£200	£83	£83	£0	-
IT costs and Phones	£149	£149	£62	£50	(£12)	Under investigation
Furniture & Fittings	£133	£133	£55	£55	£0	-
Stationery	£110	£110	£46	£46	£0	-
Meeting room hire	£97	£97	£40	£40	£0	-
Medicines Management - Consumables	£93	£93	£39	£39	£0	-
Medicines Management - Equipment	£90	£90	£31	£31	£0	-
Legal cost	£78	£78	£19	£19	£0	-
Training courses & accomodation	£75	£75	£33	£33	£0	-
Books & Subscriptions	£55	£55	£23	£23	£0	-
Public relations	£47	£47	£19	£19	£0	-
Discretionary non-pay spend	£41	£41	£23	£23	£0	-
Events Income	£35	£35	£17	£17	£0	-
Travel & subsistence	£16	£16	£7	£7	£0	-
Variance to YTD Target	-	-	-£491	-	£491	Variance between YTD Identified Schemes and Control Total Target
Grand Total	£14,728	£14,219	£5,530	£5,722	£192	

South East Coast Ambulance Service: CIP Workstream Pipeline Dashboard

Programme for 2017/18 to deliver a minimum of £15m savings to achieve the planned £1m control total

Financial Reporting Period: Month 5 - August 2017

Programme Summary:

1. Positive engagement and buy in from Execs and CIP Project Leads. Execs and Project Leads are making time to participate in Financial Sustainability Steering Group meetings, and engaging with the CIP Programme and processes. Progress in some areas impacted by availability, largely due to annual leave commitments.

2. £14.7m of fully validated savings as at 13 September 2017 - c. £13.3m CIP and £1.4m cost avoidance moved to delivery tracker. CIP schemes moved to delivery tracker once QIA signed off and Exec Sponsor approves mandate.

3. Working collaboratively with relevant Project Leads and Execs to develop potential schemes to meet the 2017/18 CIPs target and also to build the pipeline of recurrent schemes for 2018/19.

CIP Opportunity Classification - KEY

Opportunity Status	Description	Key
Fully Validated	Scheme with confirmed savings calculation prior to delivery tracking	
Validated	Scheme with identified benefits under development	
Scoped	Scheme to be scoped for further development	
Proposed	Proposed CIP idea in analysis	

CIP Pipeline and Delivery: Risks and Issues

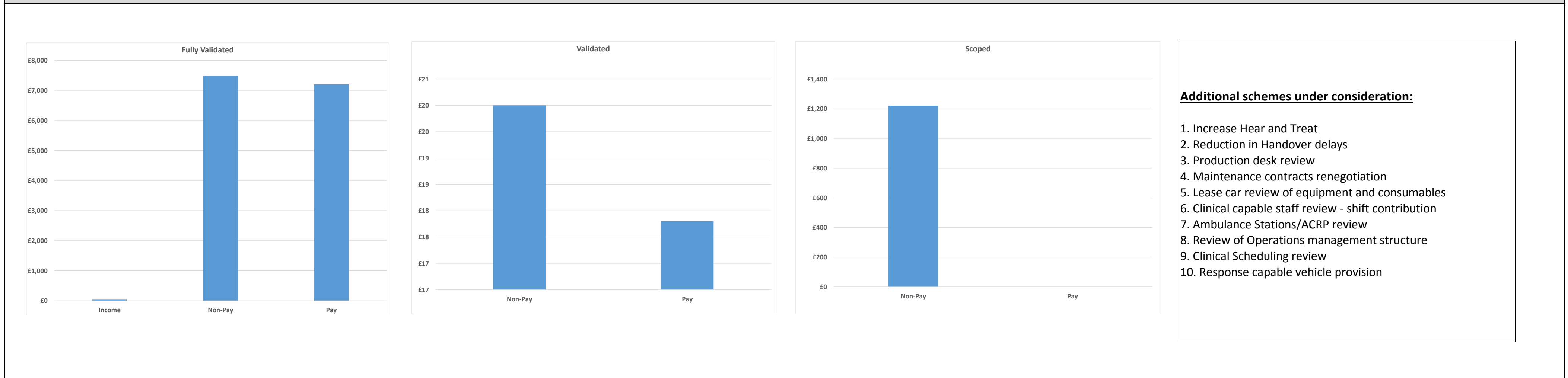
	Risk	Mitigating action	Owner	Current RAG	Previous RAG	Date to be resolved by
1	Failure to identify and scope fully the entire planned value (£15m) CIPs schemes, impacting on the Trust's ability to achieve 2017/18 year-end control total of £1m.	Holding regular FSSG meetings along with budget reviews to support budget holders to drive the development and delivery of 2017/18 CIP schemes. CIP pipeline tracker in use to monitor CIP development in line with governance framework. C. £15m of CIPs Fully validated / Validated.	Kevin Hervey	Amber	Amber	31/12/2017
2	Failure to achieve / deliver the entire planned value (£15m) of CIPs schemes, due to part-year effect of some schemes and under delivery of fully validated schemes	Aiming to identify £19m CIP savings to mitigate risk. Delivery tracker in use to individually monitor CIP schemes. Monthly financial performance review with Budget leads and FBPs in place to monitor and challenge budgets. Delivery of transformational scheme to be closely monitored due to complex and interdependent nature (see delivery tracker section 7)	Kevin Hervey	Amber	Red	TBC
3	No formal process in place to ensure that investment projects are operating within the original budget or delivering the planned financial benefits.	Develop and implement a structured process to track programme costs and finance benefits. New business case template has been developed and signed off by the Execs and SMT. Review of the last 2 years business cases is underway to align the proposed financial benefits to the CIPs programme.	Kevin Hervey	Amber	Amber	31/10/2017

	Issue to be resolved	Mitigating action	Owner	Current RAG	Previous RAG	Date to be resolved by
1	Failure to identify and develop the documentation for the £15.1m CIPs target before the departure of the EY team	CIPs leads are actively engaging with Project Leads and supporting them with the scoping and development of schemes. Action plan developed to track outstanding tasks and to facilitate effective handover and smooth transition.	Kevin Hervey	Amber	N/A	30/09/2017
2	Time taken to identify and agree CIPs schemes as budget leads juggle with conflicting priorities.	CIP team is set up to provide support to budget / CIP project leads. Email sent by DoF to CIP leads reinforcing the need to address CIPs requirements with the PMO. Exec Sponsors and CIP Project Leads have been responsive and engaged with the CIP Programme. Monthly financial performance review meetings established to monitor spend and to ensure corrective actions are in place to address schemes that are not delivering.	Kevin Hervey	Amber	Amber	31/10/2017
3	Delays in establishing further Operations efficiencies to reach the £5m target (current shortfall of £2m)	49 potential Operations schemes have been identified and initial risks scoped. CIP team working with Operations leads and relevant Execs to agree likely schemes to develop. Follow up meetings scheduled with Operations leads to review and agree benefits to be realised.	Kevin Hervey	Amber	N/A	31/10/2017

CIP Pipeline Summary

Cost Avoidance	Fully Validated	Validated	Scoped	Proposed	Grand Total
£1,400	£13,328	£38	£1,220	£0	£15,986

Pay / Non-Pay / Income Breakdown



Additional schemes under consideration:

1. Increase Hear and Treat
2. Reduction in Handover delays
3. Production desk review
4. Maintenance contracts renegotiation
5. Lease car review of equipment and consumables
6. Clinical capable staff review - shift contribution
7. Ambulance Stations/ACRP review
8. Review of Operations management structure
9. Clinical Scheduling review
10. Response capable vehicle provision

South East Coast Ambulance Service NHS
NHS Foundation Trust

		Agenda No	86/17
Name of meeting	Trust Board		
Date	29 September 2017		
Name of paper	Medicines Governance Optimisation Plan		
Responsible Executive	Fionna Moore, Executive Medical Director		
Author	Carol-Anne Davies-Jones, Chief Pharmacist		
Synopsis	This paper provides a progress update on the medicines governance optimisation plan		
Recommendations, decisions or actions sought	The Board is asked to confirm its level of assurance that sufficient remedial action continues to be taken to ensure improvement in medicines governance.		
Does this paper, or the subject of this paper, require an equality impact analysis ('EIA')? (EIAs are required for all strategies, policies, procedures, guidelines, plans and business cases).	**No**		

Medicines Governance Optimisation Plan Progress Update

1 Introduction

1.1 Following the enforcement action proposed by the Care Quality Commission (CQC) following its inspection in May 2017, relating to the management of medicines within SECAmb, a medicines governance optimisation plan was developed to ensure sufficient remedial action.

1.2 12 specific areas were highlighted and the plan aimed to ensure improvement in each of the areas by 22nd September 2017. The Trust has provided the CQC with evidence to support the action that has been taken.

1.3 Initially the Programme Management Office (PMO) supported the improvements through the Quality Steering Group (QSG) and in mid-August the decision was made to remove this element from the overall CQC delivery plan and establish a task and finish group specifically to deliver the immediate improvement for medicines. This group is chaired by the Chief Executive.

1.4 Significant progress has been made towards the delivery of the medicines optimisation plan and most elements are on trajectory to achieve the deadline, as set out in this paper.

1.5 Training of 175 management and operational team leaders in the revised standard operating procedures has taken place over the past 2 weeks to embed changes in practice and to allow roll out and cascade training to all operational staff.

1.6 A medicines hub has been set up to oversee operational delivery of the changes in practice and provision of a local assurance framework to identify themes and compliance.

1.7 The overarching governance arrangements are in place to ensure sustained improvement and monitoring.

2 Background

2.1 Twelve areas of concern were raised by the CQC regarding the storage, management, security and administration of medicines identified below;

i. Out of date medicines were available in the Omnicell for patient use.

ii. Medicines stocked on stations did not match the centrally held stock list.

iii. The process of tagging medicines bags was not working effectively; while the concept of tagging was right, the governance, control and accountability was lacking.

iv. Inconsistent management of Controlled Drugs was compromising safety and security.

v. A lack of temperature monitoring in all areas that store medicines.

vi. The current scope of practice for staff outside of those authorised to use a PGD was sitting outside the Human Medicines Regulations (2012).

vii. Duplication of storage and access to medicines on stations cupboards located outside the Omnicells for Paramedic Practitioners.

viii. Mechanisms for securing ampoules in cardiac pouches was not working, increasing risk of breakages.

ix. Security codes for medicines rooms were being written on the door to access the medicines.

x. Medical Gas storage and security did not meet in full the Department of Health (DoH) guidance 2006.

xi. Universal keys for drug cabinets on Double Crewed Ambulances (DCA), potentially compromising security of medicines.

xii. Lack of safe and secure storage and access to medicines used for purposes of training only.

3. Assurance Process

3.1 Weekly and monthly assurance checks were put in place at station level to measure completion and compliance against a number of parameters to assure against these 12 areas of concern.

3.2 These assurance checks have been undertaken by Operational Team Leaders (OTL's), initially by paper and more recently through an electronic portal developed internally and have been escalated to daily reporting whilst the organisation undertakes changes to practice and embeds SOPs.

3.3 The medicines hub holds a daily conference call to discuss findings of the station audits, shares best practice and holds teams and other departments to account for delivery against the action plans.

3.4 Following the intense review of all stations completed during August, a three monthly assurance audit by the central medicines team will resume from 1st October.

3.5 In addition the Quality Assurance Visits undertaken to do a 'deep dive' on stations using the KLOE approach will continue to include medicines management as part of that process.

4. Progress

4.1 SOP's have been written and approved. All OTL's have gone through a training process for the SOP content and followed up with an online assessment process.

4.2 Processes for identification of out of date medicines is in place. All out of date stock has been removed and cycle counts are in place to ensure regular checks which are then recorded as part of assurance process.

4.3 Stock lists have been written and distributed at station level to allow verification of current medicines stored in both Omnicell and non Omnicell sites.

4.4 All Paramedic Practitioner drug bags have been brought into centralised medicines stores, and all old and unused bags have been emptied and removed. All bags are now numbered and a three-hour weekly check is in place by the PP team at each site to undertake weekly assurance checks of both drugs and consumables stored in bags.

4.5 Tagging SOP is now in place to ensure that the management of tagged bags is consistent.

4.6 The layout of the cardiac pouch has been adapted to ensure that the medicines stored within it are more secure. There is a review of Datix to assure that the change in packing has not impacted on ampoule breakage and improves the safe storage of these medicines.

4.7 A suite of SOP's has been written to strengthen the management of Controlled Drugs across the Trust. In addition, the CD Liaison Officer from Sussex Police was asked to review one station to highlight any areas of concern to allow shared learning across the Organisation. These have been incorporated into the SOP's and he has agreed to join our quality assurance visit process in future to provide external assurance.

4.8 Thermometers have been installed in every area that stores medicines with daily minimum and maximum temperature recording recorded locally and reported centrally. An SOP sits alongside this to provide clarity for staff.

4.9 The use of Medicines Administration Protocols (MAPs) for non-registrant practitioners has ceased with immediate effect and has been replaced with Patient Group Directives (PGDs) for use by registered staff to improve governance of our medicines administration.

4.10 An SOP regarding the security of medicines room has been written and approved and is being disseminated to staff. An estates strategy to improve the security of medicines is included in the ongoing action plan for Medicines Optimisation.

4.11 All non-BOC gas cylinders have been removed from cabinets across the Trust. Storage of gases has been strengthened on stations with designated secure areas for gas storage and instruction on the safe management and transportation of gases to all staff from Community First Responders to Response Capable Managers.

4.12 The replacement of locks on all DCAs is the main action that is at risk currently due to delays in the procurement of the keys and expected delivery dates from the manufacturer. It is however anticipated that the CQC requirement of a delivery note for the locks will be in place by the deadline.

4.13 No medicines are currently in place in training centres and an SOP has been written to govern the use of medicines for training purposes.

5 Governance Processes

5.1 The overarching Governance of Medicines sits with the Medicines Governance Group (MGG).

5.2 There are two sub groups that report into the MGG which are Patient Group Directives and Medical Gasses.

5.3 MGG reports and escalation issues are discussed at the Practice Group which has been established by the Executive Management Board.

6 Summary

6.1 Significant progress has been made in the management of the project plan to deliver improvements in medicines governance.

6.2 The main outstanding risk is the procurement and fitting of vehicle keys to ensure that medicines are stored securely on vehicles. Manual locks have been purchased from the preferred supplier and are expected to be delivered by 27th September. Once received, the fleet team will commence with the installation of the new locks into all DCAs. Alongside this, the SOP for the management of drug cabinet keys has been introduced. Changes to key management practice will be communicated to all staff and implemented as new locks are installed.

6.3 There is a series of SOPs in place to provide guidance on process for staff and managers.

6.4 A structure is in place to provide Vehicle to Board assurance of both completion and compliance audits completed at local level.

6.5 In addition, there is a series of quality assurance checks at a monthly and quarterly level that are in place to provide board assurance.

6.6 Learning is shared through daily conference calls, regular updates in the Trust bulletin and face to face learning with OTL's and station management team which is cascaded down to staff.

6.7 The Trust will continue deliver the evidence of progress to the CQC and it is believed that the actions taken will provide assurance to them about our management of medicines.

7 Recommendation

7.1 The Board is asked to accept this report as assurance that sufficient progress has been made in addressing the specific issues as listed in section 2.0.

South East Coast Ambulance Service NHS
NHS Foundation Trust

		Agenda No	87/17
Name of meeting	Trust Board		
Date	29 September 2017		
Name of paper	999 Call Recording		
Responsible Executive	David Hammond, Executive Director of Finance & Corp. Services Joe Garcia, Executive Director of Operations		
Author	David Hammond, Executive Director of Finance & Corp. Services		
Synopsis	This paper provides a progress update on the steps the Trust has been taking to fix a range of issues which have arisen during 2017, resulting in some 999 calls not being accessible.		
Recommendations, decisions or actions sought	The Board is asked to confirm its level of assurance that sufficient remedial action is being taken to ensure all 999 calls are recorded and accessible.		
Does this paper, or the subject of this paper, require an equality impact analysis ('EIA')? (EIAs are required for all strategies, policies, procedures, guidelines, plans and business cases).	**No**		

999 Voice Recorder Update

1. Executive Summary

1.1. The Trust has had serious and ongoing issues with its ability to record EOC emergency calls. This was highlighted by the CQC findings as well as Trust internal processes.

1.2. As solutions have been found to fix the immediate voice recorder issues presented, the audit process employed have then identified subsequent issues. This cycle has been on-going for a considerable time.

1.3. The causes of the recording problems fall into the following categories:

- 1.3.1. Trust infrastructure issues
- 1.3.2. Telephony system fault
- 1.3.3. Voice recording system fault

1.4. A significant amount of resource and effort has been employed in each of these areas. However, with the continuation of the problems albeit new issues each time, the Executive Management Team has now concluded that there is no confidence in either the telephony or voice recording system hardware or the outsourced support agreements in place and a business case is being prepared to move the Trust to a new infrastructure and in-house support for both elements.

1.5. The proposed new solution is currently used by 10 of the 13 UK Ambulance Trusts.

1.6. In the interim, the Trust will continue to work with the manufacturers and support providers of the current solution to ensure that all efforts are being made to record all calls. For quantification, following a period of no reported issues with the voice recorder, on the 11th September the audit process picked up further calls not being recorded (8 from 655 calls have been confirmed as missing).

1.7. The voice recorder supplier following investigations of the SECAmb system, have found a software error within their code which it is believed explains these 8 missing calls and an upgraded version will be rolled out including to SECAmb on the 25th September 2017.

1.8. The Trust is currently investigating the entire voice recorder issue as a Serious Incident (SI) with this process due to be concluded at the end of September.

2. Background

2.1 The Trusts voice recorder has not been consistently recording all 999 calls for some time. The underlying issue was considered to be linked to the requirement to upgrade the Mitel telephony platform in order to work better with any voice recording solution.

2.2 The upgrade to the telephony system was completed in December 2016 and initially appeared to resolve the original voice recorder issues.

2.3 In February 2017, new issues with the voice recorder materialised. These included calls not being recorded, static or distorted audio and truncated calls.

2.4 The cause of the issues was not immediately known and investigation into the reasons centred on the telephony upgrade, the voice recorder malfunctioning, or a combination of both.

2.5 During the period from February to June 2017, various issues were fixed following detailed investigation. Whilst one clear major cause was not apparent, the solutions were progressive enhancements within the telephony system and the Trust network configuration. This process was also helped by the updating of infrastructure due to the move to the Crawley HQ which whilst a deliberate tactic slowed down the rectification of the voice recorder issues.

2.6 Since 6th June, the quality and reliability of the voice recorder has been high and from the 19th July to the 11th September there have been no significant issues on call recorder raised. On 11 September it was established that the voice recorder was again not performing optimally and an investigation was launched; the details of which can be found at Appendix 1.

2.7 The CQC have raised the Trusts inability to record all of its calls as a major risk and area of non-compliance and a series of communications and reports have been provided to the CQC to show progress and resolution of the issues.

3. Issues and Action

3.1 Whilst the investigations are still ongoing, the Executive Management Board has discussed this issue and the following areas have been highlighted:

3.1.1 **Issue 1** – the telephony and voice recorder equipment is not fit for purpose and the Executive Team no longer has confidence that either of the solutions are safe for a 999 environment.

3.1.2 **Action 1** - the Trust will replace both the EOC telephony and voice recording system at the earliest opportunity. Furthermore, the system support contracts for both telephony and the voice recorder are outsourced and as such the in-house expertise in these areas is limited. This is not uncommon, but a robust contracts management framework, including holding to account of suppliers, penalties and escalation for poor performance and ultimate termination of contracts has not been embedded within the IT function. The Director of Finance supported by the Interim AD of IT, will ensure that any current IT outsourced contracts have a robust contract management mechanism in place to ensure that issues are dealt with in a timely way. It is highly likely that the Trust will build its own internal capacity in this area with a view to bring the support and expertise back in house for the new system. Additionally, those making procurement decisions must have the appropriate level of knowledge from within but also outside Ambulance Trusts so as to avoid the 'we only know what we know' issue and whilst staff need to be involved in the process they must have the capability and expertise to make the decision.

3.1.3 **Issue 2** – Both IT and EOC have historically been working in silos.

3.1.4 **Action 2 -** the hardware belongs to IT and as such IT own the problem and must ensure that rectification is given priority. However, there needs to be an improvement in the culture of the working relationship between IT and EOC and issues reported in a collegiate way and a clear service level agreement and plan agreed to resolve the issues.

3.1.5 **Issue 3 –** the capacity within IT and EOC has been stretched due to the new CAD implementation and move to the new HQ. Both of these projects have gone flawlessly and this should be acknowledged. However, whilst the delivery has been good, business as usual has been impacted both in terms of service delivery and the high levels of staff turnover.

3.1.6 **Action 3–** IT and EOC management need to ensure that they are appropriately resourced to deal with BAU and specific projects. This needs to be identified at the business case stage and resources ring-fenced to projects. In addition, where delivery is reliant on outsourced providers, there must be clear accountability and penalties for not hitting targets which then put additional pressure downstream.

3.1.7 **Learning** – the audit process of calls and recordings needs to be monitored by Senior Management Team (SMT), Senior Operations Leadership Team (SOLT) and Executive Team as part of KPI's.

3.1.8 **Action –** the Senior Management Team (SMT) and Senior Operations Leadership Team (SOLT) will receive monthly reports in this area with exceptions being reported to the Quality and Patient Safety Committee.

4. Conclusion

4.1 The issues with the Voice Recorder are unacceptable and whilst solutions have been found each time, it is clear that there is an underlying problem which causes new issues to arise.

4.2 The Director of Finance and Director of Operations are committed to resolving and improving the telephony platform within the Trust including the voice recorder. This will commence within an infrastructure review by the Interim AD of IT and consideration of the appropriateness of the hardware, contracts and management structures for telephony within the IT team and future EOC structures.

4.3 The immediate priority is to ensure that all calls are recorded and that an audit system is in place to ensure that this is monitored. This continues to be addressed by the Interim AD of IT and the EOC Systems Manager within the Operations directorate and the most recent fix seems to have rectified the problems detailed by the CQC.

4.4 The Executive Management Team will continue to share and escalate concerns or issues in this area as required with the Board.

5. Recommendation

5.1 The Board is asked to note this report and to support the decision to replace the telephony and voice recording systems at the earliest opportunity and following the presentation of the business case to the Trust Board in line with the governance requirements.

South East Coast Ambulance Service NHS
NHS Foundation Trust

	Item No	89/17

Name of meeting	Trust Board
Date	29th September 2017
Name of paper	STP Update Briefing paper
Executive sponsor	Jon Amos – Acting Director of Strategy and Business Development
Author name and role	Jayne Phoenix – Associate Director of Strategy and Business Development
Synopsis (up to 120 words)	This paper provides an update and summary of SECAmb work with our STP partners. It identifies work that is unique to each STP and that is being done across several or which we recommend could be considered across several.
Recommendations, decisions or actions sought	The Board are asked to note this report as regards current progress and the plan to develop a SECAmb offer to STPs.
Does this paper, or the subject of this paper, require an equality analysis ('EA')? (EAs are required for all strategies, policies, procedures, guidelines, plans and business cases).	**No** If yes and approval or ratification is required, a completed EA Record must be attached.

South East Coast Ambulance Service NHS Foundation Trust

Trust Board

STP Update Briefing Paper

1.0 Introduction

The purpose of this paper is to provide an update and summary of SECAmb work with our STP partners. It identifies work that is unique to each STP and that is being done across several or which we recommend could be considered across several.

2.0 Background

SECAmb fall into the footprint of 4 STPs: -

- Kent and Medway
- Surrey Heartlands
- Sussex East Surrey
- Frimley Health and Social care

Partnership working with STPs is key for whole systems working which is vital for future sustainability. Jayne Phoenix Associate Director for Strategy and Business development sits on SECAmb's behalf on 3 of the STP programme boards and has recently begun to get involved in the Frimley area (which we only cover part of). Briefings are provided by her after every meeting to the CEO and to the Directors to which the meeting contents are relevant. Key items of interest are also circulated to Board members and governors.

Each STP has numerous work streams and sub workstreams including variations on the following:

- Local care (including developing accountable care models that include both providers and commissioning)
- Hospital care
- Prevention
- Urgent and Emergency Care
- Mental Health
- Workforce
- Digital
- Estates
- Productivity
- Finance
- Commissioning reform
- Communication and Engagement
- Clinical Board

There are also some area specific groups such as Back office consolidation in Kent, and Devolution in Surrey Heartlands.

We also have a national STP CQUIN which is focused on STP support, engagement and contribution, and which is currently agreed at each STP.

3.0 SECAMB work with specific individual STP initiatives

3.1 Kent and Medway STP

We have recently met with the STP programme SRO and Project director to review our ongoing involvement and joint working, recognising all is working well, and that we do need to consider what should be considered across more than one STP area to avoid replication.

Board/ work stream	
Programme Board	Attend all and are core members therefore contributing to all key STP decisions
Local care	Attending and working with all local care meetings and workshops at STP level and at local level where set up. Direct work includes on developing accountable care systems, including the number shape and function of these. We are also involved in workforce modelling for integrated local care.
Hospital Care	Attending and working with all STP wide meetings and those at sub area level. Extensive involvement with East Kent work and Delivery Board. Work on modelling impact of all proposed configuration changes as part of the developing cases for change, with involvement in Stroke across the area, and Emergency , medical and orthopaedic in East Kent.
Urgent and Emergency Care	Attending and working with all A&E Delivery Boards and the Urgent care network which will feed into the STP
Mental Health	This item is developing at present and we will be engaged in this work .
Workforce	We are attending and engaging in this work stream when the agenda shows it is useful to do so.
Digital	An initial scoping meeting with this area led to us jointly setting up a wider cross STP digital forum which is in progress. We attend other key meetings when asked by lead as being seen key to items being worked on
Estates	We are attending and engaging in this work stream when the agenda shows it is useful to do so, and remotely by ensuring all returns and joint programmes are contributed to
Finance	We are attending and engaging in this work stream when the agenda shows it is useful to do so, and remotely by ensuring all returns and joint programmes are contributed to
System reform	We attended one recent workshop on this to help contribute to discussion including what should be commissioned at what level. Work is under way with the aim of shaping how a K and M strategic commissioning function may look in the future , alongside local commissioning at accountable care level (see Local care above)
Communication and Engagement	We are attending and engaging in this work stream when the agenda shows it is useful to do so, and remotely by ensuring all returns and joint programmes are contributed to
Back office functions	We are attending and engaging in this work stream when the agenda shows it is useful to do so, and remotely by ensuring all returns and joint programmes are contributed to
Clinical Board	We have recently reengaged in this and either attend or contribute remotely when attendance is not possible

We have reached agreement on the CQUIN for this area which will be assessed for achievement jointly between ourselves, the lead CCG and STP lead.

3.2 Surrey Heartlands

We have a meeting being set up with the new STP programme SRO and Project Director to review our ongoing involvement and joint working, and to discuss what should be considered across more than one STP area to avoid replication.

We have also recently submitted a bid for local STP transformation funding based on extension of our digital solutions to interoperability.

Board/ work stream	
Programme Board	Attend all and are core members therefore contributing to all key STP decisions This board had a 3-day leadership development workshop in week of 11/9/17 which we attended. We are also one of three organisations in the STP attending an invited session at the Kings Fund on Accountable care models
Out of Hospital care	Attending and working with all local care meetings and workshops at STP level and at local level where set up. Direct work includes engagement in developing accountable care systems
Hospital Care	Attending and working with relevant STP wide meetings and those at sub area level. Extensive involvement with Stroke reconfiguration work
Urgent and Emergency Care	Attending and working with all STP wide meetings
Devolution	Attending and working with as required.
Mental Health	We are attending and engaging in this work stream when the agenda shows it is useful to do so and when requested by the lead
Workforce	We are attending and engaging in this work stream when the agenda shows it is useful to do so.
Digital	An initial scoping meeting with this area supported setting up a wider cross STP digital forum which is in progress.
Estates	We are attending and engaging in this work stream when the agenda shows it is useful to do so, and remotely by ensuring all returns and joint programmes are contributed to
Business support - includes HR, Finance, Procurement, Patient Admin , Communications, Estates Management, Legal, IT,	This is a new work stream that is currently being scoped and which we are currently considering our involvement in relevant aspects of.
Finance	We are attending and engaging in this work stream when the agenda shows it is useful to do so, and remotely by ensuring all returns and joint programmes are contributed to
Communication and Engagement	We are attending and engaging in this work stream when the agenda shows it is useful to do so, and remotely by ensuring all returns and joint programmes are contributed to
Clinical Board	We have recently reengaged in this and either attend

	or contribute remotely when attendance is not possible

We have agreement on the STP wide CQUIN for this area which is the same for all partners and is assessed as one by the STP programme board.

3.3 Sussex East Surrey

We have a meeting in October with the STP programme SRO and Project Director to review our ongoing involvement and joint working, and to discuss what should be considered across more than one STP area to avoid replication. It is noted that the leadership arrangements of this STP are under review

We have a Governance Memorandum of Understanding from the STP for all partners to sign, which is currently under consideration by our Executive Management Team.

Board/ work stream	
Programme Board	Attend all and are core members. This STP also has an executive group which we are not members of.
Local care	Attending and working with all local care meetings and workshops at STP level and at local level. Work includes the development of accountable care systems
Hospital Care	We are a member of this work stream however there have not been any recent meetings, as this workstream is under review .
Urgent and Emergency Care	Attending and working with all local A&E delivery boards and other meetings. This care area is now becoming integrated into the STP meetings initially via system wide winter planning.
Commissioning reform	Work is under way with the aim of shaping how future commissioning may look, including local commissioning at accountable care level (see Local care above)
Mental Health	We are attending and engaging in this work stream when the agenda shows it is useful to do so, and at the request of the lead officer.
Workforce	We are attending and engaging in this work stream when the agenda shows it is useful to do so.
Digital	This area is joining us in setting up a wider cross STP digital forum which is in progress. We attend other key meetings as required
Finance	We are attending and engaging in this work stream when the agenda shows it is useful to do so, and remotely by ensuring all returns and joint programmes are contributed to
Clinical Board	We have recently reengaged in this and either attend or contribute remotely when attendance is not possible. There is key work commissioned by the board on Clinically effective commissioning, looking at all treatments and procedures commissioned across all CCGs to reduce unwarranted clinical variation.

We have not yet reached agreement on the CQUIN for this area. This is under discussion for resolution in October 2017.

3.4 Frimley Health and Social care

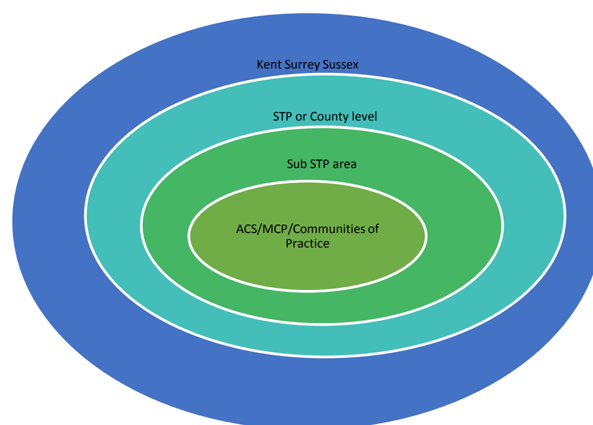
Our lead recently attended a workshop in this STP via the invite of the STP programme director. A meeting is being set up with the STP programme SRO and Project Director to agree how we work together most effectively given we are only covering part of their area. Meanwhile we have met with their digital lead to ascertain what work we have in common and they will be attending the digital meeting being set up across the SECAmb footprint with the 4 STPs, see section 4.

4.0 STP work that is or should be considered on wider than one STP basis

We are working on how we further develop our work with the CCGs and STPs to optimise use of our collective resources.

