South East Coast Ambulance Service NHS Foundation Trust

Trust Board Meeting to be held in public.

29 November 2017

10:00-13:00

Crawley HQ

Agenda

Item No.	Time	Item	Encl.	Purpose	Lead
120/17	10.00	Chairman's introduction	-	-	RF
121/17	10.01	Apologies for absence	-	-	RF
122/17	10.02	Declarations of interest	-	-	RF
123/17	10.03	Minutes of the previous meeting: October 2017	**Y**	Decision	RF
124/17	10.05	Matters arising (Action log)	**Y**	Decision	RF
Organisational culture					
125/17	10.10	Patient story	-	Set the tone	
126/17	10.15	Chief Executive's report	**Y**	Information	DM
Trust strategy					
127/17	10.25	Delivery Plan	**Y**	Information	DM
128/17	11.05	Safeguarding Mid-Year Review & Strategy	**Y**	Decision	SL
129/17	11.20	Surge Management Plan	**Y**	Decision	JG
Ten minute Break					
130/17	11.40	Ambulance Response Programme / AQI	**Y**	Decision	JA
131/17	11.50	Strategic Risks	**Y**	Information	PL
Monitoring performance					
132/17	12.00	Integrated Performance Report	**Y**	Information	JA
133/17	12.30	Learning	**Y**	Information	SL
134/17	12.40	Clinical Outcomes Deep Dive	**Y**	Information	FM
135/17	12.55	JRCALC	**Y**	Decision	FM
136/17	13.00	Any other business	-	Discussion	RF
137/17	-	Review of meeting effectiveness	-	Discussion	ALL
Close of meeting					

Date of next Board meeting: 25 January 2018

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, 26 October 2017

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

Present:

Richard Foster	(RF)	Chairman
Daren Mochrie	(DM)	Chief Executive
Alan Rymer	(AR)	Independent Non-Executive Director
Angela Smith	(AS)	Independent Non-Executive Director
Fionna Moore	(FM)	Executive Medical Director
Graham Colbert	(GC)	Independent Non-Executive Director & Deputy Chair
Jon Amos	(JA)	Acting Executive Director of Strategy & Business Development
Joe Garcia	(JG)	Executive Director of Operations
Steve Graham	(SG)	Interim Director of Human Resources
Steve Lennox	(SL)	Executive Director of Nursing & Quality
Tim Howe	(TH)	Independent Non-Executive Director
Terry Parkin	(TP)	Independent Non-Executive Director

In attendance:

Peter Lee	(PL)	Trust Secretary
Phil Astell	(PA)	Deputy Finance Director

99/17 Chairman's introductions

RF welcomed members and those observing.

100/17 Apologies for absence

David Hammond	(DH)	Executive Director of Finance & Corporate Services
Janine Compton	(JC)	Head of Communications
Lucy Bloem	(LB)	Independent Non-Executive Director

101/17 Declarations of conflicts of interest

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

102/17 Minutes of the meeting held in public in September 2017

Subject to some minor typographical errors on pages 4 and 6, highlighted by JG, and amending on page 7 reference to repaying loan to being "on course to repay (it)", the minutes were approved as a true and accurate record.

103/17 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.

104/17 Patient story

RF explained that the patient story this month isn't available as the person concerned needed to withdraw for personal reasons.

105/17 Chief Executive's report [10.08 – 10.20]

DM talked through the issues listed in his report, including;

- Board recruitment - update was provided. Appointments to be made during November.
- CQC findings were disappointing overall, although a really positive outcome for 111 services.
- Operational performance – a number of challenges which JG will pick up later on agenda.
- Trust strategic plan – engagement with stakeholders continues.
- Winter planning – much work ongoing to ensure we are prepared.

AR referenced a need to identify key risks and to distinguish between the urgent and the important, given the number of issues we need to deal with. DM agreed and explained this is an on-going challenge. RF confirmed that he and DM have had this very discussion to ensure we focus on the very immediate, for example call response times, in addition to the longer term strategic issues to deal with the causes of the symptoms. DM added that this is what our unified improvement plan aims to do; it is the first 12-18 months' focus of the strategic plan.

GC asked about the Quality Summit and the next steps regarding the support pledged from stakeholders. DM explained that we captured all the pledges and will be using Single Oversight Group in November to establish progress. Some we know have progressed, as we have had offers of help.

Action:
The Board to receive an update in November on the progress against the pledges of support made by our partners at the Quality Summit.

106/17 Unified Recovery Plan [10.20 – 10.51]

JA confirmed that we continue to iterate the plan. In doing so, we are reviewing milestones and KPIs. The Dashboard sets out the milestones and the progress made. From a governance perspective, the UIP links to our strategy and includes the improvement needed over the next 12 months.

Service Transformation:
JA outlined the steps being taken to ensure readiness for the ambulance response programme (APR). RF asked how big a shift this actually is. JG confirmed that it an opportunity to re-engineer our whole approach to how we provide services; enabling the right response for patients. This will require changing shift patterns and fleet mix.

AR asked whether there is a form of go / no-go decision ahead of 22 November. JG explained that there will be as part of the go-live plan although the 22 November is a start date imposed on us. Between then and April 2018 will be a transition period, with some of the likely changes, such as fleet mix, taking a longer period of time to address. JG expressed confidence that we will be ready to go live by 22 November, which will include ensuring all training is complete and systems updated.

FM added that there will be changes to the AQIs. Currently we report against four and these will continue, with two new ones relating to sepsis and elderly fallers. It is unclear when these will come in to effect, but likely to be from April 2018.

There was further challenge from the independent non-executive directors with AS asking about staff numbers in EOC, challenges with training, and whether we have enough staff to deal with the additional challenge of ARP and winter. JG explained that we have enough dispatchers, the gap is mostly with emergency call handers, which will be covered in the IPR later on the agenda.

TP referred to the discussion at the workforce and wellbeing committee about the workforce challenges of ARP and confirmed that the committee was assured this is being managed well internally, but surprised about the amount of uncertainty there still appears to be nationally on ARP.

AS asked about section 4 (medicines) and whether management is content that this isn't too overly bureaucratic and has clear line of responsibility. DM reinforced the recent review of our governance arrangements which he was confident is working, particularly the groups responsible for medicines management. FM assured the Board that she is very clear where responsibility sits; as the medical director and accountable officer for control drugs. She explained that the medicines group is where business as usual continues. The sub-groups are temporary, to ensure the current focus continues to support the improvement we have seen.

DM reminded the Board that the CQC task and finish group timeline sets out the compliance areas which CQC will be testing, arising from its findings in May 2017. If we address these areas, we stand good chance of getting out of special measures.

107/17 Learning from Deaths Policy [10.51 – 11.04]

FM introduced this policy which is based on national guidance. Initially, it seemed ambulance trusts were exempt, but we felt as a foundation trust we should develop it too. The policy sets out which cases we need to screen and which require deeper investigation. It is in draft pending approval by SMT, and is here before the Board for information.

TH asked about section 2.3 and FM confirmed that we will pick up deaths from specific patient groups, some will be more challenging than others.

In terms of NED oversight, the plan is to use the quality and patient safety committee.

There was a discussion about the number of deaths which may be covered by the policy, which is covered in section 2.3. The Trust attends circa 300 cardiac arrests a month and so will need to screen them all, but of this number a fairly small percentage will require detailed review. Until we do the screening the precise numbers is unclear.

The Board then considered its responsibilities, as set out in the policy (sections 6-9), and felt that there needed to be clarity between accountability and responsibility, listing the line of responsibility through the various lines of management. FM confirmed this will be amended accordingly, before submission to SMT for approval.

108/17 Our People [11.04-11.27]

DM explained that this paper sets out the high level cultural change plan, which is underpinned by detailed actions through the unified improvement plan.

SG added that the new culture steering group has been established, with a focus on staff engagement; refreshing our values; leadership and management, ensuring we understand competencies of our managers and leaders; creating a talent pool; appraisals; health and wellbeing; and clinical education.

Some of these are well-established, others less so, and some work-streams cross over in to the compliance steering group, such as policy implementation and safeguarding. Updates and progress will be reported through the unified improvement plan.

The Board explored through challenge by the independent non-executive directors whether this was too theoretical, and whether there is a relative disconnect between senior management and middle management. The Board agreed that while this approach is academically correct, phase 1 needs to clearly define the actions we need to take, including being clear how we want people to act, and how the Board will demonstrate how it should lead this and model the change we are supporting.

GC asked how we will as a Board know we are affecting change in culture, in addition to staff surveys and Pulse. SG explained that we are reviewing the staff survey and the intention is to have board representation on the barometer group. Feedback from this group will come to the Board. In addition, metrics on change are being developed which takes it beyond anecdotal evidence. And we are looking at ideation software, which puts out questions to staff electronically (via i-pads) which will give us intelligence too.

RF asked all Board members to reflect on what we can do personally to help lead / exemplify this area of change. Asking that every critical part of the Trust be touched by this and suggesting that no member of staff is promoted if they can't demonstrate understanding of the cultural change needed and their role in supporting it.

109/17 EPRR [11.27-11.32]
JG explained the 999 EPRR includes a self-assessment and a separate assessment by NARU on internal interoperability arrangements. On the latter, it helps to highlight the consequences of how we have in the past worked in silos. We have a first draft of an action plan addressing the non-compliance areas, using the same process as other plans within UIP.

110/17 Winter Plans [11.32 **–** 11.44]
JG introduced this high level plan and the assumptions they are based on, explaining that there are more local tactical plans that arise from this.

The Board asked about management's confidence in managing over winter. JG explained that we have better data with new CAD and so better clarity on the issues; main one currently is ability to take calls. We have 60% turnover of EMAs which is a key factor. We have doubled our recruitment effort; 32 new EMAs are set to join next month. We have doubled training courses to ensure they can start ASAP. We are taking best practice from the 111 service to help retain staff. And the 18-point action plan is being delivered. In addition, we have dedicated senior dispatcher focused on Red 1.

The Board acknowledged this and asked whether it will see us through the winter. JG conceded that it will be tight and this is why we are reviewing process to help make resources go further. In terms of Board support, JG explained there may be some decisions needed on how we remunerate EMAs. The executive will first be considering this in early November.

Before the Board meeting a member of the public asked a question which RF which related to winter planning;

"*A key part of the winter resilience plan is co-responding however we are aware that in Kent this is highly compromised at the moment due to Union action. What account has been taken of this and what plans are in place to fill this gap"*

In response to this question JG explained this isn't just about Kent, but across all fire services. We are looking to compensate this through a range of initiatives, including for example increasing our use of CFRs.

Comfort break 11.44-11.57

111/17 Integrated Performance Report [11.57 –12.31]

DM explained that following previous discussions we have tried to present the data in a different way. This is the first iteration of this. As a Board we will at end of each year review whether the metrics are still relevant and to agree the targets.

Action:
The Board to agree the 2018/19 IPR in February

JA added that this is a refresh. Some further changes are planned over the coming months. It provides an overview dashboard, and gives trends with more focused commentary. There are some blank pages and going forward we will pull out the key issues, and the areas outside of the control limits by way of exception reporting. Finally, we have re-ordered the data, starting with clinical outcomes/safety.

The IPR was taken as read, and before opening out to questions RF asked the lead directors to highlight any specific areas.

Clinical Safety:
FM explained we have five metrics. Area of improvement is the care bundles relating STEMI and stroke; we need to consider what can to differently to ensure improvement. For example, we still are not consistently recording two pain scores.

Clinical Quality
SL highlighted two issues; incidents and complaints have increased and duty of candour, although better, there is still much to do.

Operational Performance:
JG highlighted the key areas set out in the report.

Workforce:
SG highlighted vacancy rate which is adjusted to take account of staff in the pipeline to start.

Finance:
PA confirmed that we are slightly better than plan, year to date, and took the Board through the position as set out in the report.

AS confirmed that the audit committee will be reviewing the IPR to ensure it has the right focus, and then working with the other board committees will help to ensure it has the right balance of information and depth of scrutiny. We need as a Board to strike the right balance between no getting lost in too much detail, and maintaining focus on the key issues.

The Board agreed that overall the report is improved and what should be included is effectively what the executive needs to manage the business. Also needs to be dynamic to pick up emerging areas of concern.

TH asked about page 17 which has £5m YTD, yet in the narrative refers to £3.7m. PA confirmed £3.7m is the correct number.

The Board then explored the fact that we seem to be stuck on performance (at around 50%) with the executive explaining its focus on the range of things needed to ensure improvement. For example, looking at demand and capacity and how we can improve in areas such as time on scene and time at hospital. Two of focuses within the unified improvement plan is related to EOC and 999 performance.

In terms of workforce data and a need identified by the Board for vacancy rates in clinical posts, SG confirmed this will be coming soon.

TP referred to a discussion at the workforce committee about how we report Appraisals and the need to record career conversations on a rolling basis, aiming to get to 100%. Currently the form of presenting this data isn't very helpful as it only shows the numbers in-year.

112/17 Clinical Outcomes Deep Dive
Item deferred to November to enable clarity on the actions we are taking.

113/17 Complaints Annual Report 2016/17 [12.31 – 12.33]
This is last year's report. SL reminded the Board that the CQC identified we weren't where we needed to be with complaints management, primarily because of our backlog/timeliness of responding to complaint and inadequate sharing of learning. SL reflected that we are quite good at identifying learning on an individual basis, but not good and sharing more widely.

The Board noted this annual report and the separate work ongoing to improve complaints handling, as part of the unified improvement plan.

114/17 WWC [12.33-12.36]
TP set out the focus at the last meeting as listed in the paper. With regards the workforce plan TP confirmed that the committee is assured the executive have enough information to get posts filled. With regards the controls to manage vacancies, the committee acknowledged this is a gap and has asked management to review how it can be closed.

On disciplinary timeliness the committee received an adequate level of assurance that we are improving but we need to see this as a trend.

115/17 QPS Escalation Report [12.36-12.38]
TH provided a general overview to support the paper, commenting that the committee is assured that the executive understands the issues, but evidence is needed to show progress / outcomes.

116/17 FIC [12.38-12.41]
GC highlighted the need identified by the committee for management to produce a digital enabling strategy to ensure ongoing use of ECRP / informatics / call recording etc. Not in the report, but GC confirmed that the committee agreed the need to develop a fleet strategy.

117/17 Committee Terms of Reference [12.41-12.42]
There was discussion about the purview map being helpful, but 'bottom up 'oriented, and the committees need also to look 'top down' to ensure the right focus.

Decision:
The Terms of Reference were approved.

118/17 Any other business [12.42]
None

119/17 Review of meeting effectiveness

Questions from observers

There being no further business, the meeting closed at 12.42pm

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

Date _____

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	29.11.2017	Board	C	On agenda 29.11.2017
29.06.2017	45 17	Ipad business case to be reviewed by Finance and Investment Committee in October 2017.	DH	18.01.2018	FIC	IP	Added to FIC meeting agenda on 18 January 2018
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	C	On agenda 29.11.2017
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		C	WWC considered this at its meeting in 20.10.2017. The draft workforce strategy on part 2 agenda 29.11.2017
29.09.2017	84 17	Board away day to discuss our strategic approach to be scheduled for February 2018.	RF	Feb.17		IP	
26.10.2017	105 17	The Board to receive an update in November on the progress against the pledges of support made by our partners at the Quality Summit.	DM	29.11.2017	Board	IP	
26.10.2017	111 17	The Board to agree the 2018/19 IPR in February	Board	23.02.2017	Board	IP	On agenda for February - in the meantime the IRP is being reviewed on behalf of the Board by the Audit Committee.

Key

- Not yet due
- Due
- Overdue
- Closed

South East Coast Ambulance Service NHS
NHS Foundation Trust

SOUTH EAST COAST AMBULANCE SERVICE NHS FOUNDATION TRUST

CHIEF EXECUTIVE'S REPORT TO THE TRUST BOARD

November 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 and Non-Executive Team

2.1.1 Recruitment to the roles of the Director of Human Resources & Organisation Development, the Director of Nursing & Quality and the Director of Strategy & Business Development is underway, with interviews currently taking place.

2.1.2 We have seen a number of strong applications for each position and I hope to be able to provide an up-date on appointments shortly.

2.1.4 Interviews for a Non-Executive Director (NED) with a clinical background took place on the 17th November and for a NED with an organisational development background on the 23rd November.

2.1.5 Stakeholders from our Inclusion Hub Advisory Group, staff-side, the Trust's diversity forum, existing NEDs and members of the Council of Governors participated in the selection process, which included an interview panel made up of three Governors and which was chaired by Richard Foster.

2.1.6 Recommendations to appoint are expected to go to the Council of Governors, who have responsibility for appointing NEDs, at their meeting of 30th November.

2.2 CQC

2.2.1 On 5th October 2017 a Quality Summit was held to consider the findings of the report and how the broader system can help the Trust to address the issues identified. This was led by NHS Improvement and the CQC and was a useful opportunity to gain input from a number of local and regional partners.

2.2.2 During the Summit, support was pledged by a number of partner organisations to provide help and assistance to the Trust in a number of broad areas including:

- Serious Incidents
- Workforce

- Demand Management
- 999 performance including hospital handover
- Medicines Management

2.2.3 Since the Summit, a number of specific work-streams under the areas above are being taken forward. Progress is being monitored via the system-wide monthly Single Oversight Group meetings.

2.2.4 At the beginning of the month, I was very pleased to receive confirmation from the CQC that they had formally recognised the improvements we have made in how we store and manage medicines, as well as in our 999 call recording, by removing conditions they placed on us previously in these two areas. This followed their recent unannounced visits to a number of our sites, as well as consideration of evidence that we submitted to them.

2.2.5 It's important that we maintain the level and pace of improvements in these areas, as well as in others but this feedback was a positive step forwards in the Trust's recovery.

2.3 Operational Performance

2.3.1 As all training in delivering the new CAD and preparation for ARP was reaching a close towards the end of October 2017, the Director of Operations increased the level of scrutiny and oversight being applied to all elements of resourcing, both in EOC and Field Operations, with a view to maximising availability of hours and personnel in both call handling and patient facing operational duties.

2.3.2 The regime of daily conference calls, which includes each weekend day, has resulted in a much higher focus on both the resourcing we are providing, within budget limitations, and subsequently the performance we are delivering. As this is a multi-disciplinary call involving EOCs, Fleet, Scheduling and each Operating Unit, it is a good opportunity to share best practice and learning across the entire SECAmb scope of delivery. The results of this scrutiny are now reflected in both an improvement in call handling performance and response performance across all of the particular metrics of Red 1, Red 2, Red 19 and Green 2 performance.

2.3.3 As we move into the new operational requirements of the Ambulance Response Programme (see 2.4 below), this degree of scrutiny is being maintained and will continue until such time as the Director of Operations feels it is appropriate to de-escalate this level of scrutiny.

2.3.4 The very early results from our first few days of going live on ARP are quite positive but we will need to see at least two weeks' worth of data before we can determine any specific trends in performance.

2.4 Ambulance Response Programme (ARP) go-live

2.4.1 On 22nd November 2017, SECAmb implemented the new national response standards for ambulance services as part of the Ambulance Response Programme.

2.4.2 The move to ARP went smoothly, with no interruption to the service provided to patients and followed many weeks of planning, training and testing. I would like to thank all staff involved in the implementation for their hard work and commitment.

2.4.3 ARP sees the previous categories of call (Red 1, Red 2, Green) replaced with four new categories of call:

- Category 1 - is for calls about people with life-threatening injuries and illnesses. These will be responded to in an average time of seven minutes.
- Category 2 – is for emergency calls. These will be responded to in an average time of 18 minutes. Stroke patients will fall into this category and will get to hospital or a specialist stroke unit quicker because we can send the most appropriate vehicle first time.
- Category 3 – is for urgent calls. In some instances, patients in this category may be treated by ambulance staff in their own home. These types of calls will be responded to at least 9 out of 10 times before 120 minutes
- Category 4 – is for less urgent calls. In some instances, patients may be given advice over the telephone or referred to another service such as a GP or pharmacist. These less urgent calls will be responded to at least 9 out of 10 times before 180 minutes

2.4.4 As we develop our operational deployment approach (e.g. our staff skill-mix and ratios of ambulances and cars) to match the new ARP model, our response to all categories of patients should improve. This will not be an instant change but will develop over a number of months.

2.5 Pause in using the electronic Patient Care Record (ePCR)

2.5.1 During the past couple of weeks, the Executive Team made the decision to ask staff to pause using electronic Patient Care Records (ePCRs) and revert to using the paper version of the Patient Care Record.

2.5.2 This decision was taken following a transmission issue that had been identified with the transfer of data to acute Trusts and although no data had been ‘lost’, urgent maintenance needed to be undertaken on the ePCR system.

2.5.3 Whilst use of the system is paused to look at the data transfer issue, we have also decided to take the opportunity to address a number of other issues including addressing why the app crashes periodically and up-dating the crew list on the system. This work is already underway and is going well.

2.5.4 Subject to testing, we are planning to re-introduce the ePCR within the next few weeks but this will be on a phased roll-out, to ensure it’s working properly.
2.5.5 As a Trust, we remain committed to providing staff with an ePCR system, as we know provides benefits in many areas compared to the paper version but we also need to make sure it’s working properly.

2.6 Engagement with local stakeholders

2.6.1 During recent weeks, I have continued to meet with a range of key external stakeholders, including the Kent Police & Crime Commissioner, as part of my programme of meetings all PCCs in our area and a number of local MPs.

2.6.2 These meetings have been extremely constructive and have provided a good opportunity to discuss a number of issues including potential areas for closer working and managing mental health patients in the community with the Police and response times, STPs and system issues including hospital handover with the MPs.

3. Regional issues

3.1 Hospital handover delays

3.1.1 SECAmb has established a system-wide Task and Finish Steering Group to address the issues of hospital handover delays. It is chaired by Paula Head, Chief Executive of Royal Surrey County Hospital NHS Foundation Trust and its scope is to provide a focused and consistent approach for an overall and sustained improvement in delays across SECAmb's region. A Programme Director has been appointed by SECAmb to provide dedicated leadership and support.

3.1.2 The Task and Finish group will have two sub-groups reporting into it that will be responsible for delivering the required, system-wide operational changes needed for improvements to be made. The groups will cover the East and West geographical areas of SECAmb's footprint. Each group will be chaired by a Chief Operating Officer from an identified acute hospital and membership will include the Programme Director, CCG representatives, a representative from each acute trust, a representative from a community trust and senior SECAmb account and operational managers

3.2 Contract up-date

3.2.1 The externally-led Demand and Capacity Review is progressing and will report to the Trust and our Commissioners in the New Year.

3.2.2 In the interim and ahead of the Review concluding, £1.3m of additional funding has been provided to support the provision of additional operational ambulance hours between November 2017 and January 2018. We are also in discussion with our commissioners about additional, one-off funding for February and March 2018.

3.2.3 From April 2018, there is agreement to move to a single regional commissioner for the 999 contract in our area, North West Surrey Clinical Commissioning Group (CCG). Ahead of the formal move, this is already simplifying communication and contract management with our commissioners. Negotiations for the 2018/19 999 contract will begin in the New Year.

4. National issues

4.1 Autumn Budget

4.1.1 In the Autumn Budget, the Chancellor announced an extra £6.3 billion of new funding for the NHS. £2.8 billion of this was going towards improving A&E performance, reducing waiting times for patients and treating more people this winter.

4.1.2 We will now wait to see how this will be applied to ambulance services.

5. Recommendation

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

Daren Mochrie QAM, Chief Executive

23rd November 2017

South East Coast Ambulance Service
NHS Foundation Trust

South East Coast Ambulance
Trust Delivery Plan 2017-2019
November 2017

Content

- Overview
- Root Cause & Why
- CQC Findings
- Impact so far
- On-going work
- Example of Progress – Incident Management

Aspiring to be
Better Today and Even Better Tomorrow
for our people and our patients

South East Coast Ambulance Service NHS Foundation Trust

OVERVIEW

- This document describes the Delivery Plan for South East Coast Ambulance Service (SECAmb) NHS Foundation Trust for 2017-2019, in line with the current 2 year contract period and years 1-2 of the Trusts Strategy.
- The Delivery Plan brings together an overarching view of the Trust's work for the next 18 months in order to:
  - Achieve our **aim** of being an Outstanding Trust by 2022
  - Deliver the strategic objectives set out in our Trust strategy
  - Address the root causes of our historic challenges
  - Have a CQC rating of Requires Improvement by 2018, Good by 2020 & Outstanding by 2022
- The plan aims to provide an overview of key work to achieve the above goals and does not provide an exhaustive summary of all Trust activities
- This plan focusses predominantly on the internal challenges that are within the gift of the Trust to address, however work is also underway with commissioners and partner organisations to ensure the Trust has the right operating model going forward to meet the needs of local communities as well as supporting the Health & Social Care system across the Region.

South East Coast Ambulance Service NHS Foundation Trust

Root Cause

Of the problem

From around 2011, despite the Trust delivering consistently on response time & financial performance whilst pursuing clinical innovation, there was a lack of focus, investment and leadership on other core priorities.

This led to a breakdown in governance systems and processes as well as culture, engagement and leadership as identified through the Care Quality Commission inspection in 2016 and other reviews carried out over the past two years.

Why?

Did it go wrong

South East Coast Ambulance Service NHS Foundation Trust

Leadership

- Non unitary board combined with silo working of Executive Team & Directorates
- Insular thinking leading to the wrong priorities (underpinned by a culture of ‘we know best’)
- Lack of accountability, performance management & assurance

Governance, Systems & Processes

- Disinvestment in key structures, systems and processes
- Poor change management
- Governance structures not aligned with best practice
- Strategies, policies & procedures either absent or out of date

Culture & Engagement

- Limited learning from complaints, incidents, national benchmarking and external reports
- Lack of support, openness and honesty
- Getting the basics wrong
- Acceptance of poor practises and behaviours

South East Coast Ambulance Service NHS Foundation Trust

Findings in 2016

From the CQC Report (Well-Led)

- Roles and accountability within the executive team lacked clarity, specifically regarding the respective roles of the three clinical directors
- The board had numerous interim post holders and we saw evidence of inter-executive grievance
- Although there was a comprehensive clinical strategy, there was no form of measurement to monitor the attainment of the strategy pledges by the board
- Risk management was not structured in a way that allowed active identification and escalation to the board. Risks managed at board level did not have robust and monitored action plans
- Staff reported a culture of bullying and harassment
- The trust had a culture of encouraging innovation, notably in the development of the paramedic workforce and the introduction of critical care and advanced paramedics

South East Coast Ambulance Service NHS Foundation Trust

Findings in 2017

From the CQC Report (Well-Led)

- The executive team did not have sufficient understanding of the scale and severity of the risk relating to call recording failure.
- We found insufficient or no progress with making improvements in the majority of the concerns for EUC reported in the previous May 2016 inspection, particularly around medicines management.
- The culture of the EOC did not always encourage openness and candour.
- Staff satisfaction was inconsistent and there was some inconsistency in the way staff were treated with regard to accessing mandatory training and the implementation of the sickness absence management policy.
- The trust's governance processes remained inadequate. Whilst there had been changes to ensure improvements were made at a strategic level, monitoring of risks and quality in front line services had not always been implemented. Where it had been, practices had not been embedded. The trust could not fully provide adequate assurance of clinical and operational oversight.
- Overall communication with staff was still poor, in particular changes of policies, processes and practices in areas such as medicines and transportation / vehicles. This meant the trust could not be fully assured that communication was effective and that practice was consistent across the trust.
- Trust strategy and core values were not recognised by front line staff and staff did not feel engaged with the trust's vision. Staff generally felt supported by their immediate managers but told us there remained a disconnection between front line staff and senior managers.
- There were still no local risks identified and there was limited knowledge of the trust wide risk register.

South East Coast Ambulance Service NHS Foundation Trust

Findings in 2017

From the CQC Report (Well-Led)

- However:
- We observed positive examples of local leadership from the operating unit managers (OUMs) at all three EOC. We saw that the EOC listened to staff and worked to address concerns raised in the local “Pulse” staff survey. All staff we spoke with felt supported and valued by their OUM.
- We saw improvements in staff and public engagement since our last inspection. These included reward and recognition badges and the introduction of a patient experience group.
- Staff were proud of the work they did and the support they and their colleagues offered one another. They felt positive about the organisation and that they were ‘heading in the right direction’.
- There was a medicines improvement strategy and associated annual plan in development.
- Managers had put a number of processes in place to deal with bullying and no longer tolerated it. In addition, staff felt bullying was a problem that was “dying out”.

South East Coast Ambulance Service NHS Foundation Trust

Summary

of why so little progress in 2016-17

Evidence of some progress identified, however this was slow to occur, inconsistent and not embedded

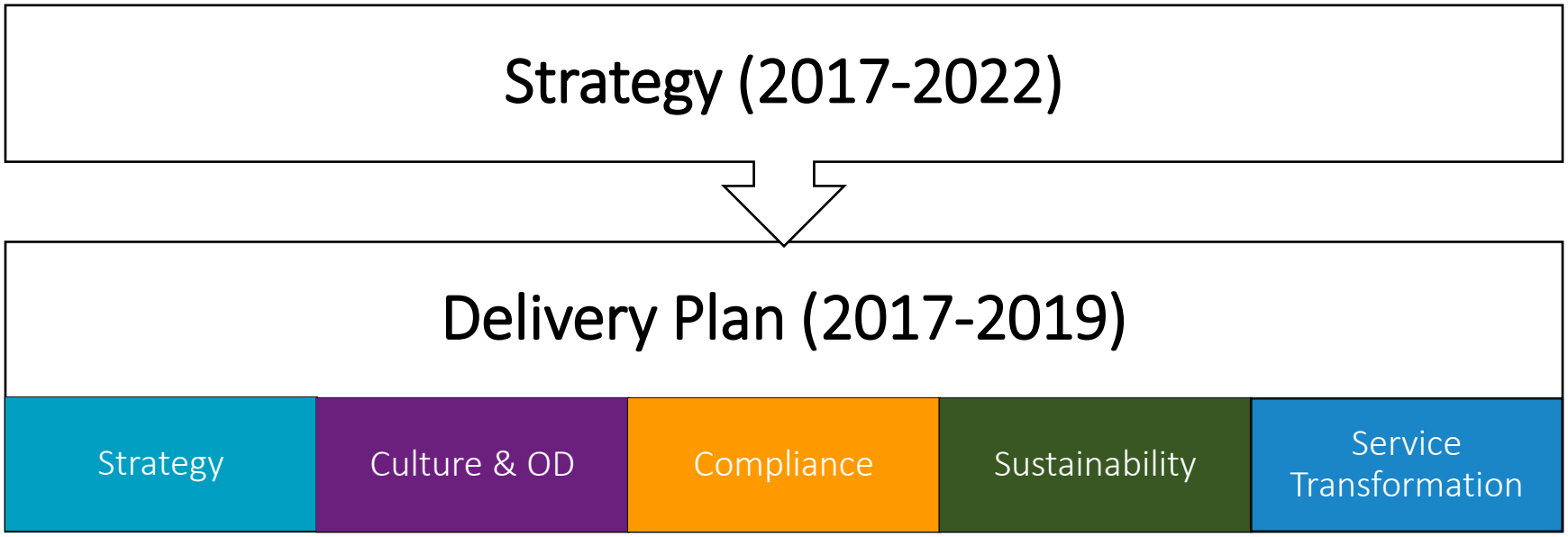
Why?