In our STPs some workstreams, such as digital, have up to 10 subgroups. We attend as many as we can that are of relevance to us and that we can support and influence. However, we are unable to attend as many as requested and are also increasingly finding ourselves being asked to replicate work across different STPs, and to respond to multiple requests for similar information. For example, we are being asked to respond and work with up to 8 versions of the summary care record. This is not sustainable and shows significant replication across STPs when we could be working across wider footprints for some work, and therefore saving on costly replication and infrastructure; which will assist in our shared cost reduction programmes. Another example is several people are doing work on stroke and acute reconfiguration in one form or another. We are trying to bring sharing of experience and modelling where we can as this reduces replication and utilises our considerable experience of this; also often ambulance impact is not considered as early in planning as it should be.

As an organisation that works across several STPs we are working to develop an offer from ourselves to the STPs as to what is likely to be best delivered at a Kent, Surrey Sussex level, STP or county level, or at a more local area as determined by Accountable care or equivalent areas and by communities of practice. The following diagram illustrates the layers of that offer.



We are developing a paper that articulates that offer across the relevant workstreams. We have had initial discussions to float this idea and help shape initial thinking with the Kent and Medway lead officers, who support and understand our need to minimise replication, and the overall need to get the areas STP leads to consider what can be done together. We are now setting up meetings with each of the SROs and leads for the other 3 areas.

We agreed it would also be useful to set up a meeting with all 4 STP leads together with us to look at what we could do once for the wider area across STPs focused on SECAmb but that could be also used for other work that would be better tackled at scale. We plan to jointly set this up.

Areas for possible consideration in this work are: -

- Digital
- Stroke
- Other areas of acute reconfiguration
- Aspects of development of accountable care models
- Workforce solutions
- Aspects of emergency and urgent care
- SECAmb response to accountable care systems
- National STP CQUIN

Work in progress across all STPS: -

Digital - We have begun to tackle this for the digital workstreams in each STP where our lead has agreement from each of the STP digital leads to meet to consider what can be done once across the 4 STPs. NHSE Digital lead has agreed to set this up and facilitate it, as they have also expressed concern regarding replication. CCG leads are also being invited.

We also have a joint bid in across Sussex and Kent and Medway regarding interoperability and development of the IBIS platform.

Stroke –work is currently taking place in 2 of our 4 STPS separately, but impacts on all 4. We are ensuring we use our developing expertise on modelling the impact of proposed changes using one methodology, and using our involvement over a wider area to share ideas, and to deal with cross area issues.

5.0 Recommendation

The Board are asked to note this report as regards current progress and the plan to develop a SECAmb offer to STPs.

Jayne Phoenix

21/9/17

South East Coast Ambulance Service **NHS**
NHS Foundation Trust

	Item No	90/17

Name of meeting	Board Meeting
Date	29th September 2017
Name of paper	Integrated Performance Dashboard
Executive sponsor	Daren Mochrie
Author name and role	Executive Team
Synopsis (up to 120 words)	The monthly Integrated Performance Dashboard gives the board oversight of the key performance indicators for the Trust, together with explanatory commentary to give suitable context and what actions are being taken to address any shortfalls. The dashboard includes score cards for each area (Workforce, Performance, Clinical Effectiveness, Quality & Patient Safety and Finance), suitable supporting commentary and charts with historic performance for trending purposes. The Integrated Performance Dashboard is an evolving item and is expected to undergo continuous improvement and change going forward.
Recommendations, decisions or actions sought	For Discussion

Does this paper, or the subject of this paper, require an equality analysis ('EA')? (EAs are required for all strategies, policies, procedures, guidelines, plans and business cases).	Yes / **No** If yes and approval or ratification is required, a completed EA Record must be attached.

1. SECAMB Regulation Statistics 4
2. Workforce 5
3. Operational Performance 10
4. Clinical Effectiveness 18
5. Quality & Patient Safety 23
6. Finance 32

1. SECAMB Regulation Statistics

ID	KPI	Value
R1(b)	**Use of Resources Metric (Financial Risk Rating)**	3
R2	**Governance Risk Rating**	Red
R3	**CQC Compliance Status**	Trust: Inadequate (Special Measures) 111 service: Requires improvement
R5	**IG Toolkit Assessment**	Level 2 - Satisfactory
R6	**REAP Level**	3

2. Workforce

2.1. Workforce Balanced Scorecard

Workforce Commentary :- Data from Aug 2017

ID	KPI	Current Month (Plan)	Current Month (Actual)	Current Month (Prev. Yr.)	YTD (Plan)	YTD (Actual)	YTD (Prev. Yr.)
Wf-1A	Short Term Sickness - Rate		**1.9%**	2.4%		**1.9%**	2.4%
Wf-1B	Long Term Sickness - Rate		**3.0%**	2.6%		**3.0%**	2.6%
Wf-2B	Objectives and Career Conversations		**34.1%**			**34.1%**	
Wf-3	Mandatory Training Compliance (All Courses)	85.0%	**60.0%**	64.3%	85.0%	**60.0%**	64.3%
Wf-4	Total injuries		**0**	57		**181**	302
Wf-5	Physical Assaults (Number of victims)		**17**	13		**87**	87
Wf-6	Vacancies (Total WTE)		**478**	418		**2185**	1895
Wf-7	Annual Rolling Staff Turnover		**17.5%**	16.9%		**17.5%**	16.9%
Wf-8	Reported Bullying & Harassment Cases		**0**	0		**8**	7
Wf-9	Cases of Whistle Blowing		**1**	0		**1**	1

2.2. Workforce Commentary

2.2.1. Vacancies for this month have risen slightly again to give an overall vacancy rate of 13.60%. However, when the vacancy rate is adjusted to include those already recruited, and in the pipeline to be in place by 31/3/18 (152 wte) it drops to 9.29%.

2.2.2. Within Corporate services there continues to be a high vacancy rate in the areas undergoing restructure and also in the PMO. The majority of these roles are filled by interim staff during the restructure activity. Work continues for the resourcing team to fill the PMO roles.

2.2.3. Within Operational Services, the vacancy rate breakdown is as follows:

- In the 999 service it is 12.7% adjusted to 7.25% when the 115 wte in the pipeline are taken into account

- In the EOC it is 10% adjusted to 4.4% when the 27 wte in the pipeline are taken into account

- In 111 it is 16% (or 27 wte) dropping to 14% when the 4 wte in the pipeline are taken into account

2.2.4. The increased turnover rate has led to the situation of losing more people over the last two months than we have recruited, so the activity in the recruitment team has been to work closely with Operation colleagues to increase the number of new hires per month.

2.2.5. As predicted the turnover rate continues to increase slightly and will do so until the impact of the cultural work planned for Q3 this year starts to take effect.

2.2.6. Once the corporate restructures are complete recruitment into those vacancies will be targeted.

2.2.7. The roll out of the online appraisal system Actus, continues with 95% of the workforce live on the system.

2.2.8. There has been a significant increase in usage between July (19%) and August (34%) of staff that have had Objective/career conversations for the year going forward. The team continue to work with managers to increase this rate.

2.2.9. The new year for mandatory training has commenced and a new process for recording training has been introduced. We will continue to review the most accurate way of reflecting statutory and mandatory training.

2.2.10. The diagnostic review of Bullying and Harassment was delivered on schedule and a round of focus groups are underway to consult with staff. An action plan to support all the recommendations will be developed following this activity.

2.2.11. The Q2 run of the quarterly Pulse Survey produced an increased response rate.

2.2.12. Banstead EOC staff successfully moved into Nexus House in September 2017.

2.3. Workforce Charts

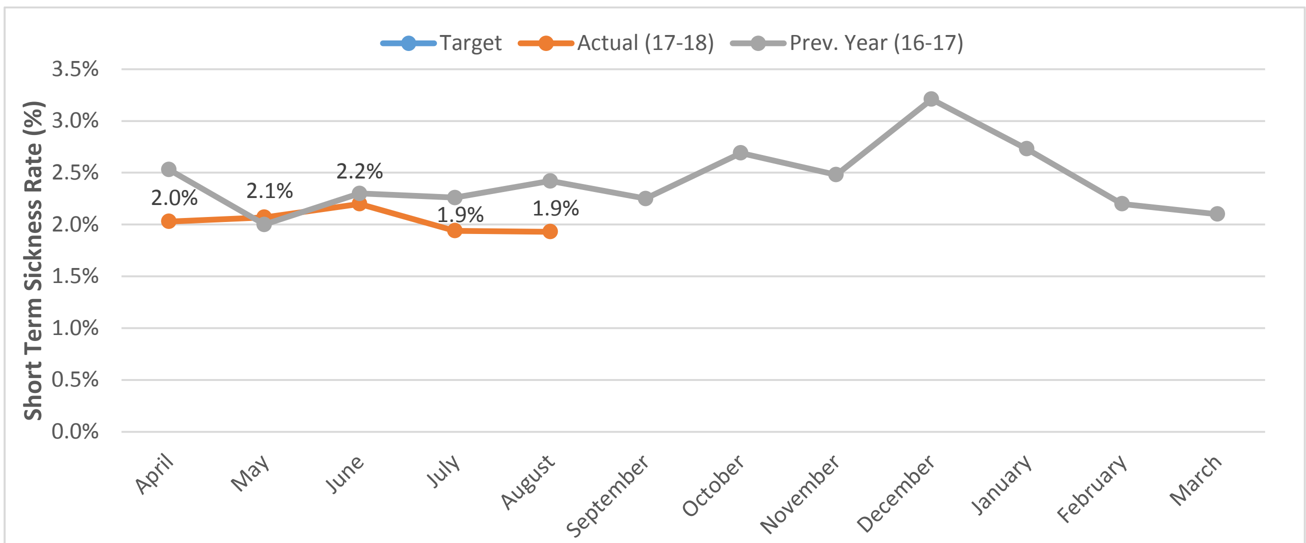


Figure Wf-1A - Short Term Sickness Rate

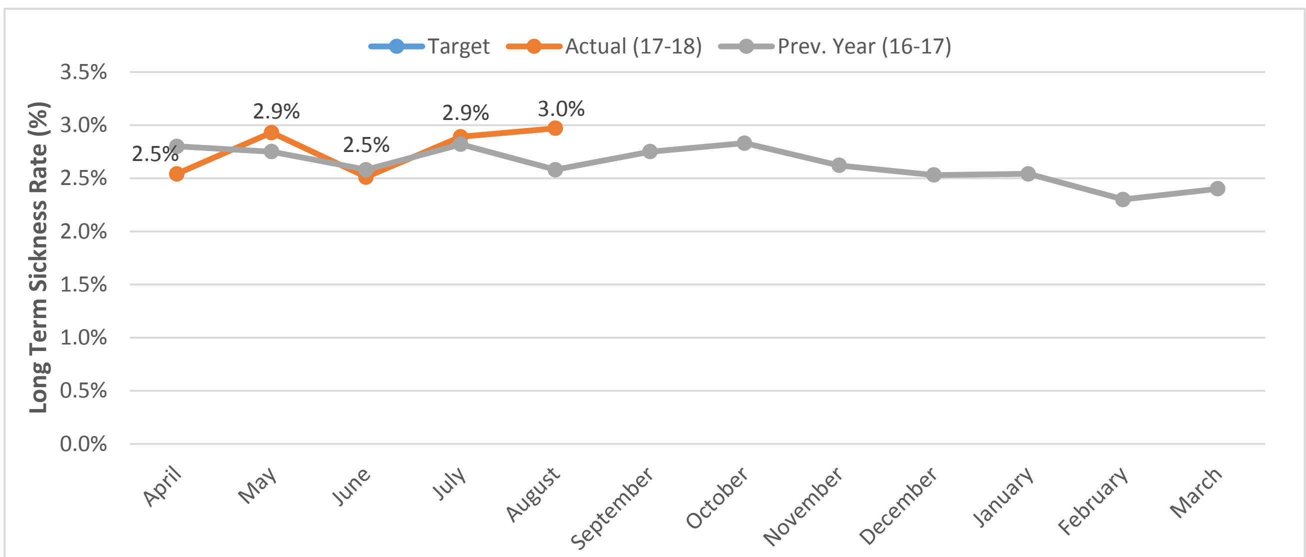


Figure Wf-1B - Long Term Sickness – Rate

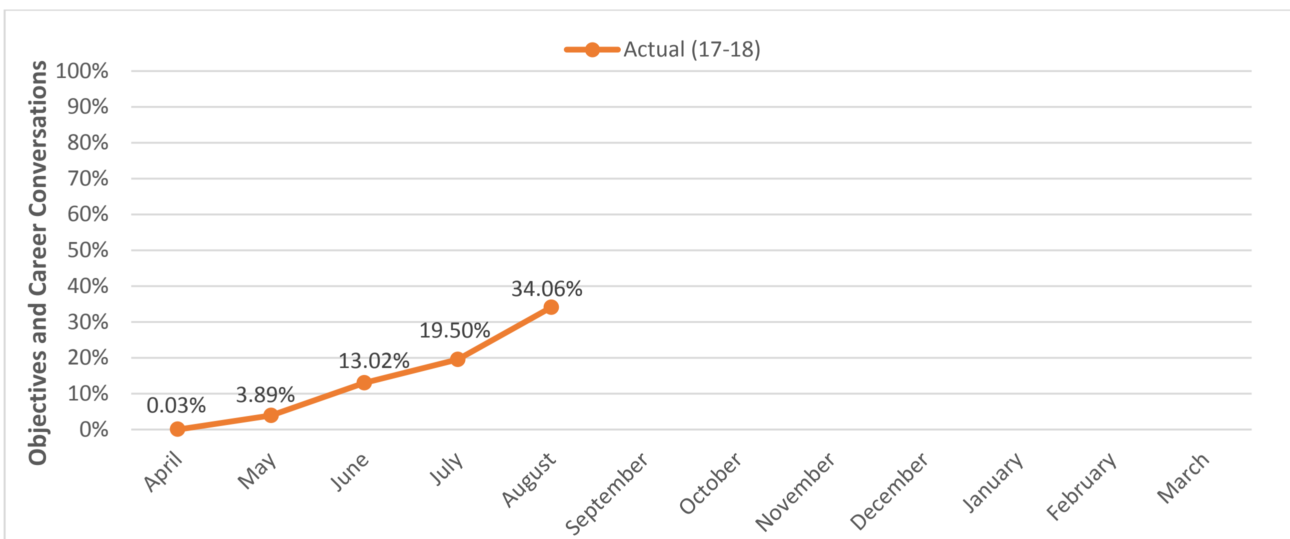


Figure Wf-2B - Objectives and Career Conversations

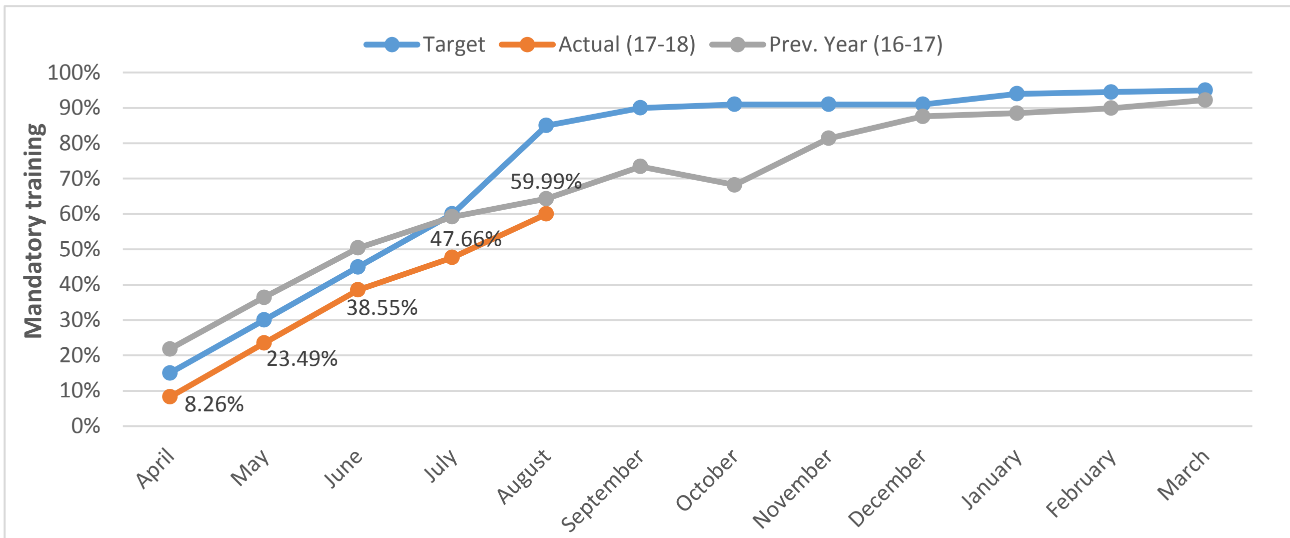


Figure Wf-3 - Mandatory Training Compliance (All Courses)

Unavailable
Figure Wf-4 - Total injuries.

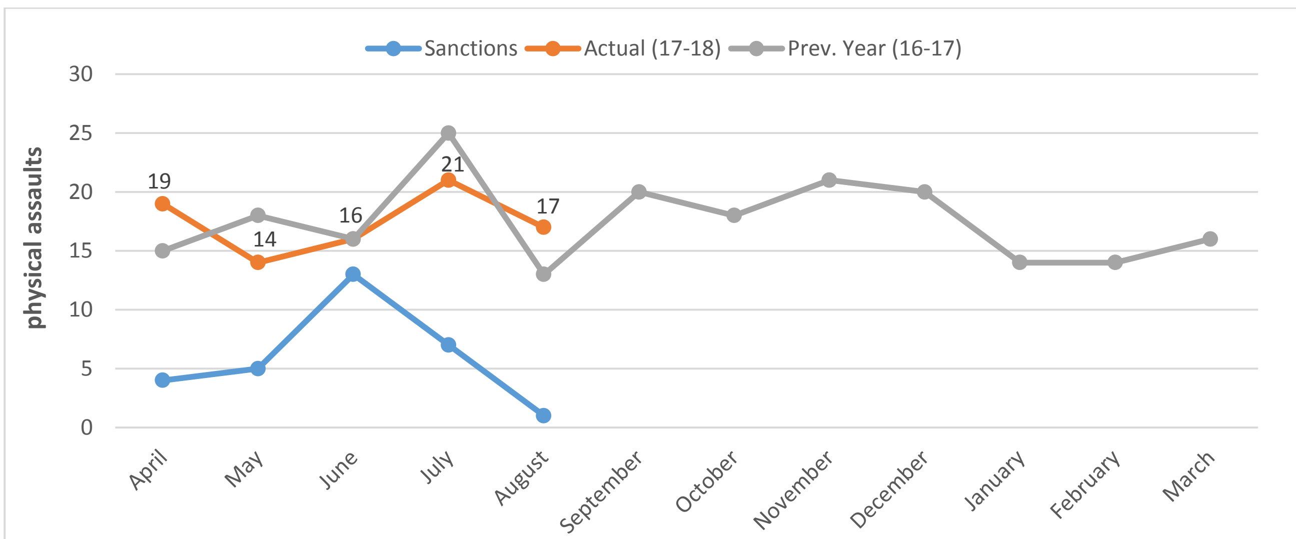


Figure Wf-5 - Physical Assaults (Number of victims).

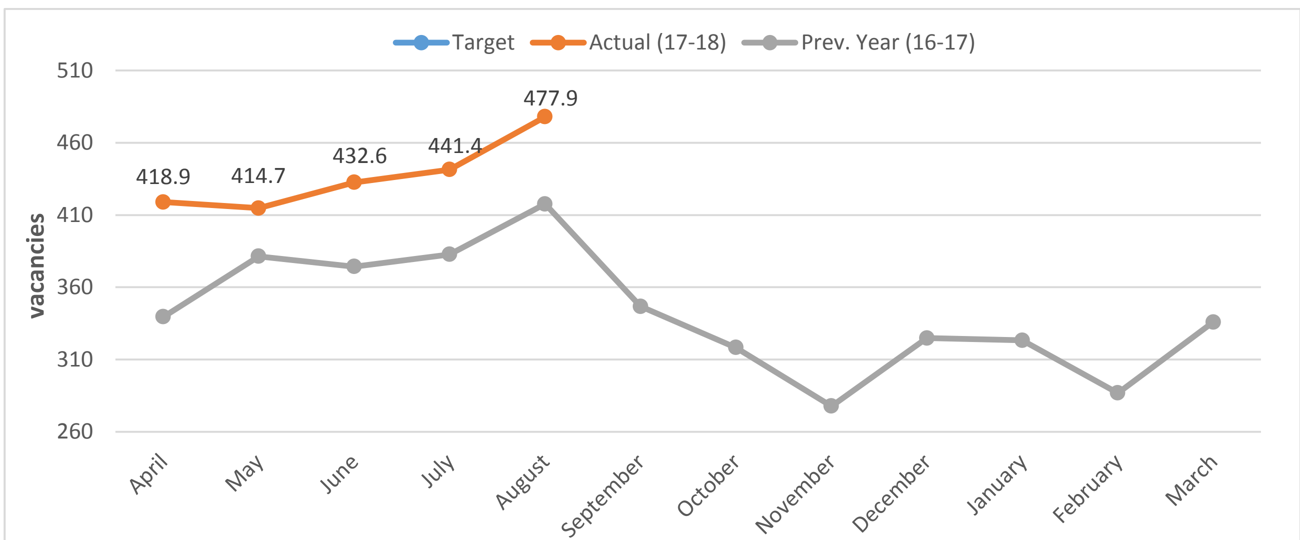


Figure Wf-6 - Vacancies (Total WTE)

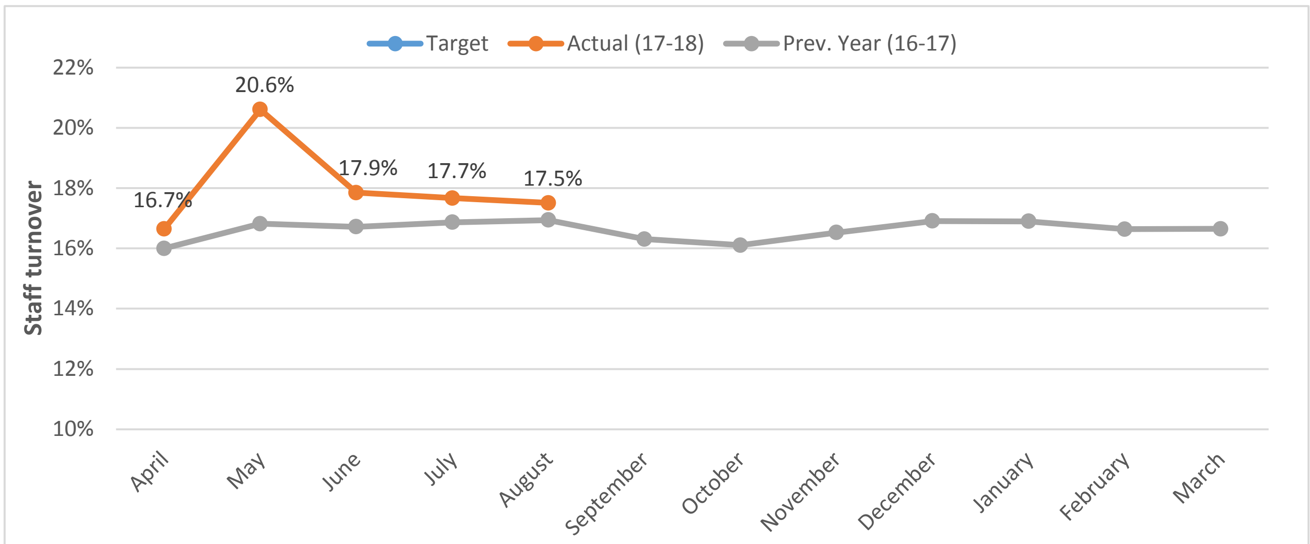


Figure Wf-7 - Annual Rolling Staff Turnover

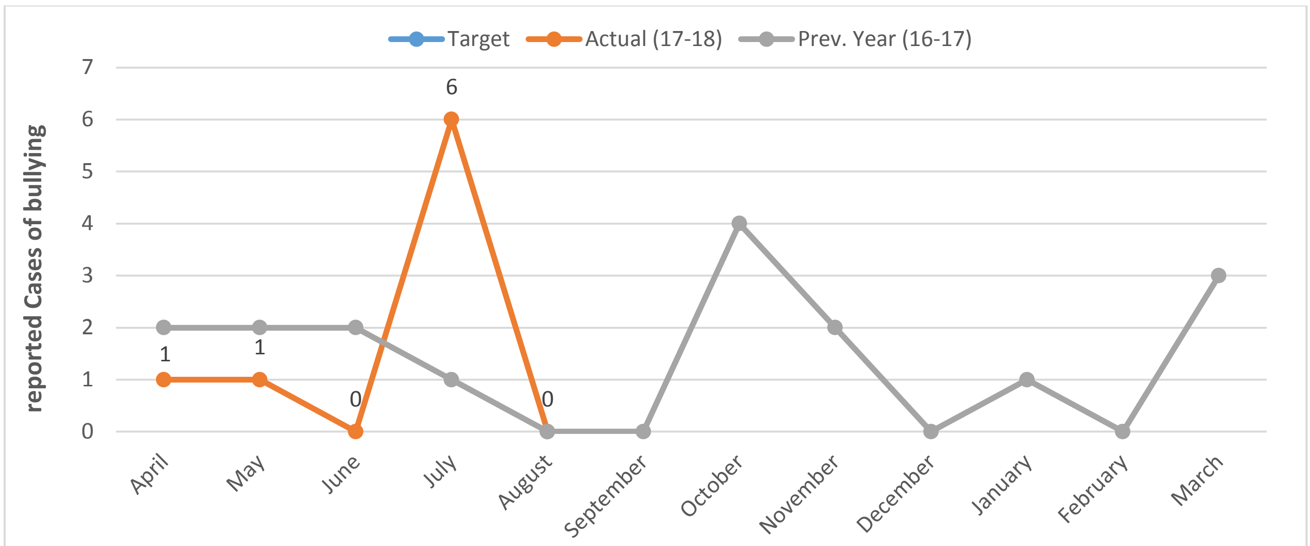


Figure Wf-8 - Reported Bullying & Harassment Cases

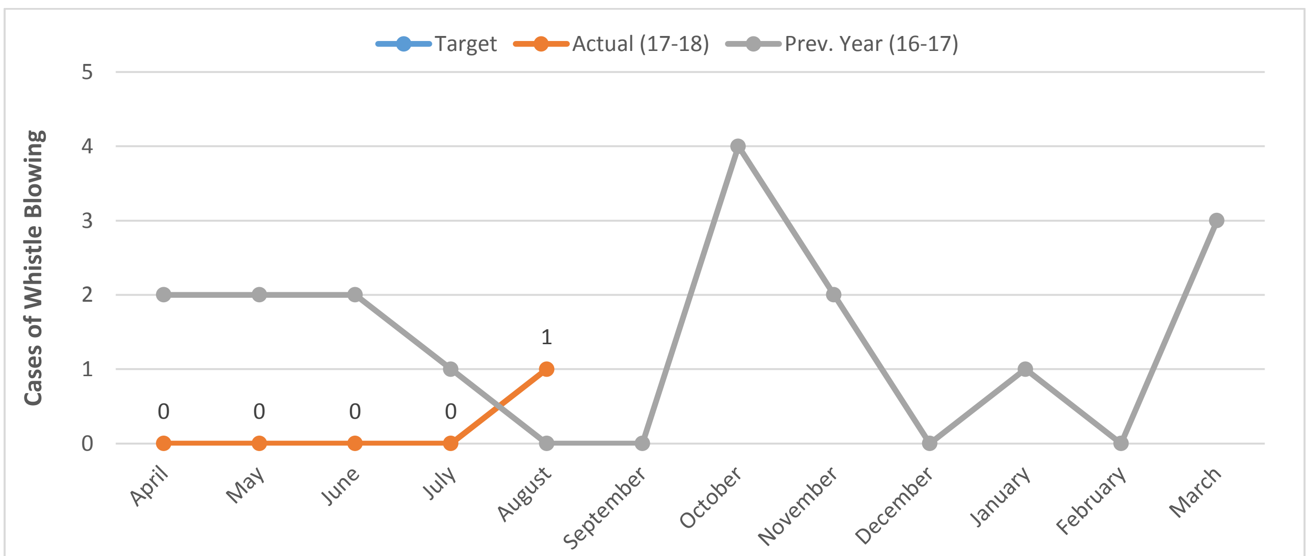


Figure Wf-9 - Cases of Whistle Blowing

3. Operational Performance

3.1. Operational Performance Summary

3.1.1. SECAmb's 999 response time performance was below the national target for August 2017 and also below the planned levels of response for Red 1 and 2. Red 19 was close to the planned level, at only 1% below plan. Despite not meeting national targets, the Trust did witness an increase in performance on all three areas of performance over July.

3.1.2. Hospital turn-around delays stayed consistent and were over two and a half times above the planned level for August, causing a significant impact on operational performance. There was a circa 200-hour reduction over the hours lost within July, however, with demand 7.4% below in comparison to July, the delays are above the level anticipated.

3.1.3. Demand was 10.2% below the commissioned level of activity, and below the level seen in August 2016. It is currently believed that this is as a result of the new CAD system being implemented across two of the three EOCs, which contains improved functions to stop the duplication of calls and provide an accurate account of the Trust's current position.

3.1.4. Call answer performance continued to decline, dropping to 58% for August. This would have had a direct impact on the Trust's Red 1 performance. This has been an area of difficulty for the Trust whilst the CAD transition has been on-going, due to the high levels of abstractions required to train staff on the new CAD. It is hoped that this performance will improve once the CAD training has been completed and the two EOCs settle into the new ways of working.

3.2. Operational Performance Scorecard

Operational Performance Scorecard:- Data From August 2017

ID	KPI	Current Month (Plan*)	Current Month (Actual)	Current Month (Prev. Yr.)	YTD (Plan*)	YTD (Actual)	YTD (Prev. Yr.)
999-1	Red 1 response <8 min	67.3%	**59.3%**	64.6%		**64.1%**	64.5%
999-2	Red 2 response <8 min	51.1%	**46.5%**	52.5%		**49.4%**	54.0%
999-3	Red 19 Transport <19 min	88.1%	**87.1%**	89.7%		**88.1%**	89.9%
999-4	Activity: Actual vs Commissioned	70725	**63465**	68142	349906	**333359**	337185
999-5	Hospital Turn-around Delays (Hrs lost >30 min.)	2081	**5236**	5346	11415	**25847**	24938
999-6	Call Pick up within 5 Seconds	90.1%	**58.3%**	70.9%		**71.9%**	67.3%
999-7	CFR Red 1 Unique Performance Contribution	0.8%	**1.3%**	1.2%		**1.3%**	1.2%
999-8	CFR Red 2 Unique Performance Contribution	0.7%	**0.8%**	0.8%		**0.8%**	0.8%
111-1	Total Number of calls offered		**80524**	90429		**436740**	482005
111-2	% answered calls within 60 seconds	95%	**93.5%**	91.4%	95.0%	**92.2%**	73.7%
111-4	Abandoned calls as % of offered after 30 secs	2.0%	**0.6%**	0.9%	2.0%	**0.9%**	**5.9%**
111-5	Combined Clinical KPI (% of Call Back >10mins & % of all 111 calls warm referred to a Clinician)	90%	**80.1%**	82.2%		**75.9%**	**75.0%**

** For the following KPI's, the "Plan" in the table above is the Unified Recovery Plan (URP) target agreed with commissioners. The URP targets and the standard national targets are both shown in the Charts on the following few pages. KPIs affected: 999-1 to 999-3; 999-6; 111-2, 111-4 and 111-5.*

3.3. Operational Performance Commentary

3.3.1. Red performance was below the anticipated plan and below the national performance targets for August, however, this level of performance was an improvement on July's position, with an increase of circa 2% on July for Red 1 performance and a 0.7% increase on Red 2 performance. The Red 19 performance target shows the Trust's ability to manage the tail of response for Red calls, with SECAmb's position close to the national average which has been circa 90% for May – July.

3.3.2. Response demand was 10% below that commissioned for August and 7.4% below the level received in July. This is believed to be as a result of the new CAD system reducing the number of duplicate calls recorded.

3.3.3. The Trust has implemented plans to increase contribution from community first responders (CFRs). This entails improving technical links with CFRs, new processes in EOC to mobilise the CFRs and an extensive engagement campaign with the CFRs themselves. However, although benefits are being realised, we have seen a sustained reduction in performance against the planned trajectory for this group of responders. There are further plans being put in place to improve the CFR contribution to the Trust, whilst looking further forward to see where CFRs can be utilised under the new Ambulance Response Programme (ARP) measures.

3.3.4. Due to differences in the dataset the new CAD reports, hear and treat performance is currently unavailable.

3.3.5. Call answer performance took another reduction in August, falling to 58.3%. This would have had a direct impact on the Trust's Red 1 performance. This has been an area of difficulty for the Trust whilst the CAD transition has been ongoing, due to the high levels of abstractions required to train staff on the new CAD. It is hoped that this performance will improve once the CAD training has been completed and the two EOCs settle into the new ways of working.

3.3.6. SECAmb has been working with both commissioners and acute hospitals to improve the current hospital handover position for the Trust. Although there was a 200-hour reduction in hours lost in August in comparison to July, this is higher proportionally due to the reduction in demand seen for August.

3.3.7. KMSS 111 continues to provide a good level of service and in August 2017, it outperformed the NHS E national monthly average in the main five key performance indicators of SLA (Answered in 60 seconds), Combined Clinical performance, and Abandoned call rate along with both 999 and ED referral rates.

3.3.8. On a monthly volume of 80,524 Calls Offered, the service recorded a Service Level of 93.5%, ahead of the national average of 92.7%. This included 19 individual days exceeding 95% performance. Conversely the Call Abandonment rate fell to just 0.6%, and the Average Speed to Answer fell to just 11 seconds, the second fastest monthly rate in KMSS 111 over the last eighteen months.

3.3.9. For the financial Year to Date (April 2017 onwards), the KMSS 111 Service Level stands at 92.16%, with a Call Abandonment rate below 1%.

3.3.10. The service also continues to maintain an excellent level of clinical focus, as demonstrated by KMSS 111 exceeding 80% for Combined Clinical performance on the third occasion over the last eight-month period. Again KMSS 111 comfortably

outperformed the national clinical KPI in August (68.8%). In addition, the service continues to mitigate pressure on the wider system, by actively managing Ambulance referral rates (10.48% compared to the national 11.08% and the second lowest monthly 999 referral rate in 2017) and ED referral rates (7.90% compared to the national 7.99%). Despite the challenges that KMSS 111 has encountered over the summer period, Clinical In-line Support (CIS) has been maintained in both contact centres at core times, and the rota for our floor-walking clinicians to support ambulance validation was extended before the end of August to become operational on a 24 hours a day, 7 days a week basis.

3.3.11. The flexibility of the KMSS 111 service and its influence across the wider health economy was demonstrated during the evening of Sunday 27th August, as a result of the Birling Gap "toxic cloud" incident in East Sussex. The Ambulance service and local "Acutes" were under severe pressure, with over 200 admissions directly relating to this incident. KMSS 111 experienced a surge in call volume over a three-hour period in the early evening. This adversely impacted on operational performance; however, a high quality and safe service was maintained, not least by the 111 clinicians who protected services across the wider health system by actively managing Green (non-emergency) ambulance dispositions and securing alternative appropriate outcomes without compromising patient safety.

3.3.12. The service continues to make progress on the six Joint Commissioner Provider clinical pilots, in collaboration with other providers and commissioning units across the KMSS region. Project Leads are held accountable for actions and specific milestones in order to maintain a satisfactory rate of progress and to stay aligned with Commissioner-agreed objectives. In addition, work continues towards a revision of the KMSS 111 operating model, although this has been subject to a delay, attributable to the service being asked by Commissioners from another locality to prepare (at short notice) contingency plans to mobilise in support of another NHS 111 service provider currently struggling.

3.4. Operational Performance Charts

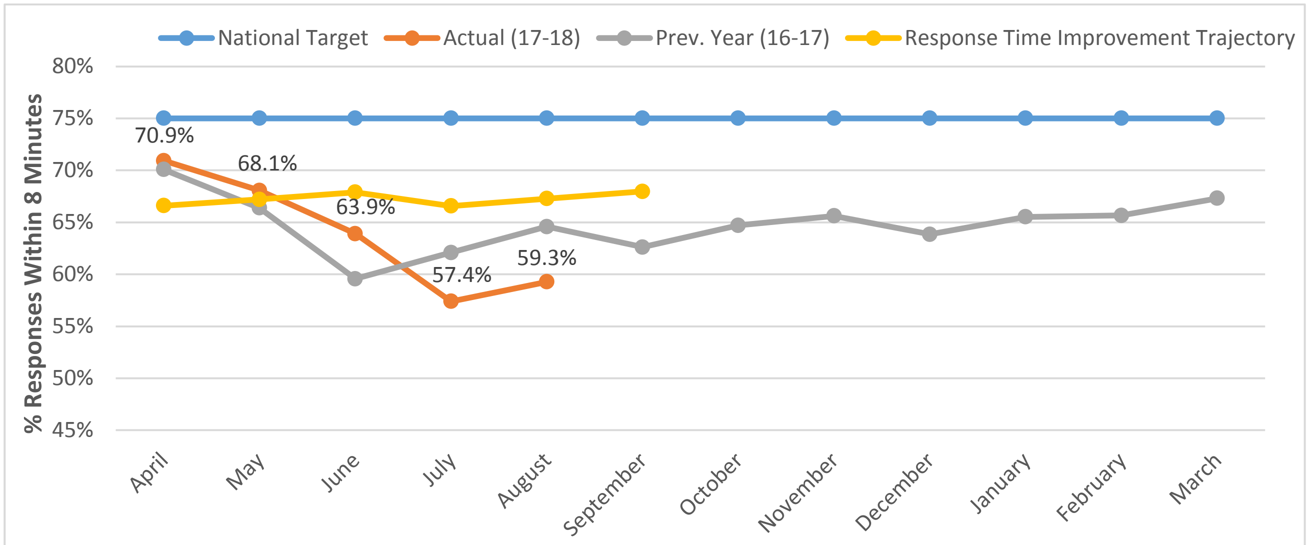


Figure.999-1 - Red 1 response <8 min

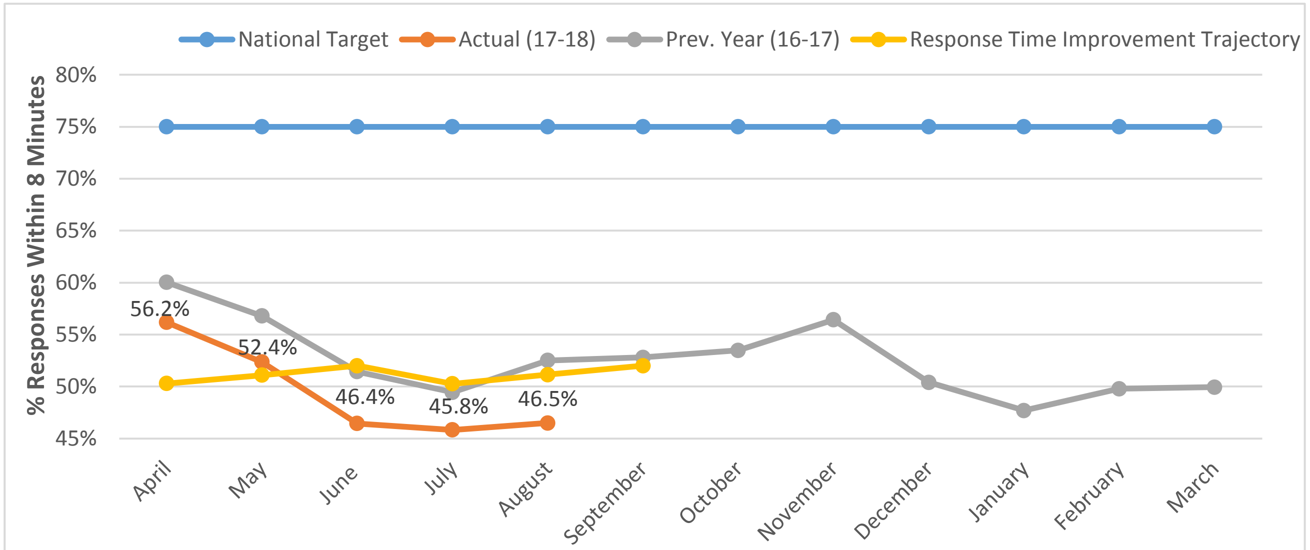


Figure.999-2 - Red 2 response <8 min

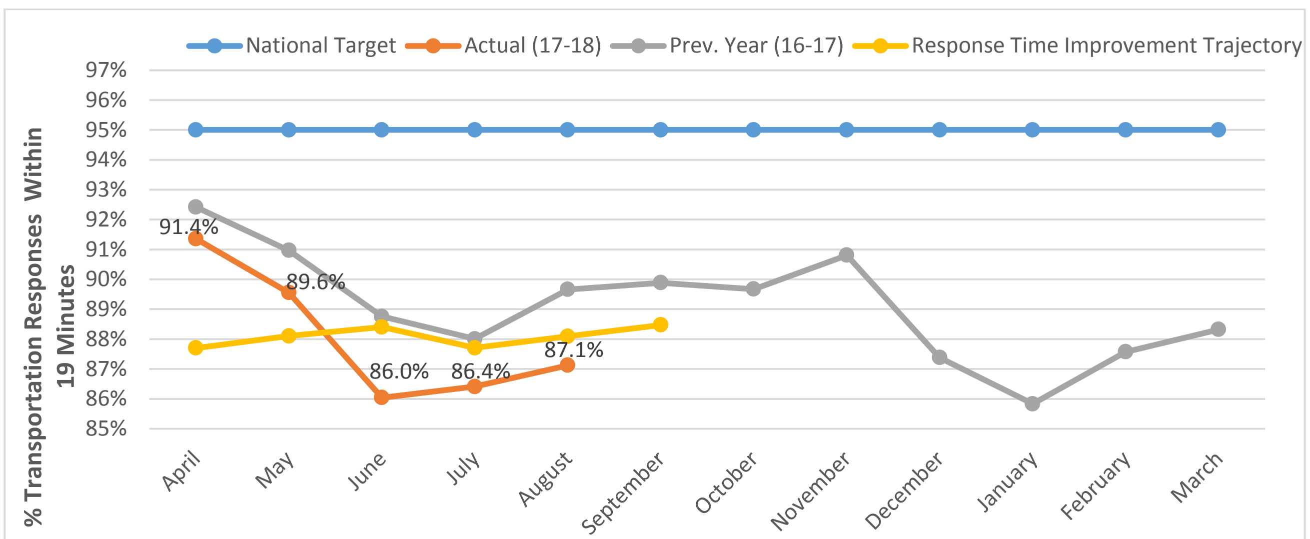


Figure.999-3 - Red 19 Transport <19 min

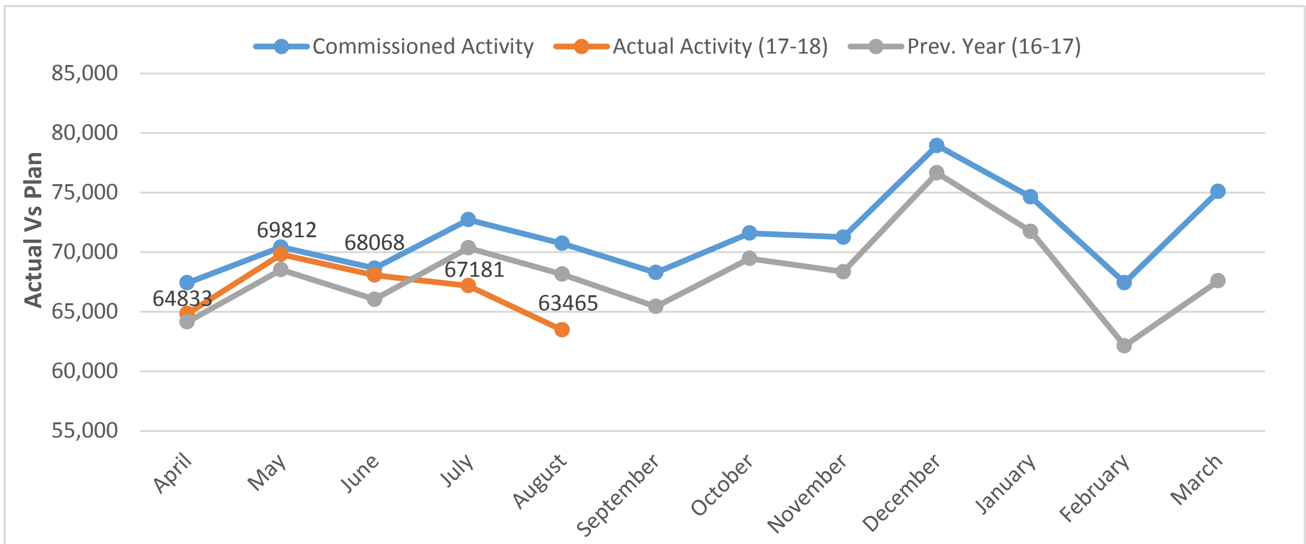


Figure.999-4 - Activity: Actual vs Commissioned

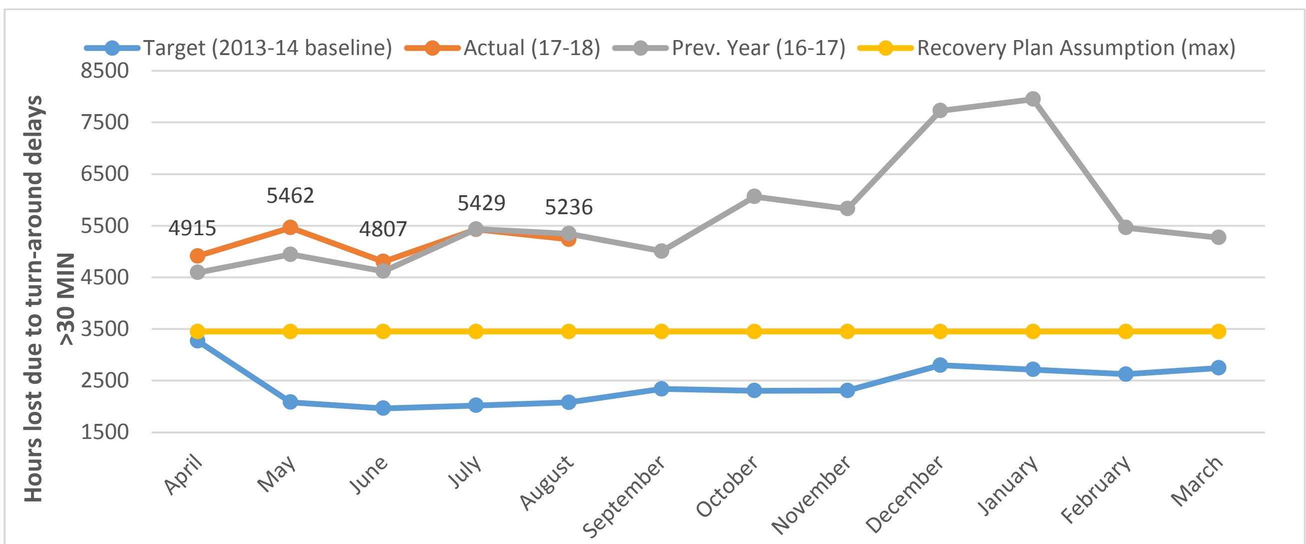


Figure.999-5 - Hospital Turn-around Delays (Hrs lost >30 min.)

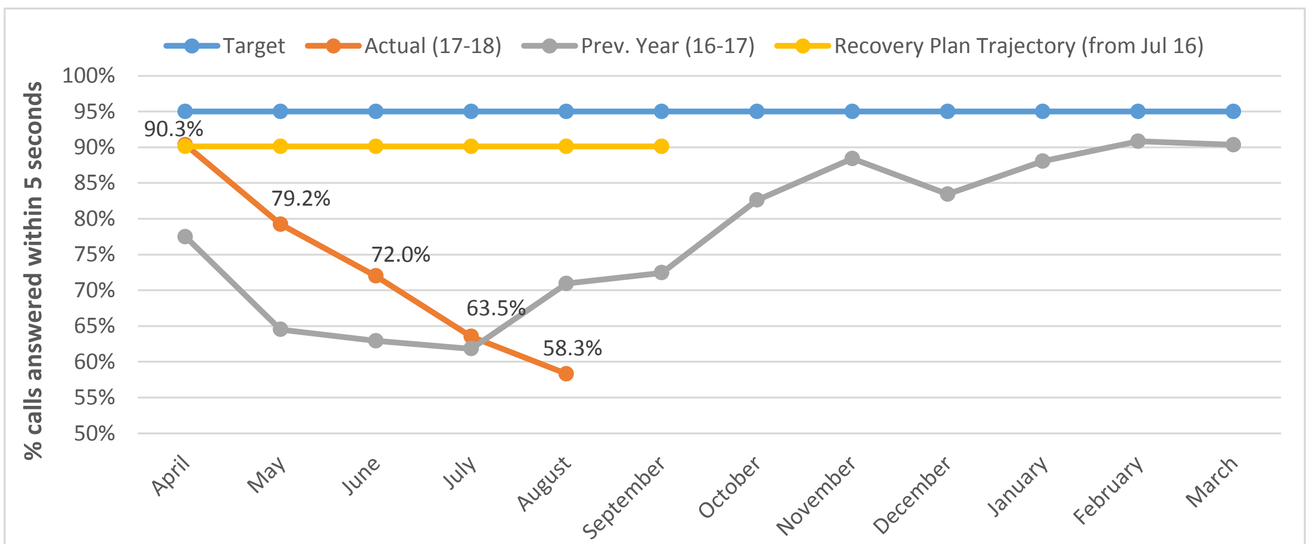


Figure.999-6 - Call Pick up within 5 Seconds

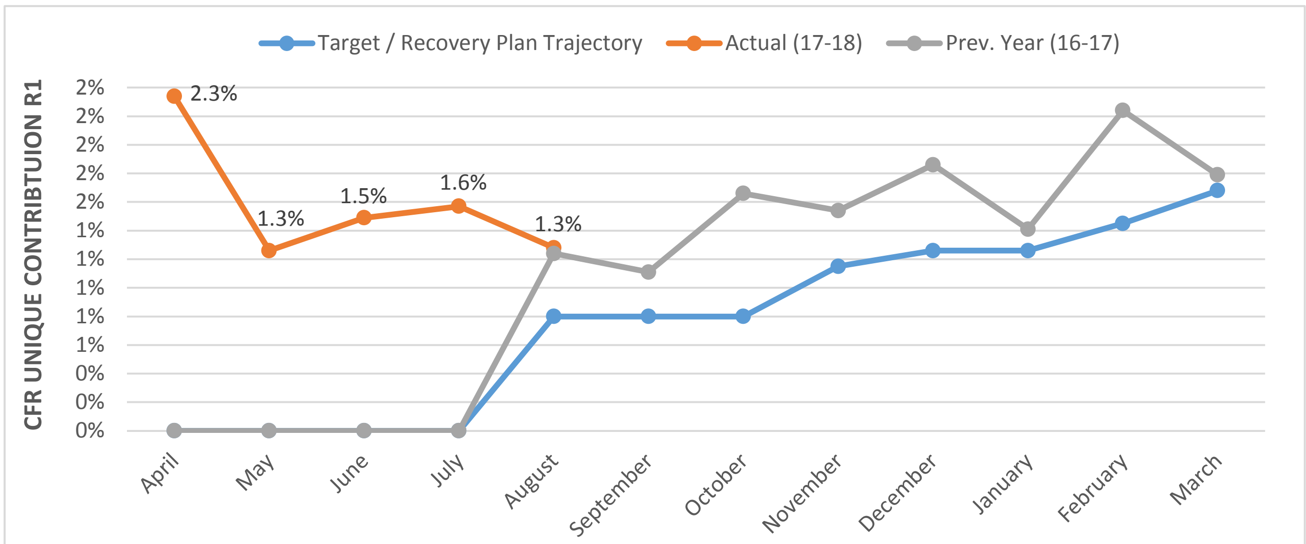


Figure.999-7 - CFR Red 1 Unique Performance Contribution

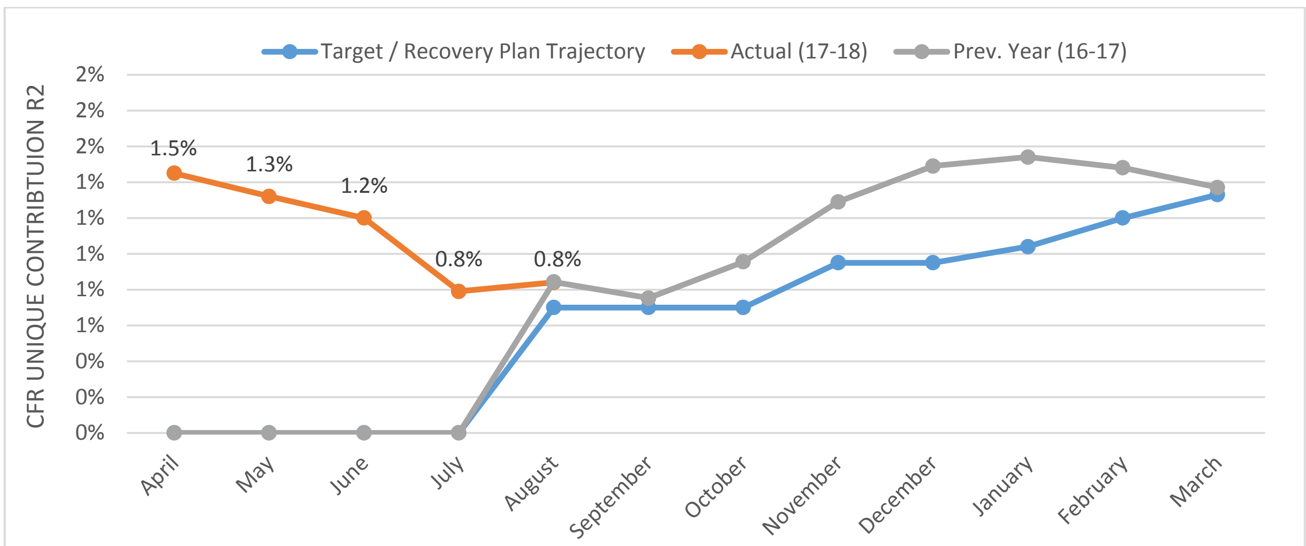


Figure.999-8 - CFR Red 2 Unique Performance Contribution

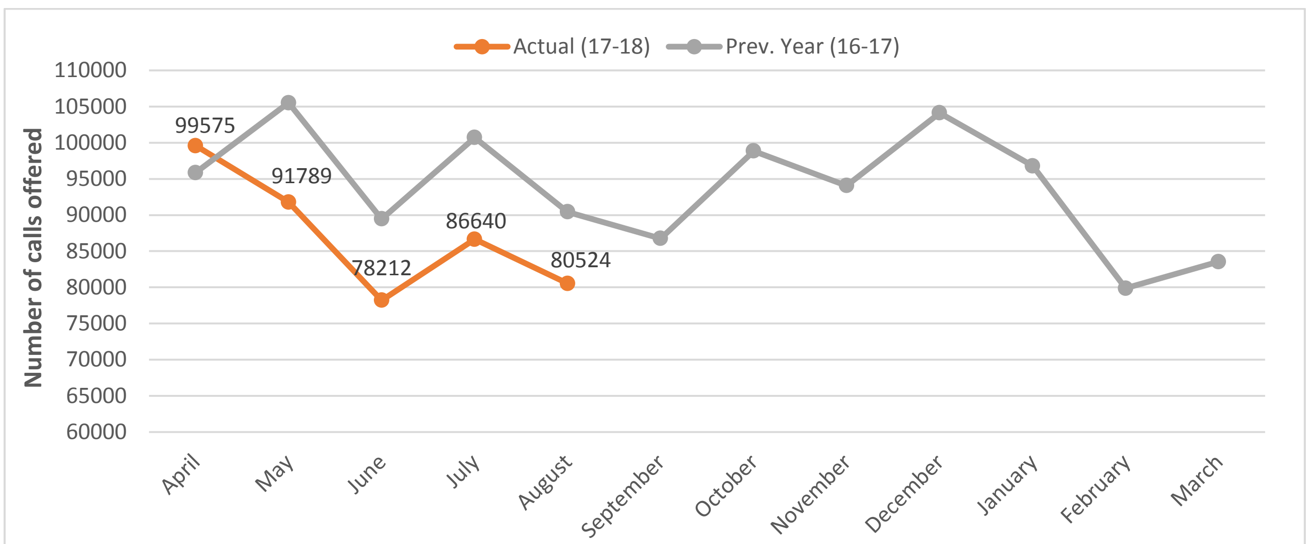


Figure.111-1 - Total Number of calls offered

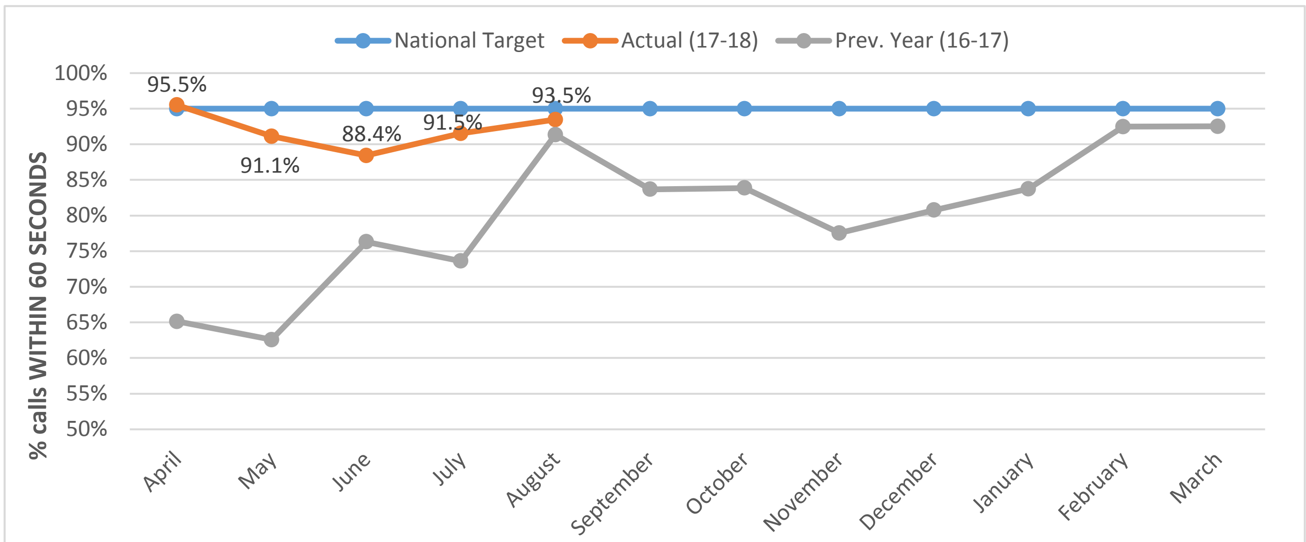


Figure.111-2 - % answered calls within 60 seconds

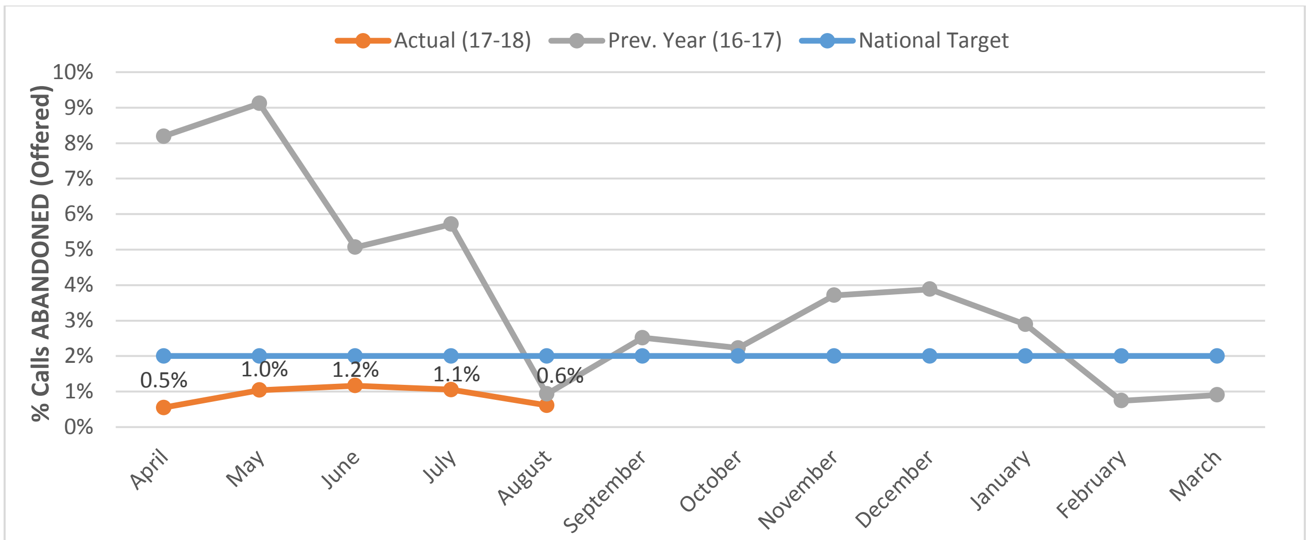


Figure.111-4 - Abandoned calls as % of offered after 30 secs

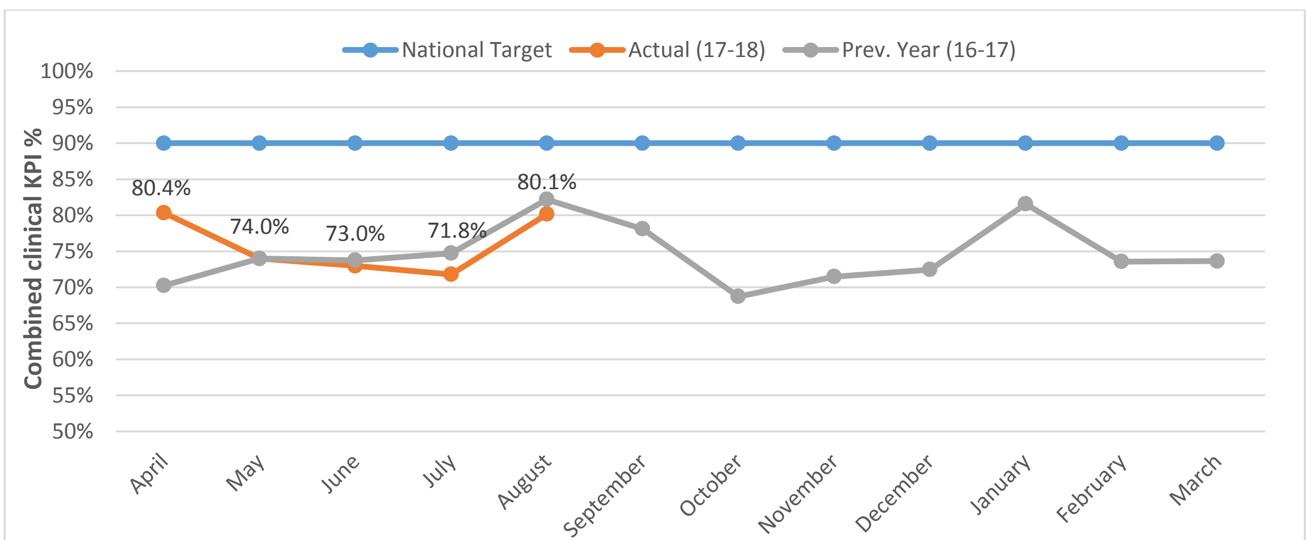


Figure.111-5 - Combined Clinical KPI (% of Call Back >10mins & % of all 111 calls warm referred to a Clinician)

4. Clinical Effectiveness

4.1. Clinical Effectiveness Summary

4.1.1. This report demonstrates the Trust's performance against the eight Ambulance Clinical Quality Indicator (ACQIs) reported to NHS England for Month 1 (April 2017). The data continues to show variable achievements in delivering patient outcomes in relation to the ACQIs.