- Didn't own or believe the report or the issue identified
- Didn't have a robust improvement process, with clear measurement
- Instability within the previous Executive Team
- Under resourcing of key corporate teams and core infrastructure and process
- Under developed communication processes with clinical staff
- Disengaged clinical workforce

South East Coast Ambulance Service
NHS Foundation Trust

Action

Created a Strategy & Delivery Plan



South East Coast Ambulance Service NHS
NHS Foundation Trust

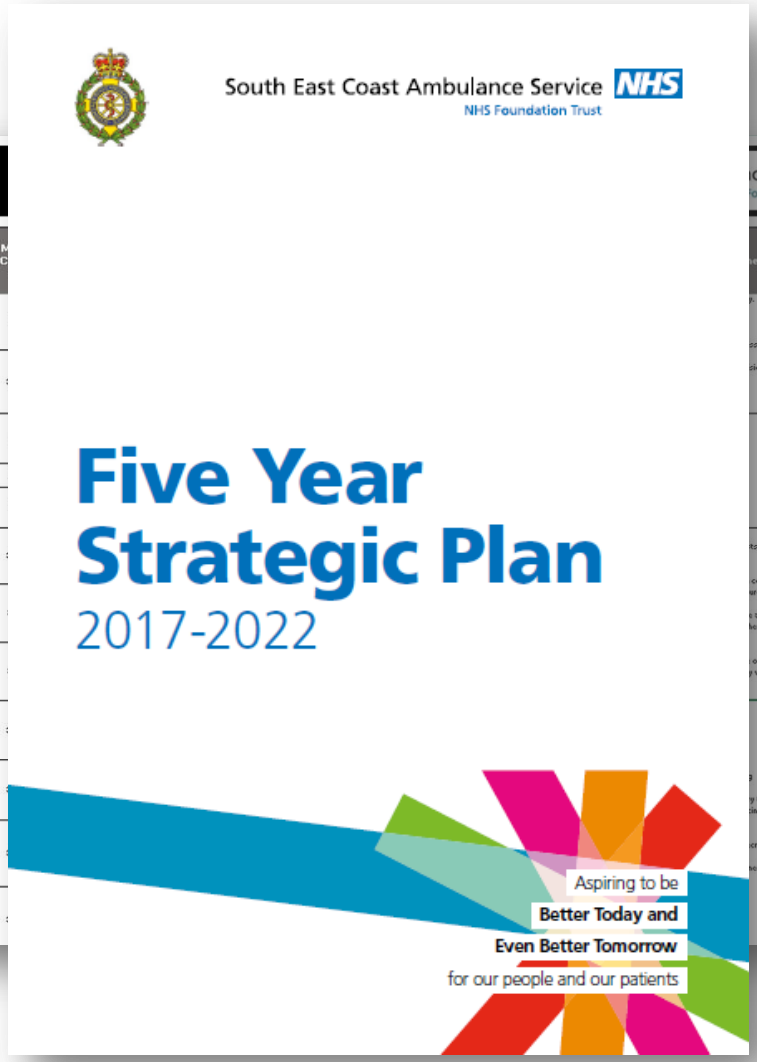
Action

Created a Strategy & Delivery Plan

Delivery Plan Dashboard

RAG Keys:
- Red: At significant risk of failure due to circumstances which can only be resolved with additional support
- Amber: A risk of failure but mitigating actions are in place and these can be managed and delivered within current capacity
- Green: On track and scheduled to deliver on time and with intended benefits
- Blue: Completed

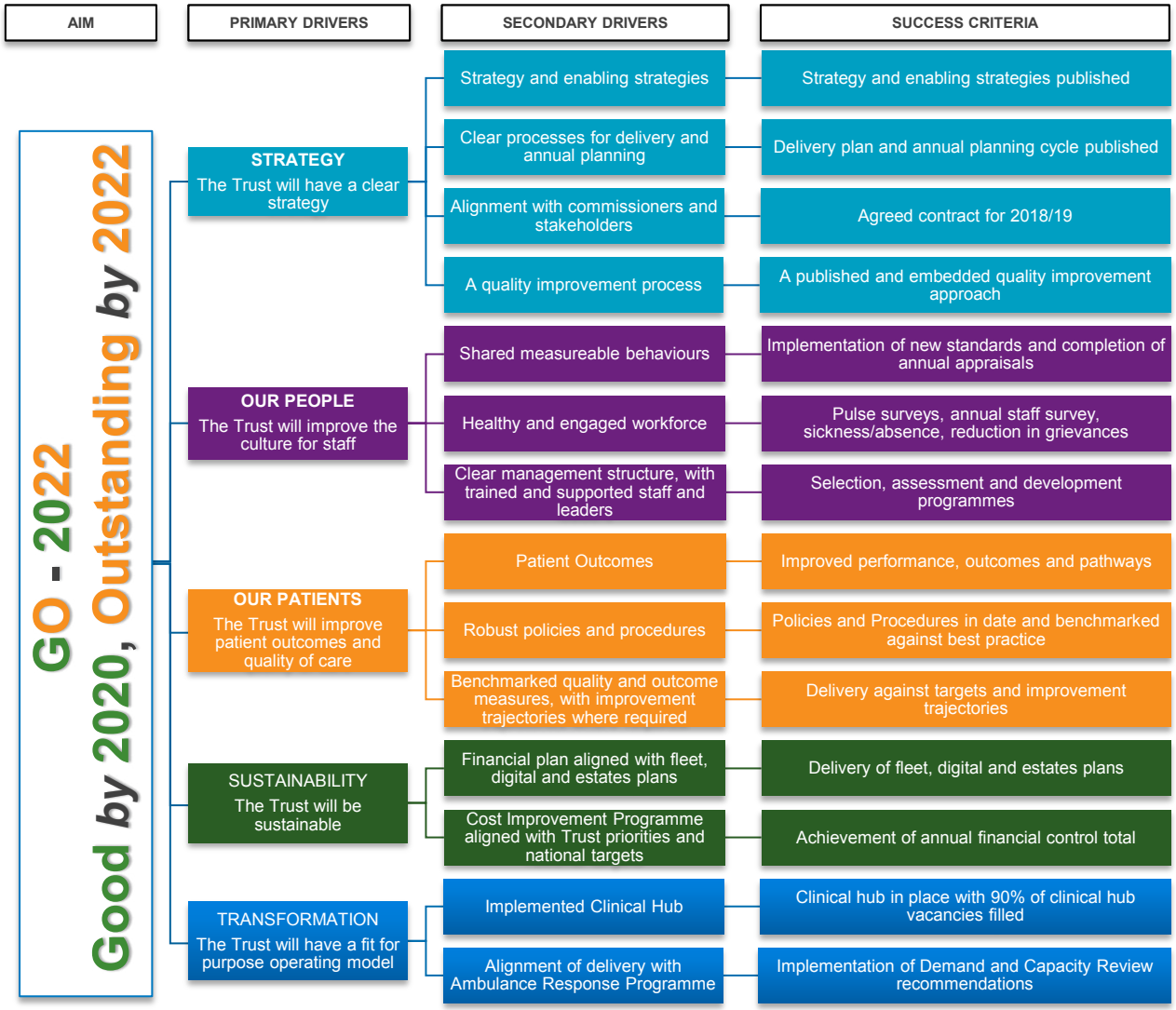
Work stream	Project Name	Project RAG Current Period	Project RAG Previous Period	Project Lead	Executive lead	Project Completion Date	Process / Milestone
Compliance Steering Group	Governance, Records & Clinical Audit	Green	Green	Fiona Wray	Fiona Moore	25/03/2018	The Trust Patient Data & Health Records Policy will always be contemporary and reflect national guidelines and best practice.
							Incidents will have Patient Clinical Record linked so that we can ensure safe and accurate records.
	Engagement	Green	Green	Mark Power	Steve Graham	TBC	Project Mandate and OIA to be signed off
							High level objectives with clear measures identified
							Improvement Action Plan developed in draft
	Complaints	Green	Green	Louise Hutchinson	Steve Lennox	31/03/2018	80% of complaints will be concluded within 25 working days.
							We will be able to provide evidence of learning from at least 95% of complaints that are upheld in any way and this will drive improvements to our service.
							We will have improved the sharing of learning from complaints.
	EOC	Red	Green	Sue Barlow	Joe Garcia	28/03/2018	The Trust will have taken action to ensure there are a sufficient number of clinicians in each EOC at all times in line with evidence-based guidelines.
							The Trust will have taken action to ensure that the minimum amounts of audits are carried out in line with the requirement needed by pathway to maintain the licence.
							The Trust will have improved call answering time to align within the national standard
							Recruitment and retention of EMAs to establishment of 171



South East Coast Ambulance Service
NHS Foundation Trust

Action

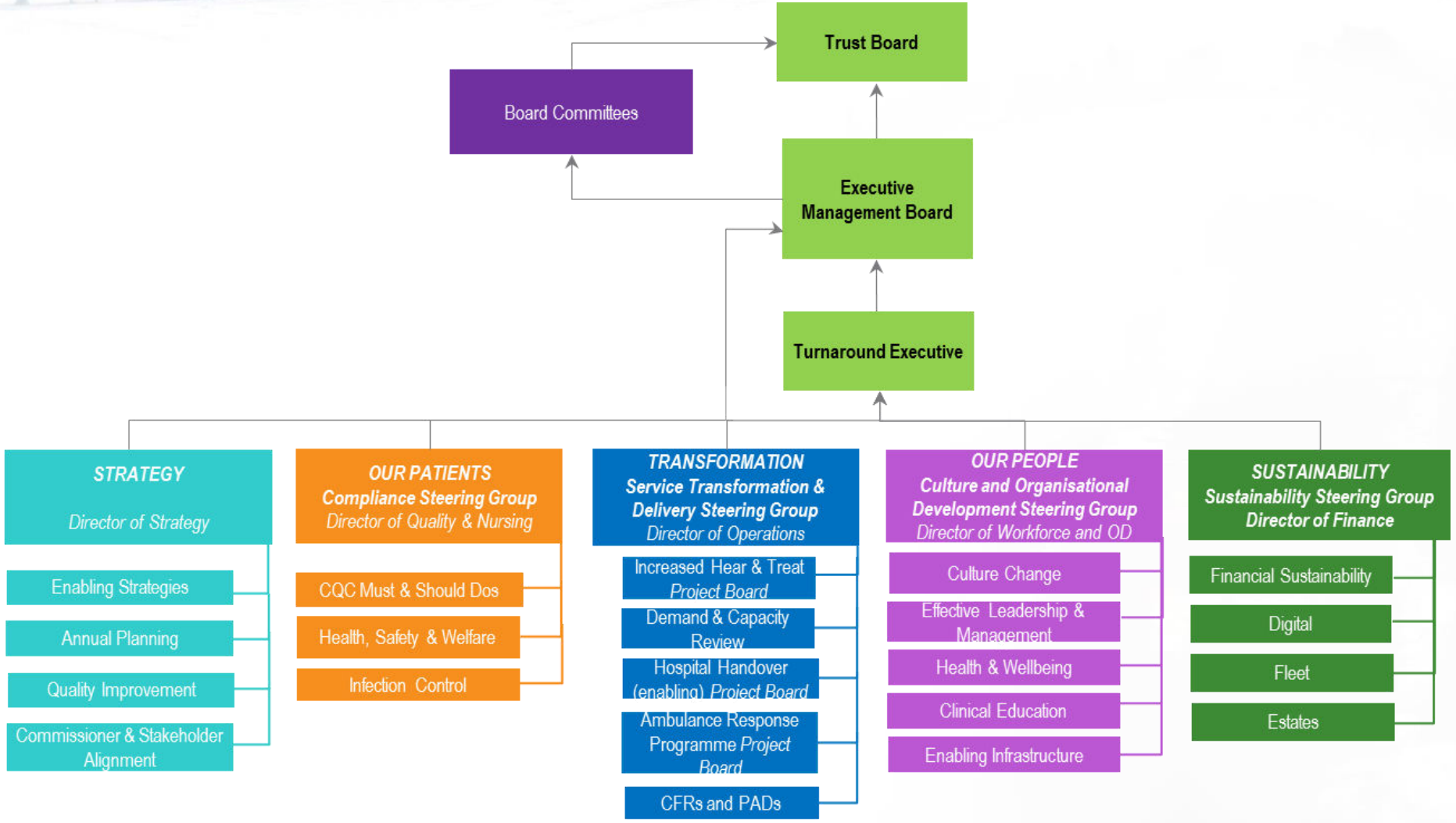
Clear AIM & Driver diagram



South East Coast Ambulance Service NHS Foundation Trust

Action

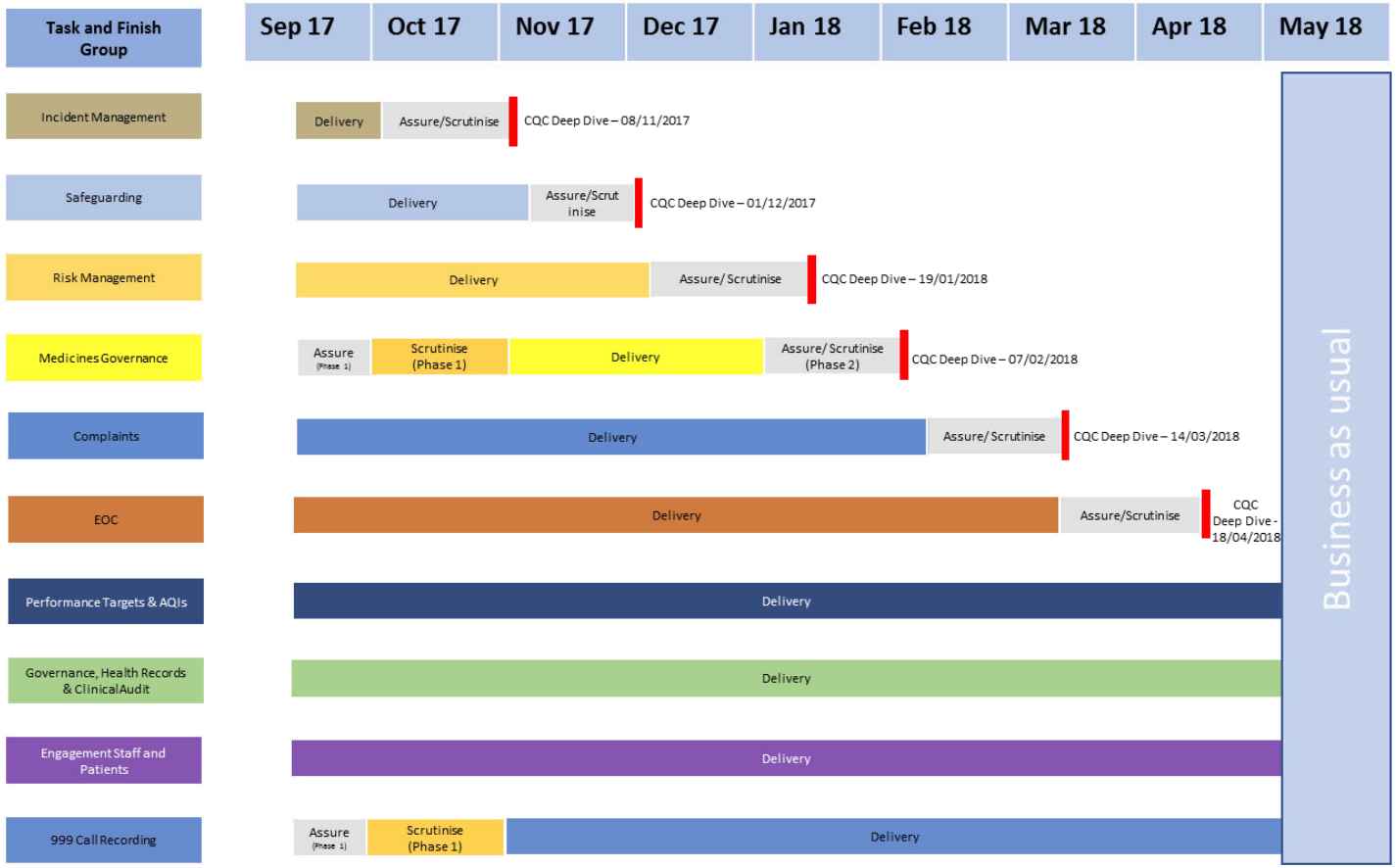
Internal Governance



South East Coast Ambulance Service
NHS Foundation Trust

Action

Clear CQC Task & Finish Groups



NOTE:

After the scrutiny phase, the project will move into Sustainability (BAU), with quarterly station visits. Aim is to do every station every quarter. Results feed into Area Governance Meetings and Executive Committee.

If assurance is not provided, project will go back to delivery stage.

South East Coast Ambulance Service NHS Foundation Trust

Action

Creation of Improvement Plans

Incident Management - Improvement Action Plan

Project Reference	INM170925
Project Title	Incident Management
Project Lead	Samantha Gradwell
Executive Lead	Steve Lennox
Date Updated	02/11/2017
Today	02/11/2017
Version	1.1

The Trust will be able to identify all incidents on a single system and complete robust investigations to a good standard and within appropriate timescales. This will enable learning to be shared, ultimately improving patient safety.

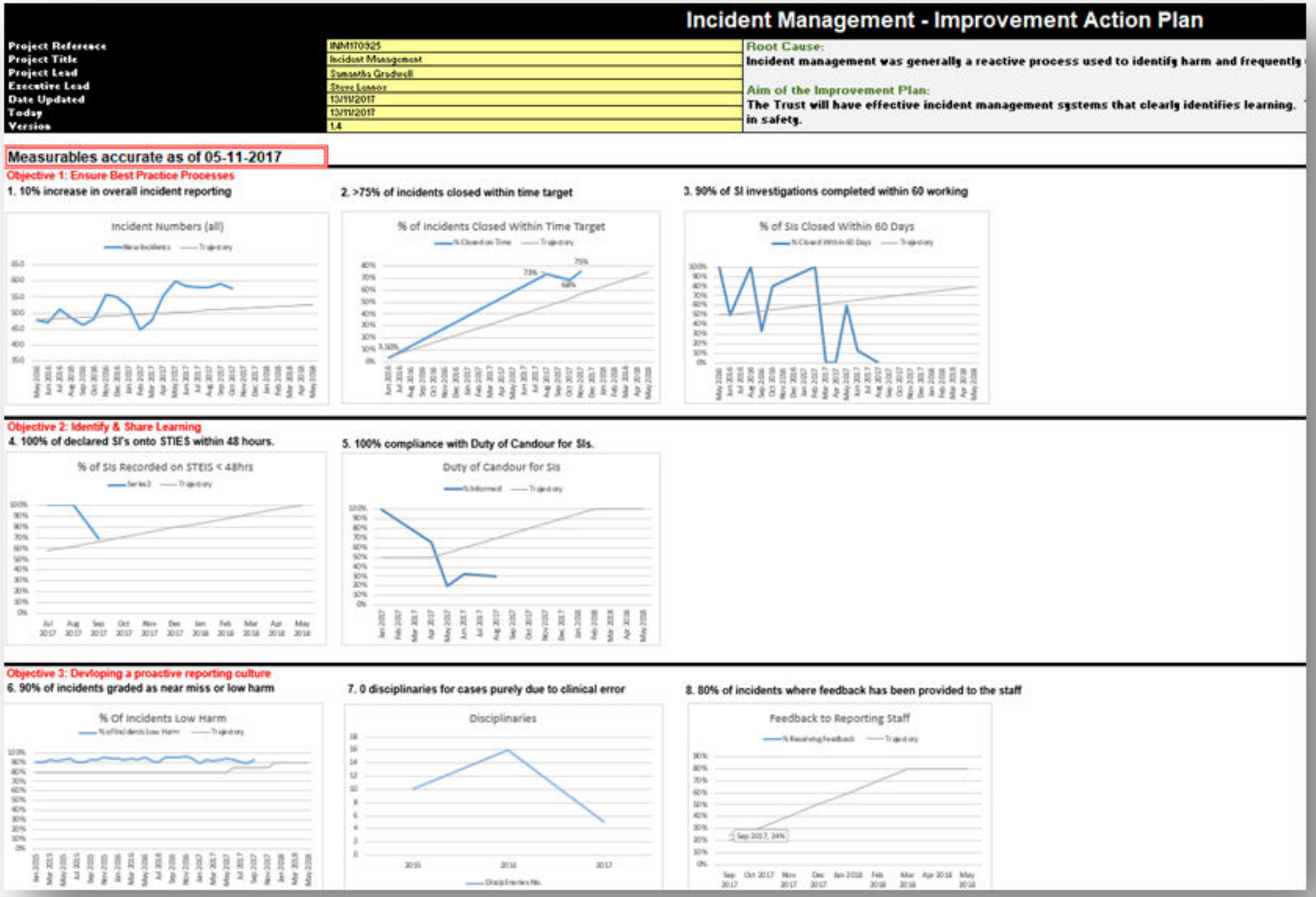
AUTOMATIC FORMULAS - DO

Project Objective/ CQC Must Do & Page No	Milestone #	Action #	Description	MileStone Complete Date	Action owner	Dependency work stream	Outcome Measures	Start date	Due date	Status	Delayed (days)	Overdue (days)	Date completed*	Evidence	Evidence Location	Comments
Objective 1: **By the 31/03/2018, the Trust will be adhering to national policy/guidance and best practice and will be able to demosntrate it values the information and learning available from incident reporting. This will be demonstrated through;** **1. 10% increase in overall incident reporting** **2. >75% of incidents closed within time target** **3. Less than 5% of incidents within a backlog** **This will enhance safety and quality of care for pateints and improve safety for Trust staff.** Source/Reference **CQC Inspection Report:** The service did not encourage staff to report incidents. Incidents were not always investigated in a timely way, and learning was not always widely shared to mitigate the risk of recurrence. The data provided by the trust differs to the data reported to NRLS. Page 46. **CQC Inspection Report. Must Do:** The Trust must take action to ensure all staff understand their responsibilities to report incidents. The Trust must ensure improvements are made on reporting of low harm and near miss incidents. Page 6 & 94 **CQC Inspection Report**. With some staff having never reported an incident and lacking knowledge of the Trust's incident reporting processes. Page 2 & 8 **CQC RInspection Report.** Some staff welcomed the use of portable electronic tablets which were issued to all frontline staff. The majority of staff we spoke to told us they still used the computer system at stations instead. Suggesting reporting incidents using tablets was not embedded. Page 47 **CQC Inspection Report**. A backlog of incident forms meant the service did not always address safety concerns quickly enough. Page 2, 19 & 8 **CQC Inspection Report.** Staff told us incidents involving motor vehicle accidents were reported using paper forms which we re completed and faxed or posted to the insurance department. Page 24	**1**		**The Trust will have produced clear and robust policies and procedures for the internal and external management of incident reporting. This will include roles and responsibilities and will be aligned to regulatory requirements.**	**31/03/2018**			**Governance documentation will show approvals from all JPF and SMT members, as an agreement to adopt and embed the new Incident Management Policies.**			**Amber**	-	-				
		1.01	Create a standard operating procedure for the risk & incident team. This will include capability and capacity and plan for surges in reporting to ensure the backlog does not re-occur.		BB/SG/CT		Plan is approved by the Director of Quality & Safety, and circulated across the directorate.	01/12/2017	28/02/2018							
		1.02	Identify and produce a list of all departments within the Trust which do not use Datix for incident reporting.		BB			01/12/2017	28/02/2018							
		1.03	Consolidate all incidents reporting mechanisms onto a singular platform (Datix). This will include Complaints, Claims, PALS and RTCs.		SG/LH		A report from Datix to show all incidents in one place.	01/03/2018	31/03/2018							
		1.04	Produce and agree a Incident Reporting & Learning Policy at JPF and SMT.		BB		Policy is approved at JPF and SMT.	25/09/2017	01/12/2017	In Progress						
		1.05	Produce and agree a Incident Investigation Policy at JPF and SMT.		SG/IPL			01/01/2018	31/03/2018							
		1.06	Produce and agree a Serious Incident Policy and Procedure at JPF and SMT.		CT		Policy is approved at JPF and SMT.	25/09/2017	01/12/2017	In Progress						
		1.07	Update and agree existing Duty of Candour Policy and Procedure.		GA		Policy is approved at JPF and SMT.	01/02/2018	31/03/2018							
		1.08	Produce a procedure for quality assuring new incidents (checklist).		BB		Approved by the Head of Risk.	01/11/2017	30/11/2017							
		1.09	Produce a process to automatically alert appropriate leads of certain types of incidents.		BB		Approved by Head of Risk and implement.	01/09/2017	30/11/2017	In Progress						
	2		**The Trust will have fully implemented, communicatated and embededded the new Incident Reporting & Learning Policy, both within the Incident and Risk Teams, and the wider Trust.**	**30/01/2018**												
		2.02	Plan and deliver training programme targeted to the risk and incident management teams and make this available to the wider Nursing & Medical directorate.		SG/BB/CT		Approved by Head of Risk. Confirmation of training delivered.	01/12/2017	30/01/2018							
		2.03	Produce a communications and engagement plan to inform all Trust staff on the procedural changes in relation to the reporting of incidents.		TBC		Approved by Head of Risk and Head of Communications.	01/12/2017	30/01/2018							
		2.04	Deliver targeted training sessions for EOC staff to engage on what to report and how to report an incident.		BB/DP/SG			06/12/2017	15/01/2018							

South East Coast Ambulance Service NHS Foundation Trust

Action

Benchmarked measurement of Improvement Journey



South East Coast Ambulance Service NHS Foundation Trust

On-Going

Remaining Work

Leadership

- Executive team recruitment
- Refocus of Senior Management Team
- Implement divisional management structures

Governance, Systems & Processes

- Clear focus, pace and accountability through Trust and external governance
- Quality Improvement Plans

Culture & Engagement

- Agree and embed shared behaviours to support strategy
- Engagement with workforce

Quality Improvement

- Work with other organisations to define best practice, including our buddy Trust
- Delivery against benchmarked plan with clear milestones
- Underpinned by data and developing Quality Improvement Approach

System

- Ensure that post-ARP operating model aligns with strategy and system expectation

South East Coast Ambulance Service
NHS Foundation Trust

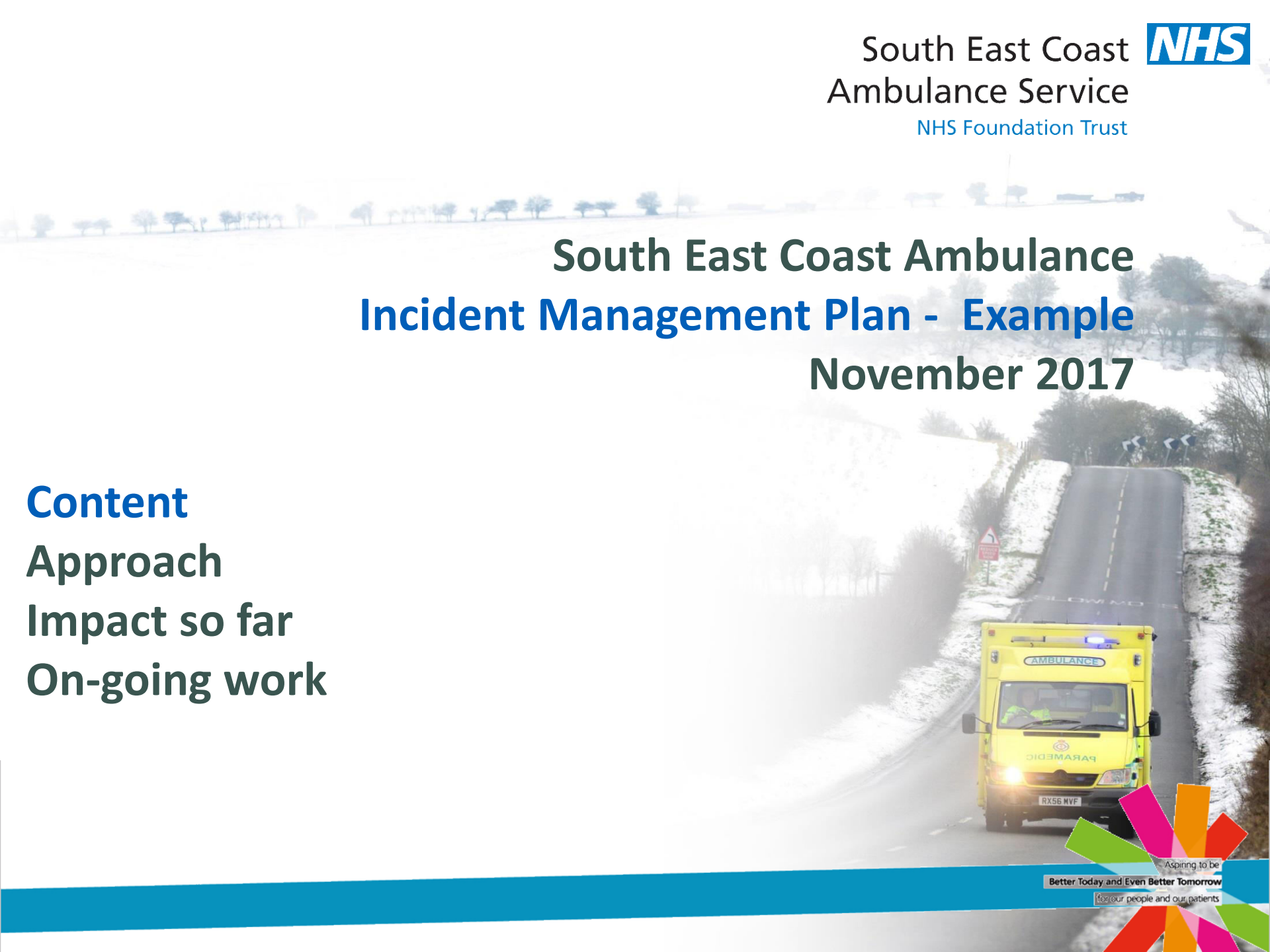
South East Coast Ambulance
Incident Management Plan - Example
November 2017

Content

Approach

Impact so far

On-going work



Aspiring to be
Better Today and Even Better Tomorrow
for our people and our patients

South East Coast Ambulance Service NHS Foundation Trust

Example – Incident Management

Identified Objectives

Objective 1: Ensure Best Practice Processes (ADD IN OBJECTIVES FROM DELIVERY PLAN

1. 10% increase in overall incident reporting
2. >75% of incidents closed within time target
3. 90% of Serious Incident investigations will be completed within 60 working days.

Objective 2: Identify & Share Learning

4. Declaring 100% of Serious Incidents onto STIES within 48 hours.
5. 100% of Serious Incidents have Duty of Candour performed

Objective 3: Positive Incident Culture

6. 90% of incidents graded as near miss or low harm
7. 0 disciplinary cases that are purely clinical error
8. 80% of incidents where feedback has been provided to the reporting member of staff

South East Coast Ambulance Service NHS Foundation Trust

Example – Incident Management

Identified Objectives

Objective 1: Ensure Best Practice Processes ADD IN HOW WE ARE DOING

1. 10% increase in overall incident reporting
2. >75% of incidents closed within time target
3. 90% of Serious Incident investigations will be completed within 60 working days.