4.2. Clinical Effectiveness KPI Scorecard

Clinical Effectiveness KPI Scorecard:- Data From April 2017

ID	KPI	Current Month (Nat. Av.*)	Current Month (Actual)	Current Month (Prev. Yr.)	YTD (Nat. Av.*)	YTD (Actual)	YTD (Prev. Yr.)
CE-1	Cardiac arrest - ROSC on arrival at hospital (Utstein)	54.8%	62.1%	61.1%	54.8%	62.1%	52.5%
CE-2	Cardiac arrest - Return of spontaneous circulation on arrival at hospital (All)	30.2%	28.0%	26.3%	30.2%	28.0%	28.0%
CE-3	Cardiac arrest -Survival to discharge - Utstein	31.1%	33.3%	25.7%	31.1%	33.3%	21.0%
CE-4	Cardiac arrest -Survival to discharge - All	9.1%	8.1%	6.2%	9.1%	8.1%	6.1%
CE-5	Acute ST-elevation myocardial infarction - Outcome from STEMI (Care bundle)	76.7%	59.6%	69.1%	76.7%	59.6%	67.2%
CE-6	Acute ST-elevation myocardial infarction - Proportion receiving primary angioplasty within 150 minutes	87.6%	87.9%	94.2%	87.6%	87.9%	89.6%
CE-7	% of FAST positive patients potentially eligible for stroke thrombolysis arriving at a hyperacute stroke unit within 60 minutes	58.7%	66.8%	76.4%	58.7%	66.8%	63.9%
CE-8	% of suspected stroke patients assessed face to face who received an appropriate care bundle	97.3%	94.1%	95.8%	97.3%	94.1%	95.8%

** The Clinical AQIs (CE-1 to 8) do not have a target, and so are benchmarked against the national average.*

4.3. Clinical Effectiveness

4.3.1. The data above shows the Trust's clinical performance for the month of April 2017. These are the most up to date figures which have been submitted to NHS England. There is a time delay with submission of figures to enable hospital outcome information to be obtained.

4.3.2. There are four indicators where the Trust is above the national average for April 2017 and four indicators where performance is below the national average.

4.3.3. The cardiac arrest ROSC indicator for the Utstein group for April was 62.1% which is significantly higher than the national average of 54.8% and puts the Trust in fourth place for this indicator however this is a decrease of 0.8% on the previous month. ROSC for all patients however remains below the national average at 28%. Survival to discharge for the Utstein group is 33.3% which is above the national average and significantly higher than March which was 16.7% however overall survival to discharge is 8.1% which is slightly below the national average of 9.1% but is an improving picture on the previous month of 6.7%.

4.3.4. In April 2017 the Trust's performance for Acute ST-elevation myocardial infarction who received primary angioplasty within 150 minutes was 87.9% which is very slightly above the national average of 87.6% however this is a reduction from March of approximately 4%. Compliance with the Stemi care bundle is 59.6% which is a decrease from March of 6%.

4.3.5. 66.8% of FAST positive patients potentially eligible for stroke thrombolysis arrived at a hyper acute stroke unit within 60 minutes which is significantly higher than the national average of 58.7% and puts the Trust in second position. This is an increase of 7% from March. Compliance with the care bundle is 94.1% which remains the same as last month and slightly below the national average of 97.3%.

4.3.6. The Clinical Audit team (CAT) continue to ensure that all data submitted and published by NHS England is accurate, this is achieved by the Clinical Audit Coordinators utilising the revised procedure for adherence to the national technical guidance for ACQI reporting. The outcome of this revalidation of previous submissions using the revised procedure may result in changes to the Trust's data but will ensure all national guidance is adhered to. There is an opportunity twice yearly for the Trust to make resubmissions to NHS England.

4.3.7. To improve the accuracy of the ROSC and patient outcome data submitted collaborative working between the health records and clinical audit department continues. This work includes matching and reviewing of incidents to patient clinical records and defibrillation downloads to ensure that the Trust is capturing all cardiac arrests in its monthly returns. A monthly meeting is also taking place to interrogate the data further and to identify areas for further quality improvement.

4.3.8. The Trust currently only reports data for those patients we are able to confirm have survived to discharge and those who have died. Currently there are a number of patients where the outcome is not known and therefore the data submitted is not as accurate as it could be. Work is taking place to address this issue and also quality improvement work is taking place to interrogate the cardiac arrest data further to identify and address issues which might impact on the patient's outcome.

4.4. Clinical Effectiveness Charts

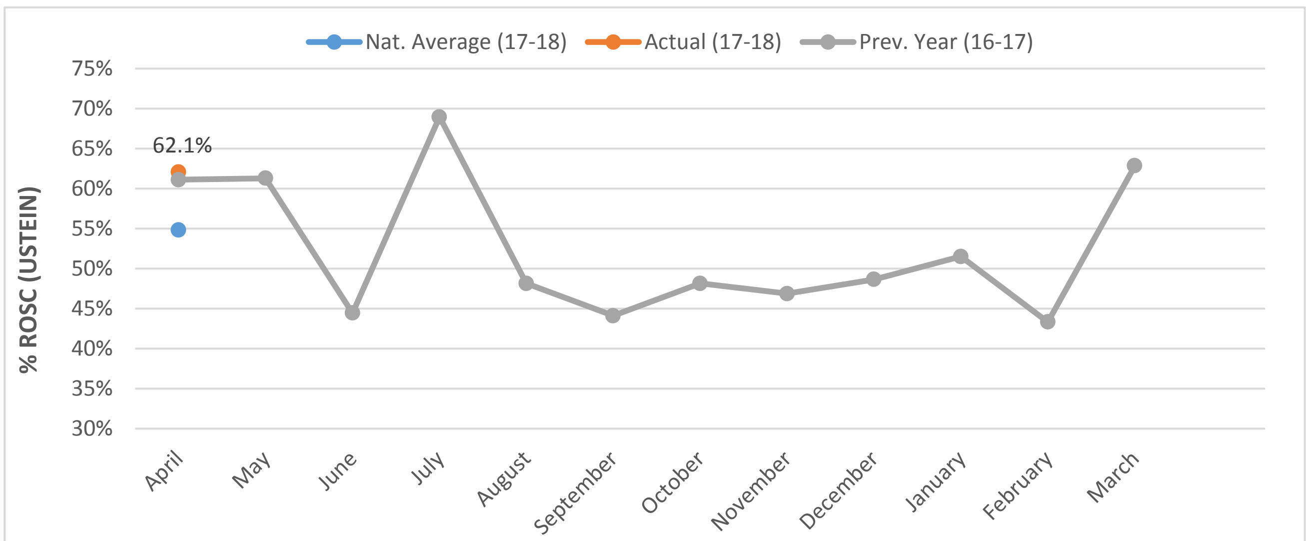


Figure.CE-1 - Cardiac arrest - ROSC on arrival at hospital (Utstein)

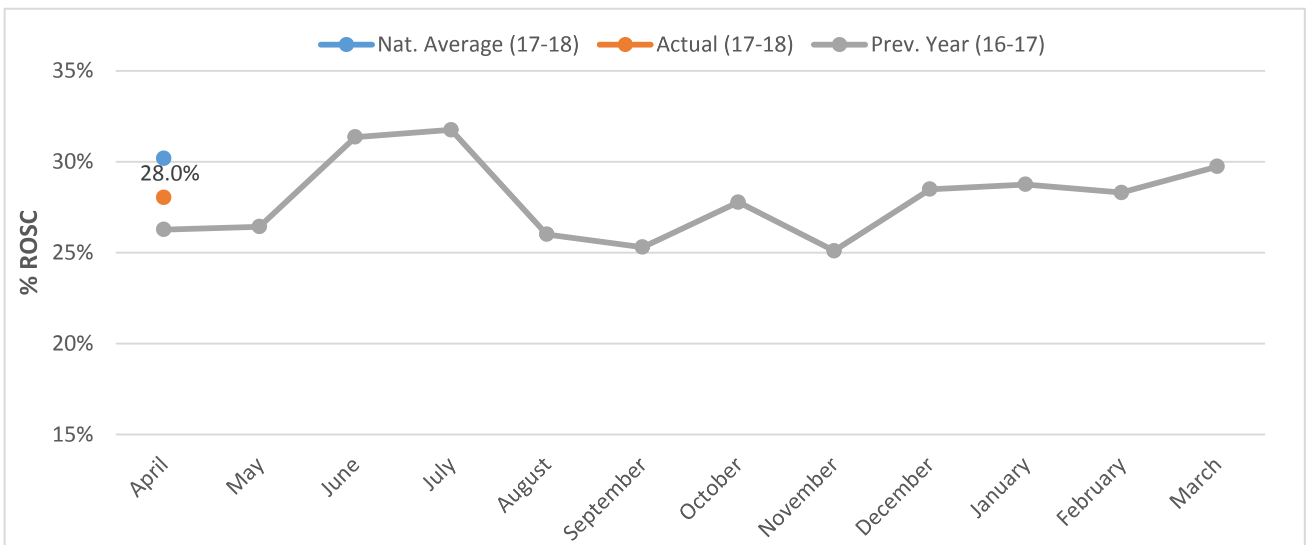


Figure.CE-2 - Cardiac arrest - Return of spontaneous circulation on arrival at hospital (All)

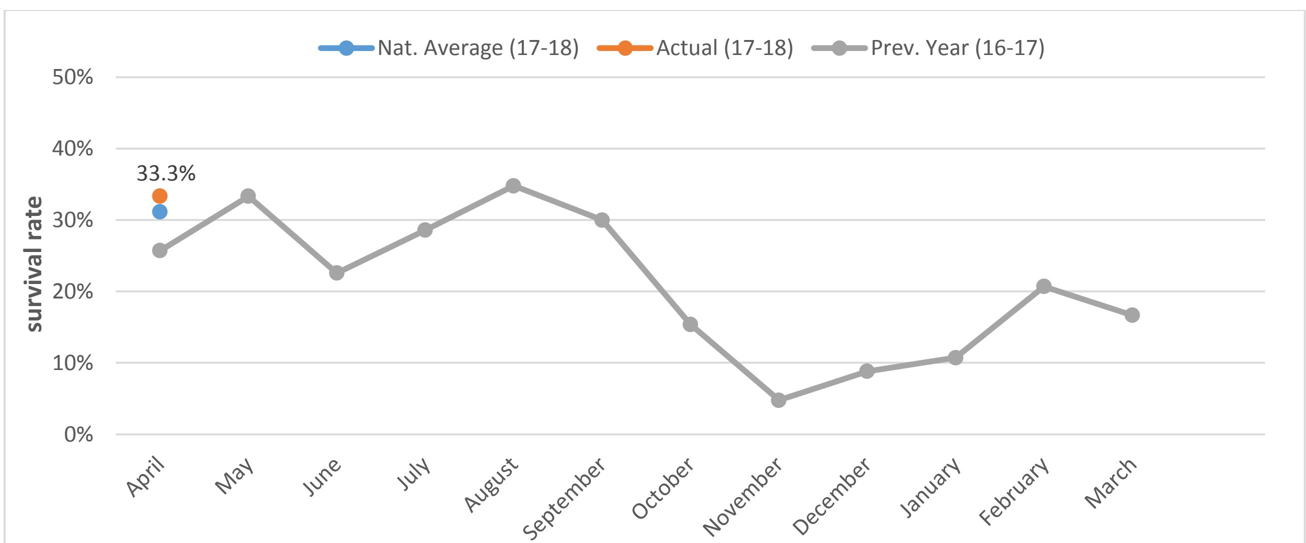


Figure.CE-3 - Cardiac arrest -Survival to discharge - Utstein

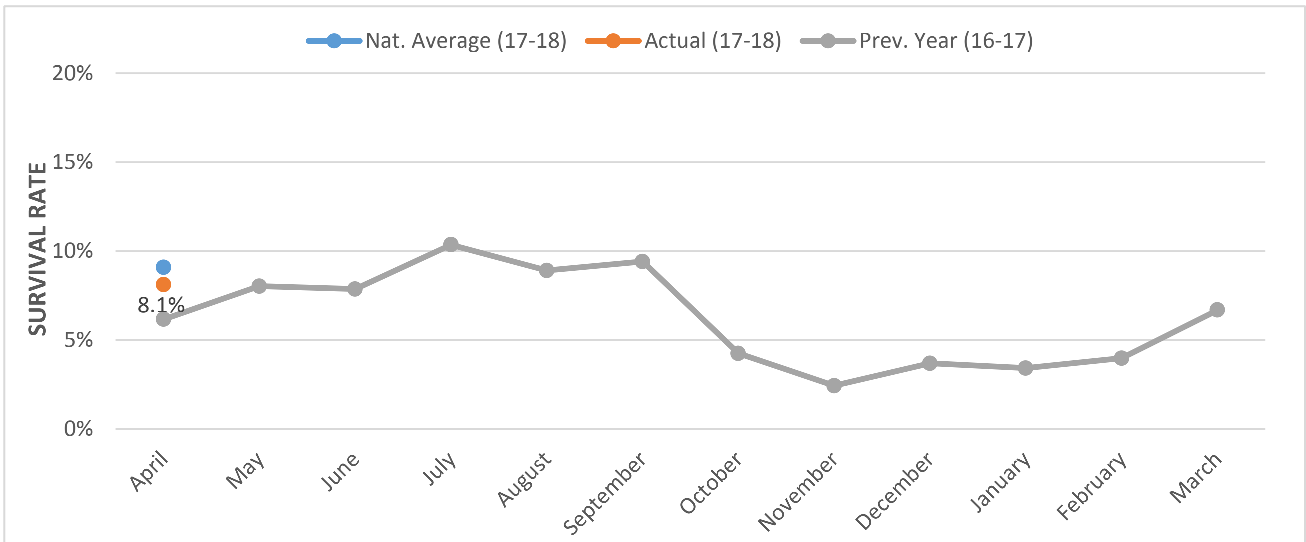


Figure.CE-4 - Cardiac arrest -Survival to discharge – All

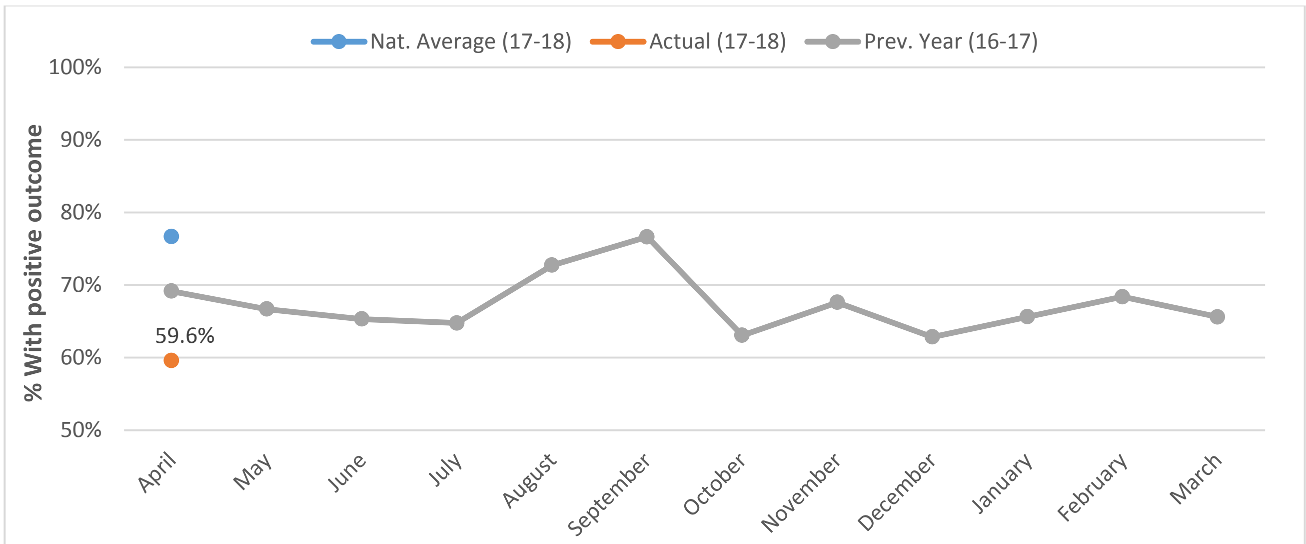


Figure.CE-5 - Acute ST-elevation myocardial infarction - Outcome from STEMI (Care bundle)

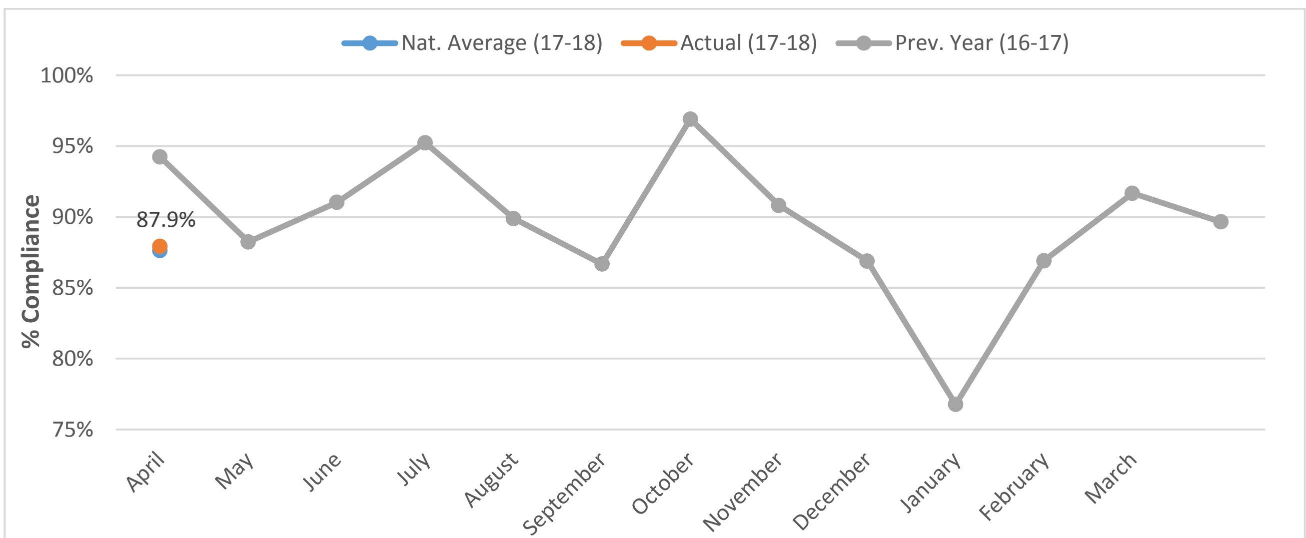


Figure.CE-6 - Acute ST-elevation myocardial infarction - Proportion receiving primary angioplasty within 150 minutes

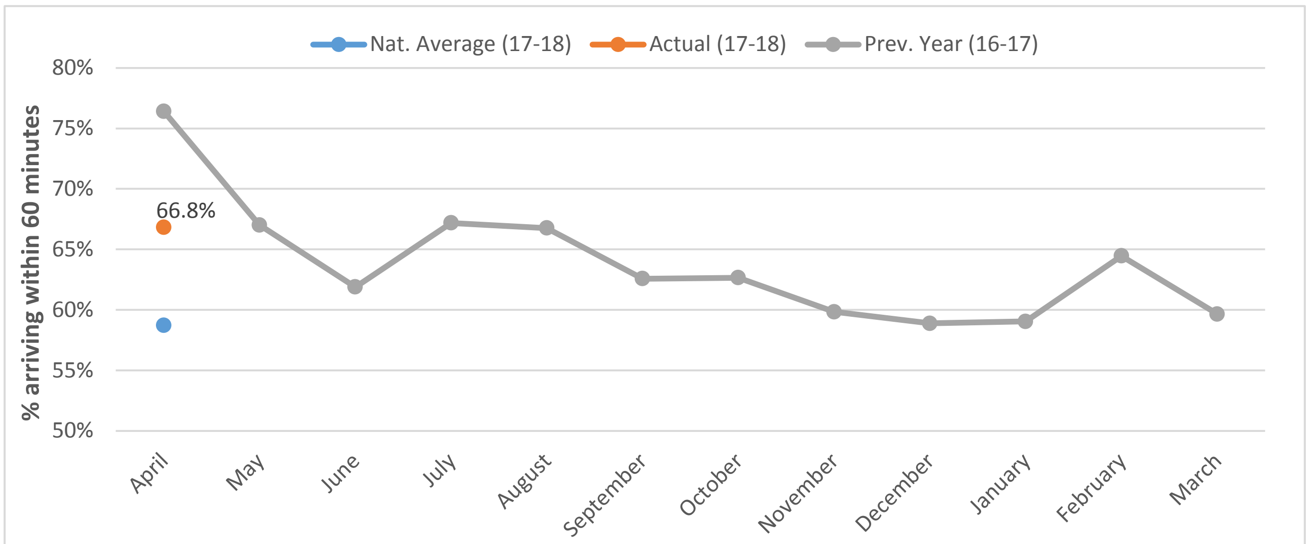


Figure.CE-7 - % of FAST positive patients potentially eligible for stroke thrombolysis arriving at a hyper acute stroke unit within 60 minutes

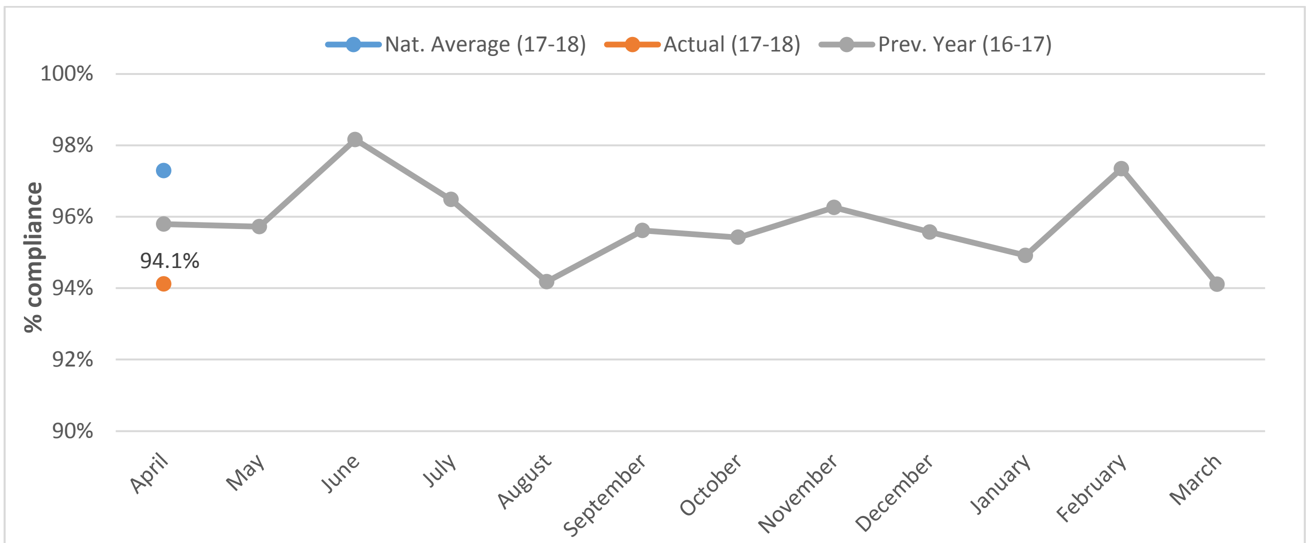


Figure.CE-8 - % of suspected stroke patients assessed face to face who received an appropriate care bundle

5. Quality & Patient Safety

5.1. Quality & Safety KPI Scorecard

Quality & Safety KPI Scorecard:- Data From August 2017

ID	KPI	Current Month (Target)	Current Month (Actual)	Current Month (Prev. Yr.)	YTD (Target)	YTD (Actual)	YTD (Prev. Yr.)
QS1a	SI Reporting timeliness (72hrs)	100%	**30.0%**	22.2%	100%	**11.1%**	19.0%
QS1b	SI Investigation timeliness (60 days)	100%	**0.0%**	100.0%	100%	**12.5%**	86.4%
QS1c	Number of Incidents reported		**573**	493		**2875**	2489
QS1d	Number of Incidents reported that were SI's		**10**	4		**36**	15
QS1e	Duty of Candour Compliance	100%	**30%**		100%	**30%**	
QS2a	Number of Complaints		**105**	144		**439**	696
QS2b	Complaints reporting timeliness (All Complaints)	95.0%	**47.1%**	75.0%	95.0%	**63.4%**	54.4%
QS2c	Mental Capacity Assessment Training		**0.0%**			**0.0%**	
QS3a	Number of Safeguarding Referrals Adult		**718**	760		**3537**	3745
QS3b	Number of Safeguarding Referrals Children		**140**	129		**722**	753
QS3c	Safeguarding Referrals relating to SECAmb staff or services		**2**	1		**4**	2
QS3d	Safeguarding Training Completed (Adult) Level 1	42.0%	Unavailable	Unavailable	42%	Unavailable	Unavailable
QS3e	Safeguarding Training Completed (Children) Level 1	42.0%	Unavailable	Unavailable	42%	Unavailable	Unavailable
QS3f	Safeguarding Training Completed (Adult) Level 2	42.0%	**34.1%**	Unavailable	42%	**34.1%**	Unavailable
QS3g	Safeguarding Training Completed (Children) Level 2	42.0%	**36.0%**	Unavailable	42%	**36.0%**	Unavailable
QS3h	Safeguarding Training Level 3 (Adult/Child)	Unavailable	**23.8%**			**23.8%**	

5.2. Quality & Patient Safety Commentary

Incident Reporting

5.2.1. The new team managing the incident process are now gaining a better understanding of the position and the issues within the Datix system.

- Per Week 130 approx.
- Per Month 550 approx.

5.2.2. At the time of writing this report the current backlog within the closure stage was approximately 29 incidents. This is with a deadline for the team to review all incident for final approval within 20 working days.

5.2.3. In order to manage the backlog and enable the team to prioritise and focus new incident deadlines have been applied. These figures have been revised again and the 40 working days has now been reduced to 20 working days.

Original deadlines:

- Allocating investigator 5 Working Days
- Completing investigation 20 Working Days
- Complete Final Review 40 Working Days

5.2.4. It is intended that the 20 day deadline for final approval will be further reduced to 10 working days at a later stage.

5.2.5. Datix is undertaking a health check on 21st September 17, in order to ensure that it is functioning to meet best practice and enable the trust to perform at an optimum level within the incident reporting and risk modules.

5.2.6. One of the challenges to the efficient management of incidents is the organisations ability to allocate the incidents to an investigator. There has already been some work undertaken to train a number of staff in Investigation techniques which has improved the situation however more is required. Ongoing training in investigation techniques is part of the planned work that the Interim Head of Risk will be undertaking in partnership with colleagues. A date has been agreed for this to start in October 17 and will continue on a monthly basis until further notice. This training will include duty of Candour.

5.2.7. In order to solve other delays in the systems the risk team are collecting data to identify where the delays are and the reasons. This data will be used to specifically target areas that require further support. The significant backlog at present is the 'awaiting allocation of the incident to be investigated. In order to ensure that these are reduced the staff hierarchy needs to be updated. It is hoped that this will be completed by the end of September 17.

5.2.8. In order to improve the timeliness of SI investigations work is being planned to review the process for identification, reporting, investigation and final sign off of serious incidents together with developing trust wide learning mechanisms. The work around identification of SI's has commenced and a team review all incident reporting on a daily basis with any more serious incident being escalated on the day.

Duty of Candour

5.2.9. Duty of Candour reporting, monitoring and compliance remains a challenge for the organisation. The main area that requires immediate improvement is serious incidents.

5.2.10. These improvements include; staff training on the requirements and the development of key skills to undertake duty of candour and robust systems in place to monitor and obtain assurance that the trust has been compliant with the duty of candour requirements.

5.2.11. The Datix reporting has revealed the organisation appears to need more awareness raising regarding “Duty of Candour”. Some incidents are inappropriately categorised as moderate (which triggers the Duty of Candour requirements) and many have the Duty of Candour fields completed incorrectly.

5.2.12. From September the Serious Incident Lead will assume ownership of the Serious Incident Compliance Reporting. Moderate harm will continue to be managed via the Datix electronic incident reporting system and a new Duty of Candour Policy and Duty of Candour Procedure will be finalised and relevant training will be planned.

5.2.13. Both Q1-Q2 completed SI investigation reports will be robustly audited and a duty of candour compliance report provided at Q2 end. In addition, further accredited Investigator/DoC training (Kent/Surrey/Sussex Quality and Patient Safety Collaborative) has been completed for September 2017which has trained a further 5 Serious Incident investigators to add to the cohort trained in both February and June 2017.

Patient Experience

5.2.14. The number of complaints received in August was 105, compared to 82 in July. The top three complaints subjects remain as previously reported but in a different order. Complaints about timeliness are now greater than complaints about staff: 1) patient care (72% of which were about call triage/disposition), 2) timeliness of response, and 3) concerns about staff attitude/conduct.

5.2.15. Of the complaints opened in August, two have been declared as serious incidents; one about patient care and one about timeliness. The 105 complaints are broken down by service area as follows:

Service area	Number	% of total
NHS 111	16	15%
A&E	35	33%
EOC	54	52%
Total	**105**	

5.2.16. Complaints are shown by subject area below. Although there were 105 complaints, some have more than one aspect, e.g. patient care and staff conduct/attitude.

Subject	
Patient care*	51
Concern about staff	23
Timeliness	30
Admin error	5
Miscellaneous	1
Total	**110**

5.2.17. Of the 51 complaints about patient care, 37 were about triage (27 EOC and 10 NHS111). Nine complaints were about inappropriate treatment being provided, two about crew diagnosis, two that the patient was not taken to hospital, and one was a patient injury.

5.2.18. The top three complaints subjects remain patient care, concerns about staff attitude/conduct, and timeliness of response. Patient care increased to 51 from 34 last month, concerns about staff reduced to 23 from 31 last month, and timeliness complaints increased to 30 from 27 last month.

5.2.19. Of the 103 complaints due to be concluded and responded to during August 2017 (excluding SIs, which have a longer timeframe for completion), 82 had been concluded at the time of writing, with 72% upheld at least in part. The outcome of these complaints was as follows:

Outcome	**Number**	**Percentage**
Upheld	42	51%
Partly upheld	17	21%
Not upheld	20	24%
Withdrawn	3	4%
Totals:	**82**	

5.2.20. There were 100 complaints (excluding SIs and complaints subsequently withdrawn) due for response in August and of these 47% (47 number) were closed within the Trust's 25 working day timescale. This is a deterioration from July where 58% were closed within timescales. The most common reason for delay was that the investigation report was received late (29), and at least five reports were returned by the Patient Experience Team as they were unsatisfactory. In addition, a number are delayed at the final Quality Assurance check with the patient experience Team due to vacancies. However, these are now at interview stage at the time of completing the report.

Safeguarding

5.2.21. The Level 3 training is below plan. This is proving difficult to deliver as a face to face programme and is heavily dependent upon the Safeguarding Lead to deliver this training. A proposal has been prepared for the Executive team that suggests the Trust moves to a mixed model of Face to face and on-line.