Objective 2: Identify & Share Learning

4. Declaring 100% of Serious Incidents onto STIES within 48 hours.
5. 100% of Serious Incidents have Duty of Candour performed

Objective 3: Positive Incident Culture

6. 90% of incidents graded as near miss or low harm
7. 0 disciplinary cases that are purely clinical error
8. 80% of incidents where feedback has been provided to the reporting member of staff

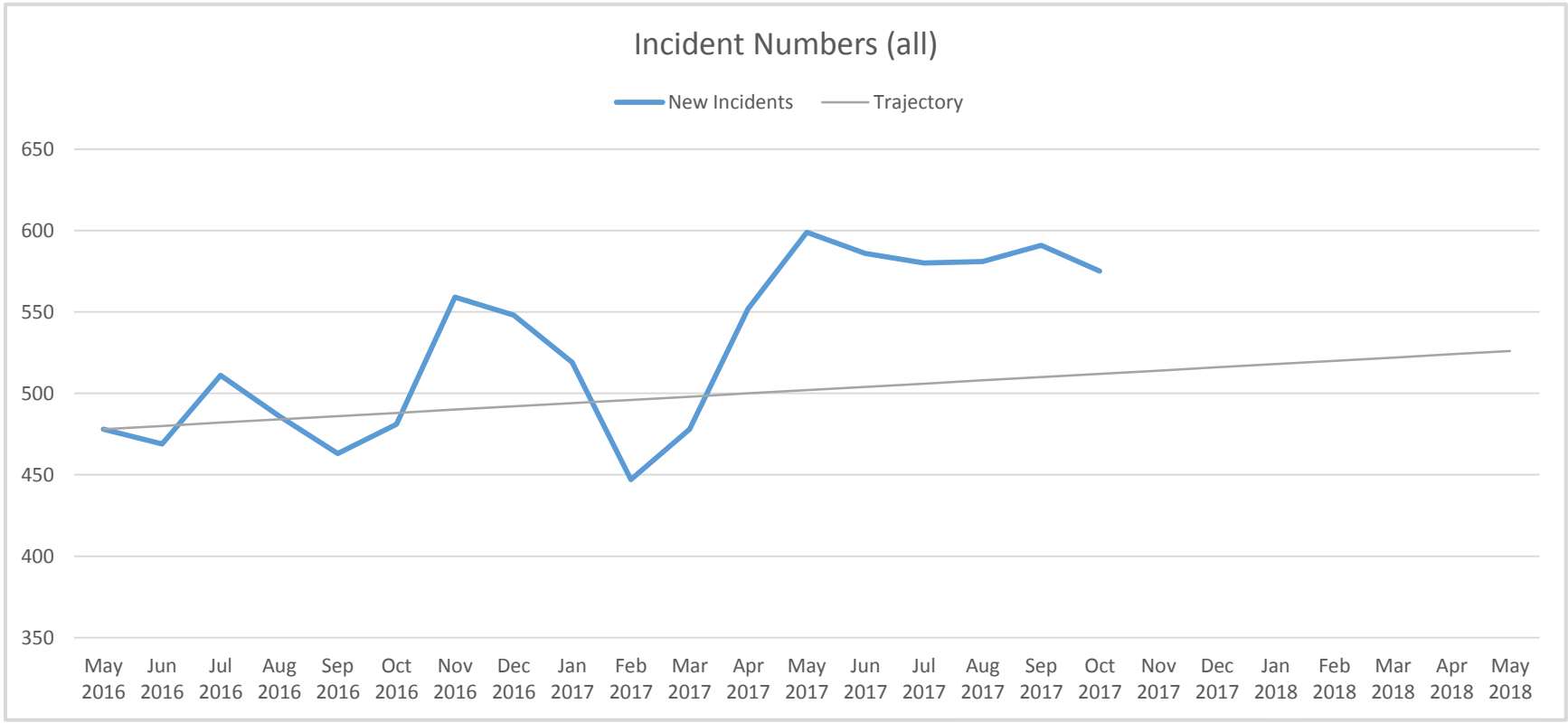
South East Coast Ambulance Service
NHS Foundation Trust

Impact

Impact so far

Objective 1: Ensure Best Practice Processes

10% increase in overall incident reporting



Increase of 20% Since May 2016

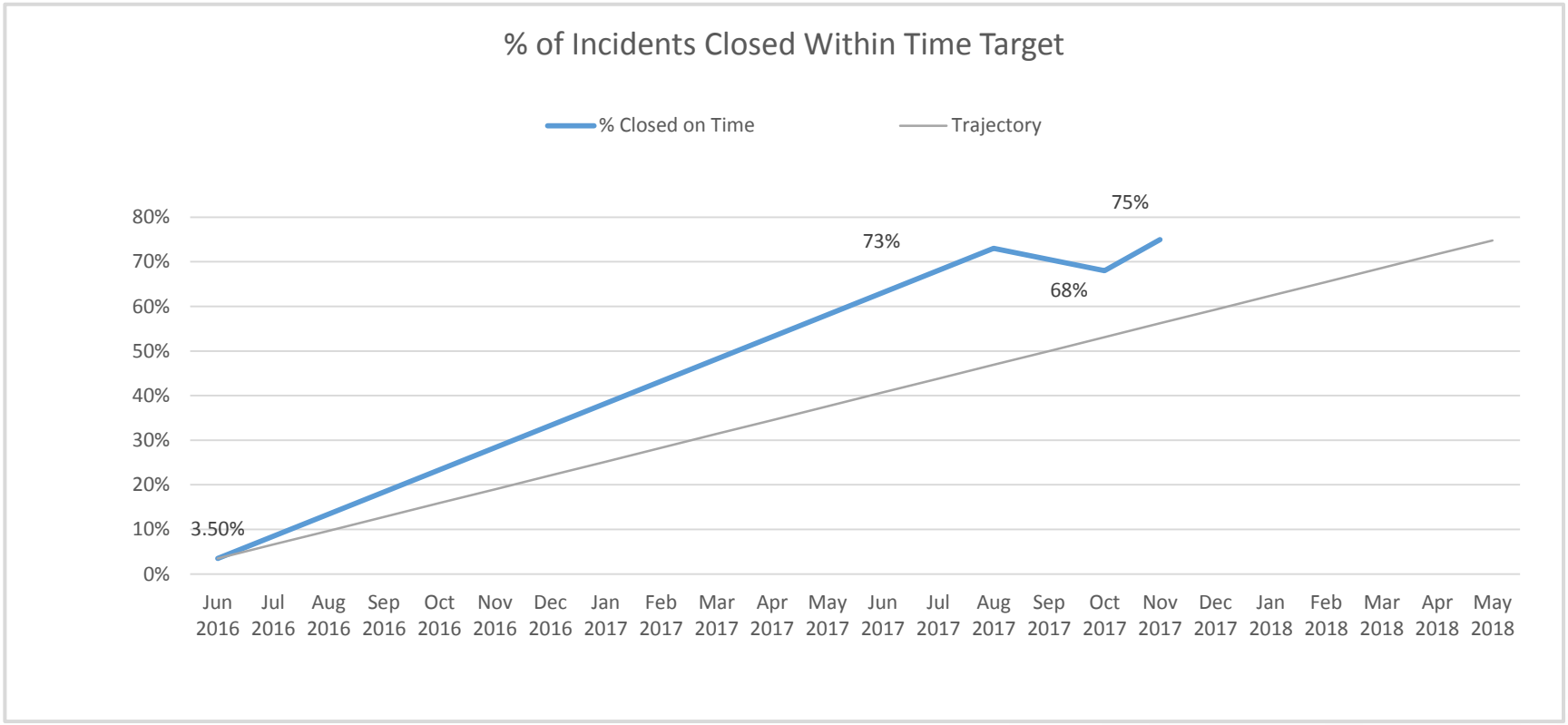
South East Coast Ambulance Service NHS Foundation Trust

Impact

Impact so far

Objective 1: Ensure Best Practice Processes

>75% of incidents closed within time target



Hit Target in November. Plan is now to sustain

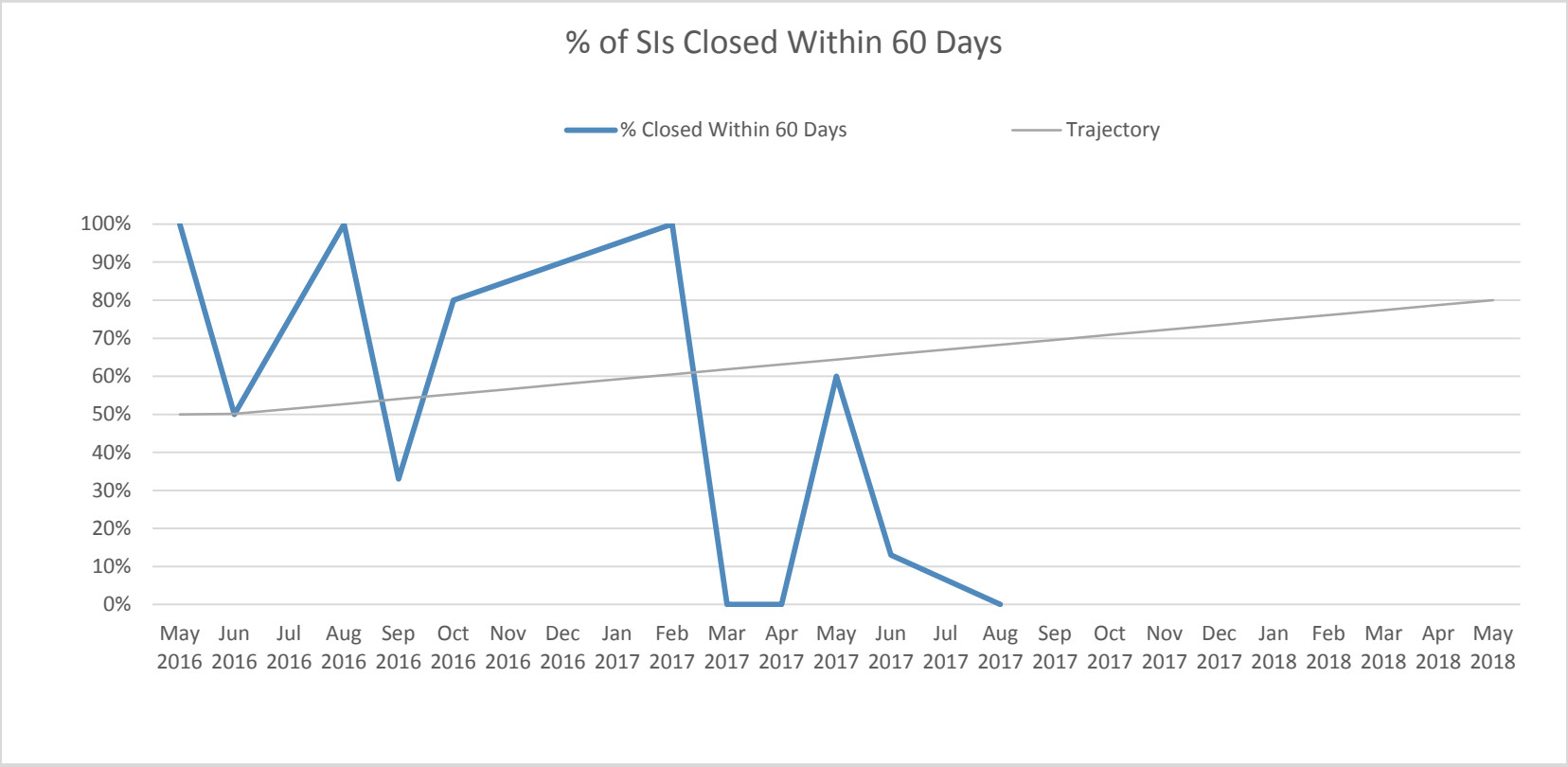
South East Coast Ambulance Service NHS Foundation Trust

Impact

Impact so far

Objective 1: Ensure Best Practice Processes

90% of Serious Incident investigations will be completed within 60 working days



Targeted improvements being made

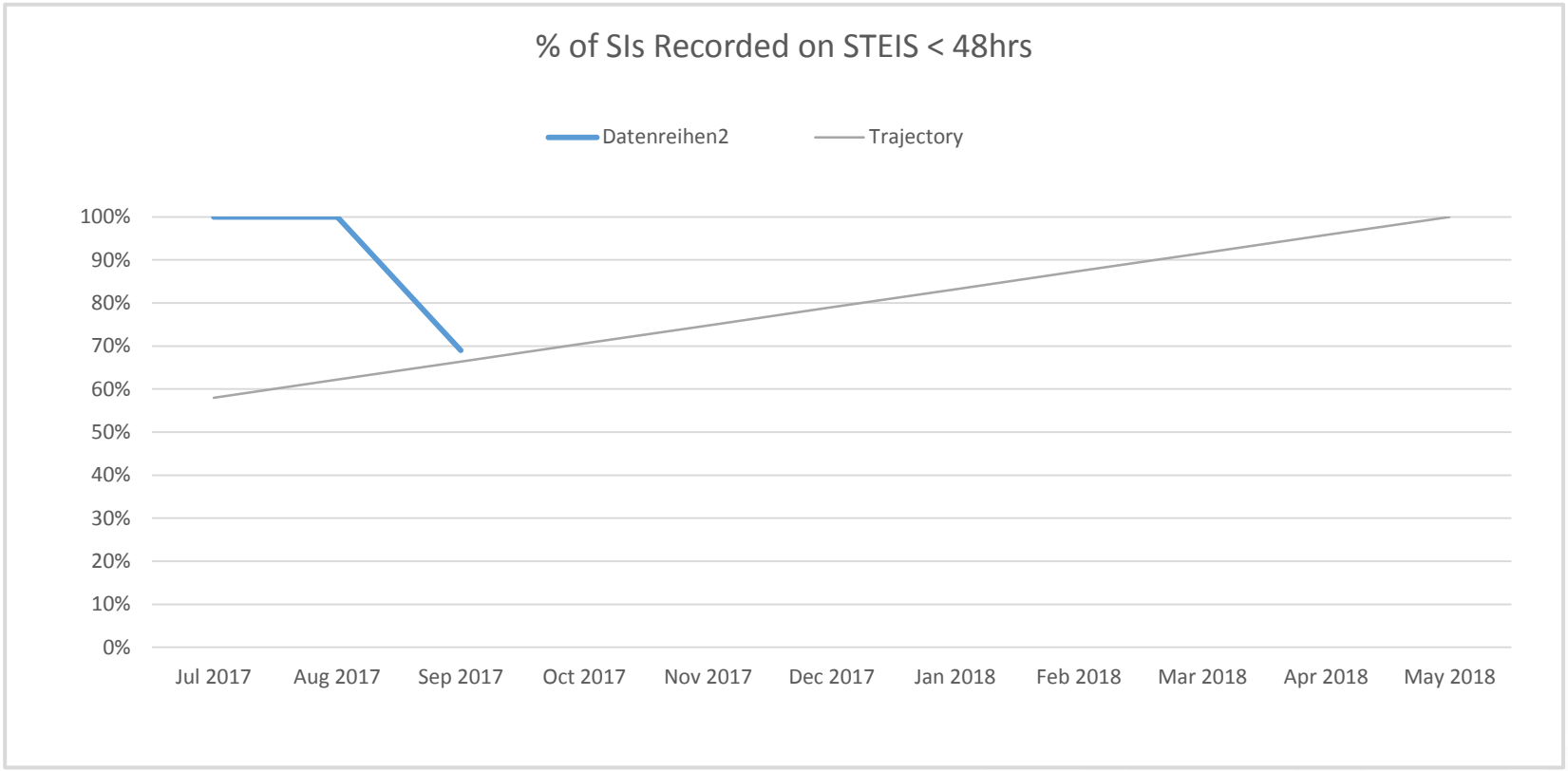
South East Coast Ambulance Service NHS Foundation Trust

Impact

Impact so far

Objective 2: Identify & Share Learning

Declaring 100% of Serious Incidents onto STIES within 48 hours.



Within trajectory

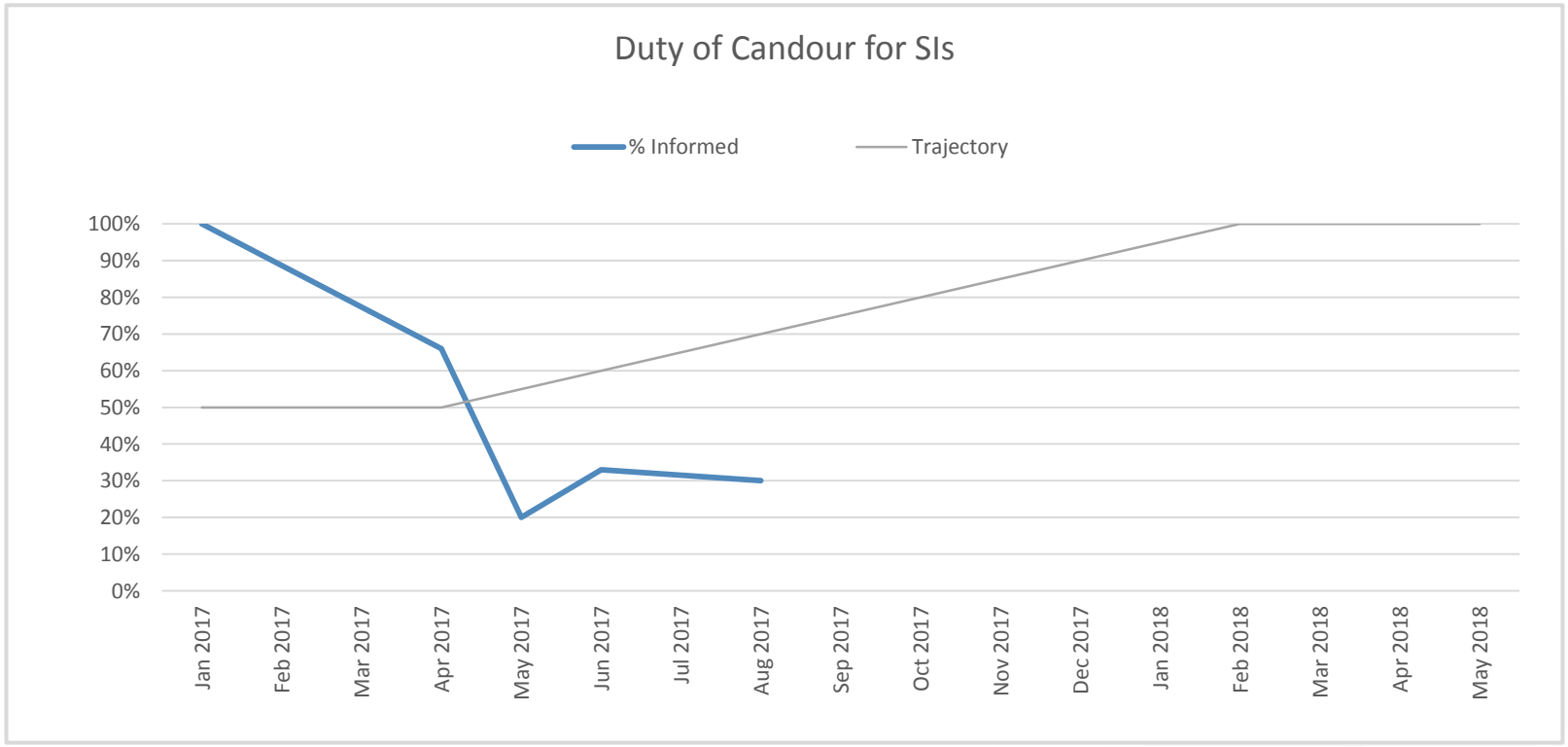
South East Coast Ambulance Service
NHS Foundation Trust

Impact

Impact so far

Objective 2: Identify & Share Learning

100% compliance with Duty of Candour for Serious Incidents



Changed processes to ensure recovery

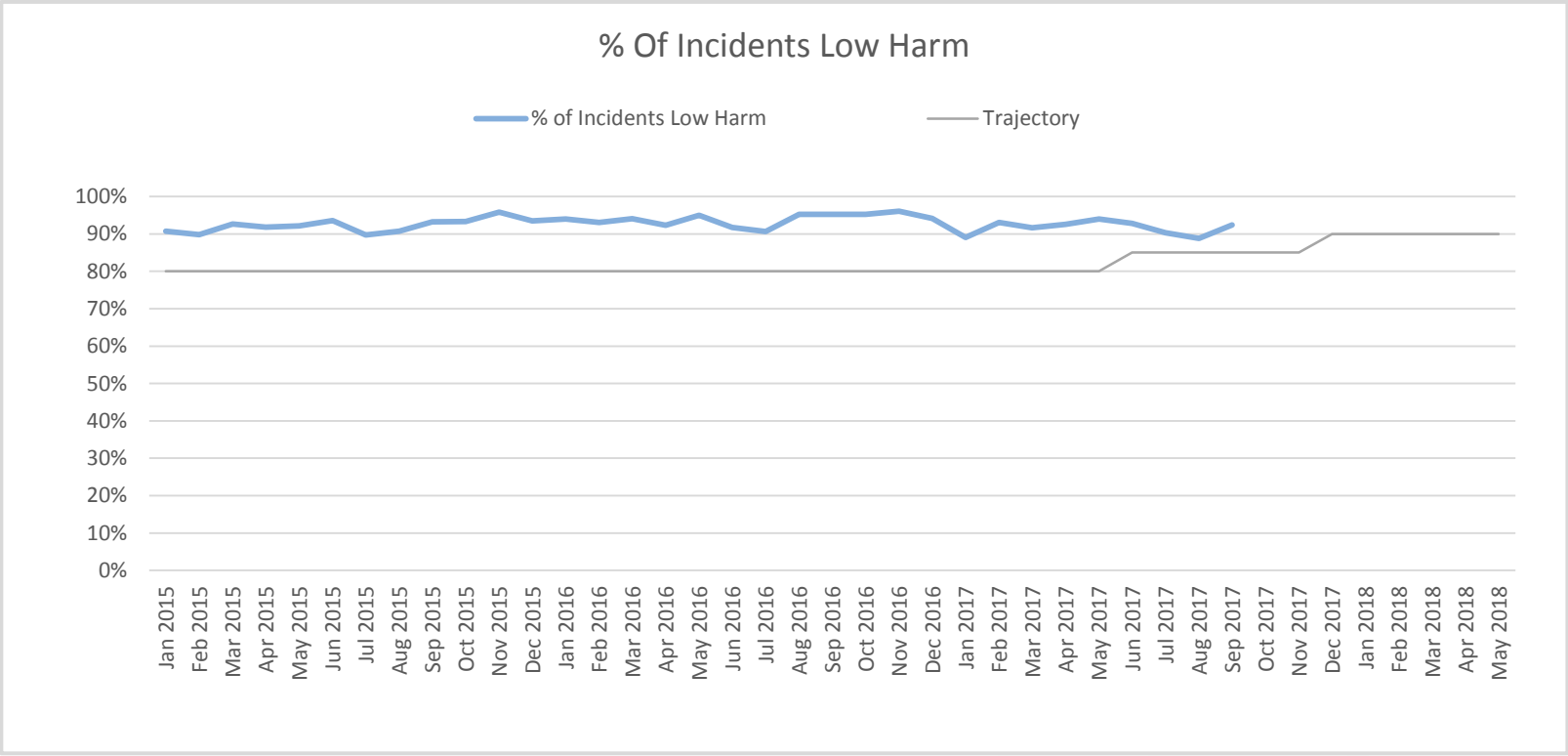
South East Coast Ambulance Service
NHS Foundation Trust

Impact

Impact so far

Objective 3: Positive Incident Culture

90% of incidents graded as near miss or low harm



Above trajectory

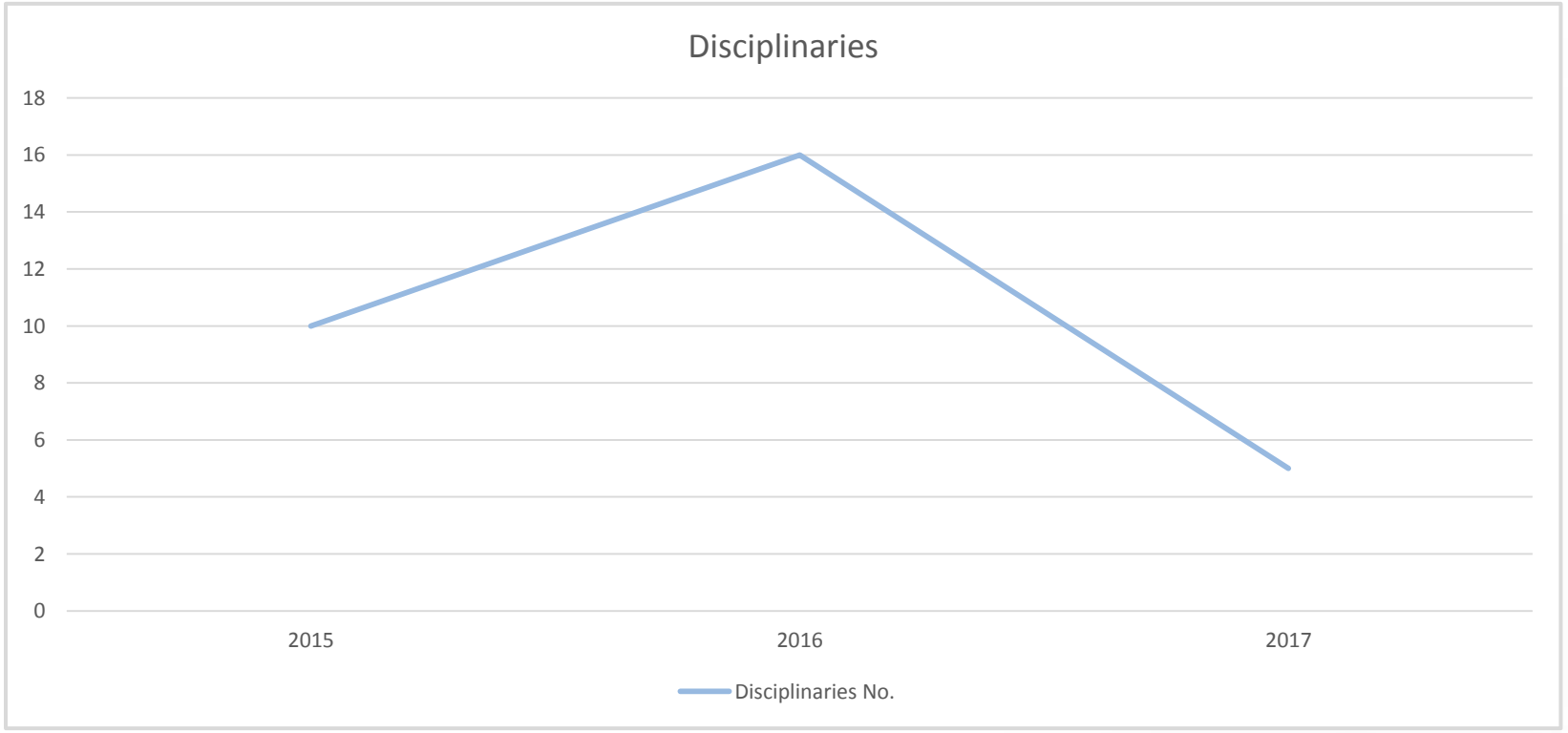
South East Coast Ambulance Service NHS Foundation Trust

Impact

Impact so far

Objective 3: Positive Incident Culture

0 disciplinary cases that are purely clinical error

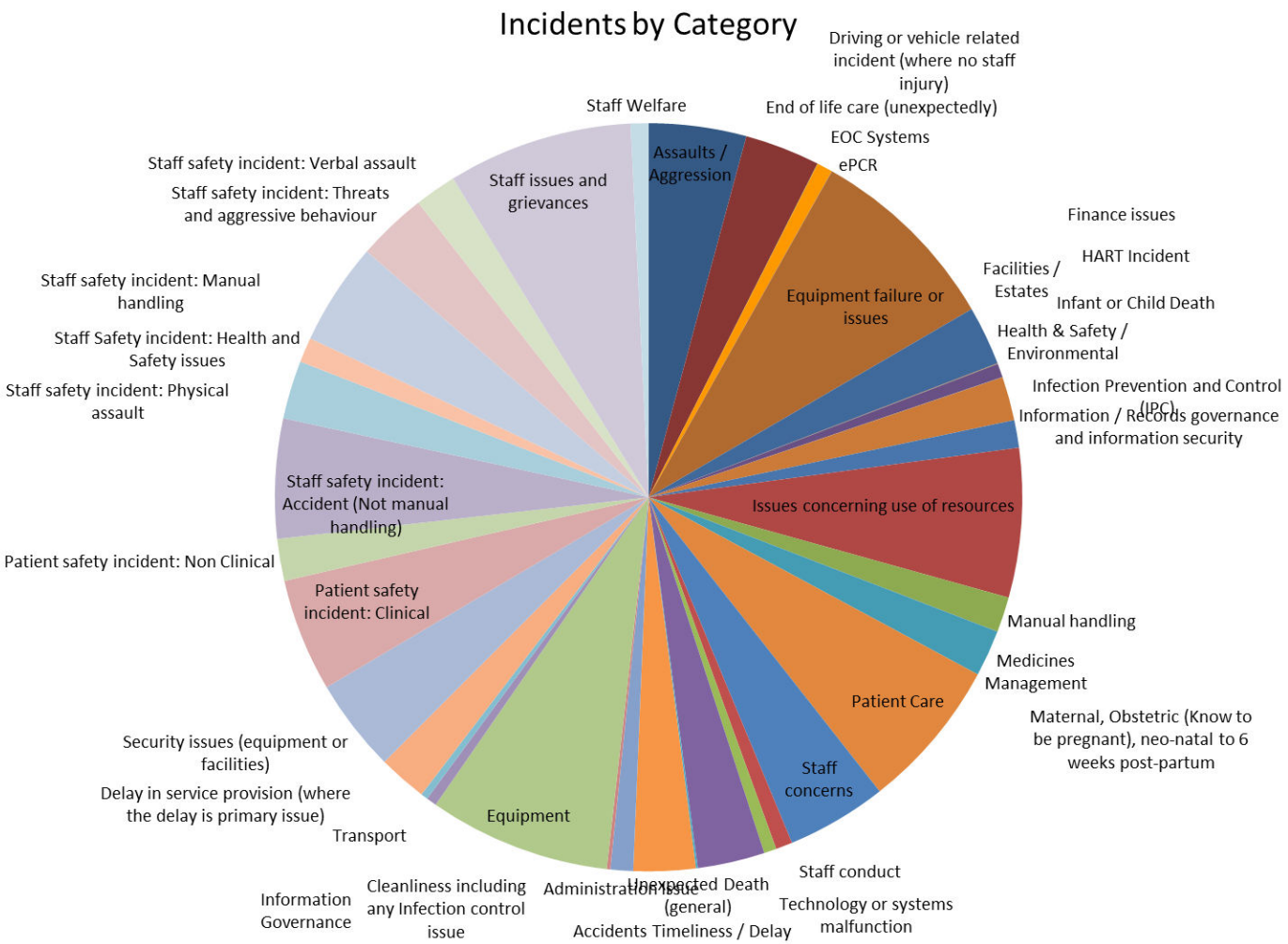


New process for deciding disciplinary

South East Coast Ambulance Service
NHS Foundation Trust

Themes

Of Incidents



South East Coast Ambulance Service NHS Foundation Trust

Impact

Impact so far

Objective 3: Positive Incident Culture

80% of incidents where feedback has been provided to the reporting member of

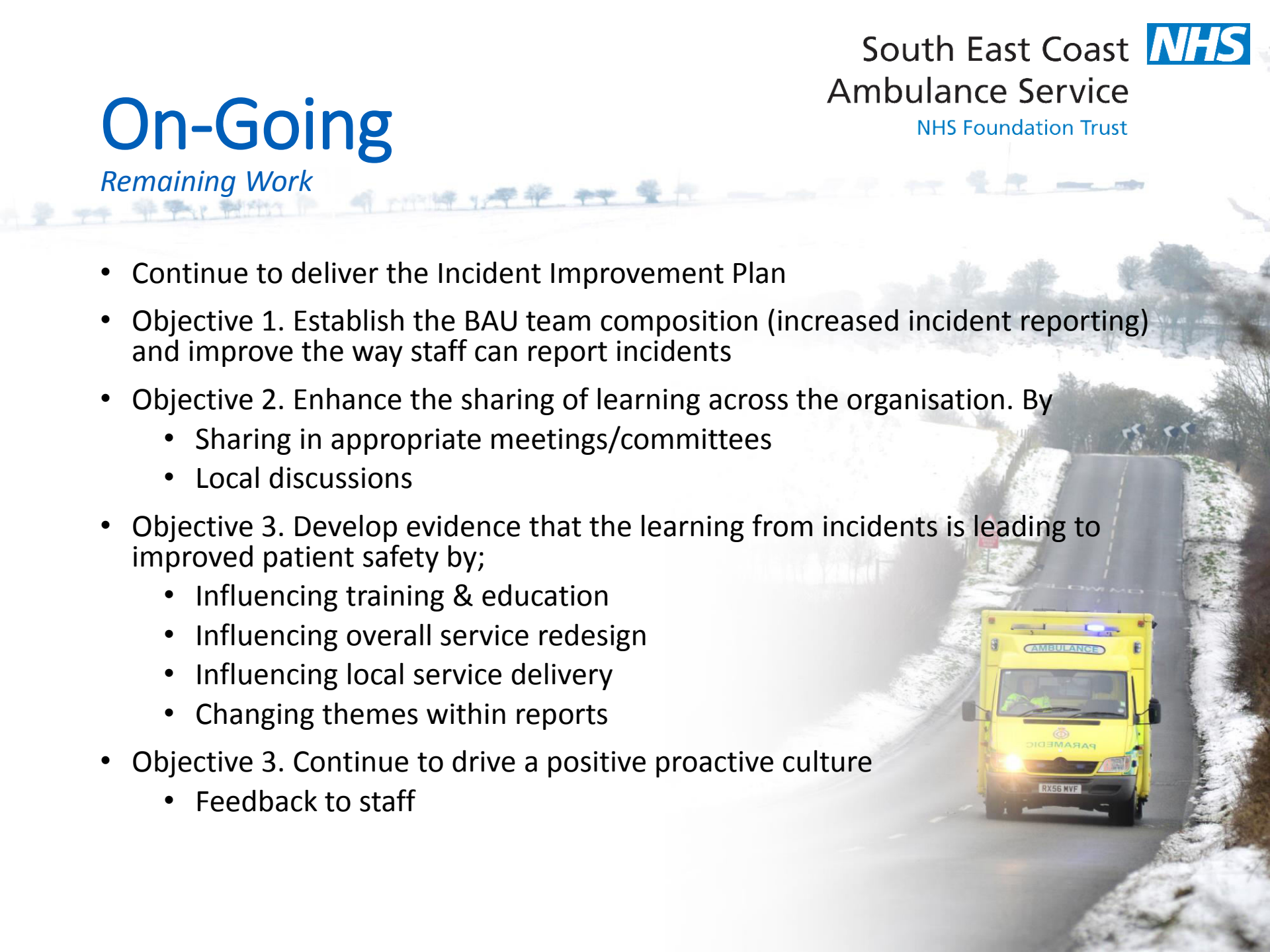
Targeted improvement

South East Coast Ambulance Service NHS Foundation Trust

On-Going

Remaining Work

- Continue to deliver the Incident Improvement Plan
- Objective 1. Establish the BAU team composition (increased incident reporting) and improve the way staff can report incidents
- Objective 2. Enhance the sharing of learning across the organisation. By
  - Sharing in appropriate meetings/committees
  - Local discussions
- Objective 3. Develop evidence that the learning from incidents is leading to improved patient safety by;
  - Influencing training & education
  - Influencing overall service redesign
  - Influencing local service delivery
  - Changing themes within reports
- Objective 3. Continue to drive a positive proactive culture
  - Feedback to staff



South East Coast Ambulance Service NHS
NHS Foundation Trust

Agenda No	127/17

Name of meeting	Trust Board
Date	21 November 2017
Name of paper	Delivery Plan Progress Update
Responsible Executive	Jon Amos, Acting Executive Director of Strategy & Business Development
Author	Eileen Sanderson, Head of PMO
Synopsis	This paper provides an update on the progress made in the Trust's Delivery Plan.
Recommendations, decisions or actions sought	• To note the continued progress made • To note the developments of the CQC Task and Finish Groups • To review the dashboards to be fully sighted on the current progress of the Delivery Plan
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**

Delivery Plan Progress

1. **Introduction**

This paper provides the Board with a summary of the progress of the Programme Management Office (PMO).

2.0 **PMO Progress**

Good progress is being made with the CQC Task and Finish Groups, with them all reporting weekly to the Compliance Steering Group which progress will be tracked against the Improvement Action Plan.

2.1 Each group will go through a three phased cycle;

1. Delivery (this is the stage where we ensure the action is right and that it delivers to plan)
2. Assurance & Scrutiny
3. Intensive support (before CQC deep dive)
4. Business as Usual (only once assurance has been provided otherwise the project will go back to the Delivery Phase)

2.2 Only until the assurance has been provided, the focus area will move into sustainability, Business as Usual. If assurance is not provided the 'project' will go back into Delivery stage.

2.3 Appendix A is a revised timeline which illustrates when each of the focus areas will be going through the phased cycle.

3.0 *Culture and Organisational Steering Group*

The Culture and Organisational Steering has now met and the project mandate and QIA which will outline the scope of the project is under development. The project will essentially cover the following key areas;

- Culture Change
- Effective Leadership and Management
- Health and Well Being
- Clinical Education
- Enabling Infrastructure

Once the Mandate and QIA has been signed off, a project plan will be developed to monitor pace and traction on the areas described above.

4.0 *Service Transformation & Delivery Steering Group*

Good progress is being made on the Ambulance Response Programme with the project on track to go live with the new Pathways 14 training on Wednesday 22nd November 2017. Increased Hear and Treat is also making good progress with ensuring that we have sufficient enough clinicians to use the decision support tool.

4.1 Deloitte has recently been commissioned to undertake Demand and Capacity Review to develop our future workforce. A report is expected in the early New Year.

5.0 *Sustainability Steering Group*

5.1 Discussions with Executive Directors/Budget Holders/CIP Project Leads have now identified £15.7m of fully validated CIPs schemes against the Plan target of £15.1m. Further potential schemes have been identified and are in the course of development. Actual achievement of CIPs to the end of month 7 is running ahead of the Plan figure of £8.2m by £0.2m. The forecast achievement for the year is £14.9m, £0.2m adverse to Plan.

5.2 The CAD system has now been live across all controls since the beginning of September 2017 and following some initial problems around freezing, the system is operating as expected. The final elements of the work related to CAD are now to plan the decommissioning of the Banstead datacentre and to relocate the hardware infrastructure into Crawley.

5.3 99% of on boarding is now completed against original iPad stock. Discussions underway with core Acute Trusts to implement transfer of electronic records. All have now accepted the need to do this and trajectories being agreed. Temporary withdrawal of ePCR software to enable stability upgrades. Phased roll out planned from early December 2017.

6.0 Dashboards

6.1 Dashboards are provided for the Delivery Plan (previously the Unified Improvement Plan) and Financial Sustainability (CIP focus).

6.2 The Delivery Plan dashboard captures the high level milestones and associated Key Performance Indicators (KPIs) for this reporting period, extracted from the Project Plans. The Project Plans will continue to be developed to provide assurance to the Executives that there is pace and grip of the projects and they continue to deliver the expected outcomes.

7.0 Summary

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

8.0 Recommendation

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

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

Delivery Plan Dashboard

Progress made to date 21/11/2017

RAG Key:

Red	At significant risk of failure due to circumstances which can only be resolved with additional support
Amber	A risk of failure but mitigating actions are in place and these can be managed and delivered within current capacity
Green	On track and scheduled to deliver on time and with intended benefits
Blue	Completed

South East Coast Ambulance Service NHS
NHS Foundation Trust

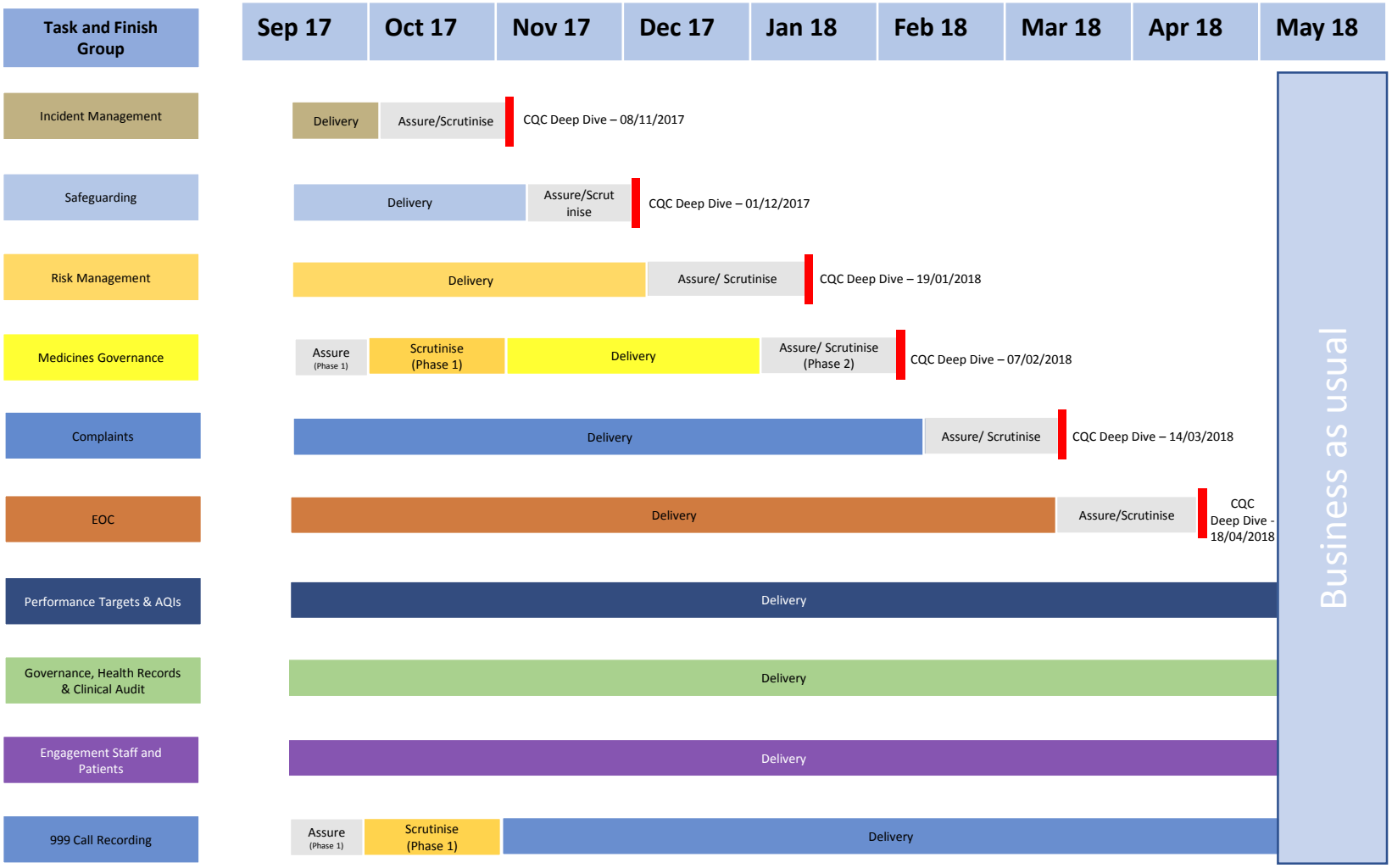
Work stream	Project Name	Project RAG Current Period	Project RAG Previous Period	Project Lead	Executive lead	Project Completion Date	Process / Milestone	Milestone Completion Date	RAG	KPI / Outcome	Actual	Planned	End Target	High-level Commentary
Service Transformation & Delivery Steering Group	Increased Hear and Treat Project	Amber	Amber	Scott Thowney	Joe Garcia	31/03/2018	Development of Clinical Supervisors recruitment and retention plan. Proposal in draft.	30/11/2017	Amber	45 clinical supervisors in post in EOC	29	45	45	Whilst staffing continues to be the predominant challenge within hear and treat currently 64.9%there has been a reduction in attrition over last 4 weeks Additional resource in place for 2 days a week to support Hear and Treat from 6/11/2017. Workstreams within the Hear and Treat project have been re-assigned to leads to assure delivery of project. Midwifery function secured for developing ICAS. Exit interview process in place to understand why there is a higher than normal attrition rate with clinical supervisors.
							Develop and implement an efficient and identified roster to meet demand	31/05/2018	Green	Obtain staffing Abstraction reports to monitor individual rotas / shift patterns to show and differentiate planned vs actual rota fill and adherence rates	Data development in progress			
							Functionality for PDS lookup by EOC Staff with ability to report on usage. (CQUIN)	30/06/2018	Green	Improved access to patient information at point of call will increase efficacy of Hear and Treat process. This will be measured in the overall Hear and Treat performance.				
	Demand and Capacity review	Green	Green	Jon Amos	Jon Amos	01/01/2018	Tendering process completed for the procurement of an external provider to conduct a review of current demand and capacity	29/09/2017	Complete	External provider appointed and interim report will be published in early January 2018				Review jointly commissioned with CCGs and provided by Deloitte and ORH. The work has commenced and will provide an interim report in late December and final report at the end of January 2018. The outputs will include: - Review of historic demand and provide a future capacity plan aligned to the ARP standards to include rota profiles and vehicle mix. - Case for Change to seek support from the wider system. - New contract process and payment model to support the new standards. - Timeline and transition plan to move from current state to the new rota profile, fleet mix etc.
							The External provider will have established accurate and current interim reporting procedure	29/12/2017	Green					
							Final report submitted with recommendations	30/01/2018	Green					
	Ambulance Response Programme	Amber	Amber	Sue Barlow	Joe Garcia	22/11/2017	A training programme is in place to train dispatch and team leaders in new ARP processes and procedures (new call categorisation, automated dispatch)	22/11/2017	Green	Training plan and materials have been developed and training course is underway	Data not available			ARP is progressing at pace on track to meet the nationally agreed deadline of 22nd November 2017. However ongoing organisation wide issues around recruitment and retention are evident and monitored at Project Board with any escalations to Turnaround Executive on a fortnightly basis. Awaiting final data to evidence completed training.
							Dispatch and Team Leaders will be trained in ARP changes identified in the training programme	06/10/2017	Complete	100% of all dispatch staff trained	Awaiting final Data	100%	100%	
							Develop and implement forecasting models that will enable the impact of ARP to be established and allow for accurate forecasting of demand changes. This will be managed in PHASE 3.	28/02/2018	Green	Forecasting models in place, reporting on a monthly basis	Data not available			
Sustainability Steering Group (see separate Dashboard for Cost Improvement Programme)	HQ PHASE 2	Red	Green	Ibrahim Razak	David Hammond	30/09/2018	New EOC positions in Coxheath are fully operational and can receive a 999 call	30/11/2017	Red	32 new EOC positions are sufficiently equipped and ready to be used by an EOC member of staff to answer a 999 emergency call.	0%	0%	100%	Options are being appraised to secure the long term base for Clinical Education, Fleet, Logistics and Production, enabling the Banstead site to be vacated by 31st March 2018. Construction work is underway in Coxheath to implement new EOC positions. It is acknowledged that 32 of 51 planned positions will be in place by 30th November 2017. Project RAG is red due to concerns around provision of IT equipment and furniture in time for the 30th Nov. Project team working on sourcing furniture already available within the Trust, and IT are working on reusing IT kit where possible.
							Relocation of Clinical Education to the chosen solution is completed	31/03/2017	Amber	100% of Clinical Education staff have been relocated and are able to complete their duties	0%	0%	100%	
							Relocation of Fleet, Logistics and Production to chosen solution is completed	31/03/2017	Amber	100% of Fleet, Logistics and Production staff have been relocated and are able to complete their duties	0%	0%	100%	
	Electronic Patient Clinical Records ("EPCR").	Red	Amber	Steve Topley	Jon Amos	29/03/2018	All hospitals are trained to be able to adopt the new iPad process which will increase efficiency in hospital handover.	30/11/2017	Red	The number of on-boarded hospitals	11	20	25	
							ePCR portal is developed and embedded which will allow access to ePCR records and training to all departments.	18/12/2017	Green	All key departments to be trained and this will be measured through weekly tracking by completion of training	0.0%	0.0%	0.0%	99% of on boarding completed against original iPad stock Discussions underway with all core acute Trusts to implement transfer of electronic records. All have now accepted the need to do this and trajectories being agreed. Temporary withdrawal of EPCR software to enable stability upgrades. Phased roll-out planned from early December
							All policies, procedures and clinical instructions will be signed off so that ePCR is functioning safely in accordance with trust policy. This will ensure the safety of patient information and ensure that staff are clear on how to use the application.	14/02/2018	Amber	There are currently 14 policies/procedures in draft awaiting approval	0.0%	0.0%	0.0%	
	CAD	Green	Green	Barry Thurston	Jon Amos	30/11/2017	New Computer Aided Dispatch (CAD) system implemented	05/09/2017	Completed	Data control centres live with new CAD.				The CAD system has now been live across all controls since the beginning of September and following some initial problems around freezing the system is operating as expected. The final elements of the work related to CAD are to now plan the decommissioning of the Banstead datacentre and to relocate the hardware infrastructure into Crawley.
							Banstead decommissioned to allow data centre relocated to Crawley	30/11/2017	Green	Data centre fully relocated to Crawley.				
	Informatics	Green	Green	Barry Thurston	Jon Amos	18/12/2017	Design and implement the backend for the database scheme / warehouse.	31/03/2018	Green	Database scheme / warehouse built				The Trust are currently continuing with the existing information system and structures which provides a number of challenges to ensuring the timeliness and appropriateness of information provision. The plan to replace the system is being executed with a new server build now complete and West Midlands Ambulance Service (WMAS) agreeing, and commissioned, to provide a new backend database structure. The project has appointed a temporary database administrator (DBA) to support the implementation of the system internally and work progressing on a new interface programme to extract data from the CAD system and upload into the new data warehouse. In addition, the Trust have just approved the business case for the supply of business intelligence (BI) tools to support a self service portal for Trust managers and appropriate tools for the software developers to provide the more complex reporting, for example, ARP, commissioning/commissioners reports. It is expected that the new system will begin to provide reports, dashboards and screen based information before the end the calendar year.
							Develop an interface to lift the data off the existing system and export to the new warehouse.	30/11/2017	Green	Interface fully implemented.	0.0%	0.0%	0.0%	
							Developing tools and people to use the new data warehouse.	31/01/2017	Green	Recruitment completed for substantive informatics team. Procurement of front end system.	0.0%	0.0%	0.0%	
	Financial Sustainability	Amber	Amber	Kevin Hervey	David Hammond	31/03/2018	CIP schemes totalling £15.1m in line with 2017/18 Plan identified	30/11/2017	Amber	£15.7 million current schemes fully validated	£15.7m	£15.1m	£15.1m	On track to deliver, some CIP schemes under-delivering, additional CIP schemes under development.
							Achieved projected financial deficit of £1.0m as agreed with NHSI	31/03/2018	Amber	£1.0 million of financial deficit forecast	£1.0m	£1.0m	£1.0m	

							Identified CIP schemes for 2018/19 Plan - target to be agreed	31/03/2018	Not started	To be confirmed.	

Compliance Steering Group	Incident Management	Amber	Amber	Samantha Gradwell	Steve Lennox	01/08/2018	The Trust will be adhering to national policy/guidance and best practice and will be able to demonstrate it has robust processes that facilitate rapid reporting and effective management.	01/08/2018	Red	20% increase in overall incident reporting.	575	548	576	The Care Quality Commission (CQC) identified areas for improvement with the Trust's incident management processes. A project has been mobilised with a Mandate, Quality Impact Assessment, and an Improvement Action Plan. The project aims to embed an effective incident management system, that clearly identifies learning. This learning is valued and shared widely across the Trust to continually drive improvements in safety. Currently not on trajectory to achieve: 90% of Serious Incident investigations will be completed within 60 working days. Focus is on reducing the serious incident backlog. Once this has happened the new process for investigating SI's will ensure that this tragectory is met. Compliance with Duty of Candour is below trajectory.
							The Trust will have implemented sustainable processes that allow the Trust to identify and share learning.	01/08/2018	Amber	>75% of incidents closed within time target.	68.0%	53.0%	75.0%	
							The Trust will become more incident aware.	01/08/2018	Green	90% of Serious Incident investigations will be completed within 60 working days.	0.0%	71.0%	90.0%	
										Recording 100% of declared Serious Incidents onto STIES within 48 hours.	69.0%	66.0%	100.0%	
										100% compliance with Duty of Candour for Serious Incidents.	30.0%	70.0%	100.0%	
										90% of incidents graded as near miss or low harm.	92.0%	85.0%	90.0%	
										From 01/12/2017, there will be 0 disciplinaries for cases purely due to clinical error.	5	0	0	
										80% of incidents where feedback has been provided to the reporting member of staff.	24.0%	20.0%	80.0%	
	Safeguarding	Green	Green	Philip Tremewan	Steve Lennox	23/03/2018	All Policies and procedures required to support safeguarding best practices are in place	31/03/2018	Green	The number of staff trained to level 3 Safeguarding	16.9%	85.0%	85.0%	The Trust's 2016 Care Quality Commission (CQC) report made a number of observations regarding the safeguarding function. This generated an improvement plan and the appropriate actions were completed. The most recent CQC report (October 2017) identified that improvements were required within training for Safeguarding Children level 3 but also identified that further work was still needed to continue this improvement currently 16.9% of staff are trained to level 3 with a target of 85% by 31/03/2018. This project has developed a plan and has a mandate and QIA signed off.
							All learning from internal and external safeguarding work is captured and appropriately shared across the organisation	31/03/2018	Green	95% of staff, when asked on audit, feel adequately prepared to identify safeguarding concerns and know how to obtain assistance . This will be measured through quality assurance visits and feedback through appraisal bulletins, local governance groups. No data as yet	0.0%	0.0%	95.0%	
							Safeguarding best practise is embedded and fully adopted across the trust	31/07/2018	Green	KPIs and Outcomes measures unconfirmed within this reporting period				
	Risk Management	Green	Green	Samantha Gradwell	Steve Lennox	24/03/2018	The Trust will have implemented Datix Risk Management system. Standardised reports will be provided to principle risk leads, accountable executives and forums to monitor monthly actions and controls.	01/05/2018	Green	Risk Management functionality within the Trust will be processed via Datix.	Data not available	Data not available	100.0%	Improvement Plan, Mandate and Quality Impact Assessment are in place. Work is underway to capture the current processes for risks management across the Trust. All risks will then be consolidated onto a single platform. Medical equipment - Actual percentage KPI not yet available.
							A baseline assessment will have been undertaken by the Trust of the current status of all recorded risks. The Trust will have agreed roles, responsibilities and forums for the management of risk.	01/05/2018	Green	100% of forums will receive their monthly standardised report.	Data not available	Data not available	100.0%	
							The Trust will have delivered a training program to identified staff on risk management. Staff feedback and audits will provide assurance and/or identify gaps with risk management.	01/09/2018	Green	Staff within the Risk Team are proficient in the use of Datix for risk management in line with their responsibilities.	Data not available	Data not available	100.0%	
							The Trust will ensure 90% of medical equipment will be serviced in accordance with Medical Equipment Management Policy.	31/01/2018	Amber	Medical equipment will be serviced in accordance with Medical Equipment Management Policy.	Data not available	Data not available	90.0%	
	Governance, Records & Clinical Audit	Green	Green	Fiona Wray	Fionna Moore	25/03/2018	Patient Clinical Records will be accurately completed, fit for purpose and stored securely.	31/03/2018	Green	Patient Records will be completed accurately and stored securely	Data not available	Data not available	90.0%	Task and Finish Group now established and meeting weekly. Progress is on track. There is a need to continue to develop measures of progress to remain assured. Please note risk regarding improvement methodology decision- now raised on Datix.
							The Trust Patient Data & Health Records Policy will always be contemporary and reflect national guidelines and best practice.	10/12/2017	Green	Incidents will have Patient Clinical Record linked	Data not available	Data not available	90.0%	
							Incidents will have Patient Clinical Record linked so that we can ensure safe and accurate records.	31/03/2018	Green	Records will have a PCR linked.	Data not available	Data not available	90.0%	
	Engagement	Green	Green	Mark Power	Steve Graham	TBC	Project Mandate and QIA to be signed off	22/11/2017	Green	KPIs and Outcomes measures unconfirmed within this reporting period				Mandate and QIA in progress.
							High level objectives with clear measures identified	22/11/2017	Green					
							Improvement Action Plan developed in draft	22/11/2017	Green					
	Complaints	Green	Green	Louise Hutchinson	Steve Lennox	31/03/2018	80% of complaints will be concluded within 25 working days.	31/03/2018	Green	Complaints will be concluded within the Trust's target of 25 working days.	40.0%	Data not available	80.0%	There is no national guidance or performance measure; trusts set their own target and they all differ enormously. The Trust target was set at 80% within timescale in 2017, in conjunction with our commissioners (North West Surrey leading) and the action plan reflects this measure. In September, concluded 42% of complaints within deadline and in October 40%. The volume of timeliness complaints, and lack of capacity to investigate them, is the major challenge. The CQC state that the Trust cannot demonstrate evidence of learning, and to help to ensure actions are implemented as a result of complaints that are upheld in any way, the Patient Experience Team now checks every complaint investigation report on receipt.
							We will be able to provide evidence of learning from at least 95% of complaints that are upheld in any way and this will drive improvements to our service.	31/01/2018	Green	Evidence of learning from at least 95% of complaints that are upheld in any way.	Data not available	Data not available	95.0%	
							We will have improved the sharing of learning from complaints.	31/01/2018	Green	100% of Area Governance Meetings, Clinical Evaluation & Effectiveness Sub-Group meetings will have shared learning from complaints.	Data not available	Data not available	100.0%	
	EOC	Red	Green	Sue Barlow	Joe Garcia	28/03/2018	The Trust will have taken action to ensure there are a sufficient number of clinicians in each EOC at all times in line with evidence-based guidelines.	31/03/2018	Green	Clinical supervisors in post in EOC	29	45	45	Clinical supervisor recruitment and retention is progressing Call audit figures remain significantly adrift of the trajectory that would meet the requirement of approx. 1300 by April 2018. Staffing capacity is an issue, outsourcing the function is being considered but has so far not developed into a sustainable plan/model Call answer is adrift and is impacted heavily by the EMA recruitment issues EMA levels are below trajectory due to shortfall in recruitment target. Plan is in place to bring this back on track
							The Trust will have taken action to ensure that the minimum amounts of audits are carried out in line with the requirement needed by pathway to maintain the licence.	31/03/2018	Red	The audits will take place on a monthly basis via an audit function on the info system which was created by SECAmb	10.0%	31.0%	100.0%	
							The Trust will have improved call answering time to align within the national standard	31/03/2018	Amber	95% of calls answered within 5 seconds.	51.0%	60.0%	95.0%	
							Recruitment and retention of EMAs to establishment of 172	31/03/2018	Amber	FTE EMAs in post within EOC	143	153	172	

	Performance Targets and AQI's	Green	Green	Chris Stamp	Joe Garcia	29/03/2018	The trust will minimise operational sickness abstractions through consistent management of staff under the sickness absence management policy.	14/04/2018	Green	KPIs and Outcome measures unconfirmed within this reporting period	Held an establishment summit last week which identified where there are gaps and will lead to a recruitment drive. (which will be incorporated into the plan). Teams A, B, C … operational structure has been implemented giving direct communication, issue raising and a new structure of operations management. Have agreed a trial of non-top down management and communication which will be incorporated into the plan.
							The trust will ensure that unit hours provided align with forecast demand, taking into consideration additional requirements to meet national standards.	28/02/2018	Amber		
							The trust will ensure that resources are provided to aid staff in timely clinical decision making. [Time on scene]	30/03/2018	Red		
	Medicine Governance	Green	Green	Carol-Anne Davies-Jones	Fionna Moore	31/03/2018	The Trust will have created and implemented a new Governance structure for medicines management which will take into account relevant regulations, national standards and guidance to support excellent patient outcomes and safety.	31/03/2018	Green	KPIs and Outcome measures unconfirmed within this reporting period	Continuation of workstream surrounding the safe, secure storage of medicines and the culture change around medicines, including further strengthening governance process, pathways, legislation and on-going education/training as well as implementation of NICE good practice guidance. Progress being made. Data still to be defined.
							The Trust will design systems and processes relating to the safe and secure handling of medicines to support excellent patient outcomes and safety.	31/03/2018	Green		
							A training plan will be in place for all staff in medicines governance and management for key skills delivery in 2018/19 to assure staff confidence and competency	31/03/2018	Green		
	999 Call Recording	Green	Green	Barry Thurston	David Hammond	31/03/2018	Completed further testing post voice reorder system update to provide assurance that the system is recording all 999 calls.	Ongoing	Green	100% of all 999 calls recorded	The latest fix from ASC was applied successfully on Monday 6th November 2017. 450 calls were checked immediately following the update and no issues were found. Audit of 24 hours calls undertaken and no issues found. A report is provided to the Execs on a weekly basis to provide update and assurance.
							An ongoing robust auditing procedure embedded of the current system to ensure any emerging issues are flagged and escalated in timely manner	Ongoing	Green	Auditing of calls take place on a weekly basis (circa 2500 calls)	
							Daily sample of calls carried out	Ongoing	Green	Approx. 15 sample calls carried out	
	Infection Prevention and Control	Green	Green	Adrian Hogan	Trevor Hubbard	29/12/2017	Improved station cleaning standards, monitoring/ audit systems and new ATP testing.	31/03/2018	Green	KPIs and Outcome measures unconfirmed within this reporting period	CQC Task and Finish group set up. Identifying membership and involvement. Mandate and QIA including KPIs in progress. Paper presented to SMT for ATP testing equipment.
							Awareness raised to improve vehicle cleaning standards with new monitoring/ audit systems and ATP testing.	31/03/2018	Green		
							Improved hand hygiene, uniform awareness and compliance. New audit tools introduced with partnership working with patients and hospital staff. New hand hygiene equipment for each Operating Unit	28/02/2018	Green		
Culture and Organisational Development Steering Group	Culture Change	Green	Green	Mark Power	Steve Graham	TBC	Project Mandate and QIA to be signed off	23/11/2017	Green	KPIs and Outcome measures unconfirmed within this reporting period	Steering group has reconvened.
							Improvement Action Plan developed in draft	29/11/2017	Green		
Strategy	Enabling Strategy	Green	First reporting period so no previous RAG	Jayne Phoenix	Jon Amos	31/03/2018	Milestones to be defined.			KPIs and Outcome measures unconfirmed within this reporting period.	
	Annual Planning	Green	First reporting period so no previous RAG	Jayne Phoenix, Philip Astell	Jon Amos	31/03/2018	Milestones to be defined.			KPIs and Outcome measures unconfirmed within this reporting period.	
	Quality Improvement	Green	First reporting period so no previous RAG	Jon Amos	Jon Amos	31/01/2018	Milestones to be defined.			KPIs and Outcome measures unconfirmed within this reporting period.	
	Commissioner and Stakeholder Alignment	Green	First reporting period so no previous RAG	Jon Amos	Jon Amos	31/03/2018	Milestones to be defined.			KPIs and Outcome measures unconfirmed within this reporting period.	