5.3. Quality & Safety Charts

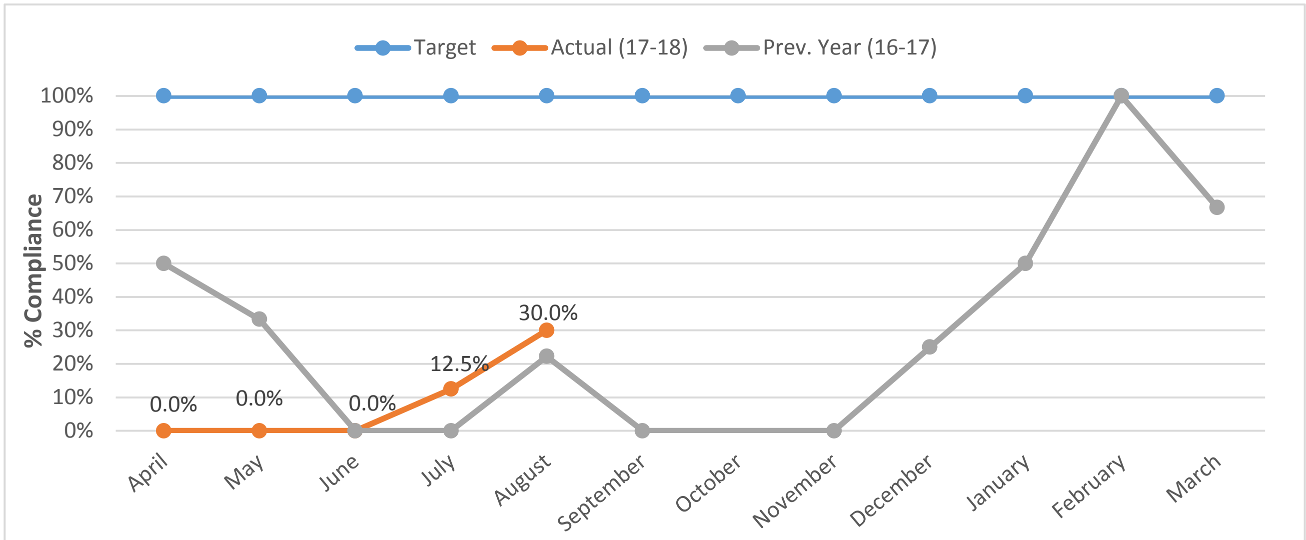


Figure.QS1a - SI Reporting timeliness (72hrs)

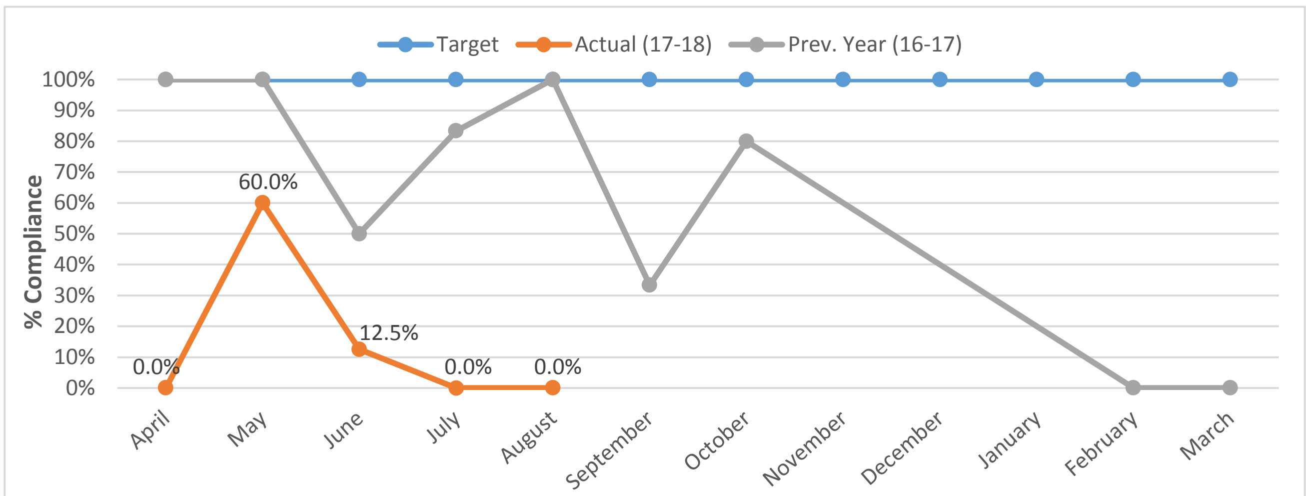


Figure.QS1b - Serious Incident (SI) Investigation timeliness (60 days).

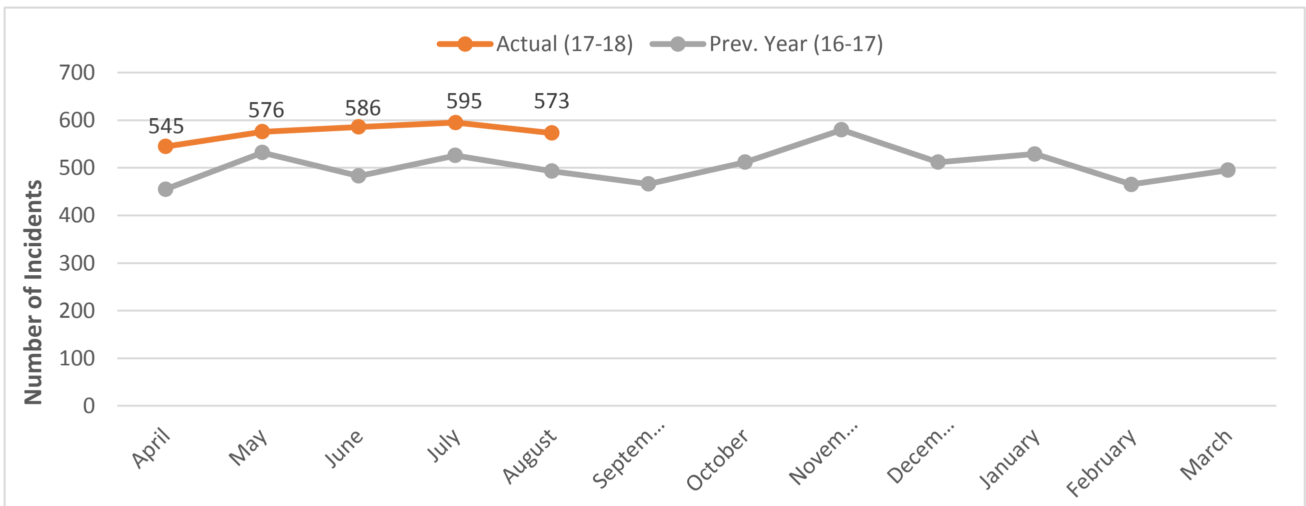


Figure.QS1c - Number of Incidents reported

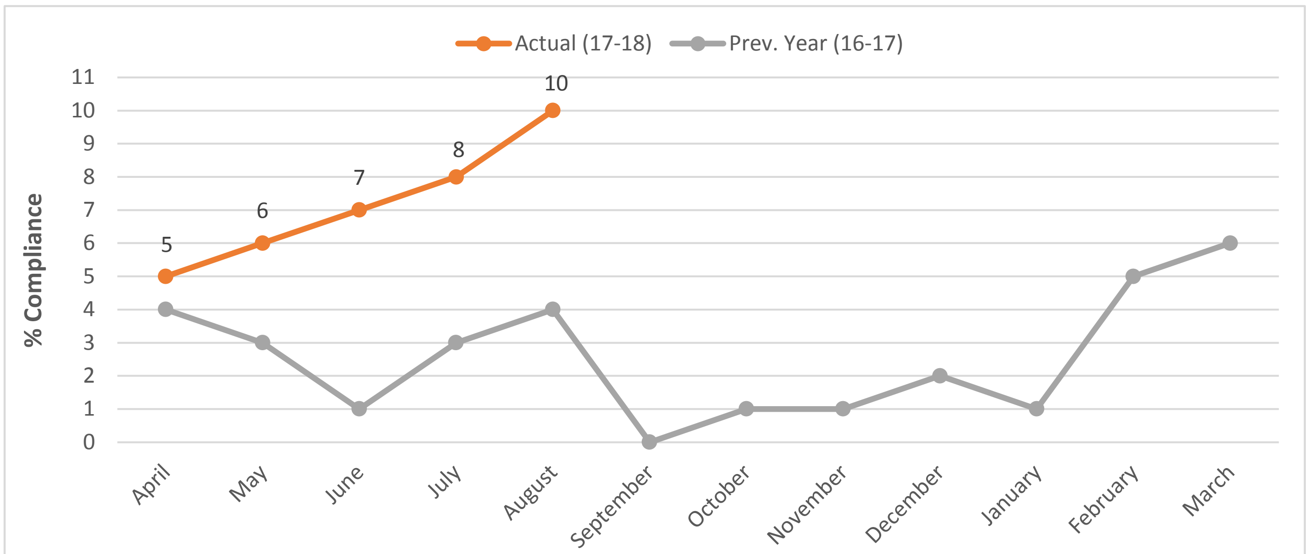


Figure.QS1d - Incidents reported that were SI's

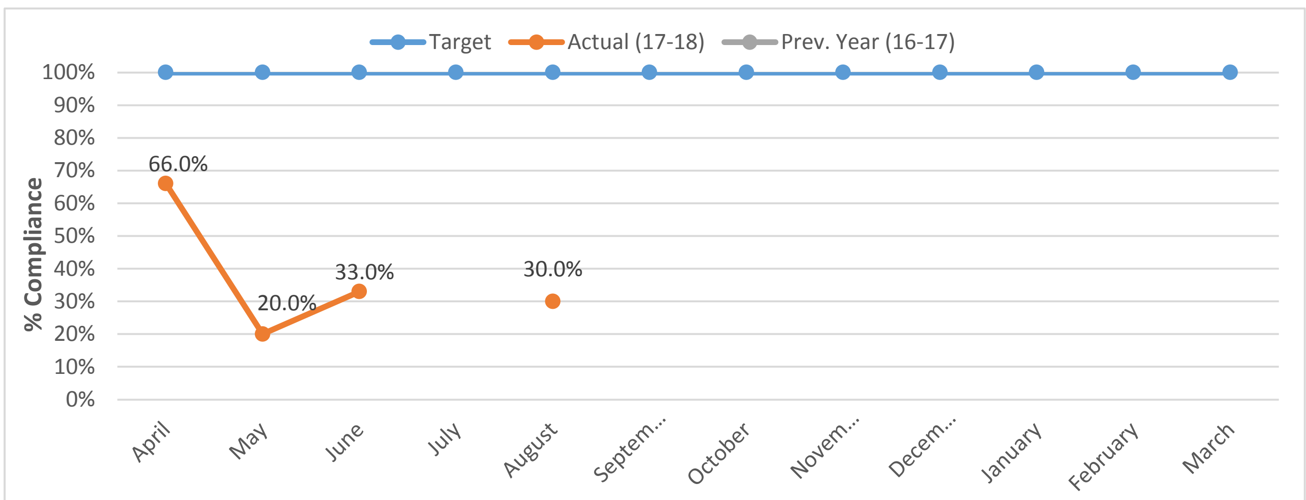


Figure.QS1e - Duty of Candour Compliance *July Data see point 5.2.11

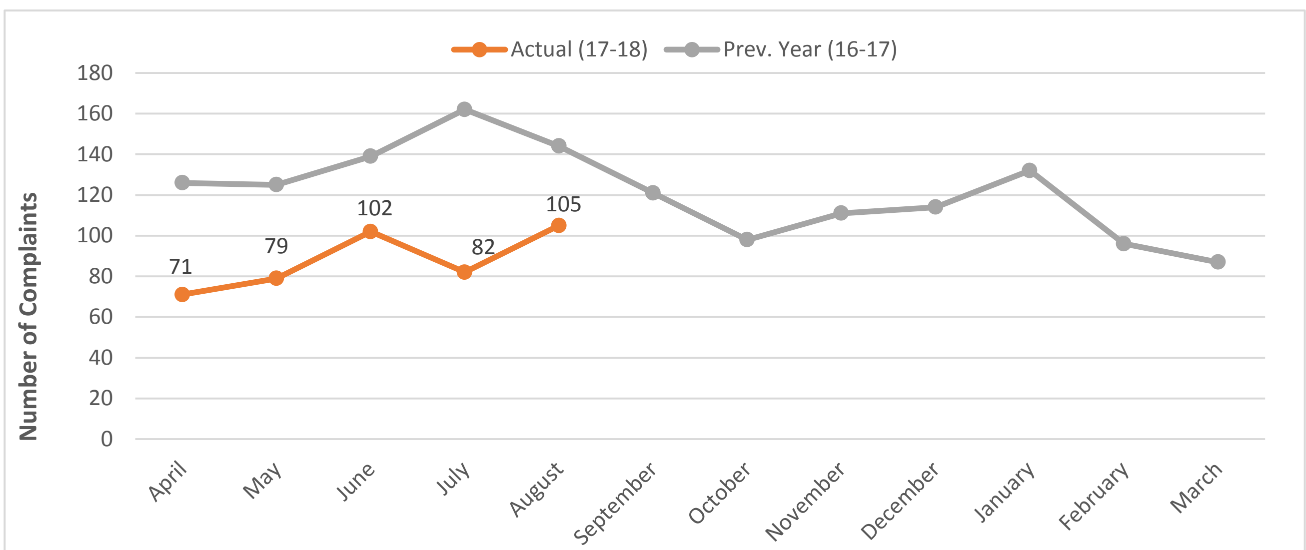


Figure.QS2a - Number of Complaints

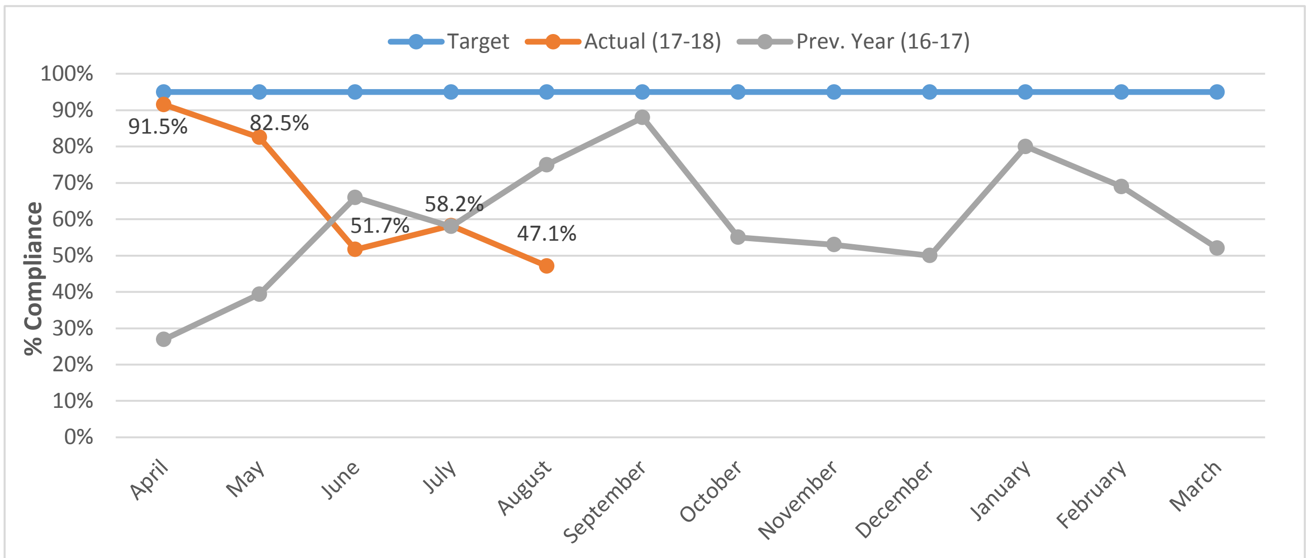


Figure.QS2b - Complaints reporting timeliness (All Complaints)

Unavailable

Figure.QS2c – Mental Capacity Assessment Training

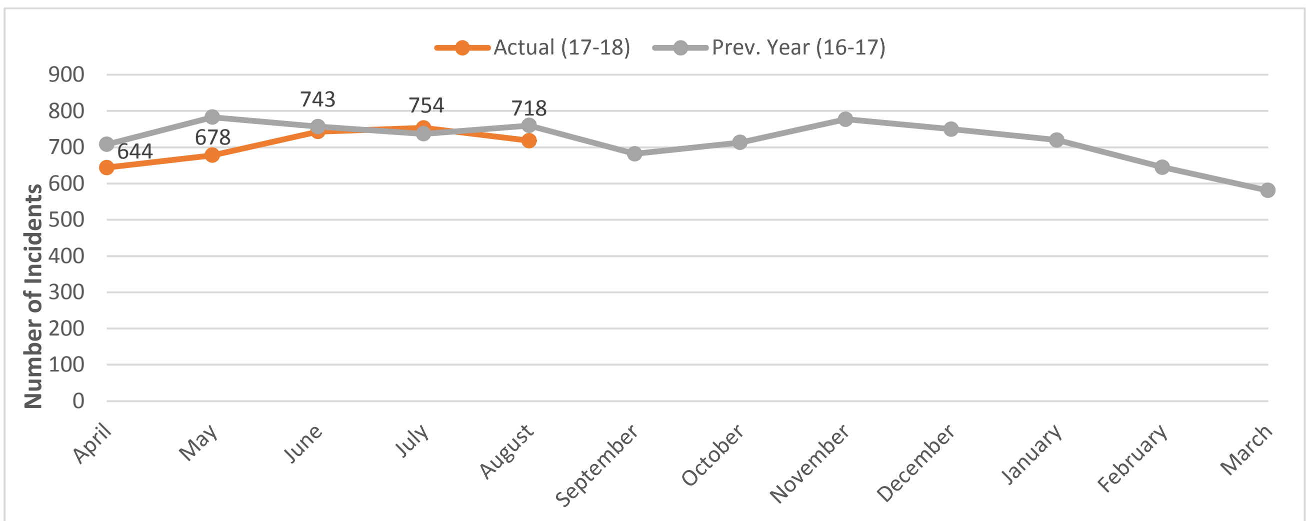


Figure.QS3a - Safeguarding Referrals Adult

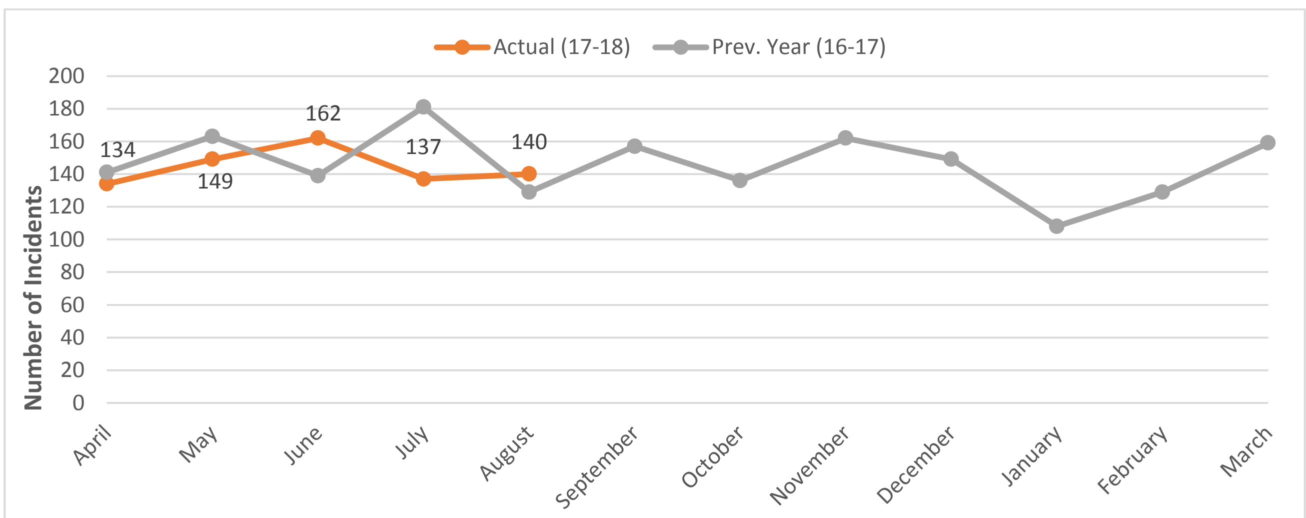


Figure.QS3b - Safeguarding Referrals Children

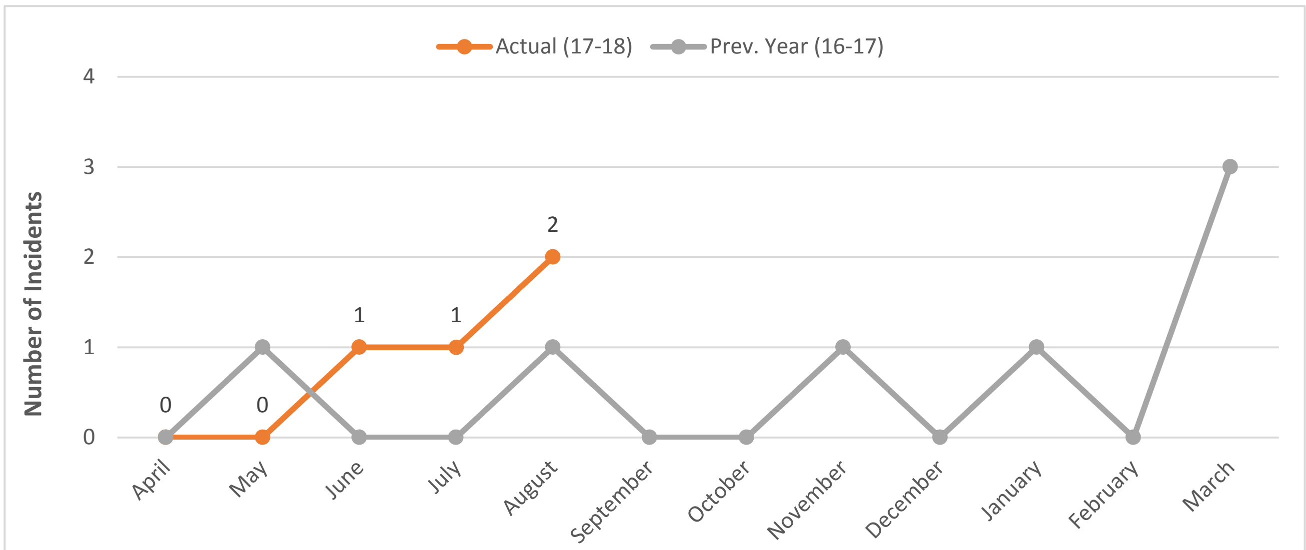


Figure.QS3c - Safeguarding Referrals relating to SECAmb staff or services

Unavailable

Figure.QS3d & e - Safeguarding Training Completed Adult, Level 1 & Child Level 1

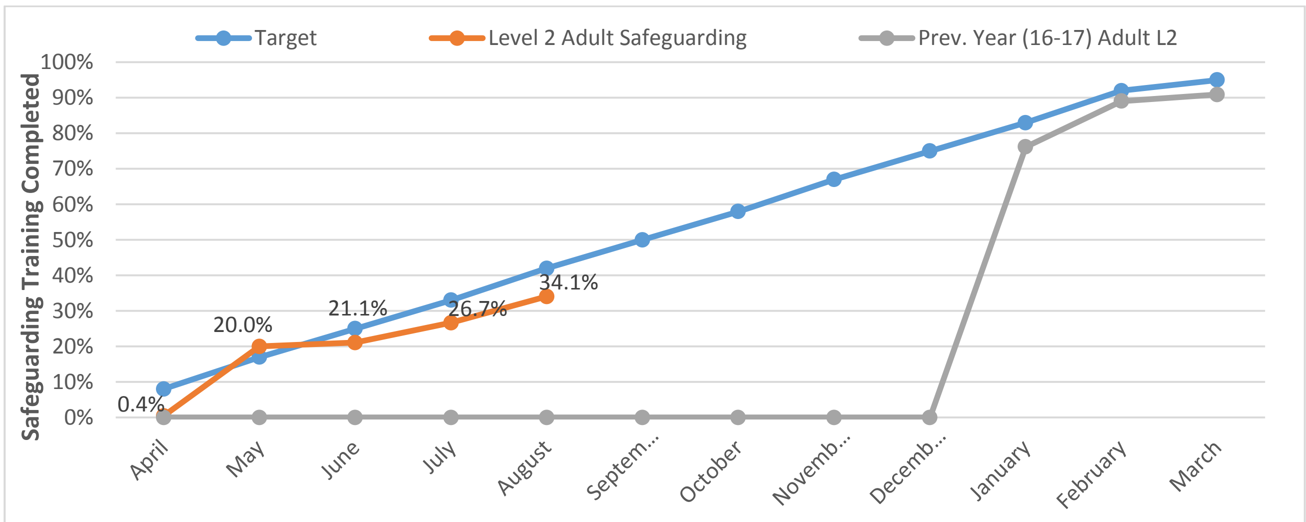


Figure.QS3f - Safeguarding Training Completed Adult, Level 2

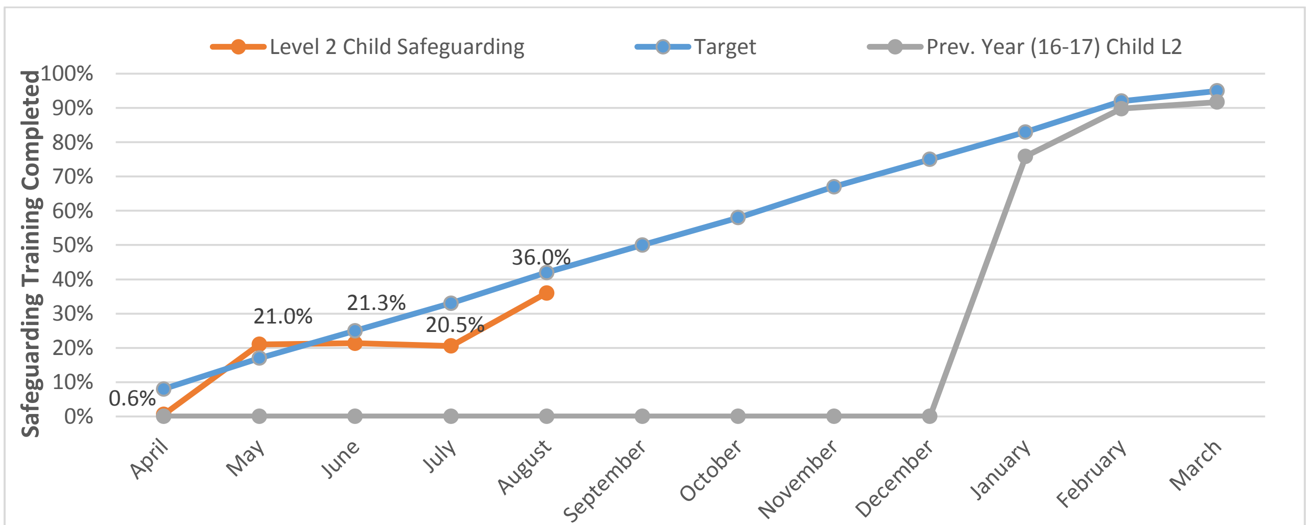


Figure.QS3g - Safeguarding Training Completed Children, Level 2

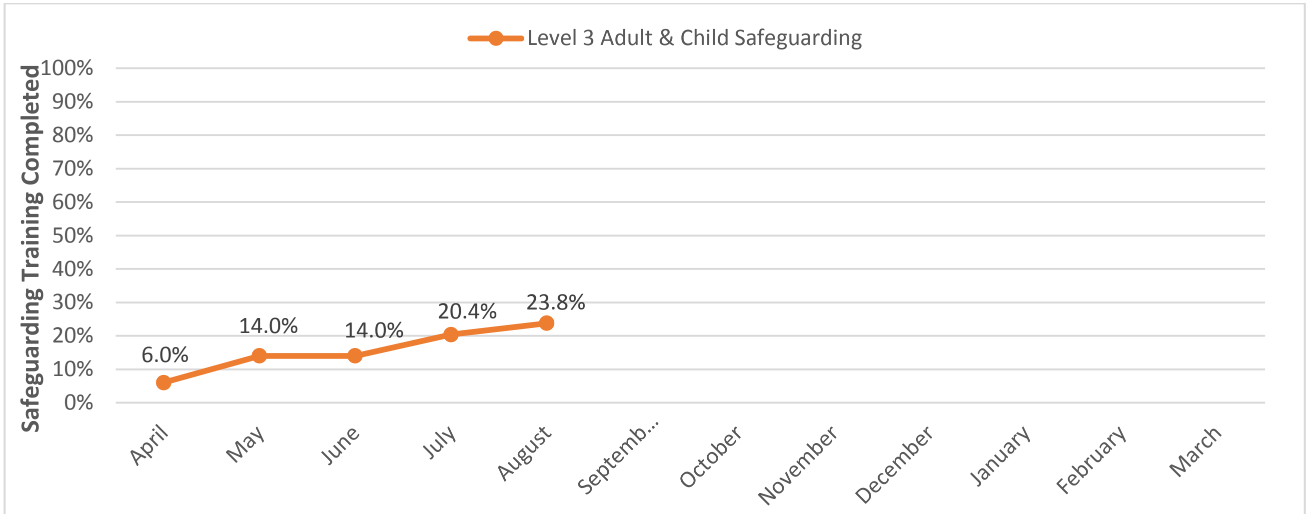


Figure.QS3h - Safeguarding Training Completed Adult & Child Level 3

6. Finance

6.1. Finance Summary

6.1.1. This section highlights the key messages arising from the month 5 financial position

6.1.2. The plan reflects the income and expenditure that would be required to deliver national performance standards, although this is above the level that has been commissioned by CCGs. The significant shortfall is described as a 'structural gap', which remains under negotiation with commissioners. To avoid distorted variances, a 'normalised' plan has been produced to align with the contractual position. Performance against the normalised plan up to Month 05 is as follows.

	Month				YTD		
	Plan £k	Actual £k	Variance £k	%	Plan £k	Actual £k	Variance £k
INCOME	**16,370**	**15,757**	**(612)**	-3.7%	**81,051**	**79,076**	**(1,975)**
Pay	12,061	11,751	310	2.6%	60,124	59,048	1,076
Non Pay	4,094	4,044	50	1.2%	19,734	18,763	972
OPERATING EXPENSES	**16,155**	**15,795**	**360**	2.2%	**79,858**	**77,811**	**2,047**
EBITDA	**215**	**(37)**	**(252)**	117.4%	**1,193**	**1,265**	**72**
% EBITDA	1.3%	-0.2%	-1.6%		1.5%	1.6%	0.1%
FINANCING COSTS	**921**	**668**	**253**	27.4%	**4,288**	**4,347**	**(59)**
TOTAL PROFIT / (LOSS)	**(706)**	**(705)**	**0**	0.1%	**(3,095)**	**(3,081)**	**13**

6.1.3. In the month the Trust reports a deficit of £0.7m, which is in line with the plan. For the year to date the deficit has increased to £3.1m, which continues to be in line with plan.

6.1.4. The forecast for the year is unchanged at £1.0m deficit.

6.1.5. The Use of Resources Risk Rating shows an overall risk of 3 (1 best; 4 worst) in both the year to date and the forecast. This is in line with plan.