CQC Task and Finish Groups



NOTE:

After the scrutiny phase, the project will move into Sustainability (BAU), with quarterly station visits. Aim is to do every station every quarter. Results feed into Area Governance Meetings and Executive Committee.

If assurance is not provided, project will go back to delivery stage.

South East Coast Ambulance Service: CIP Workstream Pipeline Dashboard

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

Financial Reporting Period: Month 7 - October 2017

Programme Summary:

1. £15.7m of fully validated savings as at 31 October 2017 reporting date- c. £14.3m CIP and £1.4m cost avoidance moved to delivery tracker. CIP schemes are moved to the Delivery Tracker after approval by Exec Sponsor and QIA sign off.

2. Positive engagement with Execs and CIP Project Leads along with effective participation in Financial Sustainability Steering Group meetings. CIP Programme governance framework and processes are fully embedded in the business.

3. Continuing to work collaboratively with Project Leads and Execs to develop further schemes to mitigate potential gaps in delivery 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	

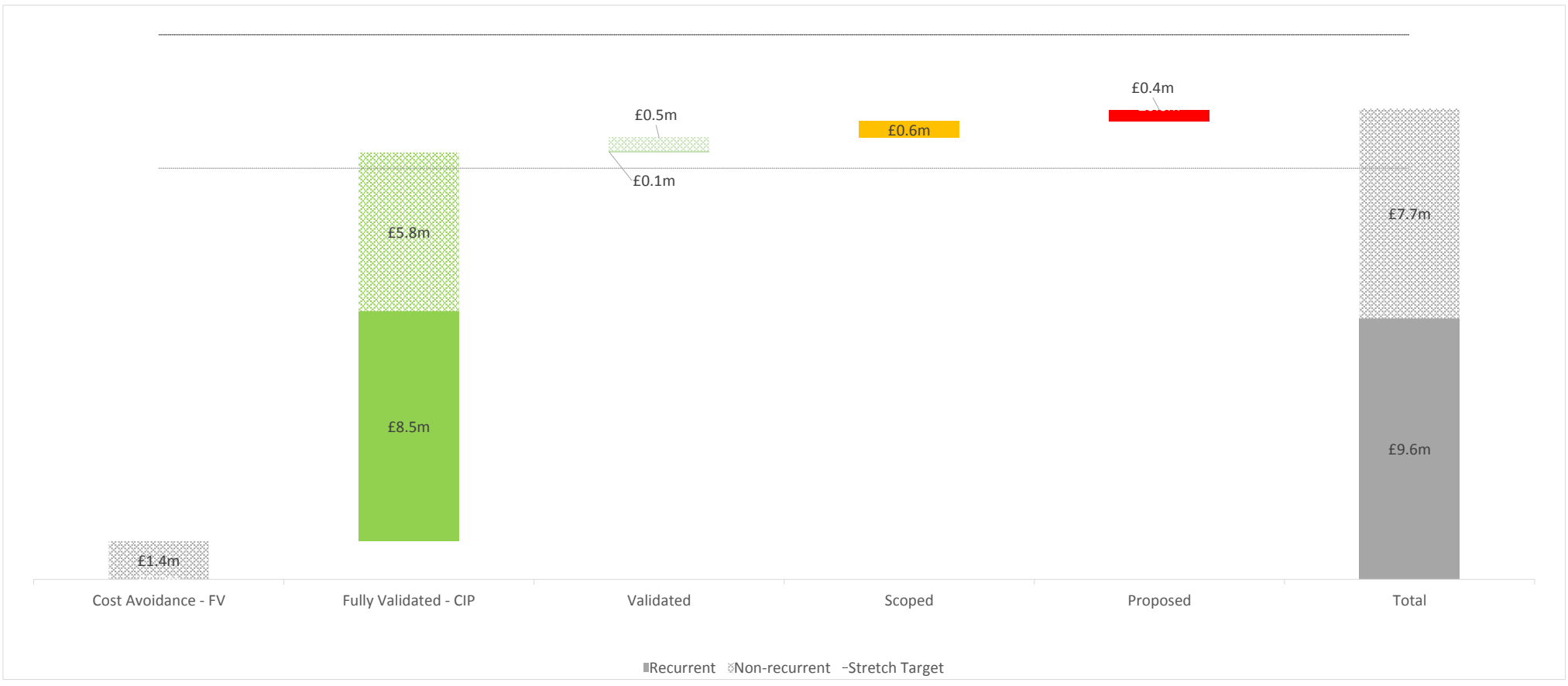
CIP Pipeline and Delivery: Risks and Issues

	Risk	Mitigating action	Owner	Current RAG	Previous RAG	Date to be resolved by
1	Failure to identify and scope fully the entire planned value (£15.1m) CIPs schemes, impacting on the Trust's ability to achieve the 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. £15.7m of CIPs currently Fully validated and further schemes being scoped.	Kevin Hervey	Green	Amber	31/12/2017
2	Failure to achieve / deliver the entire planned value (£15.1m) of CIPs schemes, due to part-year effect of some schemes, impacting on the Trust's ability to achieve 2017/18 year-end control total of £1m.	Aiming to identify £19m CIP savings to mitigate risk. Delivery tracker in use to monitor CIP schemes individually. Monthly financial performance review with Budget leads and FBPs in place to monitor and challenge budgets. Weekly meetings in progress to monitor delivery of transformational scheme due to complex and interdependent nature (see delivery tracker section 7)	Kevin Hervey	Amber	Red	31/02/18
3						

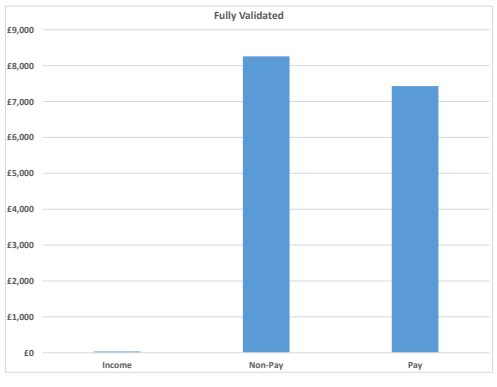
	Issues to be resolved	Mitigating action	Owner	Current RAG	Previous RAG	Date to be resolved by
1	Delays in restructures impacting on anticipating agency savings	Liaising with relevant budget leads to confirm restructure timeline. Working with Budget leads and Finance Business Partners to establish and resolve any under delivering issues. Further schemes under development to compensate.	Kevin Hervey	Amber	Amber	31/12/2017
2	Timing of clinical processes becoming fully operational to effect the transformational changes required in the Task Cycle Time Operations efficiency.	Weekly cross section meetings in place to monitor progress on Task Cycle Time clear at scene and ensure the reinforced clinical processes are fully embedded in the business. Weekly progress updates provided at Turnaround Execs and escalations of issues where required. Full leadership focus - Medical and Operations Directors nominated by CEO to support scheme delivery.	Kevin Hervey	Red	Amber	31/12/2017
3	Delays in establishing further frontline 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 meeting identified 14 likely schemes to realise savings - scoping and validation in progress.	Kevin Hervey	Amber	Amber	31/11/2017

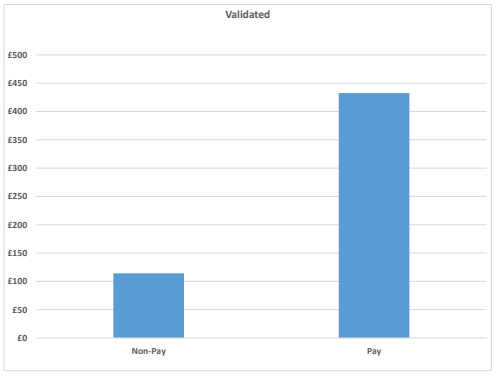
CIP Pipeline Summary

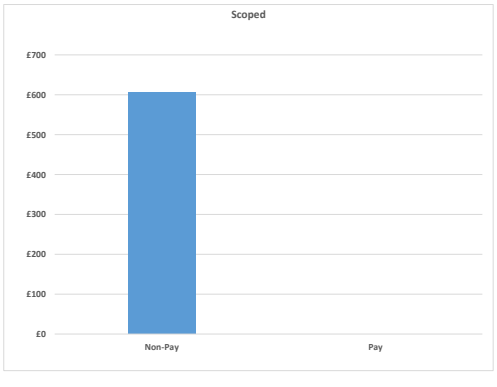
Cost Avoidance	Fully Validated	Validated	Scoped	Proposed	Grand Total
£1,400	£14,325	£547	£607	£410	£17,288

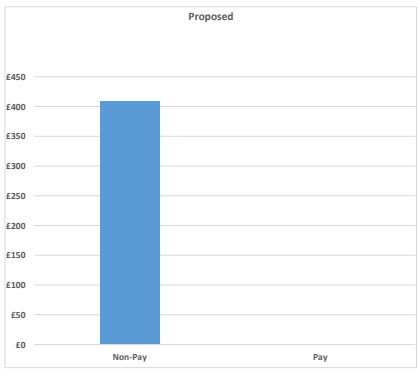


Pay / Non-Pay / Income Breakdown









South East Coast Ambulance Service
NHS Foundation Trust

Safeguarding

Mid-Year Report (Assurance & Position Paper)

November 2017

Director of Nursing & Quality

1. Introduction & Background

1.1. This position paper is produced by the Director of Nursing & Quality. The Director of Nursing & Quality is responsible for the strategic direction and compliance of safeguarding practice throughout the Trust. The Director is supported by a team of administrative staff and two clinical experts to help deliver the safeguarding agenda.

1.2. In 2016 the unannounced inspection by the Care Quality Commission revealed that Safeguarding was not in an acceptable position and this led to the Trust implementing additional senior resource into the team on an interim basis.

1.3. During the course of 2016 considerable attention was given to the oversight of safeguarding and the necessary improvements. By the time the Care Quality Commission undertook their 2017 unannounced inspection some of the issues had been resolved with the main exception of training.

1.4. However, the feedback from the 2017 inspection suggested that the Trust had responded slowly to the findings and consequently had not addressed some of the process changes and the training issues sufficiently. This lack of pace and safeguarding training was the over-riding safeguarding concern of the 2017 inspection and this resulted in the following Requirement

> *Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment*
> *How this regulation was not met:*
>
> *The provider did not operate and implement robust procedures and processes that make sure that people are protected from abuse. The appropriate level of safeguarding training did not meet with intercollegiate guidance.*

Notice.

1.5. In addition, during the early part of 2017 the Trust received two reports which made safeguarding observations. These reports concluded that some Trust staff are not free from abuse in the workplace. This has been referred to as internal safeguarding.

1.6. This paper is a follow-up to the Position Paper produced for the Trust's Quality & Patient Safety Committee on 7 September 2017. The mid-year report identifies the current position in both operational and internal safeguarding.

1.7. The report is presented in the form of two assurance statements and then presents the supporting evidence to the statements. Thus providing both a position report and the associated assurance.

2. Assurance - Statement

Operational Safeguarding

2.1. The safeguarding safety of the Trust's patients is maintained by the following;

- The Trust is committed to ensuring the Safeguarding of Patients is our highest priority. This is demonstrated through the Trust's Safeguarding Action Plan. This is in place so that the safeguarding team can clearly identify and track the delivery of actions necessary to improve safeguarding across the trust. This is supported by a Safeguarding Scorecard, monitored by the safeguarding Sub-Group, that assists in the early identification of operational safeguarding issues.
- Whilst training is below trajectory there is a plan in place to address the training gaps and measures are in place to ensure Trust staff feel adequately prepared and supported to manage safeguarding concerns.

Internal/Strategic Safeguarding

2.2. The safeguarding safety of our staff is maintained by the following;

- The Trust is committed to ensuring staff are free from abuse. This is demonstrated through an Internal Safeguarding Scorecard. This is in place to assist with the identification of any areas that may be of concern. Evidence is available, for our staff and our commissioners, that demonstrates the Trust is committed to making improvements and now takes the expected action when concerns are raised. This is supported by a comprehensive Improvement Plan. Once fully implemented this plan will ensure the Trust's staff feel supported, protected, and safe when at work.

2.3. The following sections present the evidence to support the assurance statements.

3. Assurance - Scorecard

3.1. The Trust has developed a Safeguarding Scorecard which is monitored by the safeguarding Sub-Group. The scorecard has a set of metrics for both operational and internal safeguarding and has been in place for four months. A summary and explanation of the indicators is supplied below but the full scorecard is included in Appendix I

Operational - Education of the workforce indicators

3.2. The safeguarding field rapidly evolves. As lessons are learnt through case reviews and through experience it is essential that practitioners are kept up to date. As the Trust's staff are relatively isolated practitioners it is even more essential that they receive formal training as they are less able to learn through shared experiences. Therefore, for the Trust education and training is a cornerstone of safeguarding and the scorecard measures the following elements;

- Level 2 adult training for all non-registered clinicians
- Level 2 children training for all non-registered clinicians
- Level 3 combined adults and children training for registered clinicians
- Mental capacity Act training for all clinical staff

3.3. The scorecard currently reveals that the Trust is delivering level 2 training at 50% but is below trajectory for Level 3 at 31%. This is being addressed by introducing on-line level 3 training to

support delivery of face to face training. The on line training was launched in November and compliance will be monitored weekly until the Trust is assured the process is embedded.

3.4. There has been considerable success with mental capacity act training which is indicating that 94% have received training. This was a requirement of the 2016 Care Quality Commission unannounced inspection.

Operational - Safeguarding activity

3.5. Actual safeguarding activity is challenging to measure. The Trust measures this through a monitoring of referrals. It also acts as a sense of clinical priority in that as staff can reduce the rate of referral at times of extreme pressure. The scorecard measures referral rate and we would expect this to remain the same or even increase. A continuous drop indicates the need to make enquiry. Whilst the scorecard measures referral at a Trust level there is a monthly scorecard sitting underneath this figure which monitors the rate at a unit level so that comparisons can be made. The measures on the scorecard are;

- The number of adult referrals in month
- The number of adult referrals in month

The scorecard currently reveals the Trust has no issues with referrals as the rate remains within expectations.

Operational - Engagement and experiential learning

3.6. Engagement and learning is measured through feedback from social services following a referral. There is considerable variation within local authorities with some authorities giving no feedback at all. Feedback is monitored and always shared with the referring clinician.

Operational - The competence and confidence of the workforce

3.7. Even though staff may have been trained it does not mean that staff feel adequately prepared or competent. Therefore, the scorecard includes indicators that ask staff 3 direct questions. These are;

- The number of staff who feel adequately prepared for safeguarding situations
- The number of staff participating in care who regard themselves as trained in the past year
- The number of staff who know where to go and ask for more experienced assistance

3.8. To date 40 staff have been asked as part of the monthly assurance visits by either the Director of Nursing & Quality or the Safeguarding Nurse Consultant on only 1 member of staff felt inadequately prepared.

3.9. Additionally, 100% of staff knew how to access additional clinical support if they felt unable to manage a safeguarding situation. The current expectation is that staff know to access either Bronze cover or help on the Clinical Support Desk. The Trust does not currently expect staff to identify the Safeguarding Lead.

Internal - Safety of staff in the workplace

3.10. Safety in the workplace is monitored through the following two indicators;

- The number of staff prepared to declare they have experience of bullying at work

- Concerns, investigations, disciplinary hearings, whistle-blowing, Freedom to speak up, other, down to a station level

3.11. The Director of Nursing participates in the Trust's Assurance Visits. As part of that visit staff are asked about their experiences of working within the Trust with a particular emphasis on bullying and harassment. To date only one member of staff has identified bullying as an issue. This is recorded on the scorecard to identify issues and to track improvements over time.

3.12. An essential element of the scorecard is the new Internal Safeguarding Record. This monitors human resource activity across the Trust down to unit level and is used as an overview to try and identify areas where a greater enquiry is warranted. This subject is revisited in the section on the external review "*A Review of the Culture of the Trust in Light of Safeguarding Incidents*".

3.13. In conclusion this paper identifies the Safeguarding Dashboard as a new and important assurance tool for the Trust to be able to measure safeguarding across the Trust.

4. Assurance – Action Plans

2.1. There are currently two action plans associated with safeguarding. The first action plan is the routine "*Continuous Improvement"* action plan that exists alongside the safeguarding portfolio. This is used to develop the service as lessons are learnt through Serious Case Reviews or other safeguarding work. Actions arising out of Safeguarding Boards would also be accommodated in this action plan. This action plan also reflects requirements set out in Section 11 of the Children Act 2004 and the Care Act 2014. It is also based on the Sussex Safeguarding Standards, which SECAmb are monitored against from our lead CCG.

2.2. This action plan was created 4 months ago and is monitored through the Safeguarding Sub-Group. It is presented here in full in Appendix II. The plan was previously presented to the Clinical Quality & Safety Committee on 7 September without the updates.

2.3. The action plan is divided into the following 8 Sussex Safeguarding Standards.

- Standard 1 Strategic Leadership
- Standard 2 Lead effectively to reduce potential of abuse
- Standard 3 Responding effectively to allegations of abuse
- Standard 4 Safeguarding practice and procedures
- Standard 5 Staff Competence
- Standard 6 Safer Recruitment
- Standard 7 Learning from Incidents
- Standard 8 Commissioning

2.4. The vast majority of the actions are RAG rated as Amber or Green. However, 4 actions are rated as Red.

2.5. Three of the red RAG ratings are regarding supervision of staff; especially those involved in investigations. This action links in with three Standards; standard 1, Strategic Leadership standard 3, Responding to allegations of abuse and standard 5 Staff Competence. This is a difficult requirement to address as the Trust staff are not routinely involved in safeguarding reviews but there is an expectation that staff receive some supervision. The plan is to consider the options and develop supervision guidance for staff.

2.6. The fourth red RAG rated action is the requirement that all job descriptions have a specific statement regarding safeguarding responsibilities. This is contained within Standard 5 Staff Competence. At present the safeguarding team are not assured that all job descriptions make the relevant reference. This is now on the Action Plan and will be addressed in the coming months.

2.7. The second action plan is a specific "*Recovery"* action plan known as the "Improvement Plan" and has been established to identify the most essential elements for improvement in order to meet the Care Quality Commission's 2017 inspection requirements. This Improvement Plan Also accommodates the actions arising out of the two subsequent reports commissioned by the Trust that had safeguarding elements within them; the report into the culture of the Trust in light of safeguarding incidents and the Duncan-Lewis Report.

2.8. This Improvement plan is supplied in full within Appendix III.

2.9. This plan has only recently been launched however it is a comprehensive plan that is aimed at addressing the Trust's main internal safeguarding issues. The plan has been developed with the involvement of the Trust's Commissioners, Staff Side, NHS improvement, and the West Sussex Adult Safeguarding Board.

2.10. In order to communicate the intentions of the improvement Plan across the organisation the Trust has developed a supporting Safeguarding Strategy (see following section).

5. Assurance – Safeguarding Strategy

5.1. The Trust has developed a 3-year strategy for Safeguarding (Annex 1) which supports this mid-year review.

5.2. The strategy has been developed to help support the promotion of the actions within the Improvement Plan and act as central piece of communication with the workforce.

5.3. The plan is to produce an electronic version of the Strategy and send this to staff electronically. If necessary, a poster will be produced with a summary of the main points.

6. Assurance – Serious Case Reviews

6.1. The Trust now has a tracker in place for recording the actions arising from Serious case reviews that affect the Trust. This tracker will also be used if any *Preventing Future Death* reports are received that have a safeguarding element.

6.2. There are currently 16 case reviews tracked in the document. The overwhelming theme to the reviews is mental health but this does not necessarily mean that the Trust is deficient in mental health care as the cases will have received attention from multiple providers. In the majority of cases the actions identified are for all providers.

6.3. The 16 cases can be broken into the following themes;

- Mental Capacity Act. 7 Cases
- Referrals. 3 Cases
- Training. 2 Cases
- Dispatch. 1 case
- Care Planning. 1 Case

- Information Sharing. 1 Case
- Professional Standards. 1 Case

6.4. This is a rigorous way of tracking and evidencing delivery of learning across the Trust. The current version of the tracker supplied in Appendix IV does not yet contain the evidence embedded in the tracker. This will be undertaken prior to the next Safeguarding Sub-Group meeting. If evidence is missing the action will be re-opened.

7. Internal – 2 Reviews "A Review of the Culture" & the "Duncan-Lewis Report"

7.1. In the early part of 2017 the trust received two reports that overlapped the safeguarding portfolio. The first was an external review into safeguarding culture which investigated a specific incident. Arising out of this report were a number of recommendations that were presented to the Trust Board.

7.2. Whilst focussed on a specific incident the report also made generalisations. Consequently, at the time, it was difficult to address some of the recommendations without a strategic plan for safeguarding.

7.3. The recommendations and the findings of the review together with a progress update are provided in Appendix V.

7.4. The report identified a total of 25 recommendations. To date 11 are RAG rated as Green and are considered delivered. 10 are RAG rated Amber and are in progress and 4 are RAG rated red. The new Improvement Plan has captured the recommendations that have, to date, not yet been fully implemented. Therefore, the improvement plan now supersedes the report.

7.5. The Duncan-Lewis report was published in the Spring. Whilst this was an enquiry into bullying and harassment across the trust the paper did reveal a number of safeguarding concerns. In short, some of the trust staff were not free from abuse in the workplace.

7.6. The learning that has arisen from this report is captured in a number of the actions within the Improvement Plan and are clearly identified as such.

7.7. The Safeguarding Strategy also drives the necessary changes.

7.8. Additional assurance is given in that a new investigation and report is being commissioned through the Unit Operating Manager at an additional station. This has arisen out of a number of soft concerns that have been highlighted from an investigation. This work is only just commencing but is offered here as evidence that the trust is monitoring concerns and taking appropriate action when necessary.

8. Safeguarding Boards

8.1. In 2016 it was identified that the Trust was not regularly participating in the Safeguarding Boards across the South East Coast. This was immediately rectified and the Trust tried to attend the relevant Boards. However, this has not been sustainable and it has led to only nominal participation as the Trust is unable to *fully* engage in all of the Boards activities.

8.2. Therefore, the London model is being adopted across the service. This requires one Adult and one Child safeguarding Board to act as the lead Board. Full participation in that Boards activities is then possible. This Board, in collaboration with the Designated professionals, who are also

members, and work for the Trust's commissioners can reassure the other Boards that the Trust is participating and compliant with requirements.

8.3. This arrangement does not preclude the trust's participation at Child Death Overview Panels or Case presentations form Serious case reviews. This will be undertaken by local operational staff who will link with the Trust's safeguarding team.

9. Conclusion

9.1. This mid-year report has presented the work of the safeguarding team and other Trust staff to support the assurance statements at the head of the report. These assurance statements were;

- The Trust is committed to ensuring the Safeguarding of Patients is our highest priority. This is demonstrated through the Trust's Safeguarding Action Plan. This is in place so that the safeguarding team can clearly identify and track the delivery of actions necessary to improve safeguarding across the trust. This is supported by a Safeguarding Scorecard, monitored by the safeguarding Sub-Group, that assists in the early identification of operational safeguarding issues.

9.2. This has been supported by providing the Safeguarding Action Plan and the safeguarding scorecard. Additional assurance has been provided through the Serious Case Review Action tracker and these are overseen at the Safeguarding Sub-Group

- The Trust is committed to ensuring staff are free from abuse. This is demonstrated through an Internal Safeguarding Scorecard. This is in place to assist with the identification of any areas that may be of concern. Evidence is available, for our staff and our commissioners, that demonstrates the Trust is committed to making improvements and now takes the expected action when concerns are raised. This is supported by a comprehensive Improvement Plan. Once fully implemented this plan will ensure the Trust's staff feel supported, protected, and safe when at work.

9.3. This has been supported by providing the Safeguarding Improvement Plan and the safeguarding scorecard. Additional assurance has been provided by evidencing that the recommendations from the "Review of the Safeguarding Culture of the Trust in Light of Safeguarding Incidents" and the "Duncan-Lewis Report" have been captured and carried into the Improvement Plan and this is all summarised within a new Safeguarding Strategy.

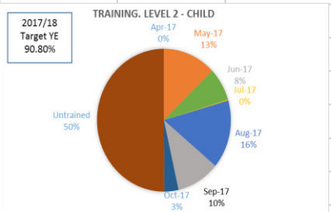
Appendix I

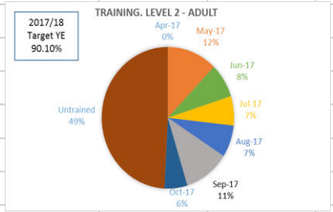
Safeguarding Sample Scorecard (print A3)

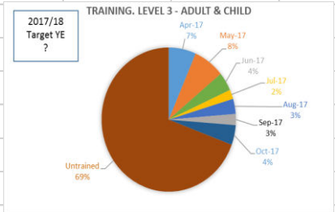
Safeguarding Scorecard - November 2017

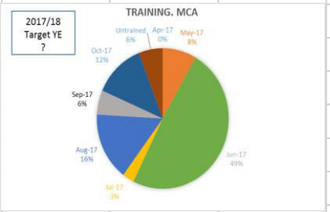
South East Coast Ambulance Service NHS
NHS Foundation Trust

Training









Referrals

Feedback

	Year end (2016/17)	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18
Surrey (adults)	7.27%	4.11%	3.29%	5.39%	0.99%	1.11%	2.08%	1.46%				
East Sussex (adults)	18.91%	15.31%	10.38%	8.70%	9.47%	2.41%	1.59%	4.03%				
West Sussex (adults)	7.06%	4.42%	4.27%	3.85%	5.88%	3.82%	1.27%	0.00%				
Brighton & Hove (adults)	8.02%	5.66%	1.79%	1.67%	1.47%	3.39%	4.35%	1.79%				
Kent (adults)	15.15%	10.84%	15.46%	10.22%	12.08%	5.56%	15.56%	7.65%				
Medway (adults)	15.82%	14.71%	11.76%	2.22%	3.28%	10.00%	7.14%	13.11%				
Hampshire (adults)	8.24%	0.00%	7.14%	7.14%	4.00%	6.25%	0.00%	0.00%				
Surrey (children)	12.83%	4.00%	0.00%	2.44%	0.00%	17.65%	14.29%	11.54%				
East Sussex (children)	12.12%	7.14%	14.29%	0.00%	10.53%	0.00%	9.09%	7.14%				
West Sussex (children)	39.76%	12.50%	17.86%	3.45%	4.35%	0.00%	0.00%	0.00%				
Brighton & Hove (children)	15.96%	0.00%	0.00%	0.00%	7.69%	8.33%	16.67%	0.00%				
Kent (children)	38.85%	26.53%	22.73%	21.74%	16.67%	9.52%	34.48%	2.08%				
Medway (children)	13.11%	8.33%	8.33%	0.00%	21.43%	0.00%	0.00%	11.11%				
Hampshire (children)	13.21%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%				
overall total feedback	**16.17%**	**8.11%**	**8.38%**	**4.77%**	**6.99%**	**4.86%**	7.61%	4.28%				

Assurance - Safeguarding Team

	Feel competent	Trained in past year	Know how to escalate	Total	
Chertsey					
Guildford					
Redhill & G'	13	13	13	13 -100%	Aug-17
Thanet	6	6	6	6 - 100%	Aug-17
Dartf'd & Med'					
Padd'k Wood					
Ashford	9	4	9	9 - 81%	Nov-17
Polgate & Has'					
Brighton					
Worthing & T'	12	10	12	12 - 94.4%	Oct-17
HART					
EOC					
Corporate					
111					
total					

Internal Safeguarding

	HR Concerns Raised		Investigation In Progress		Disciplinary Hearing Held		Whistleblowing		Freedom to Speak Up		Gievance		Other		Assuranve Visit Duncan Lewis	
	×	✓	×	✓	×	✓	×	✓	×	✓	×	✓	×	✓	×	✓
Chertsey	3	3	closed		0		0				0	0				
Guildford	1	1		1 on-going		0								1		
Redhill & Gatwick	1	1	1	1	0	0		1	1						13	0
Thanet	3	0	1				2						1		5	1
Dartford & Medway (N Kent)	0	0														
Paddock Wood		0														
Ashford		1		1		0 adjourned								1 PALS	9	0
Polgate & Hastings		2		2 with police				1						1		
Brighton		0														
Worthing & Tangmere		1		1 police		0			1					1 ? source		
HART		0														
EOC		0														
Corporate	1	0		closed		closed										
111	1	1		1				1	1							
overall total numbers	10	10	2	7	0	0	0	3	3	0	0	0	1	4		

Appendix II

Safeguarding Action Plan

Safeguarding (Operational) Action Plan

Overall Lead: Safeguarding Lead

2.

This Safeguarding Action Plan for South East Coast Ambulance Service reflects requirements set out in Section 11 of the Children Act 2004 and the Care Act 2014.

This has been based on the Sussex Safeguarding Standards, which SECAmb are monitored against from our lead CCG.

	Standard 1	**Strategic Leadership**			
Number	**Standard**	**Actions**	**Timescale**	**Leads**	**Update**
1.1	Accountability for, and ownership of, safeguarding is recognised and evidenced by each organisation's executive body	Record attendance of Director/Deputy Chief Nurse at LSCB's and SAB's Clear governance process for escalating safeguarding concerns to the internal safeguarding sub-group to be produced	Review 6 monthly September 2017	Director of Nursing & Quality Safeguarding Lead	100% attendance at West Sussex LSCB and SAB Area Governance meetings commenced. Exec oversight and sharing learning still to be established
1.2	Clear safeguarding policy is adopted at senior level with the organisation and disseminated to staff at all levels	Safeguarding awareness audit to be undertaken yearly. Safeguarding Policy reviewed yearly to ensure policy is up to date.	July 2017 February 2018	Safeguarding Lead Safeguarding Lead	Survey monkey awaiting distribution – Comms has been requested to share again QAV – SL collating information SG policy to be submitted to JPF Nov meeting
1.3	The organisation has an identified strategic lead with clearly defined responsibilities to ensure that their organisations' functions are discharged with regard to the need to safeguard and promote the welfare of children and adults	Appoint Head/Lead of Safeguarding who will fulfil this function.	January 2018	Director of Nursing & Quality	SG Lead currently in place plus executive oversight
1.4	The organisation has a strategic lead for ensuring compliance with MCA and DoLS.	Confirm who is strategic lead within the organisation and how compliance will be monitored.	July 2017	Director of Nursing & Quality	MCA & DoLS lead identified Training compliance DoLS included in

					training resources
1.5	The Organisation has an identified PREVENT lead who acts as a single point of contact for the health regional *Prevent* co-ordinators, and is responsible for implementing *Prevent* within their organisation	Confirm who is Prevent Lead for the organisation (currently safeguarding lead) Submit Prevent data to Regional Prevent Lead and CCG's (if required) quarterly. Complete Prevent self-assessment tool for organisations.	July 2017 3 monthly August 2017	Safeguarding Lead Safeguarding Lead Prevent Lead	Identified PREVENT lead Quarterly data sent to regional leads Self-assessment returns (Unysis) completed as above. Unable to identify a self-assessment tool for health (all schools)
1.6	The organisation works collaboratively with other services, teams, individuals and agencies in relation to all safeguarding matters and has safeguarding policies that link with multi-agency policies	Produce bi monthly updates to the SSG regarding attendance at LSCB's, SAB's, CDOP's, Police requests etc	September 2017 and March 2018	Safeguarding Lead Consultant Nurse	Included in SG reports
1.7	Organisations ensure that safeguarding, including MCA and DoLS is included in training strategies and/or training plans .	Review content of training plans yearly to ensure content is up to date Review training strategy annually to ensure accurate and reflects national guidance	March 2018 March 2018	Safeguarding Lead Consultant Nurse	In adult SG training
1.8	The organisation has a Named Professional role for both child and adult safeguarding, and leads for MCA and CSE (child sexual exploitation) with clearly defined responsibilities	Recruitment into the new Band 6/7 posts for lead for children and a lead for adults. Children's post holder will be the lead for CSE	January 2018 January 2018	Director of Nursing & Quality	Lead in place B6 support officer recruitment complete. Not currently delivering this model covered under current arrangements
1.9	The organisation through the Named Professional will establish strong links with the local safeguarding networks and committees	Bi annual updates on links with local regional networks will be presented to SSG. Information will be included in annual report. Any risks identified that may affect links i.e. staff shortages, to be highlighted to Chief Nurse	September 2017 and March 2018	Director of Nursing & Quality	B6 support officer now in place ensuring additional capacity to attend network meetings.

1.10	Organisations will have a clear safeguarding structure and dissemination process to ensure that all personnel understand their place in the organisation and how they receive supervision and guidance in their work with children and/or adults	New Safeguarding Structure to be shared across the organisation when in place. Safeguarding awareness audit to be undertaken Safeguarding Supervision guidance to be written for organisation	January 2018 July 2017 January 2018	Safeguarding Lead Safeguarding Lead Operations Lead	Structure review on hold As above – Survey Monkey To be written
1.11	Organisations must ensure that they have effective systems in place to highlight and respond to shortfalls in capacity which have an impact on their ability to meet their safeguarding responsibilities	Safeguarding Risks are a standing agenda item at SSG, safeguarding capacity is reviewed within the organisation.	Bi monthly reporting to SSG	Safeguarding Lead	SSG agenda SSG reports
1.12	Organisations must notify commissioners of any Care Quality Commission inspection related to safeguarding and the outcome	See Separate CQC action plan and tracker	Fortnightly updates for QSG	Director of Nursing & Quality (delegated to Head of Compliance)	CCG standing members of SSG
1.13	Each organisation cross-references its safeguarding plans with its core business plans and includes standards and targets relating to safeguarding in them	Add in core business plans relating to SG		Nurse Consultant Safeguarding Lead	To be included in SG strategy
1.14	Each organisation produces an annual safeguarding report which is signed off at Board level	Draft annual report to be produced and presented to SSG before final sign off and presentation to the Board.	June 2017	Nurse Consultant Safeguarding Lead	Complete for 2016/17
1.15	Each organisation is required to have a safeguarding audit plan that includes information on the audit process, involvement of managers & staff and how the findings from audit will be disseminated	Devise Audit Programme Undertake audits as per programme Summary of audit of findings to be presented to SSG	June 2017 June to March 2017 June to March	Nurse Consultant Safeguarding Lead Nurse Consultant Safeguarding Lead Nurse Consultant Safeguarding Lead	Draft plan in place for review prior to implementation – additional resources now in place to enable finalisation of audit plan – to be completed by end Nov 2017 for agreement at Dec SSG As above

	Standard 2	**Lead effectively to reduce potential of abuse**			
Number	**Standard**	**Actions**	**Timescale**	**Leads**	**Update**
2.1	Organisations have processes and procedures in place to enable staff to confidentially report any concerns they have about another individual's practice or behaviour, and/or organisational practice in relation to children and adults, which may place them at risk of harm ("whistleblowing" policy)	HR to carry out audit around whistle blowing or provide assurance that staff are confident to report changes. Safeguarding team to report on any allegations against staff relating to safeguarding at Bi monthly meeting and include in annual report.	December 2017	Director of Nursing & Quality & Director of Human Resources	Speak up Guardian in place Whistleblowing policy – SG dashboard
2.2	There are policies in place to ensure that organisations meet their obligations under the Equality Act 2010, and staff understand how diversity, beliefs and values of people who use services may influence the identification, prevention and response to safeguarding concerns	Is there an audit for this? How are we assured this standard is met?		Director of Human Resources	SL to speak to HR & Inclusion team about this action
2.3	Each partner organisation has clear, accessible and well-publicised complaints procedures. This includes information about how to complain to external bodies such as regulators and service commissioners, relevant advocacy and advisory services, including information regarding MCA and LPAs and is cross-referenced with the safeguarding procedures.	Complaints are monitored within the organisation. Any specific to safeguarding will be brought to SSG and summarised with the annual report.	Ongoing	Head of Patient Experience	Procedure in place - under review
2.4	People who use services understand the aspects of the safeguarding processes that are relevant to them, including MCA and role of the IMCA (Independent Mental Capacity Advocate)	For the MCA lead to provide assurance.	December 2017	Safeguarding Lead	SG lead to outline response to this for Dec SSG
	Standard 3	**Responding effectively to allegations of abuse**			
Number	**Standard**	**Actions**	**Timescale**	**Leads**	**Update**
3.1	Staff respond immediately to ensure that children and adults are protected from further harm where abuse is suspected or identified	Carry out Safeguarding awareness audit Present summery findings of training evaluations to SSG Bi annually Audit of incoming referrals	July 2017 September 2017 and March 2018 November 2017	Safeguarding Lead Safeguarding Lead Safeguarding Lead	As above Review of evaluation feedback for Dec SSG To be included in audit plan
3.2	Immediate consideration is given as to whether a criminal offence has taken place and this is reported to the police. Staff seek advice from the police where there is any	Safeguarding team monitor all referrals and will ensure correct procedures are followed.	Ongoing	Safeguarding Lead	To be included audit plan

	uncertainty.				
3.3	The organisation has a process for identifying any safeguarding incidents for children or adults and reviewing their practice in line with Pan Surrey, Sussex, Kent, and Hampshire multi-agency policies and procedures	Safeguarding team monitor all referrals and will ensure correct procedures are followed.	Ongoing	Safeguarding Lead	SECAmb procedures
3.4	There is a written procedure in place for managing allegations and complaints made against staff who work with children or adults which is compliant with the pan-Sussex multi-agency safeguarding procedures	Summary of allegations and complaints presented to SSG	July 2017, Sept, Nov, January 2018, March 2018	Director of Nursing & Quality & Director of Human Resources	Allegations policy & procedure in place Data captured in scorecard information
3.5	All serious incidents/grievances involving staff, where there are child or adult safeguarding concerns, are discussed with and, where appropriate, formally reported to the local authority	Agenda item at SSG as above Develop a robust interface between Serious Incidents and Safeguarding and ensure this is embedded	July 2017, Sept, Nov, January 2018, March 2018 September 2017	Director of Nursing & Quality & Director of Human Resources	SIs currently identified and have SG input SG attendance now at SIG to review all cases for discussion. SG attendance at SIG
3.6	The organisation must have systems in place to respond to adult and child safeguarding investigations/enquiries, serious incident investigations, serious case reviews, safeguarding adult reviews and domestic homicide reviews as required. Staff co-operate and work collaboratively, and in a timely fashion, with all relevant services, teams and agencies during any investigative process	Undertake Audit to demonstrate response to requests for information.	August 2017	Safeguarding Lead	To be included audit plan
3.7	Staff should have access to specialist advice and support when part of a safeguarding investigation/enquiry and, where appropriate, staff and staff groups should be provided with debriefing/supervision	Safeguarding Supervision guidance to be written for organisation. Develop "drop in" safeguarding supervision clinics to be held quarterly across the localities	January 2018	Safeguarding Lead	Still to be developed Safeguarding lead has regular safeguarding supervision with East Sussex Designated Nurse. SG team supervision is delivered by SG lead. Clinical supervision policy in place.

	Standard 4	Safeguarding practice and procedures			
Number	**Standard**	**Actions**	**Timescale**	**Leads**	**Update**
4.1	There are clear safeguarding procedures that are followed in practice, monitored and reviewed, which are consistent with the local multi-agency safeguarding policy and procedures for children and adults, which set out the responsibilities of all workers to operate within it. This includes clear up-to-date local information on who/how to contact for advice and support	Carry out safeguarding referral audit. Update website for staff to include a safeguarding section that has contact details and safeguarding information	 August 2017	Nurse Consultant Safeguarding Lead Nurse Consultant Safeguarding Lead	To be included audit plan Website includes SG section. Review and update to be undertaken
	The Organisation must have policies that include the principles of the *Prevent* NHS guidance and toolkit	Complete Prevent Self-assessment tool for organisations to identify any gaps or areas for development. Review training annually to ensure the needs of the organisation are met Ensure *Prevent* agenda is incorporated into the overarching Safeguarding policy or develop a standalone Prevent policy.	October 2017 March 2018 October 2017	Prevent Lead	Prevent to be included in SG strategy Included in SG TNA Prevent to be included in SG strategy. Incorporated in existing policy
4.3	Agencies must demonstrate in their assessments that the child or adults wishes and feelings are effectively heard in accordance with guidance. Where they lack capacity this must include the use of the best interest checklist and IMCA's as appropriate.	Carry out an annual audit		Safeguarding Lead	To be included in audit plan
4.4	There is a written policy readily available to staff on record keeping, information sharing and information governance compatible with multi-agency procedures and statutory guidance including MCA.	Review section within safeguarding policy annually	March 2018	Safeguarding Lead	Incorporated in existing policy
4.5	Where any form of control or restraint is used the organisation must have suitable arrangements in place to protect service users against the risk of such control or restraint being unlawful or otherwise excessive	Audit of Best interests form/ restraint undertaken to be carried out.	March 2018	Mental health Nurse Consultant	To be included in audit plan
4.6	All organisations are required to understand their legal responsibilities under the Mental Capacity Act including LPAs, Court of Protection, best interest decision making and capacity assessments.	MCA training figures to be reported on Bimonthly at SSG meeting	July 2017, Sept, Nov, January 2018, March 2018	Safeguarding Lead	Included on dashboard

		Audit of awareness	November 2017		To be included in audit plan
4.7	All organisations must ensure that people that they care for who lack capacity are not unlawfully deprived of their liberty (see Deprivation of Liberty Safeguards link on page 5 of the guidance for criteria). This should include those considered to be deprived of their liberty whist in their own home	Audit of awareness	November 2017	Safeguarding Lead	To be included in audit plan Trust does not deprive people of liberty, and would not apply for DoLS, however awareness of DoLS is included in face to face training and MCA e-learning
4.8	Up-to-date Pan-Sussex/Kent/Surrey Safeguarding Multi-agency procedures are available and easily accessible to all staff	Upload links to each procedure/Boards website page within safeguarding section on the internal website	August 2017	Safeguarding Lead	Available on website
4.9	Each organisation has a Domestic Abuse policy. which includes guidance for staff	Develop draft Domestic abuse policy. Ratification by SSG Final sign off by organisation	February 2018 March 2018 May 2018	Safeguarding Lead	Document to be developed
4.10	A dissemination process for all policy and procedure is in place across the organisation, including updates and reviews, and there is clear evidence of staff being accountable for receiving and understanding the procedures	Ensure annual report confirms and outlines how dissemination has taken place	March 2018	Trust Secretary	Policy on policies identifies dissemination and publication processes
	Standard 5	**Staff competence**			
Number	**Standard**	**Actions**	**Timescale**	**Leads**	**Update**
5.1	Staff have a clear understanding and awareness on how to recognise signs of abuse, and how to report and escalate within their organisations and with social services, where there are concerns for their safety in accordance with multi-agency procedures	Carry out Audit of Referrals Review Data on reporting from Datix and present to SSG quarterly.	July 2017, Nov 2017, March 2018	Safeguarding Lead	To be included in audit plan SG dashboard

5.2	Staff access a comprehensive training programme, including MCA which is monitored across all levels of the organisation, in accordance with intercollegiate document guidance	Level 3 Training packages externally validated yearly	February 2018	Safeguarding Lead	Review not due currently
5.3	Staff receive Prevent awareness training appropriate to their role using the NHS England Prevent Training and Competencies Framework	Carry out yearly audit Review training packages	August 2017	Prevent Lead	WRAP training delivered in line with TNA (2016/17) 1/4ly reports to NHSE
5.4	Staff understand their duty to share information, where there are child or adult safeguarding concerns, in line with multi-agency information sharing agreements and policies	Carry out safeguarding awareness audit	July 2017	Safeguarding Lead	To be included in audit plan
5.5	Staff understand the roles of other organisations who may be involved in responding to suspected abuse to the extent that is appropriate to their role.	Audit of awareness Training audits	January 2018	Safeguarding Lead	To be included in audit plan
5.6	Clear processes for supervision should be in place across the organisation which cover safeguarding issues and inform practice improvements	Safeguarding Supervision guidance to be written for organisation	January 2018	Operations Lead	Document not yet written Clinical supervision policy (all staff) in place
5.7	All staff have statements within their job descriptions and person specifications that recognise responsibilities for safeguarding and these are reviewed through the appraisal and/or PDP process	Annual Audit of a sample of JD's to ensure statements are present	February 2018	Director of Human Resources	Discussion needed with HR
5.8	Named professionals/lead for safeguarding require regular supervision from a Designated Nurse/Doctor	Confirmation of safeguarding supervision arrangement to be included in annual report	March 2018	Safeguarding Lead	Supervision in place for SG lead
	Standard 6	**Safer Recruitment**			
Number	**Standard**	**Actions**	**Timescale**	**Leads**	**Update**
6.1	All organisations adhere to the statutory requirements of the Disclosure and Barring Service	HR to audit annually and report to SSG and include summary for annual report	March 2018	Director of Human Resources	Discussion needed with HR Work ongoing with Consultant nurse and CQC action plan
6.2	All appointing staff adhere to the safer recruitment guidance and staff access training in safer recruitment as needed	HR to audit annually and report to SSG and include summary for annual report	March 2018	Director of Human Resources	Discussion needed with HR Work ongoing with Consultant nurse and CQC action plan
6.3	As part of their induction, new employees including volunteers will be made aware of policies and procedures in	HR to audit annually and report to SSG and include summary for annual report	March 2018	Director of Human Resources	Discussion needed with HR

	relation to safeguarding and any training needs they have in relation to these needs will be identified and planned				Work ongoing with Consultant nurse and CQC action plan
	Standard 7	**Learning From Incidents**			
Number	**Standard**	**Actions**	**Timescale**	**Leads**	**Update**
7.1	All safeguarding incidents (including Serious Incidents) and complaints are reported appropriately, including an assessment of safeguarding risks as part of the organisations' incident management policies and process	Safeguarding Incidents discussed as an agenda item at bi monthly SSG. Summary report included in Annual Safeguarding Report	July, September, November 2017, January and March 2018	Head of Risk	area governance team meetings now taking place across the Trust – local improvement plans to be developed from these. SG actions/SIs etc. to be developed and embedded in the processes currently in early stages of development
7.2	A clear process is in place to disseminate safeguarding updates, lessons learnt from Serious Case Review, Safeguarding Adults Review, Serious Incident or Domestic Homicide Review recommendations within the organisation including implementation and monitoring plans, and training opportunities arising from lessons learned	All recommendations from reviews added to combined action plan. Combined action plan reviewed by SSG bi monthly Summary report included in Annual Safeguarding Report	ASAP July, September, November 2017, January and March 2018 March 2018	Safeguarding Lead	area governance team meetings now taking place across the Trust – local improvement plans to be developed from these. SG actions/SIs etc. to be developed and embedded in the processes currently in early stages of development
7.3	Changes to service delivery and practice must be clearly recorded when resulting from lessons learned and recommendations, including court rulings, and law commission guidance and a clear process for disseminating and auditing service changes in place	Minutes from SSG to reflect changes to service delivery and practice. Summary report to be included in annual safeguarding report	ASAP March 2018	Safeguarding Lead	As above
7.4	Formal processes are in place to monitor compliance with recommendations and action plans	All recommendations from reviews added to combined action plan.	ASAP	Safeguarding Lead	SSG papers

		Combined action plan reviewed by SSG bi monthly Summary report included in Annual Safeguarding Report	July, September, November 2017, January and March 2018 March 2018		Combined action log
7.5	Staff are actively encouraged to discuss and debrief from incidents and near misses, and have access to training opportunities arising from these	Staff survey	August 2017	Operational lead	Updated welfare arrangements shared with staff when incidents identified (child death) TRiM coordinators included in all emails pertaining to child death
	Standard 8	**Commissioning**			
Number	**Standard**	**Actions**	**Timescale**	**Leads**	**Update**
8.1	All contracts and service level agreements require that the organisations, service providers and independent contractors have robust safeguarding processes and practices in place, including MCA and DOLs.	All Contracts to include safeguarding standards Completed assurance tool to be returned to SECAmb by end of the year Safeguarding team to review completed tools and include summary of findings in annual report	October 2017 December 2017 March 2018	Commissioner Safeguarding Lead Safeguarding Lead	Included in contracts Meeting to be scheduled with private providers to include assurance framework
8.2	Commissioners utilise information from external monitoring organisations, for example LSCB, SAB and Care Quality Commission declaration and action plans	Head/Lead for safeguarding will advise and support the commissioners with this standard.	Ongoing	Designated Professionals	CCG attendance at SSG
8.3	Commissioners obtain the views of children and adults who	Head/Lead for safeguarding will advise and	Ongoing	Designated	work to identify

	receive services when monitoring those services or commissioning new services	support the commissioners with this standard.		Professionals	existing networks to be undertaken and links to be pursued to undertake this. SG lead to work with patient experience lead to identify possible ways to do this.

Appendix III

Safeguarding Improvement Plan (print A3)

Safeguarding - Improvement Action Plan

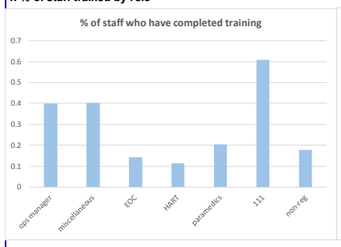
Project Reference	CQC092017
Project Title	Safeguarding
Project Lead	Philip Tremewan
Executive Lead	Steve Lennox
Date Updated	07/11/2017
Today	30/10/2017
Version	6
Data accurate as of 10-11-2017	

Root Cause:
A recent commissioned report identified significant issues within the culture of the Trust around staff reluctance to engage with the safeguarding incident reporting systems. , The most recent CQC report also (October 2017) identified that improvements were required within training for Safeguarding Children level 3

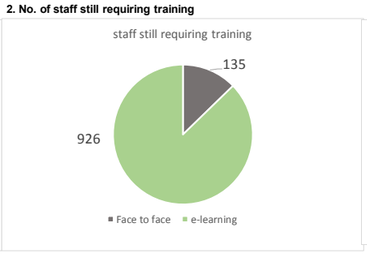
Aim of the Improvement Plan:
To define and implement a robust plan to improve safeguarding reporting, training, engaging with and empowering staff to ensure that everyone within the trust understands their responsibilities and is willing and able to undertake these. To Ensure that all staff are trained to Safeguarding Level 3.

Objective 1: Safeguarding Level 3 training

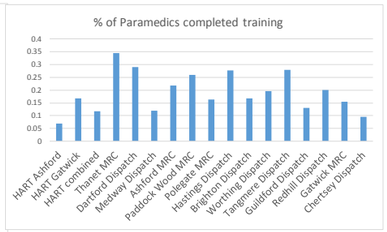
1. % of staff trained by role



2. No. of staff still requiring training



3. % of paramedics who have completed training by locality



AUTOMATIC FORMULAS - DO

Project Objective/ CQC Must Do & Page No	Milestone #	Action #	Description	Milestone Complete Date	Action owner	Dependency work stream	Outcome Measures	Start date	Due date	Status	Delayed (days)	Overdue (days)	Date completed*	Evidence	Evidence Location	Comments
Objective 1: **By 31st March 2018 85% of Registered Clinicians will be trained to Level 3 Safeguarding children.** **This will ensure that the Trust meets the training expectations contained within the NHS England Intercollegiate Document.** CQC Must Do: The trust must ensure all staff working with children, young people and/or their parents/carers, and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns, receive an appropriate level of safeguarding training P94 CQC Requirement Notice. Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment. The appropriate level of safeguarding training did not meet with intercollegiate guidance. P97 CQC Requirement Notice. Regulation 18 HSCA (RA) Regulations 2014 Staffing 18(1) Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed. 18(2) (a) The provider must ensure appropriate support, training, professional development, supervision and appraisal as necessary to enable them to carry out the duties they are employed to perform. Some staff were not up to date with their mandatory training, including an appropriate level of safeguarding training in line with national intercollegiate guidance. Safeguarding Review Recommendation: Continue with plans to ensure that all Paramedics receive level 3 training – face to face is preferred P29	**1**		**Delivery of appropriate (Face to Face or Elearning) L3 training to include all Operational Team Leaders/Operational Managers/Clinicians including 111 & EOC by the end of March 2018**	**31/03/2018**	**Jane Mitchell**		**Governance documentation will show approvals from all JPF and SMT members, as an agreement to adopt and embed the new Incident Management Policies.**	**01/04/2017**	**31/03/2018**		**-**	**-**				
		1.01	Delivery of face to face training sessions to key staff members including Operational Team Leaders, Operational managers and EOC clinical supervisors by the end of March 2018		Jane Mitchell		Plan is approved by the Director of Quality & Safety, and circulated across the directorate.	22/09/2017	31/03/2018	In Progress					Information on L3 face to face training dates can be found here - T:\Safeguarding\Sussex\training\17_18 training materials	
		1.02	All other registered clinicians will complete L3 e-learning training if they have not already attended face to face training		Jane Mitchell			22/09/2017	31/03/2018	In Progress						
		1.03	Refresh the training needs analysis for 2017/2018		Jane Mitchell		A report from Datix to show all incidents in one place.	22/09/2017	22/09/2017	Awaiting evidence						
		1.04	Training trajectory will be developed and compliance against trajectory will be monitored by learning & development and reported via the safeguarding dashboard		Jane Mitchell		Policy is approved at JPF and SMT.	01/04/2017	25/09/2017	In Progress	-	35			Information on the training trajectory can be found at T:\Safeguarding\Sussex\training\Archived training\L3 Overview Figures	
		1.05	Ensure a system is in place within the training plan to capture sickness and absentees and raise concerns should training be missed.		Jane Mitchell			01/04/2017	31/03/2018	In Progress						

Objective 2: **By 31st August 2018, At least 90% of Trust staff will feel sufficiently trained, informed and supported to identify and report safeguarding concerns and know how to obtain assistance. This will be assessed using the results of Quality Assurance Checks over a period of at least 3 months to ensure consistency.** **All learning from internal and external safeguarding work is captured and appropriately shared across the organisation. This will ensure that future risk of harm and abuse to patients, carers and Trust staff can be mitigated** CQC. Safeguarding vulnerable adults and children was not always managed according to best practice. P23 CQC. Not all staff could identify the safeguarding lead. P23 l CQC. This indicated that there was a long delay in staff knowing the outcome of any safeguarding referrals and being able to learn from that. P26 l CQC. Requirement Notice. Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment. The provider did not operate and implement robust procedures and processes that make sure that people are protected from abuse. P97 l	**2**		**All Policies and procedures required to support safeguarding best practices are in place**	**31/03/2018**												
		2.01	Dashboard showing current activity to allow identification of hot spots/ trends; Create a dashboard of data both qualitative and quantitative to identify risk and identify patterns l		Philip Tremewan		Development of a dashboard that provides up to date information highlighting performance concerns	22/09/2017	31/03/2018	In Progress						
		2.02	Develop a process that ensures safeguarding expertise has oversight of complaints and allegations that have a potential safeguarding theme		Philip Tremewan & Louise Hutchinson		Assurance of a robust process has that evidences a proportionate safeguarding response	05/11/2017	31/12/2017	Not started					Evidence\Safeguarding Improvement Action Plan email Louise.msg	
		2.03	Develop a safeguarding audit plan that includes compliance with legislation (e.g. mental capacity act)		Philip Tremewan & Jane Mitchell		Development of a safeguarding audit plan that's consolidated as a function within the Trust's wider clinical audit programme	01/01/2018	31/03/2018	Not started				email from Shelley Cummings (RSCH) 24/10/2017, forwarding MCA Audit Tool		
		2.04	Clear process in place that ensures mandatory notifications to CQC (Regulation 18) regarding allegations of abuse by SECAmb staff are in place		Philip Tremewan, Sammy Gladwell & HR Business Partner		Evidence of a clear process that records how many notifications, when they were made and any outcome	01/09/2017	30/11/2017	In Progress						
		2.05	Ensure a process is in place to feedback to clinical staff on immediate actions with their safeguarding referrals, onward referral to local authority		Jane Mitchell		Evidence of timely Reponses that provides feedback to clinical staff	09/10/2017	31/12/2017	In Progress						
		2.06	Develop a clear process to disseminate SCRs, SARs, SI's and DHRs		L&D representative		Assurance of a process that disseminates recommendations where learning has been embedded in local practice	10/10/2017	31/03/2018	In Progress						
		2.07	To identify and implement a process to monitor and review action plans and lessons learned (Area Governance Meetings and local Improvement Plans)		Jane Mitchell			10/10/2017	31/03/2018	In Progress	#REF!	#REF!				
		2.08	Ensure fundamental elements of safeguarding are audited as part of the station assurance visits and results are populated on safeguarding dashboard and fed back locally		Giles Adams, Jane Mitchell & Philip Tremewan		Evidence of embedded safeguarding component contained within the QAV template and highlighted on dashboard	09/10/2017	30/11/2017	Awaiting evidence			19/10/2017	24/10/2017 - evidenced emailed to PMO		
		2.09	Develop a clear governance process that identifies how the two lead Safeguarding Boards will assure other partner boards		Steve Lennox & Clair Stone (CCG)		Confirmation from partner Boards and CCGs clarifying their acceptance and understanding of SECAmb's proposal	09/10/2017	30/11/2017	In Progress						
	3		**Safeguarding best practise is embedded and fully adopted across the trust**	**31/07/2018**												
		3.01	Ensure SECAmb has local operational representation at all CDOP and a system for central support and information sharing is in place l		Jane Mitchell		Confirmation of local operational attendance at CDOP	09/10/2017	31/01/2018	In Progress	-	-				
		3.02	Safeguarding representation at the weekly Serious Incidents Group to ensure safeguarding consideration is applied to all potential SIs l		Philip Tremewan & Jane Mitchell		Evidence of attendance at bi-weekly meeting and minutes record safeguarding input on decision making	22/09/2017	30/11/2017	Awaiting evidence			05/10/2017	Chair of SI Group agreed to attendance and recorded in Action Log		
		3.03	Ensure Safeguarding input is provided at all station quality assurance visits and ensure staff are aware who to contact by specific questioning of staff during QA visits l		Philip Tremewan & Jane Mitchell		Evidence of safeguarding representation at QA visits with staff able to articulate key contacts and can respond appropriately to the safeguarding component of visit	25/09/2017	31/03/2018	In Progress			19/10/2017	Amendments made to QAV template to include a strengthened approach to		
		3.04	Ensure internal safeguarding group considers best practice guidance by inviting attendance by subject matter experts e.g. changes in requirements on Prevent reporting from NHS England		Jane Mitchell		Minutes of meetings record evidence of expert attendance and subsequent actions if appropriate	01/11/2017	31/12/2017	In Progress						
		3.05	Ensure a process is in place to monitor and review awareness of safeguarding procedures and ensure the ongoing embedding of the strategy.		Philip Tremewan			31/03/2017	31/07/2018	Not started	213	-				