Finance Scorecard:- : Data from August 2017

ID**	KPI	Current Month (Plan)	Current Month (Actual)	Current Month (Prev. Yr.)	YTD (Plan)	YTD (Actual)	YTD (Prev. Yr.)
F-1	Income (£'000)	£ 18,439	£ 15,757	£ 16,354	£ 83,068	£ 79,076	£80,225
F-2	Expenditure (£'000)	£ 19,144	£ 16,463	£ 17,335	£ 86,163	£ 82,154	£82,876
F-6	Surplus/(Deficit)	-£ 706	-£ 705	-£ 981	-£ 3,095	-£ 3,079	-£ 2,650
ID**	**KPI**	**Current Quarter (Plan)**	**Current Quarter (Actual)***	**Current Quarter (Prev. Yr.)**	**YTD (Plan)**	**YTD (Actual)***	**YTD (Prev. Yr.)**
F-5	CQUIN - Quarterly (£'000)*	£ 849	£ 564	£ 1,019	£ 1,698	£ 1,413	£ 1,971
ID**	**KPI**	**Current Month (Plan)**	**Current Month (Actual)**	**Current Month (Prev. Yr.)**	**YTD (Plan)**	**YTD (Actual)**	**YTD (Prev. Yr.)**
F-3	Capital Expenditure (£'000)	£ 855	£ 225	£ 1,410	£ 8,836	£ 1,814	£ 7,587
F-7	Cash Position (£'000)	£ 5,757	£ 13,146	£ 10,951	£ 29,012	£ 54,937	£ 55,403
F-4	Cost Improv. Prog. (CIP) (£'000)	£ 1,293	£ 1,491	£ 537	£ 5,530	£ 5,722	£ 2,840
F-8	Agency Spend (£'000)	£ 337	£ 230	£ 671	£ 1,703	£ 1,012	£ 2,778

** Each Quarter's data will not be available until the completion of the Quarter (e.g. Q1 will be available in July)*
*** KPI's have been re-ordered (Sep '16) however each KPI's ID has remained the same for consistency (hence the ID ordering is out of sync).*

6.1. Finance Commentary

Activity, Income and Expenditure

6.1.1. The following commentary compares actuals to the ‘normalised plan’.

6.1.2. Activity was particularly low in month, 10% below commissioned target and 7% below August 2016. As a consequence, reported A&E income in the month was £1.0m or 7% below plan. 111 contracted income is £0.2m above due to additional clinical development income received.

6.1.3. The total normalised income variance in the month was £0.6m adverse, with non-contracted income £0.2m favourable mainly due to supplementary income from East Kent commissioners to reflect the additional costs of emergency activity diverted from Kent & Canterbury Hospital to other acute sites.

6.1.4. In the month total expenditure, including Financing Costs, was favourable to plan by £0.6m and is now £2.0m favourable year to date.

6.1.5. In-month operational expenditure was £0.3m underspent, mainly attributable to Operational Hours £0.3m, Financing cost £0.3m, Redundancy provision £0.2m and Lewes Dilapidation provision release.

6.1.6. Operating Unit underspends are mainly attributable to the lower than planned activity levels, while both EOC and Fleet incurred overspends of £0.1m.

6.1.7. Estates and Make Ready have seen a surge in costs in the month, with a combined adverse position £0.4m. This mainly consists of catch up missing invoicing and charges for minor works but overall these budgets remain cumulatively underspent by £0.4m. The YTD underspend is a consequence of a budget profile mismatch and it is anticipated that expenditure will catch up in Quarter 3 when cost increases are expected for Utilities.

6.1.8. A&E activity under performed by 10.2% in the month and was 7% behind the same month last year. The Trust is implementing a new CAD and changes in counting are yet to be fully understood.

6.1.9. After 5 months A&E activity is now 4.7% below plan and 1.2% up on the same period last year.

6.1.10. Operational hours were 3% below planned, although operational efficiency was less than expected with Unit Hour Utilisation (UHU) of 0.379 below the planned 0.396.

6.1.11. The whole time equivalent worked in the month was 244 or 7.1% lower than expected, Operations have been able to flex the worked hours to match activity, contributing to the accumulated savings in Ops hours. These figures include overtime, agency and private ambulance provision.

Cost Improvement Programme

6.1.1. CIP schemes to the value of £14.7m have so far been identified and fully scoped, leaving a £0.4m gap against the £15.1m target. In the year to date the Trust reports a £5.7m CIP achievement, which is marginally ahead of plan. The PMO office are targeting CIP schemes to a total value of £19m in order to compensate for schemes which may not deliver their full year value.

Capital Expenditure

6.1.2. Capital expenditure for the month was £0.3m against a plan of £0.9m. To date the spend is £1.8m against a planned £8.8m. The shortfalls in spend are against Fleet (vehicles and equipment) £4.4m, New HQ £1.3m and CAD £0.2m. The full year programme is £15.8m. Due to the decision to finance our new fleet through an operating lease the forecast has been reduced to £7.5m.

Cash and Financing

6.1.3. The cash balance at the end of August was £13.1m, significantly higher than the planned £5.8m. The improved position is partly due to the timing of capital spend. Additional income received from NHSI of £1.2m and Canterbury and Coastal CCG of £0.8M in the last two months has also supported the cash balance. Timing on certain non-pay spend just after the month end has since decreased the cash position.

6.1.4. The latest cash flow forecast submitted to NHS Improvement indicated neither a repayment nor further draw down of loan.

6.1.5. The working capital loan balance remains at £3.2m. There is a £15m working capital loan facility in place.

Use of Resources Rating

6.1.6. The Trust's UORR after three months is 3, in line with plan. The forecast for the year remains at 3, as planned.

6.2. Finance Conclusion

6.3.1. Financial performance and risk ratings are in line with expectations to date. The underlying commissioning gap is under discussion with commissioners. CIP plans are progressing well but present an ongoing challenge. The capital programme is behind schedule excluding new vehicles but is expected to catch up. The overall position to date is satisfactory and work is underway to improve controls and embed efficiencies.

6.3. Finance Charts

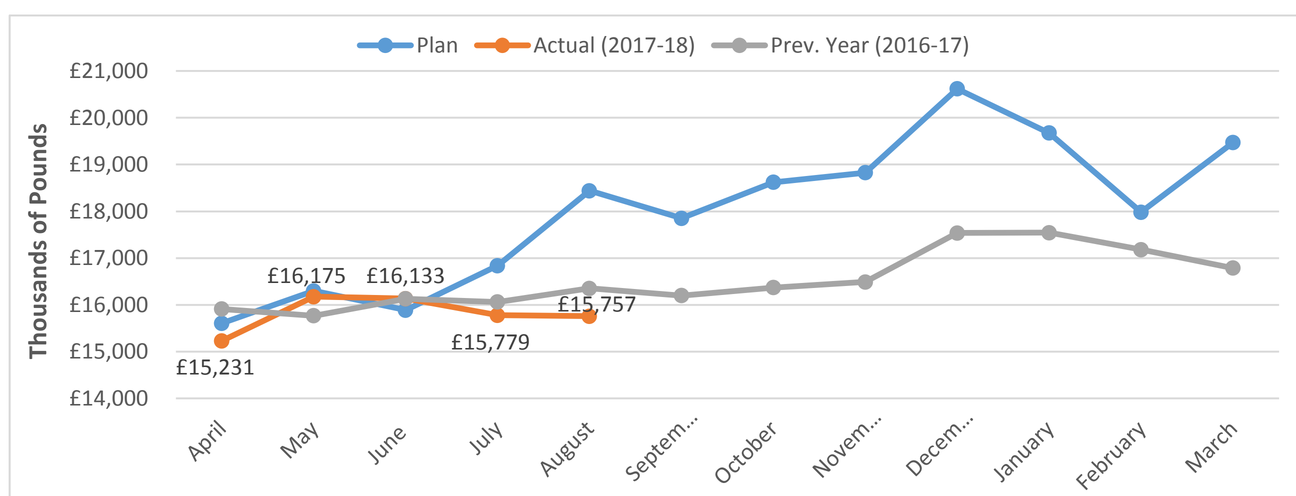


Figure.F-1 - Income (£'000)

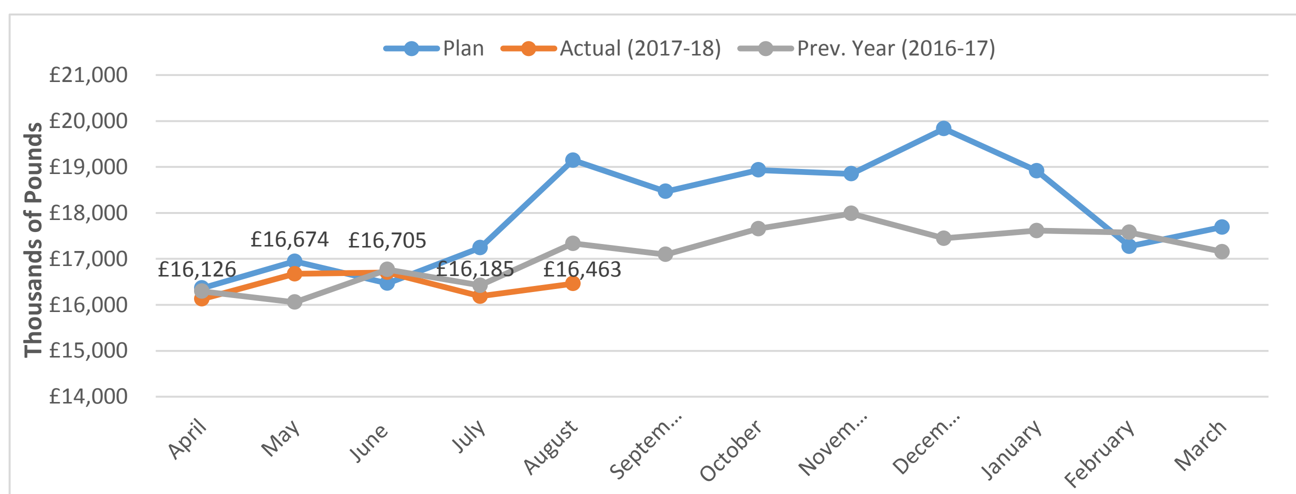


Figure.F-2 - Expenditure (£'000)

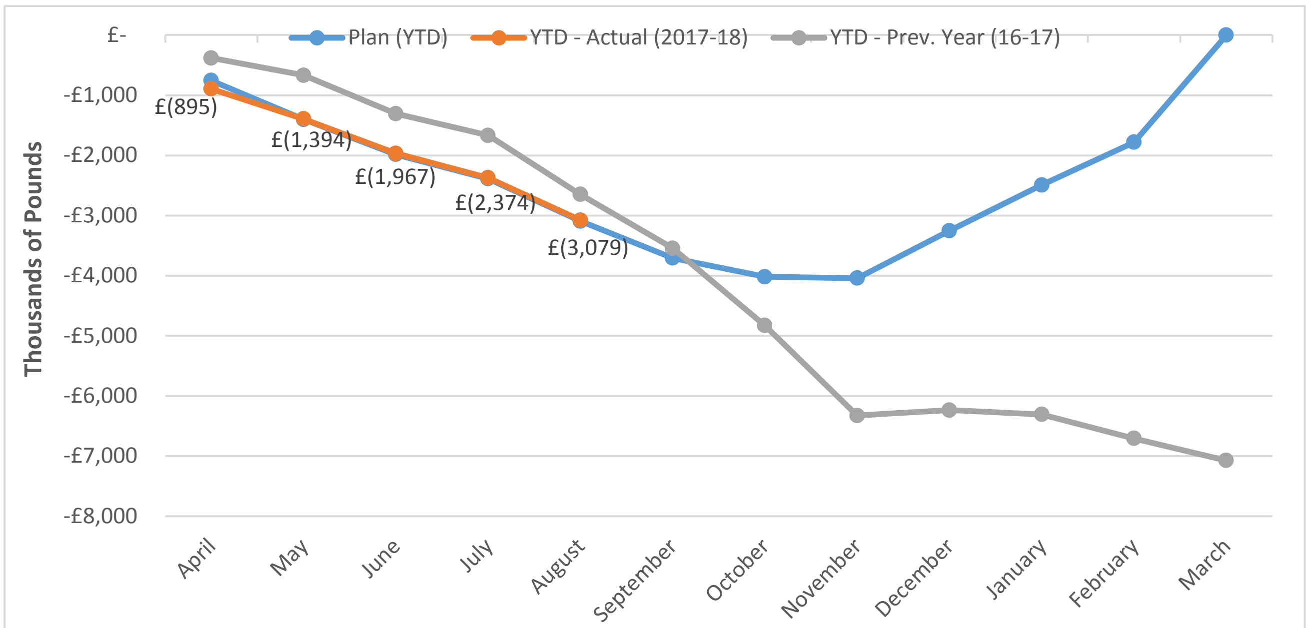


Figure.F-6 - Surplus/(Deficit) (Year To Date)

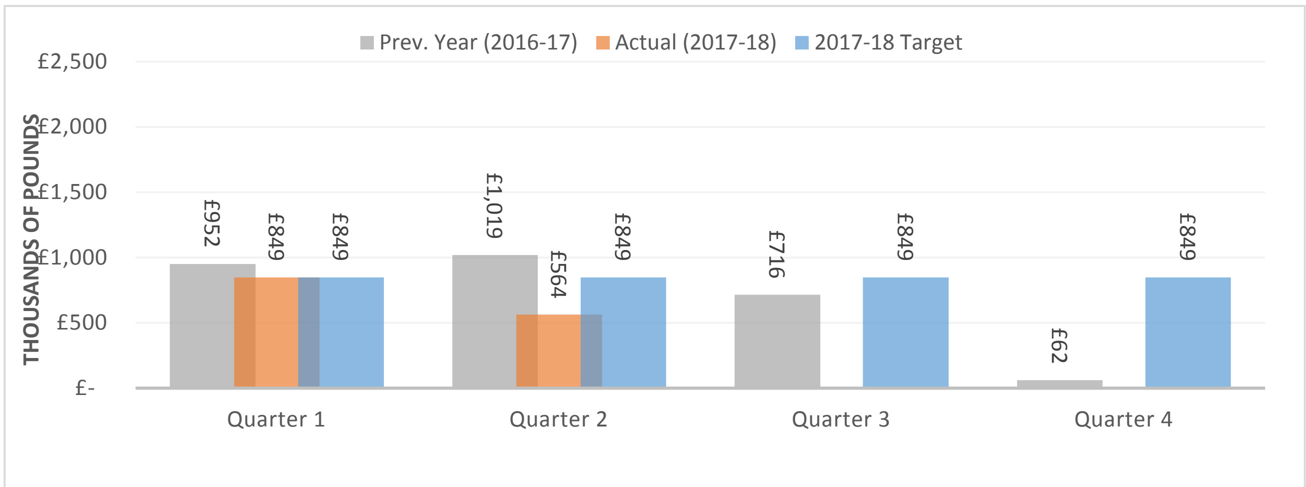


*Figure.F-5 – CQUIN - Quarterly (£'000)**

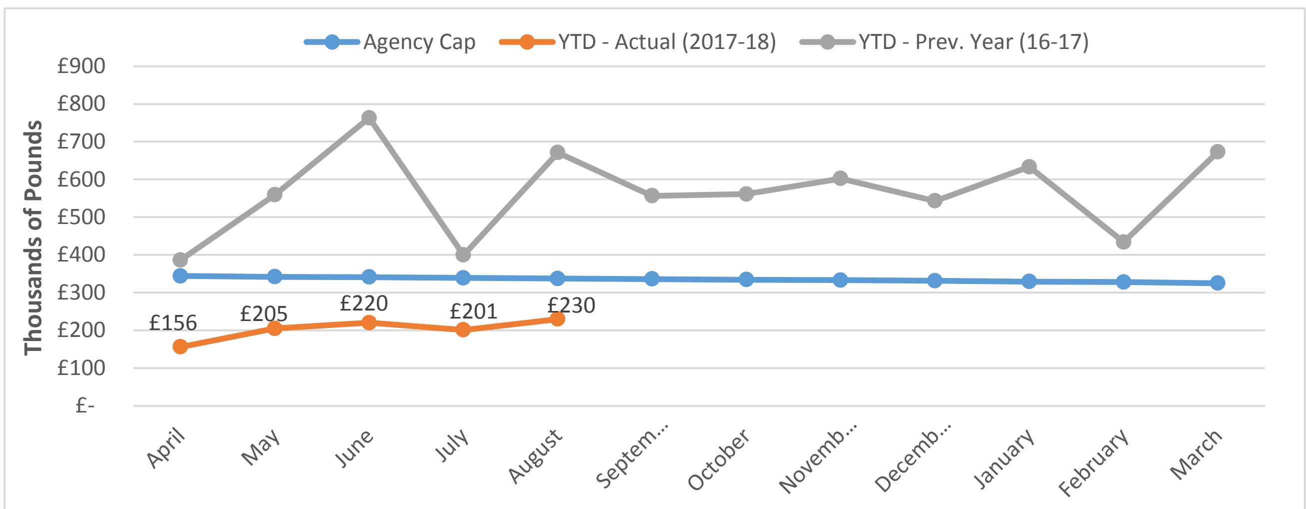


Figure.F-8 – Agency Spend (£'000)

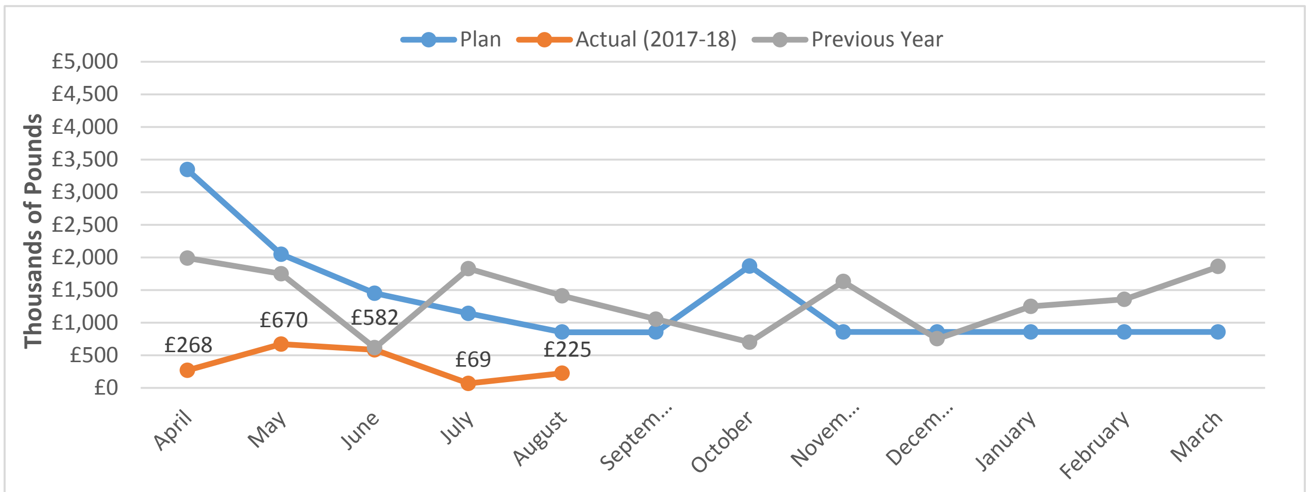


Figure.F-3 – Capital Expenditure (£'000)

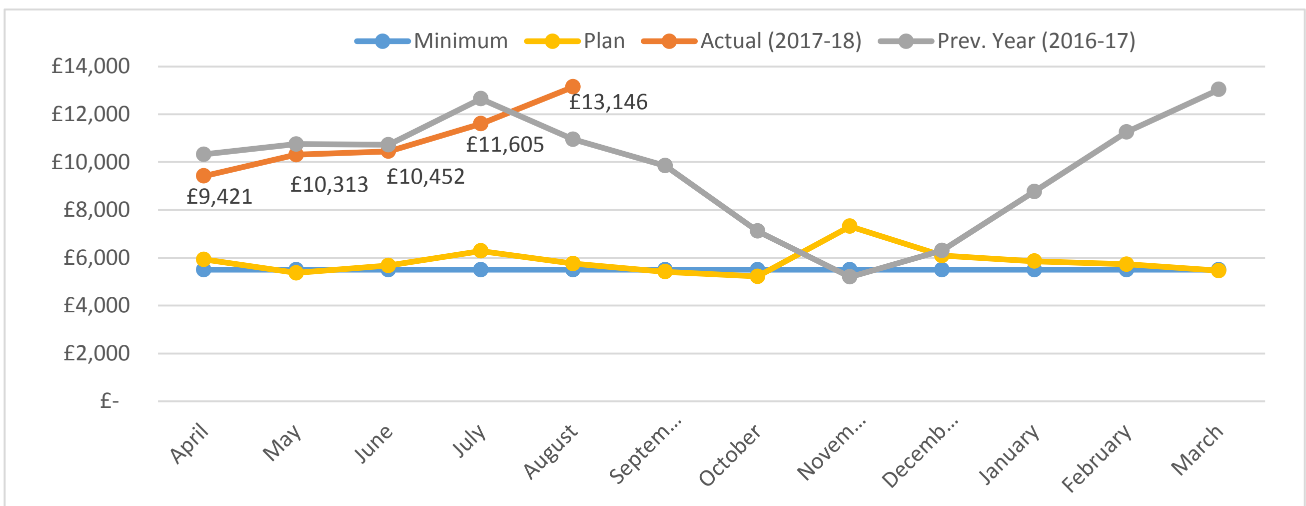


Figure.F-7 – Cash Position (£'000)

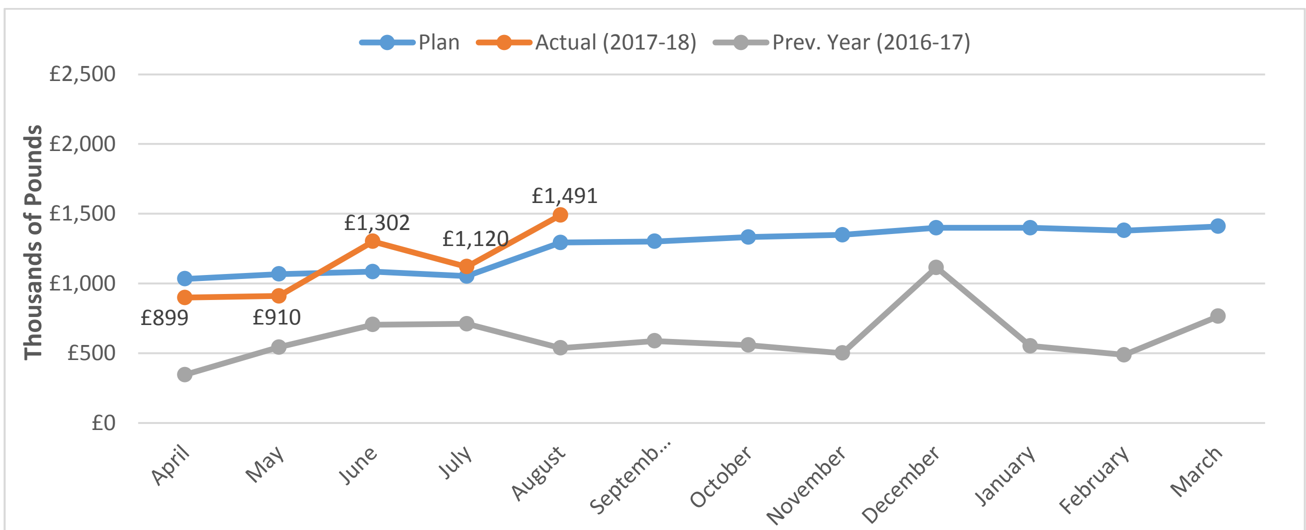


Figure.F-4 - Cost Improv. Prog. (CIP) (£'000)

Appendix 2: Notes on Data Supplied in this Report

7.1. Preamble:

7.1.1. This Appendix serves to inform the reader of any significant changes to measurement or data provided in the Integrated Performance Dashboard.

7.1.2. Two month's history are kept for easy reference and to cover when there is a month with no board meeting.

7.2. Executive Summary:

7.2.1. No changes to note.

7.3. Workforce Section:

7.3.1. Total Staff Vacancies: April & May Board data: the newly released budget is still in the process of being triangulated and finalised with finance and may, therefore, be subject to change.

7.3.2. Staff Appraisals & Mandatory Training performance reporting is currently being reviewed. See points 2.2.6 & 2.2.7.

7.3.3. Total Physical Assaults: Data amended for last financial year and to date; previous figures were based on each incident; new figures are based on each assault (per incident). Added Sanctions as a secondary line in the chart.

7.3.4. Added Objectives & Career Conversations as new KPI

7.4. Operational Performance Section:

7.4.1. No changes to note.

7.5. Clinical Effectiveness

7.5.1. No changes to note.

7.6. Quality and Patient Safety Section:

7.6.1. Safe Guarding Training Level 1 Adult & Child performance reporting is currently being reviewed.

7.7. Finance Section:

7.7.1. No changes to note.

South East Coast Ambulance Service NHS
NHS Foundation Trust

	Item No	91/17

Name of meeting	Board of Directors
Date	20 September 2017
Name of paper	Annual Serious Incident report
Executive sponsor	Steve Lennox, Director of Nursing & Quality Fionna Moore, Medical Director
Author name and role	Colin Taylor, Serious Incidents lead Fiona Wray, Assistant medical Director Kirsty Booth, Business Support Manager Steve Lennox, Director of Nursing & Quality Fionna Moore, Medical Director
Synopsis (up to 120 words)	The Annual Serious Incident report is to; • Provide assurance that the Trust follows its serious incident process. • Provide an overview of the analysis of the Serious Incidents that were declared in 2016 – 17. • Show examples of Serious Incident investigations that have been used to assist in learning and to improve the quality of patient care during the year. • Set out actions for 2017/18 where further improvement can be made to the Serious Incident management. This will include monitoring the trends identified from the serious incidents and initiate learning from this data when correlated with complaints and legal cases. The report demonstrates that the Trust has work to undertake in order to strengthen the learning from Serious Incidents and actions for 2017/18 have been identified through the report.
Recommendations, decisions or actions sought	For information

Does this paper, or the subject of this paper, require an equality analysis ('EA')? (EAs are required for all strategies, policies, procedures, guidelines, plans and business cases).	**No**

Annual Serious Incident Report

Reporting Period: 01 April 2016 to 31 March 2017

1. Introduction

1.1. This report provides a review and assurance to the Trust Board regarding the Trust's position and progress in relation to the management of, and learning from, Serious Incidents from 01 April 2016 – 31 March 2017.

1.2. The purpose of this report is to:

- Provide assurance that the Trust follows its serious incident process.
- Provide an overview of the analysis of the Serious Incidents that were declared in 2016 – 17.
- Show examples of Serious Incident investigations that have been used to assist in learning and to improve the quality of patient care during the year.
- Set out actions for 2017/18 where further improvement can be made to the Serious Incident management. This will include monitoring the trends identified from the serious incidents and initiate learning from this data when correlated with complaints and legal cases.

1.3. The Serious Incident work is part of the wider Incident portfolio and sits within the Risk Team. The Trust is committed to working in an open and transparent manner and this includes supporting staff to report incidents. The Trust is looking for increased reporting of incidents as a measure of success.

1.4. During the year a new Serious Incidents group was created where all potential Serious Incidents are discussed. This is held weekly and chaired by either the Medical Director or the Director of Nursing & Quality. Each incident is discussed in detail alongside any necessary information, such as the clinical record, and a decision whether to declare the incident as a Serious Incident is made. To ensure the accuracy of reporting the harm level reported is also clarified and updated.

1.5. Serious Incidents are described as "*any event which has given rise to potential or actual harm or injury, to patient dissatisfaction or to damage/loss of property*". This definition includes patient/service user injury, fire, theft, vandalism, assault and employee accident and near misses. The Trust's Incident Reporting and Investigation Manual and Serious Incident 'Pilot' Procedure sets out the framework for reporting, which is in line with the National Serious Incident framework (2015).

1.6. During 2016-17 there was a 3.57% increase in reported serious incidents from 56 to 58. The majority (76%) of Serious Incidents reported were from frontline Operations and the Emergency Operations Centre.

2. Incidents

2.1. The overall level of incident reporting in the Trust has increased year on year through the web- based Datix Incident Reporting system. In 2016/17, the Trust had 5,906 incidents reported. This is a monthly average of 592 incidents per month. This represents an increase of 19.8% from the previous year (2016/17).

2.2. On review of the data, 35% (2,055) of the reported incidents directly affected a patient or service user.

2.3. The majority of Serious Incidents are generated from this general incident reporting. Other routes include safeguarding, feedback on problematic inquests, potential litigation and the Trust's complaints.

3. Never Events

3.1. Never Events are defined as 'serious largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers'. There are defined national examples of Never Events.

3.2. The Trust did not report any Never events in 2016/17 and has in previous years also not reported any Never Events.

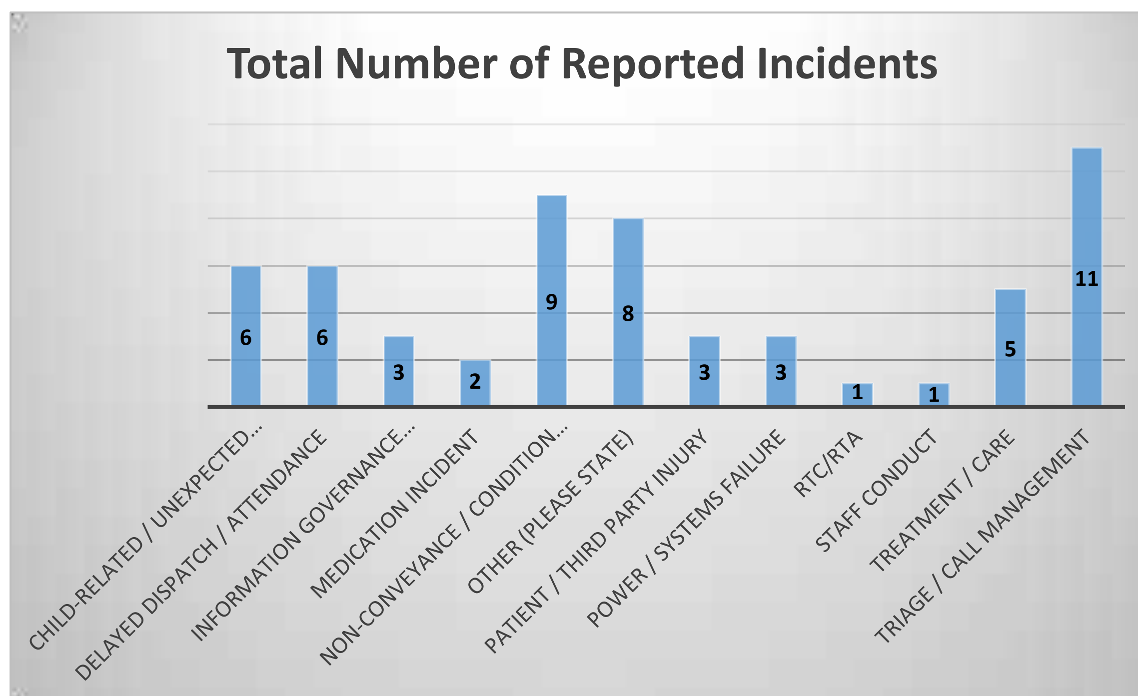
Identified Action for 2017/18: A review of the nationally defined never events will be undertaken and a process implemented to adopt this aspect of reporting in 2017/18.

4. Serious Incidents Reported

4.1. There were 58[1] Serious Incidents reported in 2016/17, this is an increase of 2 from last year. The numbers reported are illustrated in Figure 1 including the main categorisation of the Serious Incident.

[1] This was incorrectly reported in the Quality Account as 55

Figure 1: SIs Reported 2016/17 total number of incidents reported by type and date



4.2. When comparing the data to the previous year there are two main observations.

- There has been a reduction of 54% (7) of incidents relating to delayed back up/attendance.
- There has been an increase of 66% (6) of incidents relating to non-conveyance/condition deteriorated.

4.3. The majority of Serious Incidents reported were incidents affecting Patients. The three tables below identify the main themes arising from Serious Incidents that are attributed to three service areas; Emergency Operations Centre, Operations A&E, NHS111.