END OF CQC OBJECTIVES

Objective 3: **By 31st August the at least 70% of staff will identify that the Trust is a safe place to work This will be assessed using the results of Quality Assurance Checks over a period of at least 3 months to ensure consistency. It will also take into account the results of exit interviews conducted with outgoing staff members** **The quarterly pulse survey will offer a good platform to monitor engagement on a more frequent basis. This will allow us to promote a safer working culture across the organisation.** Duncan Lewis Report: Some female respondents talked about "sexual predators" amongst male colleagues who "groomed students "for sexualised ends P36. I Duncan Lewis Report: The management of incidents was often reported as a waste of time because even after deploying the IR1 process people heard nothing about the incident… "when I put in an incident form it was covered up because he was one of the boys so I haven't bothered reporting anything since" P40. I Safeguarding Review Recommendation: Urgent meeting with University to review escalation policy and Fitness to practice form P28 I Safeguarding Review Recommendation: If somebody resigns or is dismissed because of risk to children or vulnerable adults and is a regulated staff group, then the organisation must refer them to DBS. P28 I Safeguarding Review Recommendation: Establish a monitoring system for findings from disciplinary hearings to both monitor progress and disseminate learning I Safeguarding Review Recommendation: Report monthly ER cases to Senior Operational Leadership meeting P28 I Safeguarding Review Recommendation: Consideration should be given to following the Warner recommendation that 'any aspect of an employment history or reference causing concern should be checked, by telephone if easier, to obtain information', with a written record made of the conversation and retained with other candidate information (Warner, 1992) in all appropriate cases P31 I Safeguarding Review Recommendations: Recruitment processes for Paramedics in particular are reviewed urgently and that staff must attend recruitment training before interviewing P31 I Safeguarding Review Recommendation: All staff with line management responsibility across the OUs attend a programme of short updates on policies such as Recruitment, Raising Concerns, Bullying and Harassment, etc.) to raise awareness and increase understanding, and provide an opportunity for joint working beyond their own 'domains' P31 I Safeguarding Review Recommendation: Consider developing a quarterly pulse check to begin a cycle of engagement and measure improvement progress P31 I Safeguarding Review Recommendation: Plan further Raising Concerns sessions as part of the Freedom to Speak up Guardians role as staff only currently receive 1 hour at induction P30 I	**4**		**Keeping Staff Safe from abuse**	**31/03/2018**							**-**	**-**				
		4.01	Develop a communication plan that as a minimum ensures there is a monthly reminder of the Trust's zero tolerance message to abuse for 9 months (through different communication methods) and reports appropriate success stories that illustrate action is being taken		Philip Tremewan, Janine Compton & Daren Mochrie			01/11/2017	31/03/2018	Not started	-	-				
		4.02	Ensure there is Executive leadership of Zero Tolerance by ensuring all directors have a specific tailored objective to promote a policy statement I		Philip Tremewan & Daren Mochrie			25/09/2017	28/02/2018	In Progress						
		4.03	Develop a Safeguarding Strategy that has Prevention of Abuse at the centre of the strategy I		Philip Tremewan		Strategy developed, approved and cascaded throughout the Trust	09/10/2017	31/12/2017	In Progress				17/10/2017 - Draft strategy forwarded to Steve Lennox for comment		
		4.04	Ensure every member of staff receive a copy of the safeguarding strategy I		Philip Tremewan & Janine Compton		Confirmation at QAVs that staff have received the Strategy	01/12/2018	28/02/2018	Not started						
		4.05	Support Safeguarding Culture through the development of a suite of supporting policies; 1) Managing & Supporting Employees Experiencing Domestic Abuse 2) Supporting staff caring for violent and abusive relatives 3) Managing anger in the workplace 4) Staff relationships within the workplace		Philip Tremewan & Emma Stiles		Policies developed and approved as per Trust approval process	01/01/2018	31/07/2018	Not started						
		4.06	Review current policies to specifically ensure; 1) The Trust is able to operate within the law and fast track to dismissal if considered appropriate 2) Ensure policy mandates disciplinarians are heard and action taken even if staff have resigned during the process 3) How to act when employment history records cause concern 4) Mandates that the selection panel must include at least one person trained in recruitment I		Steve Graham		Confirmation within the policy that evidences how the Trust is operating within the law. Evidence that referrals to relevant professional bodies and DBS if appropriate	01/12/2017	31/07/2018	Not started						
		4.07	Once policies have been reviewed ensure all staff are aware of the new suite of policies and if necessary receive education on policies I		Steve Graham		New policies cascaded to all staff via the usual communication mechanisms	01/04/2018	31/05/2018	Not started						
		4.08	Develop a Standard Operating Procedure that identifies how the Trust will identify potential abuse		Philip Tremewan		Approved SOP in place	02/01/2018	31/03/2018	Not started						
		4.09	Support the Standard Operating Procedure with an overarching dashboard that records all the relevant elements I		Steve Lennox		Implementation of a safeguarding dashboard that identifies training figures, allegations of safeguarding concerns raised against staff, progress in investigations into staff concerns, feedback following	09/10/2017	31/03/2018	In Progress						
		4.10	Identify opportunities (such as station assurance visits) when staff can be asked about their experience of working at SECAmb and record feedback on a confidential database held by safeguarding department I		Philip Tremewan		Evidence of embedded safeguarding component contained within the QAV template and highlighted on dashboard	09/10/2017	30/11/2017	In Progress						
		4.11	Ensure any records that arise via any route contain sufficient information to be used for cross analysis. The record should identify (as a minimum); an account of the staff experience, details of victims and assailants and witnesses and the location I		Philip Tremewan			01/12/2017	31/01/2018	In Progress						
		4.12	Ensure staff have confidence in the IR1 process by ensuring a member of the incident team reads all new incidents within 24 hours of reporting and feeds back to the staff member on what action will be taken I		Samantha Gradwell		Evidence that individuals who've raised IR1/Datix incidents have received feedback in a timely way	09/10/2017	30/11/2017	In Progress						
		4.13	Ensure opportunities for reporting are maximised through student paramedic evaluation (face to face) I		Philip Tremewan		Regional PELs visit students at each university to discuss the identified behaviours and also circulate communication re the report with students and partner HEI staff via email.	09/10/2017	28/02/2018	In Progress				email from Matthew Webb 19/10/2017		
		4.14	Ensure opportunities for reporting are maximised by rolling out Freedom to Speak Up model through Trust's Diversity Champions I		Philip Tremewan			01/12/2017	31/03/2017	Not started						
		4.15	Ensure opportunities for reporting are maximised through building relationships with safeguarding nurse consultant and staff side representatives I		Philip Tremewan			09/10/2017	28/02/2018	In Progress						
		4.16	Develop a code of ethics (or similar) to promote boundaries on behaviour at work		Steve Graham			09/10/2017	30/06/2018	In Progress						
		4.17	Meet with universities to develop escalation protocol for alerting the lead in the Trust when there are student concerns I		Philip Tremewan & HR Business Partner		**Positive relationships with each partner university which evidences disclosure**	01/11/2017	31/03/2018	In Progress						
		4.18	All staff consider safeguarding as their responsibility by embedding a safeguarding element within the Appraisal/Clinical Supervision of those who manage staff		Steve Graham			09/10/2017	30/06/2018	In Progress						
		4.19	In order to ensure a consistent approach and appropriate action is always taken; develop a Standard Operating Procedure on "How to Act When Safeguarding Triggers are Met" I		Philip Tremewan		Approved SOP in place	02/01/2018	31/03/2018	Not started		-				
		4.20	Ensure culture and new policies are highlighted as part of induction of new staff and presented by an appropriate leader/manager		Philip Tremewan & HR Business Partner			02/01/2018	31/07/2018	Not started		-				
		4.21	Visit police force and identify any shared learning from similar work undertaken.		Philip Tremewan		Evidence of learning by the police is reflected in organisational learning within the Trust	09/10/2017	31/01/2018	In Progress		-				
		4.22	Undertake an audit of vetting procedures (especially DBS) to ensure recruitment processes adhere to policy and to best practice guidance		Internal Audit (Peter Lee)		Evidence that internal audit of vetting procedures demonstrates 100% compliance against Trust policies	09/10/2017	31/01/2018	In Progress		-				
		4.23	Ensure a safeguarding review and safeguarding recommendation is given on all cases of behaviour or misconduct that are brought to HRs attention		Steve Lennox & Philip Tremewan & HR Business Partner		Recorded evidence that safeguarding recommendations have been if appropriate	09/10/2017	31/12/2017	In Progress		-				
		4.24	Ensure a safeguarding review and recommendation on all cases of fraud and corruption prior to reporting to NHS Protect		David Hammond & Philip Tremewan		Recorded evidence that safeguarding recommendations have been if appropriate	10/12/2017	31/01/2018	Not started		-				
		4.25	Ensure the Trust has identified opportunities for fraud and corruption and ensure these are on the risk register and part of the Trust's audit programme.		David Hammond & Philip Tremewan			09/10/2017	31/01/2018	In Progress		-				
		4.26	Quarterly report on incidents/issues to Executive and Trust Board I		Steve Lennox & Philip Tremewan		Quarterly exception assurance report provided to the Trust Board	09/10/2017	31/01/2018	In Progress	-	-				
		4.27	Develop a short pulse survey to monitor improvements and staff perception I		Steve Graham & Philip Tremewan			31/01/2018	31/11/2018	In Progress	-	#VALUE!				
		4.28	Develop system for monitoring Entonox usage		Carol-Anne Davies-Jones		Effective monitoring system in place	01/01/2018	31/03/2018	Not started	-	-				
		4.29	Share Improvement Plan with the local safeguarding board chair and modify as appropriate.		Steve Lennox		Evidence that Improvement Plan has been shared, discussed and agreed by relevant Safeguarding Board	09/10/2017	30/11/2017	In Progress	-	-				
		4.30	Assess capability of actus based exit interview to gather data on safety		Philip Tremewan / Emma Stiles											

Objective 4: **Ensure staff in positions of power or in relationships of power do not abuse their position and measure compliance through a year on year trajectory for reducing the number of staff reporting abuse by colleagues/SECAmb staff. This will ensure that staff feel empowered and supported when raising their concerns.** Duncan Lewis Report: Statements such as "not putting my head above the parapet" were commonly used. As such, the concepts of fear and power determined that individuals were too scarred to speak out P41 l Duncan Lewis Report: Individuals being viewed as "untouchables" P45 l Safeguarding Review Recommendation: The service will need to consider how it 'tests' interviewees for values and behaviours and not simply technical abilities P31 l	**5**		**To ensure that those individuals in a position of influence within the Trust use this position to empower staff to actively raise their concerns**	**01/12/2019**							-	-				
		5.01	Develop a 2-year trajectory to identify the reduction in the number of staff reporting abuse by colleagues/SECAmb staff		Philip Tremewan & Emma Stiles			01/12/2017	01/12/2019	Not started	-	-				
		5.02	The principle of Safeguarding is represented at interview panels (either directly by safeguarding representative or through an identified process) for senior management (8b and above) which will recognise potential for abuse of power relationships l		Philip Tremewan & HR Business Partner			01/01/2017	30/05/2018	In Progress	-	-				
		5.03	Ensure the staff voice is involved and can be evidenced that their view was considered in the recruitment of managers over 8B l		Philip Tremewan & Steve Graham			01/01/2018	30/05/2018	In Progress	-	-				
		5.04	All staff of 8b and above have awareness raising on power relationships.		Steve Graham			01/01/2018	30/05/2018	In Progress	-	-				
		5.05	Ensure there are clear and open lines of communication with higher education establishments which will highlight Power gradient/ safeguarding issues l		Steve Graham			09/10/2017	28/02/2018	In Progress	-	-				
		5.06	Identify any potential employee groups/individuals at risk quickly and ensure they receive appropriate support and guidance l		Steve Graham			09/10/2017	28/02/2018	In Progress	-	-				
		5.07	Ensure social media policy adequately addresses abuse of power and all staff are aware of social media policy		Steve Graham			09/10/2017	28/02/2018	In Progress	-	-				
		5.08	Introduce 360 style of appraisal for managers with >5 direct reports		Steve Graham			09/10/2017	28/02/2018	In Progress	-	-				
		5.09	Review all recruitment policies to ensure there are no un-necessary power differentials and ensure they promote equity of opportunity l		Peter Lee			09/10/2017	28/02/2018	In Progress	-	-				
		5.10	Where possible publish the actions the Trust has taken to correct behaviour at all levels l		Janine Compton			09/10/2017	28/02/2018	In Progress	-	-				
											-	-				
Objective 5: **By the 31st of March 2018 100% of safeguarding incidents alleged against our own staff will be managed in line with the Trust's documented policies and procedures**	**6**		**To ensure appropriate reporting and escalation of incidents that have a safeguarding theme**	**31/12/2017**			**This will be measured against the safeguarding dashboard currently in development. Historical data will be added to the dashboard to identify areas for improvement in reporting, recording and review**				-	-				
		6.01	Ensure the DBS Risk Assessment Process prior to appointment and clarification of DBS referrals post disciplinary processes are adhered to		HR Business Partner			25/09/2017	31/12/2017	In Progress	-	-				
		6.02	System in place that confirms when all staff who have been dismissed or have resigned due to conduct of a sexual nature have been reported to DBS		Philip Tremewan & HR Business Partner			25/09/2017	31/12/2017	In Progress	-	-				
		6.03	Confirm in writing that recently dismissed registered health care professionals have been referred to the appropriate registering body e.g.. HCPC, GMC, NMC etc.		Philip Tremewan & HR Business Partner			25/09/2017	31/12/2017	In Progress	-	-				
		6.04	Establish quarterly audit of all staff safeguarding cases to ensure 100% compliance with policy		Philip Tremewan, Peter Lee & Stave Graham			09/10/2017	31/12/2017	In Progress	-	-				
											-	-				
Objective 6: **By 31st August 2018, At least 60% of Trust staff will identify safeguarding as an element of the Trust's 5 year strategy. This will be assessed using the results of Quality Assurance Checks over a period of at least 3 months to ensure consistency.**	**7**		**To promote an embedded safeguarding culture across the organisation**	**28/02/2018**							-	-				
		7.01	Undertake a review of the current strategy to ensure safeguarding is an explicit feature		Jon Amos			25/09/2017	31/03/2018	In Progress	-	-				
		7.02	Embed safeguarding and raising a whistleblowing culture within the Trust level cultural development action plan following the B&H report		Philip Tremewan			25/09/2017	28/02/2018	In Progress	-	-				
		7.03	Design a procedure and confirm thresholds that allows escalation of areas of concern across the organisation		Philip Tremewan			01/11/2017	28/02/2018	Not started	-	-				
Safeguarding Review: Challenge the acceptance of the use of pornographic material during work as well as the impact of behaviour outside work update safeguarding, induction and recruitment training to raise awareness of what makes a safer culture. P28		7.04	Ensuring staff are aware of names and contact details of safeguarding team across the organisation. (Intranet directory) Raising team profile using Comms.		Jane Mitchell			09/10/2017	30/11/2017	In Progress	-	-				
Safeguarding Review: Use existing forums to share the learning from this review to increase awareness P28. l		7.05	Use the opportunity within Station Assurance Visits to review locker room posters and if necessary discuss at feedback session l		Giles Adams & Philip Tremewan		Evidence QA visits review and action recommendations made in the Knapp Hill report into locker room posters	09/10/2017	30/11/2017	In Progress	-	-				
											-	-				

Appendix IV

Serious case Review Action Tracker

Action Tracker from Serious Case Reviews

source of action	case	action	responsible	by when	evidence	progress
SECAmb IMR	Redacted	MCA training for SECAmb staff	SG lead	Apr-17	MCA e-learning	complete
SECAmb IMR	Redacted	MCA documentation developed and available	SG lead	Dec-16	MCA assessment form Best Interest form	complete
Overview report West Sussex	Redacted	The West Sussex Board seek assurance from partner agencies that non-urgent referrals for social care and support are effectively risk assessed and response times communicated to both the referrer and the service user	tba	tba		
Overview report West Sussex	Redacted	The West Sussex SAB seek assurance from South East Coast Ambulance NHS Foundation Trust that its revised procedures for receiving, triaging and implementing requests for ambulances and paramedics are being effectively implemented and monitored	tba	tba		
SECAmb IMR	Redacted	Staff to be reminded of MCA documentation requirement	SG lead	Sep-16	MCA assessment form Best Interest form also included in L3 training	complete
SECAmb IMR	Redacted	Staff to be reminded of their duty to make safeguarding referrals for adults at risk	SG lead	Sep-16	L3 training	complete

Overview report Kent	Redacted	KMSAB partner agencies will ensure that front line staff/officers and their managers are trained to recognise self-neglect and associated level of risk, particularly in relation to people with complex mental health issues, where there can be an impact on behaviour and psychological needs, and escalate appropriately.	tba	tba		
Overview report Kent	Redacted	KMSAB partner agencies will ensure that appropriate and effective training is in place for staff who are responsible for undertaking Mental Capacity Act assessments. This training is to be updated/renewed via refresher training.	tba	tba		
Overview report Kent	Redacted	KMSAB partner agencies, with responsibility for managing safeguarding and risk associated with people with complex mental health needs or other vulnerabilities, must demonstrate a joined-up approach. The lead practitioner must take responsibility for co-ordinating the work of all agencies involved in the individual's care to enable accurate risk assessment, risk management and improved outcomes.	tba	tba		
Overview report Kent	Redacted	Responsible agencies will ensure where there is an adult with complex mental health and care needs, that their health and social needs are jointly reviewed on at least an annual basis to improve information sharing and co-ordination of care, or more frequently as determined by the specific circumstances of the individual case.	tba	tba		

Overview report Kent	Redacted	KMSAB partner agencies are to map the current provision/arrangements in place where information is shared in relation to vulnerable persons with repeated safeguarding issues/incidents. Agencies are to consider how to address/manage any gaps in provision and agree an assessment process and referral mechanism to a multi-agency risk management forum	tba	tba		

SECAmb IMR	Redacted	Action 1: P1 and ECSW1 to be managed under the Trust Capability Policy, providing them support with regard to their failing to take and record observations of a patient. This will be monitored on a local level and if no improvement is noted this will be escalated within the Capability Policy and could result in Disciplinary action. Action 2: DTL1 will be managed under the Trust Capability Policy with regard to failure to follow correct scope of practice with regard to clinical advice and not following up on a request to secure staff safety. Action 3: East Sussex County Council Adult Social Care / Mental Health Department are conducting an inter-agency review and have requested that the SI report from SECAmb be shared at the earliest opportunity to assist with the investigation. Action 4: This incident meets the criteria for a safeguarding adult review (SAR) which SECAmb will need to complete an internal management review (IMR) for.	1. & 2. Operational managers 3. Professional Standards 4.Safeguarding Lead	4. 01/02/2017	4. IMR	Complete (SI actions)
SECAmb IMR	Redacted	Deliver MCA training	Safeguarding Lead Learning & Development	Mar-18	ongoing training figures	80% staff completed e-learning MCA included in L3 face to face training
SECAmb IMR	Redacted	Revise MCA section within current paper clinical record	Safeguarding Lead	Nov-16	New PCR	complete

SECAmb IMR	Redacted	Develop MCA assessment form	Safeguarding Lead	Jan-17	Forms available for staff	complete
SECAmb IMR	Redacted	1. Supporting staff directly involved to ensure referrals completed where concerns for surviving siblings/other safeguarding concerns identified 2. 111 staff to be supported to ensure adequate information is shared between 111 & 999 services	1. Operational Manager 2. Safeguarding link at 111	Dec-16		complete

Appendix V

Report

“A Review of the Culture of the Trust in Light of Safeguarding Incidents”

Findings & Recommendations Progress

Findings

Learning from National Policy and Reviews for Safer Organisations	Findings from SECAmb	Literature Review	Implications for SECAmb
• Focus on improvement is vital - creates an environment for 'caring' and compassion and helps to prevent burnout • Culture - setting the scene from the top is vital • Improving openness to critical challenge • Developing staff and continual learning • Focus on behaviours and values as well as technical competencies • 'Self-contained' cultures can lead to 'dysfunctional 'behaviour going unchallenged (Francis 2013, Kennedy 2001) • Functioning teams support cultural change and engagement • Getting the basics right in recruitment and post recruitment are essential • Human Factor Training improves safety	• Leadership styles at every level have not supported candour and openness • Disconnect between Executive and frontline • More work to be done on safeguarding awareness 'training' for staff/more case studies, less e-learning. Level 3 missing. • Needs feedback on learning from incidents/near misses • Too much emphasis on technical abilities means miss human factors • Improve feedback to frontline teams • Appraisal process and documentation needs updating. Improve talent management process. • Culture of tolerating pornography and not challenging offensive behaviour. – Good union support • Escalation of risks and incidents poor • Increase in bullying and harassment	• Tension in the paramedic role – having to respond at speed vs the widening role of the paramedic -? provider of mobile health care • Leaders who understand system thinking and operational issues • Building compassionate caring takes time • Focus on targets decreases productivity • Tackle culture through OD • Dissatisfaction of Ambulance staff mainly due to environment and not feeling valued or included • Team working is the key • Unconscious bias can lead to a failure to challenge at Board and Executive level (Confirmation bias)	• Strengthen OD Resources • Transformation not change • Recruitment/reference procedures need to be rigorous • Probationary periods (learning from the NSPCC) • Safeguarding – clearly in JDs and induction processes • Level 3 safeguarding a priority • Roll out Raising Concerns sessions • Human Factors awareness is vital • Investigators must have RCA training • Monitoring system needed for investigations and tracking trends which could then feed into improvement plans • Break down barriers between OUs through sharing information at Senior Leadership Team Meeting • Clear actions from the staff survey • Needs overall of supervision and appraisal processes • Ensure appraisal of senior managers are completed and link to the overall strategy in a way that can be monitored and delivered. • How does the tolerance of pornography and offensive language translate on call outs and visits?

Recommendations & Action

Theme	Recommendation/Action	Update October 2017	RAG Rating for delivery & Further Action
1. **Raising Concerns and Professional Standards/Compliance with the Code of Conduct** **By Chief Nurse (Succeeded by Director of Nursing & Quality)**	1.1 It is recommended that there is a progress of work to ensure Professional standards align with the HCPC standards of Proficiency and that this should be linked to appraisals. This programme should provide clarity on process and roles and responsibilities	Added to Safeguarding Improvement plan. "*In line with professional regulatory bodies expectations appraisals for registered practitioners reflect standards of proficiency*"	Deliver action over coming months
	1.2 Professional Standards should move as soon as possible into the Quality Directorate as per the NSHI recommendation	The Professional Standards team were transferred into the Medical Directorate which was considered a more appropriate fit.	None
	1.3 Challenge the acceptance of the use of pornographic materials during work as well as the impact of behaviour outside work update safeguarding, induction and recruitment training to raise awareness of what makes a safer culture	Added to Safeguarding Improvement plan. "*Use the opportunity within the Station Assurance visits to review locker room posters and if necessary discuss at feedback session*"	Underway
	1.4 Use existing forums to share the learning from this review to increase awareness (5th January feedback session at managers meeting)	Report has been incorporated into new safeguarding strategy and is now incorporated in the Station Assurance visits.	Underway
	1.5 Urgent meeting with University to review escalation policy and Fitness to Practice form	Dialogue has taken place at the Joint University Partnership meeting and directly with students on courses.	None
	1.6 RCA Training should be mandatory for Managers	47 Managers have received training to date (31 Oct 17)	Continue to undertake RCA training (more scheduled)

	1.7 Implement the actions from the Well led Review including Human Factors support	The RCA training now contains training on Human factors (47 trained up to 31 Oct 17)	Continue to undertake RCA training (more scheduled)
2. **Regulated Activity** **By January 31st 2017 Interim Director of HR**	2.1 Check if Paramedics who have been dismissed or have resigned due to conduct of a sexual nature have been reported to DBS. The Trust may be operating contrary to the Protection of Freedom Act which is a criminal offence. If somebody resigns or is dismissed because of risk to children or vulnerable adults and is a regulated staff group, then the organisation must refer them to DBS	Delivered Added to Safeguarding Improvement plan. *"To ensure appropriate reporting and escalation of incidents that have a safeguarding theme".*	No further specific action but an action is captured in safeguarding improvement plan
	2.2 Confirm in writing that recently dismissed Paramedics have been referred and removed from the HCPC register (either permanently or temporarily)	Delivered Added to Safeguarding Improvement plan. "*To ensure the DBS risk assessment process prior to appointment and clarification of DBS referrals post disciplinary processes are adhered to*"	No further specific action but an action is captured in safeguarding improvement plan
	2.3 Establish a monitoring system for findings from disciplinary hearings to both monitor progress and disseminate learning	There is currently no formal process in place. Added to safeguarding Improvement Plan; "Review current disciplinary policy to specifically ensure; 1) The Trust is able to operate within the law and fast track to	Deliver Improvement Actions

		dismissal if considered appropriate 2) Ensure policy mandates disciplinaries are heard and action taken even if staff have resigned during the process 3) How to act when employment history records cause concern 4) Mandates that the selection panel must include at least one person trained in recruitment" Added to Safeguarding Improvement plan. "Develop a process that ensures safeguarding expertise has oversight of complaints and allegations that have a potential safeguarding theme"	
	2.4 Report monthly ER cases to Senior Operational Leadership meeting.	Regular reports now provided to Director of Operations and Senior Operational Leadership Team. In addition, reporting now also given to Safeguarding Nurse Consultant & Director of Nursing & Quality. Also captured on safeguarding dashboard.	No further action
3. **Executive Team and Board** **By CEO and Chair**	3.1 There is evidence to suggest that the "top team" is not cohesive and requires urgent action. The NHSI culture and Leadership resource has a board level culture diagnostic which is a useful start. It is recommended that the Trust considers the Lencioni model for building trust in	Different leadership in team since report was published. However, added to Safeguarding Improvement plan. "*Ensure there is Executive Leadership of zero tolerance by*	Deliver Improvement Plan Action

	dysfunctional teams.	*ensuring all directors have a specific tailored objective to promote a policy statement*"	
	3.2 The relationship issues are a risk to safety and must be addressed either by mediation or external performance review.	Different leadership team in place.	No further action
4. **Further Investigative Review** **Agree by January 2017 by Chief Nurse**	4.1 Undertake a more detailed investigative review across the whole trust which should look at all cases over at least a 5-year period per Unit. This should include instances of dismissal, resignation and suspension. Further in-depth investigations are required into specific stations. This review should then work closely with the Regional Operating Managers to enable greater learning and feedback via the Senior Operational Leadership Team meeting.	Agreed not to take action forward. However, action will be taken on an individual station level if concerns are raised.	No further action
5. **Further Investigative Review** **Agree by January 2017 by Chief Nurse**	5.1 Continue with plans to ensure that all Paramedics receive level 3 training	In progress. 30.5% of Trust trained by 31 Oct 17	Continue with plan

	5.2 Continue to make arrangements to strengthen capability in the current team with an experienced senior practitioner and complete performance management of existing lead	Nurse Consultant commenced in post. Performance manager not commenced but report shared with lead	No further action
6. **Promote Team based Working** **By Paramedic Director and Chief Nurse (Succeeded by Director of Nursing & Quality)**	6.1 The new operational structures lend itself to a team approach. It is recommended that there is a greater emphasis on development within "teams" particularly in the first instance at Regional and Operating Unit Manager level. Peer support/ action learning approaches are helpful plus professional forums.	To be incorporated into operational leadership review in 2018.	Implement leadership review
	6.2 'There is also a growing recognition that Collective Leadership is fundamental to the achievement of effective integrated working and to services which are organised around the needs of the patient or service user, rather than the needs of the organisation or individual staff member" Michael West Kings Fund	All OLT, OM and OUM appointments have been through an assessment centre and as a consequence have development plans including 1:1 Feedback and access to management training. This is also being reviewed further by "Ignite" to ensure behaviours line up.	Continue with review
	6.3 It is worth remembering that team based working (TBW) is about creating organisational cultures which improve decision making by teams, rather than by	Developing a culture plan	Implement plan

	individuals, and at the closest possible point to the patient or service user. Constant Aston OD Team and Leadership Academy		
	6.4 Human Factors training would add value and focus staff thinking beyond just technical competencies and abilities	This has been incorporated into our RCA training and was also included in a recent conference with +200 attendees	No further action
	6.5 Plan further Raising Concerns sessions as part of the Freedom to Speak Up Guardians role as staff only currently receive 1 hour at induction.	Added to Safeguarding Improvement Plan. "Ensure opportunities for reporting are maximised by rolling out FTSU model through the Trust's diversity champions.	Implement action.
7. **Back to basics** **By Director of HR**	7.1 Recruitment processes for Paramedics in particular are reviewed urgently and that staff must attend recruitment training before interviewing	We have re designed the ECSW and AP recruitment processes this year and are in the process of moving Paramedic assessments to MMI to mirror other operational roles. This will allow us to focus questions around values, behaviours and understanding of the role, rather than the current interview. We are aiming to have the MMI format up and running for the next assessment days in early 2018. We have been working with Clinical Education and members of staff side on this to ensure its fit for purpose. We ensure that the interview panels are built from	Continue to Implement Action

		those who have completed interview training. For Support roles, we will also be looking at the makeup of panels and try to ensure there is diversity within the panel to increase our BME offers. Added to Improvement Action Plan. "Review current policies to specifically ensure that it mandates that the selection panel must include at least one person is trained in recruitment"	
	7.2 All staff with line management responsibility across the OUs attend a programme of short updates on policies such as Recruitment, Raising Concerns, Bullying and Harassment, etc. to raise awareness and increase understanding, and provide an opportunity for joint working beyond their own "domains".	This action was reviewed and an alternative was considered; Managers are made aware of new policies and will have coaching from HR staff when it comes to them needing to use any policy.	No further action
8. **Staff Engagement** **By Chief Nurse**	8.1 Prepare a plan of action from the staff survey with involvement from all units	Staff engagement plan has been developed and culture plan in development	Continue to Implement Action
	8.2 Consider developing a quarterly pulse check to begin a cycle of engagement and measure improvement progress	Within Resourcing, we have just launched a new starter survey, which asks about the candidate experience during the recruitment and on boarding process. The Trust will be running this bi monthly and will share results with HR.	No further action

		This will be used as a tool for process improvement. The Staff engagement advisors run a quarterly pulse survey checking on staff views. A barometer group will be established to specifically check the impact of the culture work	


South East Coast
Ambulance Service
NHS Foundation Trust
NHS
IBIS
48161
+8162
Response desk

Our Trust mission

Aspiring to be

Better Today and Even Better Tomorrow

for our people and our patients

Contents

Introduction

Introduction from the Chief Executive

SECAmb takes seriously our statutory duty to safeguard patients at risk of harm. We are committed to continually improve, learn and share vital information to protect our patients and to ensure our staff are trained in safeguarding and that the principles of safeguarding are placed at the centre of our decision making.

However, safeguarding also extends to our staff. Our staff have the right to be safe at work and to also be free from abuse. In this area we must improve.

In 2017 we commissioned a report into the work environment. This revealed serious issues in our work culture which we must address.

The wider cultural elements will be addressed elsewhere. But this strategy has been created as a direct response to the safeguarding elements raised by our staff.

The strategy sets out our vision through six safeguarding commitments. Each of these commitments are supported by a number of actions and specific time frames and apply equally to everyone.

This will ensure that safeguarding becomes the foremost concern of every individual working in the services we deliver and becomes a central consideration of our leadership team.

This safeguarding Strategy has been developed for the period 2017-2020 to promote an improved safety culture for our patents and our staff; ***caring for you and for everyone.***

Daren Mochrie QAM
Chief executive Officer

Introduction

About this strategy

Keeping our staff and our patients safe is at the heart of our business

The Trust provides services to a varied catchment of 4.7 million people. The area that we cover is 9,400 square kilometres and includes Kent, Surrey, Sussex and North East Hampshire.

The services we provide include responding to 999 and 111 calls and provision of the regional Hazardous Area Response Team (HART) which responds to specialist emergency challenges.

To ensure we are able to deliver our services we employ 3,500 staff. Of which 85% are directly involved in patient care.

The aim of this safeguarding strategy is to ensure everyone is as safe as possible and it is a fundamental component to realising our overall vision and mission which is outlined in the Trust's 5-Year Strategic Plan.

The Strategic Plan demonstrates how the Trust will ensure the provision of safe, quality care to its communities and to its staff. The plan also acknowledges that the Trust is in the process of delivering a holistic improvement plan with the aim of returning to a position of providing consistently high quality care for all.

As a trust we are determined to continue to learn from feedback from our staff, our volunteers and our patients and embed Trust-wide change as a result of this learning.

The next five years is focused on delivery of our four strategic themes which are:

Our people – supporting and developing our staff and volunteers
Our patients - ensuring timely quality of care, in the right place by the right people
Our enablers – fit for purpose technology, fleet and estates, underpinned by sustainable financial performance
Our partners – working with health, 'blue lights' and education partners

These strategic themes are translated into our strategic focus over the next five years.

The Trust's 2017 Care Quality Commission inspection report highlighted the need to improve safety and particular emphasis was placed on safeguarding. This has been highlighted in other reports commissioned by the Trust and this strategy and the supporting plan is an outline of the corrective action the Trust is taking.

This strategy outlines the approach for the next 3 years and beyond. It makes clear the roles and responsibilities of all staff to safeguard children, young people, adults at risk of harm and each other.

Safeguarding relates to a range of objectives across all of our four strategic themes but mainly sits under the themes 'Our Patients and Our People' within our Strategic Plan. It therefore relates to a number of our over-arching objectives.

Background

Our six safeguarding commitments

Responding to the need for us to improve

The Care Quality Commission Inspection Report 2017 recognised that improvements had been made in the Trust's safeguarding processes but more was still required. Especially regarding the training of our staff.

In 2017 the Trust also commissioned an independent report into an identified culture of bullying and harassment within the Trust. This report highlighted coercive power relationships and made reference to inappropriate behaviour within the workforce and identified some of our staff were not free from abuse whilst at work.