Table 1 SIs reported by Operations EOC

Operations - EOC	**16**
Triage / Call management	5
Delayed Dispatch / Attendance	4
Other (Please state)	4
Power / Systems failure	2
Child-related / Unexpected Child Death	1

Table 2 SIs reported by Operations A&E

Operations A&E	**28**
Non-Conveyance / Condition deteriorated	9
Child-related / Unexpected Child Death	5
Treatment / Care	5
Other [employee death , delay approaching scene, equipment availability]	3
Delayed Dispatch / Attendance	1
Information Governance Breach	1
Medication Incident	1
Other , Delayed Dispatch / Attendance	1
RTC/RTA	1
Staff Conduct	1

Table 3 SIs reported by NHS 111

NHS 111	**8**
Child-related / Unexpected Child Death	0
Delayed Dispatch / Attendance	0
Information Governance Breach	0
Medication Incident	0
Non-Conveyance / Condition deteriorated	0
Other	0
Patient / Third Party Injury	0
Power / Systems failure	1
RTC/RTA	0
Staff Conduct	0
Treatment / Care	1
Triage / Call management	6

4.4. In comparison to 2015/16 the above data shows an increase in both EOC and A&E reporting, the reasons for the increases shown is multi-faceted. There is a more open transparent culture and this will have made an impact on the reporting.

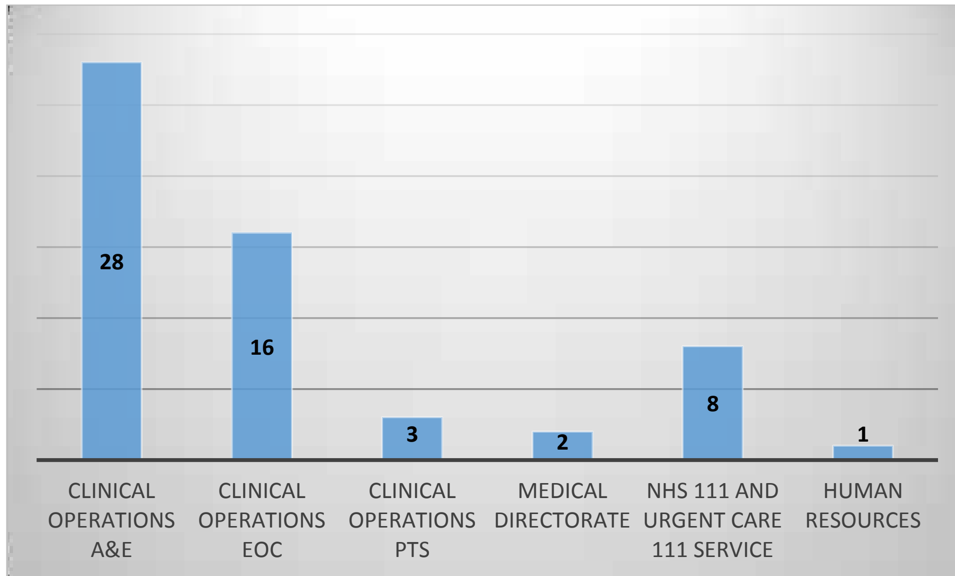
4.5. Serious Incidents arising from complaints accounted for 38% (22) of reported Serious Incidents. In comparison, 2015/16 revealed 30% (17) incidents originating from complaints. In theory, an incident culture can be measured by recording the number of Serious Incidents generated by complaints that were not initially recorded as an initial incident on Datix.

Identified Action for 2017/18: We will use the percentage of Serious Incidents identified through complaints without a prior incident report as an indicator of measuring incident awareness.

Serious Incidents: by Service Area

4.6. Figure 2 shows the number of Serious Incidents by service area and includes NHS 111 for both SECAmb and Care UK

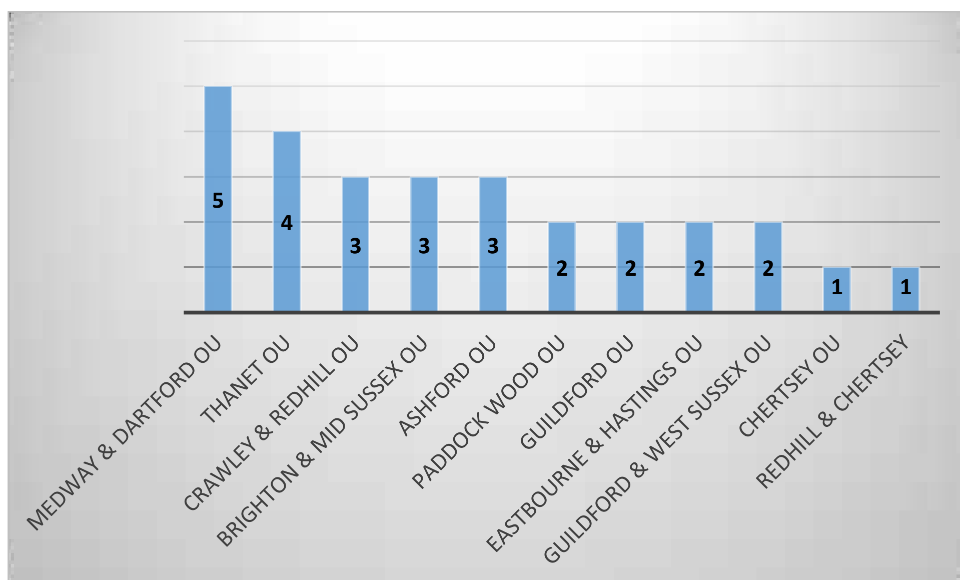
Figure 2 Serious Incidents reported by service area



Service Area: Operations A&E

4.7. Table 6 below shows the number of Serious Incidents by Operating Unit level.

Figure 3 Number of Serious Incidents by Operating Unit



4.8. It is not possible to compare 2016/17 to previous years as the Operational Unit structure was only introduced during this financial year.

Service Area: Operations A&E

4.9. Of the 16 incidents reported from EOCs, Lewes EOC had the highest number of incidents reported (10) of which four were relating to call answer delay, three to delayed dispatch/attendance, and three to triage or call management.

Service Area: Patient Transport Services

4.10. Of the three incidents for PTS, 2 related to patients slipping from their own wheelchair whilst being transported, both involved third party contractors. The third incident involved a stretcher that came loose from its fixings whilst a patient was being transported in a Trust vehicle.

Service Area: Medical Directorate

4.11. Two incidents were reported. one was concerning errors identified in the safe procurement, storage, destruction and medicines production following a Trust wide medicines management audit. An Incident was reported following an internal review into the use of defibrillators on a number of 999 calls which identified 33 cases where Patient Clinical Records (PCRs) for the patients attended, could not be located. This incident was also reported to the Information Commissioners Office (ICO)

Service Area: 111 Services

4.12. There were 8 Serious Incidents reported from 111. One incident related to a power failure, 6 concerned triage/call management and 1 related to call handling and treatment advice for a patient

Service Area: Human Resources

4.13. An Information Governance incident was reported that related to a breach by the Trust's contractor for Occupational Health involving one staff member's immunisation records being sent to another staff member.

5. Serious Incident Reporting Trends

5.1. A full breakdown of the themes of each Serious Incident is identified in Appendix **I**

5.2. The Trust has introduced in addition to the Strategic Executive Information System (STEIS) an additional categorisation to enable improved trend analysis that is relevant to the ambulance service.

5.3. The highest reported category in 2016/17 was “Triage or Call Management.” Of these 12 incidents seven were from KMSS111 contact centres and five were from A&E EOC.

5.4. The highest reported category in 2016/17 was “Triage / Call Management.” Of these twelve incidents seven were from KMSS111 contact centres and five were from A&E EOC.

5.5. There were 9 Serious Incidents reported for the reason of “Non-Conveyance or condition deteriorated”. Seven of these were reported in the Kent Area with three in the Medway & Dartford Operating Unit, and two each in Ashford and Thanet Operating Units.

5.6. Out of the “Other” category, four relate to call answer delays. All occurring in the Lewes EOC.

5.7. The “child-related/unexpected child death” category showed no geographical trend. Following investigation, the grading of the cases was; one as Severe Harm, three as Low Harm and two as No Harm.

5.8. Table 4 illustrates the reason for all 58 Serious Incident cases

Table 4 Number of Serious Incidents by category

SI Reporting Reason	Number of SIs
Child-related / Unexpected Child Death	6
Delayed Dispatch / Attendance	5
Information Governance Breach	3
Medication Incident	2
Non-Conveyance / Condition deteriorated	9
Other (Please state)	7
Other (Please state), Delayed Dispatch / Attendance	1
Patient / Third Party Injury	3
Power / Systems failure	3
RTC/RTA	1
Staff Conduct	1
Treatment / Care	5
Triage / Call management	12
Grand Total	**58**

6. Serious Incident Governance

6.1. In May 2016, the Trust's Care Quality Commission inspection identified the need to review and improve the Trust's Serious Incident procedures. As a result, the weekly Serious Incident group was formed and new policies and procedures were developed.

6.2. 20 of the 58 SI investigations were completed within 60 days in line with the National Serious Incident framework and submitted to the Commissioners for closure. However, 22 of the 58 reports were submitted out of deadline, therefore breaching the SI framework.

6.3. Sixteen of the 58 Serious Incidents declared in 2016/17 are still under investigation. These have exceeded the National Serious Incident Framework deadlines for a variety of reasons.

6.4. In order to try and improve the position the Trust undertook investigator training for 17 staff. This is clearly unacceptable and action will be taken in 2017/18 to improve this position.

> **Identified Action for 2017/18:** To increase the supervision and monitoring of investigations to ensure they are presented to the Clinical Commissioning Group within the mandated time frame.

6.5. In year, the Commissioners expressed concerns over the format and the quality of the investigation reports. A new template was introduced and piloted and whilst this has made improvements there are further adjustments to be made.

> **Identified Action for 2017/18:** To finalise the investigation template so that a precise and concise report can be created and approved on first presentation.

6.6. During a review of actions that from a specific Serious Incident it was identified that the action plans were not being linked using the Trust's DATIX risk management software. Whilst actions had been completed these were not always reflected in updates on the system.

> **Identified Action for 2017/18:** To ensure Datix is used correctly for the recording of all incidents; including Serious Incidents.

6.7. The Trust has undertaken a number of themes and analysis across the year but this could be more structured. A monthly report showing themes and lessons learned will be developed and implemented.

> **Identified Action for 2017/18:** To create a monthly report that identifies themes and lessons learned.

7. Shared Learning

7.1. To facilitate the shared learning from each Serious Incident, a one-page summary document is prepared and circulated to staff within the service area affected. This approach was adopted from identified good practice developed within the 111 service.

7.2. In addition, a number of vehicles have been used in year to share the learning across the organization. Appendix II gives a number of examples where learning has been shared in various publications across the trust.

7.3. However, the Trust can do more. In 2017/18 the Trust will introduce Area Governance Meetings across all services. These will be used as a forum for enhancing the sharing of learning from Serious Incidents.

> **Identified Action for 2017/18:** To ensure Serious Incidents are a standing item at Area Governance Meetings.

7.4. In addition, the Trust has not been regularly participating in the national sharing of incidents across Ambulance Services. The Trust will also re-engage with the National Ambulance Risk and Safety Forum (NARSF) in 2017/18 by ensuring it is represented at all NARSF meetings.

7.5. Learning from clinical SIs and HM Coroners Preventing Future Deaths (PFDs) are discussed at the National Ambulance Services Medical Directors Group (NASMeD) that meet every two months.

> **Identified Action for 2017/18:** To attend all National Ambulance Risk and Safety Forums. To continue to share learning from clinical SIs and feedback from HM Coroners' PFD recommendations.

8. Conclusion

8.1. A Serious Incident Group now meets weekly and assesses all potential Serious Incidents from incidents reported on Datix, complaints received and other sources. Incidents are reported on STEIS within two days of identification, this has strengthened the Serious Incident process within the Trust.

8.2. The reasons for the delays in the investigation and completion of Serious Incidents have identified the need for more trained resources to undertake investigations. Training is ongoing with 17 staff trained already and further courses are planned during 2017/18.

8.3. There is clear Executive leadership at the Serious Incident Group with both the Executive Medical Director and Director of Nursing & Quality being members. The identification of Serious Incidents and completed investigations has improved over the reporting period and a tracker has been introduced to monitor potential Serious Incidents referred to the Serious Incident Group.

8.4. The priority area of attention is to reduce the backlog of outstanding investigations so that future SI declarations can be investigated in a timely manner and deadlines are met.

9. Summary of Actions for 2017/18

9.1. The following actions will form part of the 2017/18 Serious Incident improvement plan;

9.1.1. **Identified Action for 2017/18:** A review of the nationally defined never events will be undertaken and process implemented to adopt this aspect of reporting in 2017/18.

9.1.2. **Identified Action for 2017/18:** We will use the percentage of Serious Incidents identified through complaints without a prior incident report as an indicator of measuring incident awareness.

9.1.3. **Identified Action for 2017/18:** To increase the supervision and monitoring of investigations to ensure they are presented to the Clinical Commissioning Group within the mandated time frame.

9.1.4. **Identified Action for 2017/18:** To finalise the investigation template so that a precise and concise report can be created and approved on first presentation.

9.1.5. **Identified Action for 2017/18:** To ensure Datix is used correctly for the recording of all incidents; including Serious Incidents.

9.1.6. **Identified Action for 2017/18:** To create a monthly report that identifies themes and lessons learned.

9.1.7. **Identified Action for 2017/18:** To ensure Serious Incidents are a standing item at Area Governance Meetings.

9.1.8. **Identified Action for 2017/18:** To attend all National Ambulance Risk and Safety Forums.

APPENDIX I

2016/17 Summary of Serious Incidents

SI Number	Date SI reported	(SI) SI reporting reason	SI Status (STEIS)
2016/11658	28/04/2016	Triage / Call management	Closed
2016/11663	28/04/2016	Triage / Call management	Closed
2016/11823	29/04/2016	Child-related / Unexpected Child Death	Closed
2016/11974	03/05/2016	Patient / Third Party Injury	Closed
2016/12117	04/05/2016	Delayed Dispatch / Attendance	Open
2016/12713	10/05/2016	Triage / Call management	Closed
2016/16653	20/06/2016	Child-related / Unexpected Child Death	Open
2016/16674	20/06/2016	Call answer delay	Closed
2016/17532	29/06/2016	Drugs Management	Closed
2016/18003	05/07/2016	Insufficient equipment	Closed
2016/18615	11/07/2016	Call Answer delay	Open
2016/18622	11/07/2016	Child-related / Unexpected Child Death	Closed
2016/19170	18/07/2016	Patient / Third Party Injury	Closed
2016/19512	20/07/2016	Non-Conveyance / Condition deteriorated	Closed
2016/20034	27/07/2016	Child-related / Unexpected Child Death	Closed
2016/21170	08/08/2016	Non-Conveyance / Condition deteriorated	Closed
2016/21205	09/08/2016	Patient / Third Party Injury	Closed
2016/21812	16/08/2016	Child-related / Unexpected Child Death	Closed
2016/22089	18/08/2016	Treatment / Care	Open
2016/22611	24/08/2016	Medication Incident	Open
2016/22713	25/08/2016	Treatment / Care	Open
2016/22757	25/08/2016	Non-Conveyance / Condition deteriorated	Closed
2016/22922	26/08/2016	Call answer delay	Downgraded, not SI
2016/23034	30/08/2016	Information Governance Breach	Closed
2016/23188	31/08/2016	Delayed Attendance	Open
2016/23501	05/09/2016	Non-Conveyance / Condition deteriorated	Closed
2016/23528	05/09/2016	Triage / Call management	Open
2016/23828	08/09/2016	Internal safeguarding concern	Open
2016/30948	30/11/2016	Non-Conveyance / Condition deteriorated	Closed

SI Number	Date SI reported	(SI) SI reporting reason	SI Status (STEIS)
2016/30953	30/11/2016	Child-related / Unexpected Child Death	Closed
2016/30956	30/11/2016	Non-Conveyance / Condition deteriorated	Open
2016/30959	30/11/2016	Treatment / Care	Open
2016/31642	07/12/2016	RTC/RTA	Closed
2016/32848	19/12/2016	Power / Systems failure	Closed
2016/32849	19/12/2016	Triage / Call management	Open
2016/33257	22/12/2016	Triage / Call management	Open
2016/9914	12/04/2016	Staff Conduct	Open
2016/9938	12/04/2016	Call answer delay	Open
2017/16	18/01/2017	Non-Conveyance / Condition deteriorated	Open
2017/2062	20/01/2017	Treatment / Care	Open
2017/2319	24/01/2017	Non-Conveyance / Condition deteriorated	Open
2017/2616	26/01/2017	Non-Conveyance / Condition deteriorated	Closed
2017/3466	06/02/2017	Power / Systems failure	Closed
2017/3486	06/02/2017	Power / Systems failure	Open
2017/3666	07/02/2017	Treatment / Care	Open
2017/4307	14/02/2017	Triage / Call management	Closed
2017/4638	17/02/2017	Information Governance Breach	Open
2017/4763	20/02/2017	Triage / Call management	Open
2017/5203	22/02/2017	Triage / Call management	Open
2017/5252	23/02/2017	Delayed Dispatch / Attendance	Closed
2017/6096	03/03/2017	Treatment / Care	Closed
2017/6118	03/03/2017	Delayed Dispatch / Attendance	Open
2017/6812	09/03/2017	Medication Incident	Open
2017/7174	14/03/2017	Triage / Call management	Open
2017/7243	14/03/2017	Triage / Call management	Closed
2017/8014	22/03/2017	Information Governance Breach	Open
2017/8744	30/03/2017	Ambulance breakdown	Open
2017/8813	31/03/2017	Delayed Dispatch / Attendance	Open
2017/8827	31/03/2017	Delayed Dispatch / Attendance	Closed

APPENDIX II

Examples of Sharing Learning

Trust Shared Learning

August 2016

SI 2016/8739

LEARNING FROM SERIOUS INCIDENTS

Serious Incident – Synopsis of Events

A young child with a high temperature had been seen at hospital and discharged with analgesia and a diagnosis of a viral infection. The following day the child became lethargic and had developed a bruise-like rash covering most of her body . The hospital had advised the child's mother that if her condition became worse, she could be brought back into the ward. As the child's mother had not been provided with a specific management plan, and she was unsure whether the ward would be open at that time, she called 999.

During the call, the EMA was unsure which Pathway to use and sought advice from a Clinical Supervisor in the EOC. It was not documented by either member of staff who the Clinical Supervisor was, or their rationale behind advising or confirming that the EMA should use the 'Particular course of action' Pathway. The patient's mother was subsequently advised to take her daughter to hospital to be seen, and no emergency response was sent. No harm is believed to have been caused to the child by the disposition reached and her mother did take her straight to hospital. The child was later diagnosed with Meningitis B which she sadly died from less than 2 weeks later.

The Trust's review of the call found that the EMA missed red flag symptoms such as the significant rash the child had developed, her high temperature and lethargy. The 'Particular course of action' Pathway was not appropriate to use as, although the mother had been advised she could bring her daughter back to the hospital ward, this did not fulfill the K.F.C criteria (where there is a Known health problem, a Firm plan in place and it is relative to the patient's Current symptoms). The child's rash was a new symptom and this is what the triage should have been focused on. The rash was not documented in the incident notes and so when later reviewed by a Clinical Supervisor, they were not concerned with the non-ambulance disposition reached from the EMA's triage.

Root Cause:

The EMA choosing the 'Particular Course of Action' Pathway instead of a pathway that took account of the "bruise like rash" information.

Recommendations:

Action 1: Operational Instruction clarifying the 'Particular Course of Action' Pathway to be published for the attention of all grades within the three EOCs.

Action 2: Following the EMA's probationary period, a review to decide if any further monitoring of the EMA (outside of usual internal processes) is required.

Action 3: Both Clinical Supervisors on duty at the time to be reminded of the importance of ensuring any involvement they have in calls is recorded on the CAD.

Action 4: Following on from Action 3, a reminder will be sent out to all Clinical Supervisors in the three EOCs highlighting their responsibilities when involved in the decision making of a triage.

Trust Shared Learning

August 2016

SI 2016/6515

LEARNING FROM SERIOUS INCIDENTS

Serious Incident – Synopsis of Events

A 40 year old male with learning difficulties had recently started calling 999 frequently, usually calling with anxiety issues. Within a month of becoming a frequent caller, the patient had called 999 again with shortness of breath and his call began to be triaged by an EMA.

The patient was having difficulty in being able to fully answer the triage questions he was being asked by the EMA and the EMA subsequently early exited the call and advised the patient that a clinician would be calling him back. Eight minutes later, a Clinical Supervisor attempted to call the patient back, however could not get an answer and so they arranged for a response to be sent to the patient within 30 minutes to check on his welfare. At the same time the welfare check was being arranged, the patient's support worker had arrived at his home for a visit and found him to be not breathing. The support worker called 999 and commenced CPR whilst Trust resources were en route.

Resuscitation attempts were unsuccessful and the patient was sadly declared deceased on scene.

The EMA's call with the patient was found to have been non-compliant, with the EMA acknowledging on reflection that they had judged the patient's call on this day against other calls they had received previously from him. They did not think the patient's call would be life-threatening and so did not probe around his difficulty in breathing or make this symptom clear in the incident notes which the Clinical Supervisor was to review. The EMA also explained that they were used to having to early exit triages for frequent callers to arrange for clinicians to speak to them, and so had already expected they would not complete a full triage for this call.

Root Cause:

It is believed that there may be a systemic issue across the Trust's EOCs with regard to frequent callers potentially being disregarded when presenting with what would otherwise be considered concerning and serious symptoms.

Recommendations:

Action 1: An urgent review involving managers from several areas of the Trust is required surrounding the patient's case and the findings from the investigation. The actions of the EMA cannot be assumed to be only an individual failing, especially taking into consideration they were a fully trained and experienced member of staff.

Action 2: Proposal for the Management of Frequent Callers to be considered for inclusion on the Trust's Risk Register.

Action 3: Proposal to increase the resourcing for the Frequent Caller project to enable it to be increased Trust wide.

Trust Shared Learning

25/08/16

SI 37200

LEARNING FROM SERIOUS INCIDENTS

Serious Incident – Synopsis of Events

We attended a 59 year old female who was complaining of head pains. The patient was not conveyed to hospital, and left at home by an ambulance crew who believed that she was suffering a migraine.

A Non conveyance form was completed with OOH GP to visit. Following GP /OOH visit her relative took her to hospital themselves where she was found to have a subarachnoid haemorrhage. A CT scan which revealed a ruptured aneurysm, a subanachroid haemorrhage (SAH) and she was transferred by ambulance to Kings College Hospital the following day. The Trust received a complaint from the patient's husband about the apparent disinterest shown to his wife by the crew and their assessment of the patient.

Root Causes

1. Root Cause of this incident would suggest the single point in time that acted as the catalyst is likely to have been the oversight of attending staff when making a clinical judgement on PAT1's condition.

Recommendations:

1. The crew will undergo a full day's training with a senior clinician. A teaching module for headache assessment will also be included
2. The crew will complete a peer review.
3. The crew will be monitored over a three month period while in an operational setting This will be conducted using Clinical Team Leaders and Ppeds and will include auditing of crews paperwork paperwork for compliance
4. The Investigating Manager to discuss with Learning and Development department to include knowledge of headache assessment as part of the yearly

Changes in Practice:

IO is in discussion with Learning and Development for headache assessment to be included in the yearly Key Skills updates. If this is not achievable, a consideration to add an e-learning tool to SECAmb LIVE will be discussed. The e-learning tool will provide the Trust with specific figures on those staff who have completed and is currently an on-going discussion as to the best way forward in achieving Trust wide learning.

CASE STUDY - FOLLOWING A SERIOUS INCIDENT

'Not following Trust Policies and Procedures'

Synopsis of Events

NHS 111 received a call from a concerned parent whose young son was complaining of head pains. The parent was advised by NHS111 to see their GP within two hours which was done. The GP diagnosed a migraine. Two days later, 111 received another call from the same parent whose son was now complaining of severe left eye pain and phototobia. The ambulance request was passed through to the EOC. An ambulance, crewed by a Paramedic and an Associate Practitioner, was dispatched to the scene.

Following assessment the child was left at home in the care of his mother. The PCR states "right eye pain due to migraine" and that the patient's mother agreed with the findings of the attending crew. The following day, a 999 call was received for the same address. The CAD notes stated that a child had been ill all week and was in bed with a migraine, signs of a rash on his chest and abdomen. A Paramedic in an SRV attended, backed up by a Critical Care Paramedic and Technician. The child had a lowered respiratory rate requiring assisted ventilations, and unequal pupils. IV access was established and fluids administered. The patient was then ASHICE'D to hospital. Later that day the child was transfered to King's College Hospital London where he sadly died later that day.

Root Causes

- Staff did not follow Trust Policies and Procedures.

Recommendations following investigation

- Remind all staff about the concept of Shared Decision Making and the importance of adhering to the Discharge Procedure and the Referral, Discharge and Conveyance Policy.
- All staff involved to take part in a peer review, where all learning points will be discussed and any specific training needs identified. Any Trust-wide learning to be shared.

Awareness & Learning

- The Clinical Development Team has recently produced the "Urgent Care Handbook" which has been issued to every clinical member of staff. The handbook contains information on safely discharging, making referrals, shared decision making and safeguarding.
- Always be alert to the fact that an earlier diagnosis from another clinical professional may be wrong - approach every patient with an open mind.
- The symptoms of meningitis, especially in the early stages, are often subtle.

CASE STUDY - FOLLOWING A SERIOUS INCIDENT

'Frequent callers potentially being disregarded'

Synopsis of Events

A 40 year old male with learning difficulties had recently started calling 999 frequently, usually calling with anxiety issues. Within a month of becoming a frequent caller, the patient had called 999 again with shortness of breath and his call began to be triaged by an EMA.

The patient was having difficulty in being able to fully answer the triage questions he was being asked by the EMA and the EMA subsequently early exited the call and advised the patient that a clinician would be calling him back. Eight minutes later, a Clinical Supervisor attempted to call the patient back, however could not get an answer and so they arranged for a response to be sent to the patient within 30 minutes to check on his welfare. At the same time the welfare check was being arranged, the patient's support worker had arrived at his home for a visit and found him to be not breathing. The support worker called 999 and commenced CPR whilst Trust resources were en route. Resuscitation attempts were unsuccessful and the patient was sadly declared deceased on scene.

Following audit, the EMA's call with the patient was found to have been non-compliant, with the EMA acknowledging on reflection that they had judged the patient's call on this day against other calls they had received previously from him. They did not think the patient's call would be life-threatening and so did not probe around his difficulty in breathing or make this symptom clear in the incident notes which the Clinical Supervisor was to review. The EMA also explained that they were used to having to early exit triages for frequent callers to arrange for clinicians to speak to them, and so had already expected they would not complete a full triage for this call.

Root Causes

- **A potential systemic issue across the Trust's EOCs with regard to frequent callers potentially being disregarded when presenting with what would otherwise be considered concerning and serious symptoms.**

Recommendations following investigation

- An urgent review involving managers from several areas of the Trust surrounding the patient's case and the findings from the investigation. The actions of the EMA cannot be assumed to be only an individual failing, especially taking into consideration they were a fully trained and experienced member of staff.
- Proposal for the Management of Frequent Callers to be considered for inclusion on the Trust's Risk Register.
- Proposal to increase the resourcing for the Frequent Caller Project to enable it to be increased Trust wide.

Awareness & Learning

- Frequent Callers often have an un-met health and/or social care need.
- Always ensure you are able to complete an appropriate and safe triage. If triage is not possible, consider the 'early exit/ triage not possible' option.
- All staff should look out for information on the new Frequent Caller process rolling out this year.

IT WOULD BE GREAT TO HAVE ANY FEEDBACK AND ALSO ANY CASE STUDIES YOU THINK SHOULD BE INCLUDED – EMAIL REFLECTIONS@[illegible]

South East Coast Ambulance Service NHS
NHS Foundation Trust

		Agenda No	92/17
Name of meeting	Trust Board		
Date	September 2017		
Name of paper	Annual Clinical Audit Report 2016/17		
Responsible Executive	Dr Fionna Moore, Executive Medical Director		
Author	Fiona Wray- Associate Director, Medical Directorate		
Synopsis	This paper sights the Board on the progress made completing the 2016/17 clinical audit programme. It also highlights the process used to develop the clinical audit programme for 2017/18.		
Recommendations, decisions or actions sought	The Board is asked to approve the Annual Clinical Audit report 2016/17 for publication.		
Does this paper, or the subject of this paper, require an equality impact analysis ('EIA')? (EIAs are required for all strategies, policies, procedures, guidelines, plans and business cases).		No	

Clinical Audit
Annual Report 2016-17

Authors: Fiona Wray, Associate Director – Medical Directorate
Patricia Bucher, Clinical Audit Supervisor

Contributors: Joe Emery, Clinical Audit Lead

Contents

1. Introduction **3**

2. Background and overall activity **4**

3. Clinical Audit Plan 2016-17 **6**

3.1 Feverish illness in children **6**

3.2 Patient Clinical Record (PCR) documentation **6**

3.3 Transportation in cardiac arrest **7**

3.4 Airway management of patients in cardiac arrest **8**

3.5 Correct diagnosis of non-conveyance of patients with chest pain. **8**

3.6 Head injury in adults **9**

3.7 Snapshot Audits **9**

3.8 Fractured neck of femur **9**

3.9 Hypoglycemia **9**

3.10 Identification and management of severe sepsis **10**

3.11 Use of activated charcoal **10**

4. National Benchmarking **11**

5. Other National Audits and Evaluations **12**

5.1 Out of Hospital Cardiac Arrest Outcomes Study (OHCAO) **12**

6. Links with other organisations **13**

7. Driving improvement into 2017-18 **13**

Appendix 1: Clinical Audit Work Programme 2017-18 **15**

1. Introduction

South East Coast Ambulance Service NHS Foundation Trust (the Trust) is committed to delivering outstanding clinical care that contributes to improved patient outcomes. This report presents an overview of clinical audit activities within the Trust between 01 April 2016 and 31 March 2017. It informs the Board how the Trust worked to ensure the delivery of evidence based care to patients, followed recommended guidelines and achieve good outcomes for patients.

The Clinical Audit team is committed to raising the profile of clinical audit within the Trust and is dedicated in its aim that the annual forward audit programme should be a valuable resource in the Trust's aim to continually improve patient outcomes and experience.

Clinical audit forms an integral part of the clinical governance framework through which like other NHS organisations, the Trust is accountable for continually improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish. Clinical audit is a quality improvement process that seeks to improve patient care and outcomes through systematic measurement against explicit criteria and the implementation of any necessary change.

The Trust has faced a challenging year with a number of competing priorities within the Trust, changes in leadership and increased external scrutiny which have all impacted on the ability to complete the 2016/17 Clinical Audit plan and utilise audit findings to inform service improvements. However, with the appointment of a new Chief Executive and recruitment to the Executive Director roles it is anticipated this will provide stability and leadership which will have a positive impact on all areas of the Trust's functions.

Fionna Moore
Executive Medical Director

2. Background and overall activity

The Trust Board is accountable for clinical audit with the Executive Medical Director maintaining overall responsibility for the clinical audit function of the Trust. During the financial year 2016/17, clinical audit at the Trust was supported by a team comprising of six whole time equivalent substantive roles: Head of Clinical (HoCA), Clinical Audit Lead (CAL), Clinical Audit Supervisor and three Clinical Audit Co-ordinators (CAC).

In May 2016 the Clinical Quality Commission (CQC) inspection highlighted several areas for improvement relating to clinical audit. In response the Trust formulated an action plan that included deadlines and responsible persons. Actions included the appointment of interim post holders to the roles of Head of Clinical Audit and Clinical Audit Lead to deliver the Clinical Audit recovery plan from 2015/16 and manage the Trust's clinical audit programme. The clinical audit team's internal systems for clinical audit projects were also reviewed and additional processes implemented to underpin the Clinical Audit Policy, Clinical Audit Procedure and local operational procedures.

Throughout 2016/17 progress in achieving the clinical audit plan was monitored through various groups and reported to the Trust Board: The clinical audit team raised the profile of clinical audit and published an article in the second edition of the Reflections magazine on Clinical Outcome Indicator performance for the period April to September 2016.

The Trust is committed to providing opportunities for all its staff that are directly responsible for delivering patient care to participate in clinical audit. All staff have been invited to submit clinical audit topics for inclusion in the annual plan and lead clinical audits with support from the clinical audit team. All clinical audits undertaken had participation from an identified clinical member of staff.

Ambulance Clinical Quality Indicators (ACQI), are measures that the Trust reports to NHS England. To raise staff awareness and understanding of these key performance indicators the CAL attended Transition to Practice sessions where newly qualified paramedics are trained on both national and local policies, procedures and ways of working. The team also undertook development days and station visits to improve our compliance with two of the ACQIs, specifically the care bundles for Stroke and STEMI.

The clinical audit team was responsible for delivering the Trust's Clinical Audit Plan (CAP) for 2016/17 together with agreeing an annual rolling audit programme. Details of these plans are outlined in Appendix 1. In accordance with new procedures the 2017/18 programme was developed following:

- Engagement with internal and external stakeholders, who were invited to suggest specific conditions or care pathways they would like the Trust to include in their programme;

- A review of all Serious Incidents (SIs) submitted to the Trust's Quality and Safety Committee in 2016-17 to identify any potential clinical care concerns or trends of specific incidents.

- A review of the National Institute for Health and Care Excellence (NICE) guidance database to identify new or amended guidelines which the Trust should consider including in its programme;

- A review of historical audits that require re-audit subsequent to implementation of recommendations;

- A review of the National Clinical Audits for inclusion in the Quality Accounts (QA), including ACQI and Clinical Performance Indicators (CPI).

The clinical audit team delivered, on behalf of the Trust, the submission of data to NHS England on the ACQIs. This involved analysing clinical data from in excess of 1000 records monthly to inform this submission.

The 2016/17 CAP included nine audits in addition to the NCPIs and COI's which are mandatory audits.

a. Feverish illness in children
b. PCR Documentation
c. Transportation in cardiac arrest
d. Airway management of patients in cardiac arrest
e. Correct diagnosis of non-conveyance of patients with chest pain
f. Head Injury in adults
g. Fractured Neck of femur
h. Hypoglycaemia
i. Identification and management of sepsis

Four of these nine audits (a-d) have been completed and approved by the Clinical Audit & Quality Sub Group CAQAG): The remaining audits are in progress, all have had data collected and analysed but the report and recommendations have not yet been completed and published. To ensure these outstanding audits are completed they have been included in the 2017/18 clinical audit plan and their completion is being closely monitored by the Head of Clinical Audit.

During 2016/17 an addition snapshot audit of the administration of activated charcoal was undertaken. This audit was carried out at the request of the Medicines Management Team who identified that a significant amount of activated charcoal was being disposed of as it was going out of date. The audit reviewed the number of incidents where this had been administered and if this in line with the Trust's Medicine Administration Protocol.

The team contributed to a range of other projects in the Trust including the development and implementation of a new process to report performance of the ACQIs at both Trust and individual station/ Operating Unit (OU) level. The team supported the work of Electronic Patient Clinical Record Project (ePCR), and participated in the Out of Hospital Cardiac Outcomes project. To promote clinical audit activity, performance reports, findings and actions were published on a revised Clinical Audit page located in the Clinical Zone of the Trust's intranet or available from the Clinical Audit team.

In 2017/18 clinical audit reporting at Operating Unit and station levels within the Trust will continue and include Clinical Outcome Indicators (COI) and Clinical Performance Indicators (CPI). This will ensure real time web-based clinical audit and performance indicator data is readily available and disseminated to the Operational Management Team to inform and drive improvements of identified issues.

3. Clinical Audit Plan 2016-17

In 2016-17 the following audits were completed and published;

3.1 Feverish illness in children under five (CA6-17/2f) (June 2016)

A snapshot audit of feverish illness in children was undertaken in 2010. The original audit identified several limitations, including; insufficient data for analysis and no clear definition of fever. The audit standards were limited to very specific areas, and not representative of wider aspects of clinical care. It was recommended that a more detailed re-audit was undertaken which would include a larger sample size, producing sufficient data that could be analysed. The audit would also provide a comparison between this group of patients and a subset of febrile convulsion patients to establish any variance in clinical practice.

The aims and objectives of the re-audit was to ensure clinicians undertook clinical assessments and delivered care in accordance with JRCALC guidelines, Trust Clinical Instructions and adherence to the use of the “Traffic Light” Clinical Assessment tool in the assessment of feverish children. It also aimed to establish any variation in the assessment of children presenting with febrile convulsions and proportion of feverish children receiving anti-pyretic medicine at the time of incident administered by Trust clinicians or parent/guardian as appropriate.

Recommendations from the re-audit advised a review of guidance on the administration of anti-pyretic medication for children with a fever above 38C. It was also recommended that consideration should be given to the re-distribution of guidance on the importance of recording blood pressures for unwell children using the paediatric observations kit. Both these recommendations have been completed A review of guidance of anti-pyretic medication for children with a fever of above 38 C has also taken place.

3.2 PCR Documentation (CA16-17/2g) (August 2016)

Documentation of care provided to patients is essential as it provides a record of the clinical assessment, the clinician’s decision making and management of the patient. All registered clinicians have a professional responsibility to ensure they complete documentation accurately. Patient clinical records are not only used by the Trust to evaluate effectiveness of care but can also be requested and used by other hospitals, Police, or the Coroner as part of their work.

At the May 2016 Care Quality Commission (CQC) inspection it was identified that patient clinical records did not always meet the Trust's clinical guidelines for data requirements. In response to these concerns an evaluation of compliance with the Trust's Patient Clinical Record (PCR) minimum data requirements was undertaken. This included a review of crew compliance with the requirement to record an initial and subsequent/final set of observations as per the Trust's Patient Clinical Record (PCR) extended data requirements. The sample was a comparison of data used for the previous audits totalling 1177 incidents.

Overall compliance with a minimum data set was found to be poor, with areas such as capacity assessment compliance ranging from 36% - 67%, patient ethnicity compliance ranging from 33% to 56% and crew condition codes ranging from 56% to 100%). The audit also identified missing clinical observations and drug codes routinely not being completed. It was noted that incident number, date, crew call signs and personnel numbers were routinely completed. Staff were not compliant with completion of the extended data set; therefore, it was not possible to always evidence clinical decisions or judgement.

This lack of compliance with collection of minimal and extended data sets has implications for patient management, continuity and handover of care to other healthcare providers. The key findings were publicised in the weekly Bulletin and the OU COI Dashboard. Further work including the introduction of regular PCR audits undertaken by local managers is ongoing and the results of these audits will be used to identify areas of good practice that can be shared Trust wide.

3.3 Transportation of patients in cardiac arrest (October 2016)

In October 2016 in support of the Return of Spontaneous Circulation (ROSC) (All and Utstein) COI performance analysis, a re-audit was undertaken to establish if there had been a reduction in the numbers of inappropriate conveyances whilst patients were in cardiac arrest following implementation of the 2013 transportation of patients in cardiac arrest audit recommendations.

The main findings of this re-audit were that there had been a failure to update clinical instruction C44 in line with the introduction of the LUCAS clinical management plan. Paediatric patients were transported rapidly in accordance with Trust guidance. The audit found crews were transporting patients in cardiac arrest with manual compressions. Some patients were transported with or without mechanical compressions following consultation with senior medical consultants.

The audit recommended that a formal review of the circumstances where transport may be appropriate and subsequently clarify guidance provided to all crews. There was a need to review and reissue a clinical instruction regarding the transport of adult patients in cardiac arrest with manual compressions ongoing. Clarification should be sought from the Critical Care Paramedics that documentation of LUCAS as an intervention and the rationale for its use is recorded and reviewed at local governance meeting. These recommendations have been implemented by

operational staff and ongoing monitoring will be undertaken by the clinical audit department.

3.4 Airway management in cardiac arrest (November 2016)

An audit of the 'airway management of patients in cardiac arrest' was undertaken in 2013. The audit identified a need to further educate crews in relation to intubation and the 'step-wise approach'.

In 2016 JRCALC Guidelines were updated to include guidance on supraglottic airways and intubation being performed in conjunction with waveform capnography. This change in guidelines identified the need for a re-audit of this topic.

The main aims of the re-audit were to ensure that airways were managed in accordance with JRCALC 2016 guidelines and to confirm that observations were being recorded in accordance with the Trust guidelines. The audit specifically considered the following

- if staff were taking a stepwise approach to airway management
- establish if an endotracheal tube (ETT) had been successfully placed
- if a subsequent end tidal CO2 (EtCO2) reading were recorded

This audit identified both areas of good practice and areas for improvement. The audit found 86% of intubation attempts were successful on the first or second attempt. However, there were a number of cases where intubation was the sole method of airway management or more than two attempts to intubate had been made. without evidence of necessity or changed technique for each attempt. There were a number of cases where intubation was recorded as successful but no $EtCO_2$ was recorded, which is not in line with best practice of always monitoring $EtCO_2$. In intubated patients

The audit recommended that clarity should be provided by the Trust on the stepwise approach, providing staff with a clinical instruction for deviation if required.
A clinical instruction should also be considered that reiterates the expectation that intubation is only attempted with capnography, and that all staff should be confident in its use. The audit was presented at the Professional Practice Group (PPG) on 06 February 2017 who supported the audit recommendations and agreed to take these forward.

3.5 Correct diagnosis of non-conveyance of patients with chest pain (November 2016)

The correct diagnosis of non-conveyance of patients with chest pain was identified as an audit proposal following a review of incident and complaint data for 2015/16. The data highlighted concerns relating to non-conveyance and referral pathway for Emergency Operations Centre (EOC), 111 and 999 services. The audit considered the diagnosis and management of chest pain for non-conveyed patients, focusing on re-contacts and pathway dispositions between 111/EOC. It also reviewed documentation for the assessment and management for face to face consultations.

A re-audit of the topic was scheduled in 2016/17. The data for this audit has been collected and analysed. The audit report and recommendations are currently being finalised prior to submission to CAQSG for approval.

3.6 Head injury in adults (December 2016)

Head injury in adults was identified as an audit proposal as a result of Serious Incidents Requiring Investigations (SIRI) and a complaint trend. An initial audit was completed in 2010-11 but no re-audit of head injury in adults had been completed in the last five years, despite there being significant changes in practice during this time. Changes include updated National Institute for Health and Care Excellence guidelines on head injury and in 2016 updates to JRCALC Guidelines with extensive additional guidance included for Traumatic Brain Injury (TBI).

Data on the assessment and management of head injury for patients on anticoagulant treatment has been collected and analysed. A draft report has been drafted and is currently being quality assured prior to the report being finalised and approved by the CAQSG.

3.7 Snapshot audits

The following snapshot audits were scheduled for 2016/17.

Snapshot audits examine specific aspects of care either within a particular geographical area of the Trust, or a specific group of patients. These focused audits examine a limited amount of data, sufficient to answer a specific question.

3.8 Fractured neck of femur (CA17-18/2)

Following a re-audit of the management of fractured neck of femur (NOF) in 2013-14, the audit recommendations included a re-audit following implementation of the action plans to address the issues identified.

A snap shot re-audit focusing specifically on the review of the current clinical practice of the assessment and management of fractured NOF, to inform the development of new clinical pathways and training has been completed. A draft report is currently under revision and the final report will be submitted to CAQSG for approval.

3.9 Hypoglycaemia (CA16-17/2e)

The Trust previously reported performance against a hypoglycaemia care bundle twice a year as part of the National Ambulance Clinical Performance Indicators (CPI), last submitted for December 2013. A snap shot re-audit of compliance to the care bundle was conducted using the CPI audit tool in accordance with clinical guidelines to identify if performance had been maintained since the cessation of the CPI

reporting cycle for hypoglycaemia.

The audit found that compliance with recording blood glucose before and after treatment and the overall care bundle had increased. However, the compliance with the treatment of hypoglycaemia had reduced when compared to the last audit from 99.1% to 98.9%. Direct referral to an appropriate health care professional had also decreased from 70.3% to 61.7% since the last audit in December 2013 when this condition was removed from reporting under the national Clinical Performance Indicators.

3.10 Identification and management of severe sepsis (CA16-17/2d)

Severe Sepsis was identified as an audit proposal following a review of complaints trends and incidents and was undertaken in 2013-14. In the last two years a number of publications have been issued including a new code yellow sepsis pathway and a review of incident data for 2015/16 identified a continued trend of missed diagnosis of sepsis and therefore management of the patient was not in line with the sepsis pathway.

An audit to assess the impact of the introduction of the code yellow sepsis pathway and the initial clinical assessment of patients with suspected sepsis was undertaken. The data has been analysed and the report and recommendations are being drafted. This report will be submitted to the next CAQSG for approval.

3.11 Use of Activated Charcoal

The aim of the audit was to ascertain if activated charcoal is being administered to patients presenting with an oral overdose within the Trust's guidance of one hour from time of ingested oral overdose to achieve an effective outcome.

Analysis of the data demonstrated that 88% of patients were given charcoal within two hours of ingestion, which is outside Trust guidance of one hour as documented the Medicine Administration Protocol (MAP) for this medicine. However, was in line with NICE guidelines which recommends its use within two hours of ingestion. The audit found that 12% of patients were given it more than two hours after ingestion which is outside both local and national guidance.

Following this audit staff were reminded of the MAP and the importance of ensuring that the time of overdose and the time the charcoal was administered in the PCR to evidence compliance with local and NICE guidance. The administration of this product is currently under review by the Medicines Governance Group who will consult with internal stakeholder and a decision will be made on administration processes.

4. National Benchmarking

The Trust collects and analyses data for a range of national Clinical Outcome Indicators (COIs) for all eligible patients who present with ST elevation myocardial infarction (STEMI; a type of heart attack), a stroke or experience a cardiac arrest. This data was collected for over 13,000 patients. The team has also provided data for the national benchmarking of Clinical Performance Indicators (CPIs) with ambulance services. These submissions included where possible, a sample of 300 cases every six months for each of the following clinical conditions: asthma, elderly falls, febrile convulsion and lower limb fractures.

NHS England publishes monthly reports on the performance of all Ambulance Trusts and these are available on their website https://www.england.nhs.uk/statistics/statistical-work-areas/ambulance-quality-indicators/

In 2016/17, the Trust participated in the five topics which comprised of the CPIs. Each CPI contains a care bundle, which lists the aspects of care which are monitored for each condition. Performance against each aspect of the care bundles is monitored using data collected from the PCRs.

Based on national audits of each CPI the Trust's performance was benchmarked against other ambulance trusts. These audits are completed twice a calendar year, the Trust performance was;

- **Care of asthma patients**

Based on June 2016 data 70.9% of care bundles were fully completed. This is a decrease when compared to the last audit undertaken in December 2015 when 79.0% of care bundles were completed. However, when benchmarked with other ambulance trusts the trust continues to be rated fourth nationally.

- **Care of patients following febrile convulsions**

The trust was rated fourth nationally based on April 2016 data with 84.1% of care bundles being completed. In October 2016 the number of completed care bundles dropped to 56.0%. This drop in performance resulted in the Trust being rated ninth nationally for this CPI.

- **Care of patients following isolated limb trauma (upper & lower limbs)**

The January 2016 data found 51.0% of care bundle were fully completed compared with 54.3% in July 2016. While the number of care bundle fully completed increased

when benchmarked with other ambulance trusts we were rated third nationally in January 2016 and sixth in July 2016.

- **Care of patients experiencing mental health (self-harm)**

  We have seen an increase in the Trust's performance for the completion of care bundles for this group of patients. In October 2015 the audit noted 22.7% were fully completed placing the Trust ninth nationally. In April 2016 completion of care bundles was 69.7% and the Trust was rated second best preforming trust nationally.

- **Care of elderly patients**

  The March 2016 data found 12.3% of care bundle were fully completed, this is the same as the findings of the September 2015 audit. The Trust's performance remains eighth nationally.

Additional information is published by NASCQG and can be obtained from the Trust's Clinical Audit Department- clinical.audit@secamb.nhs.uk;

No data for these CPIs has been submitted since September 2016, when the Trust was advised of the decision to suspend CPIs pending further discussions between NASMED, NASCQG and Ambulance Leading Paramedic Group (ALPG) into the future of Ambulance Quality Indicators. The outcome of these discussions will be taken forward for further consultation with NHS England and the Ambulance Response Programme for a decision on the CPIs.

5. Other National Audits and Evaluations

5.1 Out of Hospital Cardiac Arrest Outcomes Study (OHCAO)

The University of Warwick is leading a study on out-of-hospital cardiac arrests, a national registry is being developed with the aim to improve performance by identifying areas of good practice.

Throughout 2016/17, like several other Trusts we have participated in this study Following completion of this study, including data flow mapping and interrogation of submitted incidents, the University's Trials Steering Committee will undertake a statistical benchmark analysis exercise using the 2014 calendar year data outcomes for out of hospital cardiac arrests.

6. Links with other organisations

The Trust has continued to participate in the National Ambulance Service Clinical Quality Group and its Clinical Performance Indicator Technical Subgroup. Members of the clinical audit team have attended two national benchmarking days aimed at sharing data and learning.

The Trust is sharing information regarding patient outcomes for survival to discharge and patient transport times for STEMI reperfusion (MINAP) with our acute hospitals across Kent, Surrey and Sussex.

7. Driving improvement into 2017-18

71. The Trust has developed a clinical audit programme for 2017/18 by undertaking a desk top review of the potential risk areas for clinical audit review as well as the national audits the Trust is required to participate in. The clinical audit programme will be divided into four distinct elements and is in line with national guidance from the Healthcare Quality Improvement Partnership (HQIP). Clinical audits are prioritised into one of four levels, as per the table overleaf (Table 1), with Level 1 being given the highest priority.

Table 1 Clinical Audit Priority Levels

*Level	Audit Type	
Level 1 audits, 'external must dos'	• National audits (ACQIs) • National Research such as Warwick University –Out of Hospital Cardiac Arrest- should • NCEPOD / Confidential Inquires • CQUIN • Care Quality Commission (CQC) • DH statutory requirements (e.g. Infection Control Monitoring) • NHS England • Recommendations from Coroners • National Institute for Health and Care Excellence (NICE)	1
Level 2 audits, 'internal must dos'	• Clinical risk • Serious incidents • Complaints • Re-audit	2

Level 3 audits, Operation unit priorities'	• Local topics important to the Operation unit/directorates	3
Level 4 audits	• Clinician / personal interest	4

7.2 The clinical audit team recognises that it is not possible to anticipate all necessary activity and, therefore the clinical audit programme is flexible, to accommodate additional and / or repeat audits that are required due to Trust priorities throughout the year. Closer links with complaints and incident management will ensure themes and trends are identified and included in the clinical audit programme.

Appendix 1: South East Coast Ambulance Service NHSFT; Clinical Audit Work Programme 2017-18

Ref	Topic	Primary Aims	Quality / Performance	Clinical Guideline	SIRI/incident complaint trend	Re-Audit	JRCALC 2016/ NICE Guidance	National Audit/CPIs	Quality Account/Clinical Strategy/ URP	Key Skills	Hirsk/ high volume	CQC
Participation in National Audits (Level 1)												
COI 1	Cardiac Arrest – Return of Spontaneous Circulation (ROSC)	National Clinical Outcome Indicator Programme	•									
COI 2	Cardiac Arrest – Survival to Discharge (StD)	National Clinical Outcome Indicator Programme	•									
COI 3	STEMI Care	National Clinical Outcome Indicator Programme	•									
COI 4	Stroke Care	National Clinical Outcome Indicator Programme	•									

Examples of internal audits (Level 2)												
1	Management of Suspected Fracture Neck of Femur	To review the current clinical practice of the assessment and management of fractured NOF and inform the development of new clinical pathways and training.					•					
2	Management of Severe Brain Injury	Audit of head injury in adults was conducted in 2010-11. No head injury audit has taken place in the last 5 years with significant change in practice during this time: updated guidance on head injury (National Institute for Health and Care Excellence guidelines), update to 2016 JRCALC Guidelines with extensive additional guidance added on Traumatic Brain Injury (TBI).		• (CG 176)	•		•			•		
3	Falls: Understanding referral behaviour	The Trust URP states that referrals to the *Falls Team* must increase to 75% by the end of 16/17. Following the implementation of a standardised referral process across the Trust, referrals remain low (approx. 10%). This project will aim to understand the referral behaviour and examine variables which may be impacting on the continued low referral numbers.							•		•	•
4	Falls: Time on floor V's Patient Outcomes	There significant evidence which states that the longer a patient is on the floor following a fall the poorer their outcomes. There is some evidence that a patient on the floor for as little as one hour 1 hour will have much poorer outcomes. This project will examine existing data to understand the length of time patient have been waiting for an ambulance following a fall and							•		•	•

		what their outcomes were. The aim is to ascertain if the current call categorisation is appropriate for this cohort of patients.										
5	Documentation Standards Audit	The May 2016 Care Quality Commission inspection raised concerns about clinical records and the failure to meet the trust's data requirements. The audit will measure compliance with the minimum and extended data sets.	•	•								•
Clinical Audits identified by operational units or directorates (level 3)												
1	Mental Health	Priority for audit to be identified Trust MH Lead.								•		
2	Amiodarone infusion review	Amiodarone infusion PGD was introduced into Critical Care Paramedic practice in May 2014 a review was undertaken looking into its use during 2016/17. Records show that it has been use on 10 occasions during this period The following is a "snap shot" review of these 10 cases		•								

South East Coast Ambulance Service NHS Foundation Trust

SECAMB Board

Escalation report to the Board from the Workforce and Wellbeing Committee

Date of meeting	31st July 2017
Overview of issues/areas covered at the meeting:	**Review of o/s actions on** a. **Policies and procedures –** Assurance had been received in January that adequate processes are in place to both update and disseminate Trust policies. There was **no assurance on any follow up about understanding or compliance.** This is still outstanding and should be combined with discussion on same topic at Audit Committee in September. b. **Move to Crawley (culture change) –** Work with Ignite had not progressed as originally anticipated. Carried forward to next meeting. c. **Disciplinary/Grievance Timescales –** Some assurance that this had improved and new recording software in place from August 17. Further update in October meeting. **Partial assurance** d. **Vacancies in Critical Posts – Full assurance** received that all critical non-frontline posts had either been filled or were adequately covered by interim/temporary staff. The most problematical area remains the Safeguarding team where there is a national shortage of appropriately qualified staff e. **EOC Business continuity Plans –** The Committee **were assured** that appropriate plans were in place across all three EOC's in the event of a business continuity incident at any of them **Bank Staff -** The Committee had requested a full review paper on bank staff. Due to a misunderstanding by the Director of Workforce the paper submitted only covered the application process. The Committee were assured on this aspect but request the additional information at the next meeting and therefore at the moment, **no assurance** can be recorded. **OU Appointments –** The Committee received a paper on the recent appointment of junior and middle management as a consequence of the Operational Unit restructuring. The Committee was **assured** that the Trust had implemented this in a fair and effective manner and there now existed good processes for the selection, development and career management of these front-line staff. **Recruitment and Development of CFR's –** The Committee received a paper on the actions being taken to recruit and engage CFR's in North Kent. This was noted as the best practice that would be extended across the Trust. Therefore while this was accepted as a good start, some work is still needed to make the practices and treatment of CFR's consistent across the Trust. Consequently only **a partial assurance** was recorded. The Committee requested a strategy paper for the October Board meeting followed by a presentation of this strategy to Governors at a subsequent date. **Risk Register –** The Committee reviewed the top risks relating to workforce. The Committee **were assured that plans were in place to mitigate the top workforce risks** and these appeared adequate and were on track as far as these were within the control of the Trust.

Reports *not* received as per the annual work plan and action required	• Statutory and Mandatory Training • Bank staff – terms& conditions and legal standing • NED induction and training • Committee framework (subsequently adopted by TP to resolve with HR)
Changes to significant risk profile of the trust identified and actions required	**Significant risks remain about sufficient manpower; culture; and appraisal completion.**
Weaknesses in the design or effectiveness of the system of internal control identified and action required	Previously identified weaknesses around dissemination of policies and establishing an accepted set of measured outcomes on the progression of culture initiatives identified in January still remain. See above for action. The question of potential weaknesses on how the Trust manages major change highlighted through the CQC visit will be initially addressed and scrutinised through a report on process at the July Committee meeting (deferred until October).
Any other matters the Committee wishes to escalate to the Board	The most significant issue remains the **incomplete nature of the Workforce Plan.** With the recent clarification of structure and internal agreement on budgets, this should begin to be resolved. A paper outlining the principles and assumptions will be presented at the next meeting. It is unlikely that a formal workforce plan for 2017/18 will be produced. The Committee has also requested the Director of Operations to present a strategy paper on the recruitment and engagement of CFR's to the Board in October 2017

SECAMB Board

QPS Escalation report to the Board

<table>
<tr><td>Date of meeting</td><td>7th September 2017</td></tr>
<tr><td>Overview of issues/areas covered at the meeting:</td><td>This meeting considered:

Management Responses (response to previous items scrutinised by the committee)

• Patient Experience – The committee was <u>not assured</u>. Further clarification work has shown that the design and effectiveness of the Trusts system of internal control for patient experience following changes made in the period of Q3/16-Q2/17 have resulted in a number of issues which include
o A need to look back at the reported figures (internal audit to undertake)
o Revised Policies and procedures to be put in place (Nov 17)
o Timeliness of response
o Investigation capacity and capability to be reviewed and improved
o Changes to Datix to support the process
o Management and closure of specific actions and evidence of this
There is however a team in place to lead this and the restructure in operations will support the investigation aspects. The committee has asked for a rectification plan, which clearly articulates the issues and date for resolution to be bought to the next October meeting

• Private Ambulance Providers –Following previous scrutinty paper where the committee was a<u>ssured</u> that appropriate checks and governance processes are in place for PAP's the committee had asked for evidence that snap checks are being undertaken and this was provided.

• LifePak12 short term plan – The committee were <u>assured</u> by the short term plan for LP12's (and deployment of LP15's) and that there are no patient safety issues relating to this. A long term plan will be bought to the December QPS meeting.

Scrutiny Items (where the committee scrutinises that the design and effectiveness of the Trust's system of internal control for different areas)

PCR Rectification Plan– <u>not assured</u>
The committee acknowledged that significant effort had been put into identifying and starting to resolve issues relating to PCR' there are still significant issues in the area of health record handling as well as compliance with new process put in place to enable identification of unreconciled PCR's. In addition issues relating to ePCR's reconciliation.The committee escalated this to the Executive and asked for an update at the next meeting.

EOC: rise in complaints – not assured
This paper gave rise this significant discussion on the categorisation of complaints against EOC where the root cause is timeliness however, the rise in complaints and SI's was of significant concern. The root causes of the complaints/SI's were not clear and it was agreed that a root cause analysis would be undertaken for all SI's and a sample of complaints would be undertaken. In addition analysis of pathways audits would be bought to committee and also consideration would be given to categorisation of complaints/SI's/incidents.

Safeguarding: External safeguarding - <u>partially assured</u>
Internal safeguarding – <u>not assured</u></td></tr>
</table>

	Overall there are improvements since the committee last scrutinised safeguarding- there is oversight and clear accountability for safeguarding, up to date policies, and a sub-group for safeguarding are in place and well attended, mental capacity training has been put in place and there is a safeguarding training strategy. Safeguarding processes for referring patients (external) are in place and progress has been made embedding these. However although there is now a policy for internal safeguarding and allegations this area is not robust, embedded and needs further work. This area was escalated to the Executive for discussion. **Learning from Deaths – Assured** The Learning from Deaths Policy was shared for information and comment which is expected to be published by all NHS Trusts by end September. It was agreed further work needed to be done to understand the magnitude of work to investigate deaths. This would be bought to the Board. **Quality Account Priorities- Assured** The Quality Account plan and updates on the quality measures were shared. The committee felt that the renewed focus and support by Head of Communications provided assurance required. **Medicines Management Optimisation Action Plan Progress Update** The date for the full implementation for this plan, as requested by the CQC is the 22nd September. Assurance was provided that daily calls were being undertaken to ensure all actions would be complete except fitting of locks on vehicles but a robust plan was in place to complete this and that the 'culture change' element would be ongoing but significant steps had been taken with regard to this including all 150 team leaders attending briefing meetings with the CEO about their accountabilities.
Reports *not* received as per the annual work plan and action required	None
Changes to significant risk profile of the trust identified and actions required	1. **Patient Care Records-** additional concerns raised relating specifically to the Health Records Dept and ePCR's **2. Internal Safeguarding –** embedding of the policy into the Trust **3. Patient Experience/Complaints –** Resolution of issues
Weaknesses in the design or effectiveness of the system of internal control identified and action required	
Any other matters the Committee wishes to escalate	• **Mobile Data Terminal** - The committee asked that an action plan with appropriate priority, and clarity about which of the recommendations from the review is bought in October.

to the Board	• **Backlog of incidents**- this was now reduced to 40 • Internal Audit Reports being included in relevant committee agendas

o

SECAMB Board

Summary Report on the Audit Committee Meeting of 4st September 2017

Date of meeting	**4 September 2017**
Overview of issues/areas covered at the meeting:	Whilst the holiday period inevitably had an impact, the papers for this meeting were late yet again. There may always be legitimate and appropriate reasons for individual late papers, however, the role of the Audit & Risk Committee is such that it is essential that Members have an appropriate period to study and consider the papers. The agreed standard is 7 days, a target that has not been achieved thus far in 2017. Whilst no formal target exists for production of draft minutes, it is unhelpful to be writing this escalation report two weeks later without the benefit of draft minutes The standard of papers presented improved slightly but in general needs further improvement. The exception on this occasion was the Board Assurance Framework which was an excellent paper. The key areas covered were: • BAF: Effort commended but neither the 1st Iteration nor the proposed 2nd iteration will of itself deliver the sort of Assurance that the Board (or at least the Audit & Risk Committee) is seeking • Risk Register: Effort commended but top down and bottom up perspectives on risk need to be brought together • Policy Review: The ambition of the Executive was commended but with so many priorities in play and doubts about the quality of existing policies, the End of 2017 seems like a courageous target
Board Assurance Framework (BAF)	A proposal for a 2nd iteration of the BAF was presented to the meeting. Whilst the committee commended the paper and appreciated the efforts and commitment of the Executive, and felt that the 2nd iteration would almost certainly be an important part of an appropriate board assurance framework, with the benefit of six months' experience using the first iteration the committee felt that neither iteration would be able to give the Board (and certainly the Audit & Risk Committee) the level of Assurance that it was seeking. The chair had the support of the committee in proposing that an effective framework should comment upon and/or answer ALL of: • Are policies appropriate, up to date and working effectively? • Are Key controls identified and working effectively? • Progress against Strategy/plans and other agreed target standards • Have key risks been considered and managed appropriately? The Committee were confident that the executive is working towards answering all these questions and that accordingly, an effective framework can be established relatively quickly The Chair offered to run a workshop for the Executive if this would be helpful

Risk Register (RR)	The committee commended the work in progress and improvements evident in this version; however, the committee felt that: • The RR and the BAF (as presented) were not entirely consistent • Whereas the Executive might choose to establish several more detailed RR, that there should only be ONE summary RR • The Summary RR can usefully be presented to the Audit & Risk Committee, but normally only as an appendix to a paper setting out Executive views and opinions as to priorities, focus areas, progress and so forth The Chair again offered to run a workshop for the Executive if that would be helpful
Policy Suite Review	The Committee noted the courage and ambition of the Executive in seeking to review all policies before the end of 2017; however following a preliminary review of a small number of SECAmb policies in July, the Chair was concerned that more work might be required than the Executive have allowed for – Ideally a policy should have clear and appropriate scope, clarity of responsibility and accountability within the context of given authorities and should have provision for subsequent testing in order to give assurance that the policy is both working effectively as designed and is effective in meeting the objectives for which it was originally required/designed
Internal Audit and Fraud Management	The Committee enjoyed an effective discussion on both areas clearing matters outstanding from 2017. The committee were pleased to see clear progress in achieving agreed but outstanding actions. No Audits have yet been completed/presented from this years plan.