In order to further protect children, the young, adults at risk and our own staff, this strategy will ensure the delivery of the required skills for our staff whilst also robustly addressing the safeguarding components recommended in the report into bullying, harassment and abusive behaviour.

This strategy identifies six key commitments. Each contains a number of robust actions with timescales that will evidence how measurable outcomes will be achieved and will be used as a benchmark to support the implementation of this strategy.

The six key safeguarding commitments are:

1. To deliver appropriate training to all staff that ensures our clinicians are prepared for appropriate safeguarding interventions.

2. Improved and strengthened governance around safeguarding by ensuring all learning from internal and external safeguarding work is captured and appropriately shared across the organisation.

3. To fulfil our obligations as a responsible employer by ensuring our staff are free from abuse in the workplace.

4. To ensure that those individuals in a position of influence use their position to empower staff to actively raise their concerns and to make sure that staff in positions of power do not abuse this privilege.

5. To ensure appropriate reporting and escalation of incidents that have a safeguarding theme and to confirm that appropriate actions are taken following safeguarding incidents.

6. To promote and embed a safeguarding culture across the organisation which continues to promote safeguarding as a priority.

Our Safeguarding Duties

Our obligations

We understand and value our obligations as an employer

All providers of healthcare services are required to be registered with the CQC. In order to be registered, providers must ensure that those who use the services are safeguarded and that staff are suitably trained, skilled and are supported.

The government has published guidance to all NHS organisations on their responsibilities to safeguard children and adults at risk. In July 2015 NHS England updated the Accountability and Assurance Framework that promotes the safeguarding of vulnerable people in the NHS. This guidance clarifies that each NHS organisation must have access to effective safeguarding training, promote a culture where concerns are reported and address poor practice.

The Care Act (2014) establishes a clear legal framework for how local authorities and other statutory agencies, such as the Trust, should protect adults who are at risk of abuse and neglect. Further legislation contained within Section 11 of the Children Act (2004) places a statutory duty upon the Trust to ensure its functions are discharged with regard to the need to safeguard and promote the welfare of children and young people.

Professor Duncan Lewis' report into the bullying and harassment at the Trust (2017) highlighted a culture where inappropriate behaviour was not always addressed or that individuals in a position of influence would abuse this position. Consequently, many staff had become too scared to speak out.

The Health and Safety at Work Act 1974 states that employers have a legal duty under this Act to ensure, so far as it reasonably practicable, the health, safety and welfare of their workers when at work. In addition, the Management of Health and Safety at Work Regulations (1999) clarify that employers must consider the risks to workers (including the risk of reasonably foreseeable violence); decide how significant these risks are; decide what to do to prevent or control the risks; and develop a clear management plan to achieve this;

This strategy and the supporting improvement plan considers how the Trust's Duty of Care to safeguard our patients and our staff will be planned out and evidenced over the coming years.

As a health care provider the Trust is required to demonstrate, and evidence, that it has safeguarding leadership and has commitment at all levels of the organisation. In addition, that there is full engagement with local accountability and assurance structures such as commissioners, NHS England and Safeguarding Boards.

We also need to ensure it is easy for staff to raise concerns. We have a *Freedom to Speak Up* champion and have plans to extend this scheme.

Our Safeguarding Vision & Values

Our focused approach

Things we need to get right to protect our patients and staff

Our vision

Across the Trust there will be a whole organisational approach to safeguarding. Promoting the welfare of children, young people, adults and our staff.

Safeguarding will be embedded across all service areas and in every aspect of the Trust's work.

There will be robust governance arrangements around safeguarding and all staff working in the Trust will be able to discharge their statutory responsibilities within their professional boundaries. Shared learning will enhance and shape service provision.

The patient and carer experience will be enhanced by the provision of effective partnership working with other agencies, which will promote seamless service provision across Kent, Surrey and Sussex.

Development of this Safeguarding Strategy divides into two overarching themes:

- In developing its Strategic Plan, the Trust has identified safeguarding as a quality priority area. The Strategic Plan emphasises that the Trust is committed to consolidating and continuing to improve its safeguarding capability, response and processes.

- To ensure the Trust has competent, confident and empowered staff, with awareness of their safeguarding responsibilities, and a supportive internal response to incidents that minimises risk of abuse to patients, carers and its own staff.

Our values

As an organisation we must recognise the need to continually learn and develop. Feedback from our patients, our staff, and our volunteers is essential to this learning. Our vision for safeguarding embodies this approach. To achieve this vision, the Trust has identified four strategic areas:

- Our People: develop a highly professional robust safeguarding service with strong leadership which drives change and compassion of care throughout the Trust.
- Our Patients: be observant of change, respond effectively and support the child, young person or adult at risk
- Our Enablers: using existing and developing standards in training, effective multi-agency working and responses to safeguarding
- Our Partners: professional interagency working with a child/adult focus but not afraid to challenge to uphold their professional judgement

Our Safeguarding Aims

A summary of our main areas of focus

12 Aims to achieving this safeguarding strategy

Our Aims

Underpinning this strategy is a wider Safeguarding Improvement Plan that will provide assurance to patients, Trust Board, Trust employees and commissioners that holds the organisation to account and ensures delivery of the six safeguarding commitments.

The safeguarding improvement plan is summarised in the following 12 aims

1. Promoting a safeguarding culture across the Trust
2. Strengthen and improve safeguarding governance across the Trust, for example aligning safeguarding oversight with Serious Incidents reviews
3. Keep Trust staff safe from abuse
4. Promote positive and healthy professional relationships in the Trust
5. Provide high quality training based on national and local standards to all Trust staff that is evaluated, reviewed and effective
6. Support the Trust-wide implementation of the recommendations made in the Duncan Lewis report
7. Develop robust processes that highlight areas good safeguarding practice and identify potential areas across the Trust that may require further enquiry
8. Embed a system that has safeguarding oversight when concerns have been raised against SECAmb employees
9. Support the safeguarding agenda in multi-agency forums and strengthen relationships with a lead Safeguarding Board
10. Measure the quality of our work by audit and case reviews to ensure staff are given advice and support at the right time to make the right decision e.g. compliance with the Mental Capacity Act
11. Develop a culture of learning so that when we have not put safeguarding children, adults and our staff safety at the centre of our work we reflect, review and adapt our work practice to improve, without a culture of blame
12. Personalise the safeguarding service by listening to children, families and adults at risk who have used the services

How

A summary of our Improvement Plan

Keeping our staff and our patients safe is at the heart of our business

Safeguarding Commitment	Safeguarding Aim	Action in Improvement Plan
1. To deliver appropriate training to all staff that ensures our clinicians are prepared for appropriate safeguarding interventions.	• Promoting a safeguarding culture across the Trust • Provide high quality training based on national and local standards to all Trust staff that is evaluated, reviewed and effective	• Delivery of face to face and e-learning training sessions to identified staff groups • Training trajectory will be developed and compliance against trajectory will be monitored by learning & development and reported via the safeguarding dashboard
2. Improved and strengthened governance around safeguarding by ensuring all learning from internal and external safeguarding work is captured and appropriately shared across the organisation.	• Strengthen and improve safeguarding governance across the Trust, for example aligning safeguarding oversight with Serious Incidents reviews • Develop robust processes that highlight areas good safeguarding practice and identify potential areas across the Trust that may require further enquiry • Measure the quality of our work by	• Ensure safeguarding input is provided at all station quality assurance visits and ensure staff are aware who to contact by specific questioning of staff during QA visits • Dashboard showing current activity to allow identification of hot spots/ trends; Create a dashboard of data both qualitative and quantitative to identify risk and identify patterns • Ensure a process is in place to feedback to clinical staff on immediate actions with their safeguarding

	audit and case reviews to ensure staff are given advice and support at the right time to make the right decision e.g. compliance with the Mental Capacity Act	referrals, onward referral to local authority • Ensure fundamental elements of safeguarding are audited as part of the station assurance visits and results are populated on safeguarding dashboard and fed back locally
3. To fulfil our obligations as a responsible employer by ensuring our staff are free from abuse in the workplace.	• Keep Trust staff safe from abuse • Support the Trust-wide implementation of the recommendations made in the Duncan Lewis report	• Develop a communication plan that as a minimum ensures there is a monthly reminder of the Trust's zero tolerance message to abuse for 9 months (through different communication methods) and reports appropriate success stories that illustrate action is being taken • Develop a Standard Operating Procedure that identifies how the Trust will identify potential abuse • Identify opportunities (such as station assurance visits) when staff can be asked about their experience of working at SECAmb and record feedback on a confidential database held by safeguarding department • Ensure staff have confidence in the IWR-1 (incident reporting) process by ensuring a member of the incident team reads all new incidents within 24 hours of reporting and feeds back to the staff member on what action will be taken • Ensure opportunities for reporting are maximised through student paramedic evaluation (face to face) • Develop a code of ethics (or similar) to promote boundaries on behaviour at work • Meet with universities to develop an escalation protocol for alerting the lead in the Trust when there are student concerns • All staff consider safeguarding as their responsibility by embedding a safeguarding element within the Appraisal/Clinical Supervision of

		those who manage staff • Ensure a safeguarding review and safeguarding recommendation is given on all cases of behaviour or misconduct that are brought to HR's attention • Ensure opportunities for reporting are maximised by rolling out Freedom to Speak Up model through Trust's Diversity Champions
4. To ensure that those individuals in a position of influence use their position to empower staff to actively raise their concerns and to make sure that staff in positions of power do not abuse this privilege.	• Promote positive and healthy professional relationships in the Trust	• Identify any potential employee groups/individuals at risk quickly and ensure they receive appropriate support and guidance • Ensure there are clear and open lines of communication with higher education establishments which will highlight Power gradient/ safeguarding issues • The principle of safeguarding is represented at interview panels (either directly by safeguarding representative or through an identified process) for senior management (8b and above) which will recognise potential for abuse of power relationships • Where possible publish the actions the Trust has taken to correct behaviour at all levels • Review all policies to ensure there are no un-necessary power differentials and ensure they promote equity of opportunity
5. To ensure appropriate reporting and escalation of incidents that have a safeguarding theme and to confirm that appropriate actions are taken following safeguarding incidents.	• Embed a system that has safeguarding oversight when concerns have been raised against SECAmb employees	• Ensure the DBS Risk Assessment Process prior to appointment and clarification of DBS referrals post disciplinary processes are adhered to • System in place that confirms when all staff who have been dismissed or have resigned due to conduct of a sexual or coercive and controlling nature have been reported to DBS • Confirm in writing that recently dismissed registered health care professionals have been

		referred to the appropriate registering body e.g. HCPC, GMC, NMC etc.
6. To promote and embed a safeguarding culture across the organisation which continues to promote safeguarding as a priority.	• Support the safeguarding agenda in multi-agency forums and strengthen relationships with lead Safeguarding Boards (Adult and Child) • Develop a culture of learning so that when we have not put safeguarding children, adults and our staff safety at the centre of our work we reflect, review and adapt our work practice to improve, without a culture of blame • Personalise the safeguarding service by listening to children, families and adults at risk who have used the services	• Embed safeguarding and raising a whistleblowing culture within the Trust level cultural development action plan following the B&H report • Ensuring staff are aware of names and contact details of safeguarding team across the organisation (intranet directory) and raising team profile using the Trust's Communications team • Use the opportunity on Station Assurance Visits to review locker room posters and if necessary discuss at feedback session

Contact

Safeguarding Team

Chief Executive

Accountable Officer
Tel. 01737 364401

Director of Nursing & Quality

Executive Lead
Tel. 07342067855

Safeguarding Lead

Operational Safeguarding Advice
Tel. 07833 972154

Safeguarding Consultant

Specialist Safeguarding Advice
Tel. 07766 498471

South East Coast Ambulance Service NHS
NHS Foundation Trust

Surge Management Plan

Review, Immediate Actions and Audit

Outline / Introduction

The proposed Surge Management plan ***(Appendix 1)*** for implementation by the South East Coast Ambulance Service (referred to from here on as SECAmb or the Trust) is proposed to facilitate how SECAmb can manage its demand effectively across the Trust, whilst remaining safe and effective for its patients and service users in relation to those of the highest acuity, through to the lowest acuity in priority of need but to meet the safety of all patients.

This plan is proposed to be implemented from the immediate 'Go-Live' of the Surge Management Plan (SMP) to ensure the Trust has an assured systematic review, with a series of options to roll-back where necessary, any aspect of the Surge Management Plan that may have inadvertently introduced unforeseen risks.

This document identifies how the SMP will be reviewed and monitored, any immediate actions and processes to be followed in the event of these, as well as the audit infrastructure that will run concurrently to the SMP for the 3-month period from Go-Live.

Review

Implementation of a central SMP log identifying dates, times of escalation, incidents, complaints, Gold interventions (as below) etc. The key request being that we as a Trust are collating information regarding the introduction of this process, have a full audit trail and are able to evaluate the patient impact as a result of this change.

Scheduled Reports

At each 24 Hour period data to be provided by SECAmb Informatics team to SECAmb Strategic On-Call, Deputy Clinical Director and Associate Director of Operations for all 'No Sends' as a result of SMP Escalation.

<u>Numerator</u>

- 'No Sends'

<u>Denominators</u>

- CAT 3 No Send (No Clinical Resource dispatched / Case Closed)
- CAT 4 No Send (No Clinical Resource dispatched / Case Closed)
- Re-presentation cases of CAT 3 and 4 (Where Caller/Patient calls back)
- No Send Upgrades (Where Patient condition deteriorates or transferred to Clinicians)

- No Send - Alternative Provider (ED/OOH etc) identified (Where Patient condition identified by Clinician to alternative non ambulance resource)

Immediate Actions

In the event of a need to revise any of the SMP actions/triggers which may be identified from the central SMP log by the 'Gold' (Strategic) lead, or any of the scheduled look-back reports to initiate an immediate 'Stakeholders conference call', to review the particular action/trigger and agree changes to be implemented.

Stakeholders included relate to the below Surge Levels

AMBER

- EOCM
- EOC Tactical
- Strategic On-Call

RED

- EOCM
- EOC Tactical
- Strategic On-Call

PURPLE

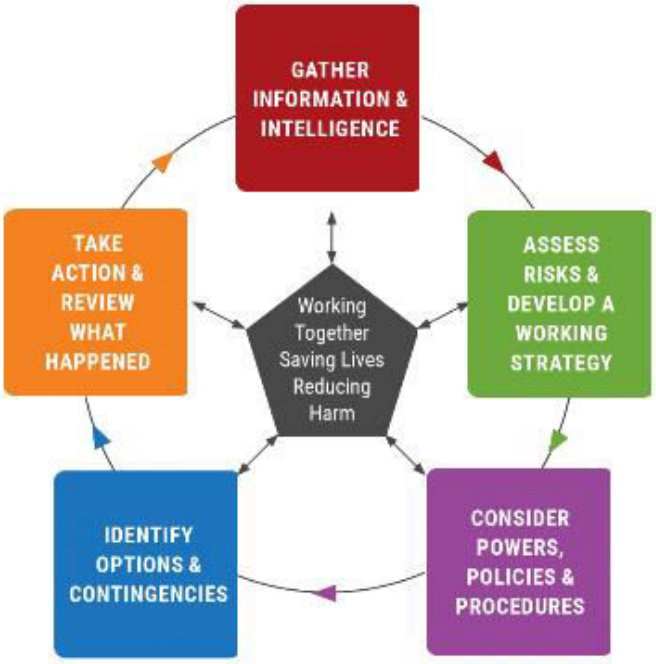
- EOCM
- EOC Tactical
- Strategic On-Call
- Deputy Clinical Director (To be included when noted from Look Back Report)
- Medical Director (To be included when noted from Look Back Report)
- Executive On-Call

BLACK

- EOCM
- EOC Tactical
- Strategic On-Call
- Executive On-Call
- Deputy Clinical Director (To be included when noted from Look Back Report)
- Medical Director (To be included when noted from Look Back Report)
- On-Call External Stakeholders to include Commissioners (Where appropriate)

For all issues relating to Surge Levels Red and above the 'Joint Emergency Services Interoperability Plan' (***Appendix 2***) is to be followed to identify risks, determine and support appropriate actions, stakeholders and reports through the 'Joint Decision Model' (JDM – ***Appendix 2*** (pages 10-13)).

JOINT DECISION MODEL



Audit and Monitoring Programme

Audit

Establishing an audit programme for the SMP from the Go-live date led by the Senior Manager Clinical Governance and Quality, in conjunction with the SECAmb Governance team and GOLD 'Cell' (Strategic) leaders, that identifies and monitors the Surge Management plan as used in operations, with specific review periods to evaluate use to date. These are to be set as

- At the end of the 1st hour
- At the end of the 1st 24 hours
- At the end of 7 days
- At the end of 1-month leading
- A final in depth 3-month review.

Each of these evaluation reviews are to be documented within a series of 'Look-Back' reports submitted to the SECAmb 'Head of Compliance'.

First Hour Audit / Review

Audit Holder - **SECAmb Strategic On-Call**

Actions

- Ensure completion and update of central SMP Log
- SMP review against 'Joint Emergency Services Interoperability Plan'.
- Collate review to complete and submit of 'SMP 1 Hour Look-Back Report'

First 24 Hour Audit / Review

Audit Holder - **SECAmb Strategic On-Call / Senior Manager Clinical Governance and Quality**

Actions

- Ensure completion and update of central SMP Log
- Scheduled conference call to review with key internal stakeholders relevant to highest surge level reached within period.
- Complete a 'dip-test' for a number of cases from each escalation level reached to include
    - Review of any incidents/complaints within Datix relating to use of End of Call scripts
    - Case audit for patients managed through 'Emergency Rule' to include patient final outcome
    - Case audit for patients managed through 'No-Send' to include patient final outcome
- Review completed associated incidents (via Datix) and NHS P audit.
- Collate review to complete and submit of 'SMP 24 Hour Look-Back Report'

First 7 Day Audit / Review

Audit Holder - **SECAmb Strategic On-Call / Senior Manager Clinical Governance and Quality**

Actions

- Ensure completion and update of central SMP Log
- Scheduled conference call to review with key internal stakeholders relevant to highest surge level reached within period.
- Complete a further 'dip-test' for a number of cases from each escalation level reached to include
    - Review of any incidents/complaints within Datix relating to use of End of Call scripts
    - Case audit for patients managed through 'Emergency Rule' to include patient final outcome
    - Case audit for patients managed through 'No-Send' to include patient final outcome
- Review completed associated incidents (via Datix) and NHS P audit.
- Formalised EOC Governance Group meeting review/exceptional meeting.
- Collate review to complete and submit of 'SMP 7-day Look-Back Report'

First Month Audit / Review

Audit Holder - **SECAmb Strategic On-Call / Senior Manager Clinical Governance and Quality and Deputy Clinical Director**

Actions

- Ensure completion and update of central SMP Log
- Scheduled conference call to review with key internal stakeholders relevant to highest surge level reached within period.
- Complete a further 'dip-test' for a number of cases from each escalation level reached to include

  - Review of any incidents/complaints within Datix relating to use of End of Call scripts
  - Case audit for patients managed through 'Emergency Rule' to include patient final outcome
  - Case audit for patients managed through 'No-Send' to include patient final outcome
- Review completed associated incidents (via Datix) and NHS P audit.
- Formalised EOC Governance Group meeting review/exceptional meeting with attendance of Associate Director of Operations, Regional Operations Manager Special Operations, Deputy Clinical Director and Head of Compliance.
- Collate review to complete and submit of 'SMP 1 Month Look-Back Report'

3 Month Audit / Review

Audit Holder - **Senior Manager Clinical Governance and Quality and Deputy Clinical Director**

Actions

- Establish Governance review system through the SECAmb Governance and Assurance teams that captures and evaluates
  - Incidents related to SMP
  - Complaints related to SMP
  - SI's related to SMP
  - External feedback via HCP reports and through CCG's
  - Patient feedback/experience related to SMP
- Collate 3-month final review and actions – as above with formal deep-dive report shared to wider stakeholders (including patient groups) and invitation to have a post-implementation workshop, inclusive of CCG Commissioners (Contractual and Quality)

South East Coast Ambulance Service NHS
NHS Foundation Trust

SECAmb Surge Management Plan

Author(s): SMP Working Group (Lead Scott Thowney)
Executive Lead: Joe Garcia
Directorate: Operations
Doc Ref:
Version: V1.06
Date of approved summary QIA: TBC
Final Decision: TBC

Date proposal reviewed	By	Decision made
	Which committee/group reviewed the final submission	*(Approve, reject, request further detail)*

Review and Approvals log:

Please ensure you log (in chronological order) all reviews and approvals to show the audit trail for support for your proposal

Version shared	Person and title or Committee	Date reviewed	Recommendation given (reviewed and support, approved, reject)	Rationale
V1.01	Surge Management Working Group	30/08/2017	Submission	Submission to SECAmb Medical Director for review prior to submission for Clinical Standards Sub-Group
V1.01	Fionna Moore	15/09/2017	Recommendations to SMP Working Group	Directed back to working group with recommendations
V1.02	Surge Management Working Group	22/09/2017	Submission	Submission to SECAmb Medical Director for review prior to submission for Clinical Standards Sub-Group
V1.03	Surge Management Plan Medical Director Review	28/09/2017	Recommendations	Review and Recommendations
V1.04	Surge Management Plan Medical Director/Operations Directorate Review	17/10/2017	Recommendations	Review and subsequent revisions based on discussions/actions
V1.05	Surge Management Plan Medical Director/Operations Directorate Review	17/10/2017	Recommendations	Review and subsequent revisions based on discussions/actions

V1.06	Appendices Reviewed and Amended EOC Governance Group, Trevor Hubbard Deputy Clinical Director & Andy Collen, Head of Clinical Development	09/11/2017	Recommendations	Reviewed and revised with amendments updated and included

Contents

1.0. Statement of Aims and Objectives

1.1. The purpose of this plan is to ensure that in times when South East Coast Ambulance Service (referred to from here on as SECAmb or the Trust) is unable to meet operational demand or is likely to experience operational challenges, the Trust prioritises its resources to address those patients with the greatest clinical need. The Trust takes an overview of the whole of Kent, Surrey and Sussex and provides multiple services to its patients; acknowledging the interdependency i.e. call handling, dispatch and clinical escalation, and the impact that one element of its services has on another part of the Trust and the wider system. The aim of this plan is to demonstrate how SECAmb can manage its demand effectively across the Trust, whilst remaining safe and effective for its patients and service users in relation to those of the highest acuity, through to the lowest acuity in priority of need but to meet the safety of all patients.

1.2. This SMP is proposed across 3 areas

- Call Handling Escalation
- Dispatch Escalation
- Clinical Escalation

1.3. The Call Handling Surge Management Plan (SMP) is implemented when 999 calls that have yet to be answered become of a high clinical risk as they are likely to include patients with life-threatening symptoms or even cardiac arrest. Until the calls are answered, the Trust is unable to determine an appropriate response or provide instructions to help the patient. Implementation of the Call Handling SMP will reduce call-cycle time and target more resources towards answering 999 calls, thereby improving our call answer time and patient care

1.4. Implementation of the Dispatch Surge Management Plan will release additional resources from normal operational duties and allow demand to be managed in a manner which continues to enable patients with symptoms of the highest acuity to be responded to in the quickest way and provide the safest possible management of all patients.

1.5. The EOC Clinical Surge Management Plan ensures safe clinical oversight of EOC functions

2.0. Principles

2.1. There are four levels of escalation from Business as Usual (Green) affecting the ability to respond to patients that rise in relation to specified triggers from level 1 through to 4 respectively;

- **Level 0 - Green**
- **Level 1 - Amber**
- **Level 2 - Red**
- **Level 3 - Purple**
- **Level 4 - Black**

3.0. Governance

3.1. The SMP for dispatch, call handling and clinical are separate elements of the 999 service, however all three are inter-linked and it is highly probable that if one element of the service is challenged, there will be a "knock-on" impact elsewhere across the 999 service. As such, although they can trigger independently of each other depending on the nature and causation of the surge, it is important to consider the impact that one element of the 999 service in SMP escalation will have impact across the wider healthcare service, including Emergency Departments, Walk in Centres, 111 and Out of Hours etc.

3.2. Authority to move through this process has been designed to allow key roles within the Trust's operational, tactical and strategic command structure to make efficient and informed decisions to support patient care.

3.3. The SMP tables outline the accountability and responsibilities for the Emergency Operations Centre (EOC) and Operations command structure.

4.0. Call Handling

4.1. The Surge Plan for call handling affects the way in which NHS Pathways (NHSP) certified Emergency Medical Advisors (EMAs) deal with incoming calls and provide guidance, which may alter the way in which they appropriately close the call with relevant instructions and/or interim care advice. Specific changes are detailed within the table for appropriate levels which are located within Section 8.

4.2. Emergency call triage is a process by which the Trust determines the priority of patients' treatment and/or response, based on the severity of their presenting symptoms/condition. This is provided via NHS Pathways (NHSP) by Emergency Medical Advisors and Clinical Supervisors, supported by specialist clinicians where further clinical advice is required. Any advice given by these staff must be documented on individual call logs within the Computer Aided Dispatch (CAD) system.

4.3. NHS Pathways is a clinical decision support software algorithmic system used by both NHS 111 and 999 services which guides patients through an assessment; the purpose of which is not to diagnose, but to rule out symptoms until a point is reached where it is not possible to progress the assessment without further clinical input, which is supported through the use of NHS Pathways accredited clinical supervisors. Examples of outcomes may include 'Home Management advice' or GP in/out of hour referrals.

5.0. Dispatch

5.1. The SMP Surge Plan for dispatch escalation supports the way Resource Dispatchers (RD) deal with incidents requiring an operational response by prioritising those calls with the highest clinical acuity and need for face to face clinical intervention.

5.2. SMP is trust wide and not linked to individual EOCs.

5.3. During SMP there will be a designated NHSP certified clinician - Clinical Reviewer, ring-fenced for this role, who will provide support to dispatch. Any advice given by the Clinical Reviewer, or any decision-making undertaken by these staff must be documented (as per best clinical practice) within the CAD. When SMP is implemented the Emergency Operations Centre Manager (EOCM) will identify who will undertake this role.

6.0. Call Backs

Welfare call backs are undertaken regardless of the SMP status. For the clarity of this plan the actions around this are outlined below.

Welfare Call Backs are determined as calls within the CAD dispatch list that have breached their identified timeframe and will be carried out in line with the Welfare Call Back Procedure (***Appendix 2***).

7.0. Service Surge Escalation Call Handling Surge Management Escalation Plan – Call Handling

The Call Handling element of the escalation plan is to ensure that 95% of incoming 999 calls are answered within 5 seconds (i.e. 2 telephone rings). The plan proactively takes into account predicted performance shortfalls and high activity forecasts; this will reflect predictive times of pressure i.e. in advance of a public holiday, external event and also in a more reactive way i.e. elevated staff non-attendance, national disaster, IT failure etc.

Surge Management Escalation Plan Cards

7.01 Surge Management Escalation Plan - Call Handling **GREEN (BAU)**

Level	Rationale / Description
GREEN	Ability to answer incoming emergency calls is within service delivery performance standards where, 999 calls are answered in a timely fashion. Current target 95% within 5 seconds / 2 rings)

7.02 Surge Management Escalation Plan - Call Handling AMBER

Level	Rationale / Description				
Level	Trigger	Owner	Actions	Review	De-Escalation
AMBER	>10% Regional shortfall in unit hour supply over a 24-hour period for any given date in the future planned period	Identified Clinical Scheduling Assistant And/or EOCM	Identify reasons for shortfall, and EOC affected Team Leaders to maximise any available resources in the room	Following day	Gap <10%
			Local Scheduling Manager to review planning with the aid of the planning spreadsheet to identify staff re-allocation, advertise overtime and review abstractions where there is advance notice of an anticipated surge in demand, or inability to meet demand		
			Implement 'Amber' (End of call) Surge Scripts		
			Make use of increasing overtime across both EOC's, utilising capacity of virtual network functionality to answer calls		
			Scheduling 24hrs before to notify EOCM group of shortfall and preparation on shift to mitigate		
			Use of Real Time Analyst to ensure schedule and call answering adherence by identifying prolonged calls to ensure EMA clearing call appropriately N.B. Although this role is not currently in place within EOC, it will be implemented at the earliest opportunity to ensure operational effectiveness		

7.03 Surge Management Escalation Plan - Call Handling RED

Level	Trigger	Owner	Actions	Review	De-Escalation
RED	Front end message for 999 system *(Aim: to facilitate call to be handled appropriately, in recognition of potential KPI breach)*				

	"You are connected to the Ambulance service. Do not hang up and redial 999 as this will extend your waiting time. We are currently receiving an exceptional number of calls to our 999 service. If your call is not an emergency, please hang up and contact 111 or your GP in hours, otherwise please hold and we will connect you as soon as possible". This message will be on all the time and will be played after 3 rings/seconds.				
RED	5-10 Calls waiting	EMATL	Start CAD log (initiate log) Alert 111 services of the SMP level to ensure cross-site, intra-Trust awareness of the demand on EOC	No longer than 15 minutes	"Zero" Calls waiting with 5 EMA staff available *EMATL can make a judgement on capacity in room, i.e. staff about to go off duty/on duty that may impact on ability to sustain call answer*
			1st EMATL to floor walk. Additional EMATL will take calls unless further floor walking needed due to clinical function in amber escalation		
			Consider break rota and non-essential absences with consideration to staff individual needs (Possible delay of Rest Breaks)		
			Implement 'Red' (End of call) Surge Scripts		
			Utilise all NHSP trained staff on duty and on site to log into phone queue (including audit staff and other functional support roles)		

7.04 Surge Management Escalation Plan - Call Handling **PURPLE**

Level	Trigger	Owner	Actions	Review	De-Escalation
PURPLE	11-20 calls waiting & longest call waiting is over 2 minutes	EMATL Clinical Supervisors (CS)	Complete red actions Advise Strategic Commander via text and e-mail of SMP status	10 minutes	=>5 Calls or less waiting. *EMATL can make a judgement on capacity in room, i.e. staff about to go off duty/on duty that may impact on ability to sustain call answer* ACTION – following de-escalation to Amber. EMATL to initiate IWR-1 within Datix
			Document within CAD log		
			Use of 111 Health Advisor Staffing where safe and appropriate to do so		
			Implement Emergency Rule (***Appendix 1***) – (EMG_RULE to be placed in instruction field) either "SEND" or "Re-triage")		

7.05 Surge Management Escalation Plan - Call Handling **BLACK**

Level	Trigger	Owner	Actions	Review	De-Escalation
BLACK	More than 20 calls waiting & longest call waiting is over 4 minutes	EOCM	Complete purple actions	30 minutes with view to de-escalate to Amber	10 Calls or less waiting. Move to appropriate level for calls waiting. *EOCM can make a judgement on capacity in room, i.e. staff about to go off duty/on duty that may impact on ability to sustain call answer.*
			Document within CAD log		
			To initiate conference call with EOC Operational Unit Manager (OUM) or out of hours EOC on call to liaise with strategic commander		
			Strategic commander considers Business Continuity Incident (BCI) and escalates to the executive on-call		
			If BCI declared - recall all staff from breaks		

8.0. Service Surge Dispatch / Operations Escalation Surge Management

Escalation Plan – Dispatch / Operations

The Surge Dispatch / Operations Escalation plan is to ensure that dispatch and response is able to meet patient needs as identified in the Ambulance Response Programme metrics. The plan takes into account predicted shortfalls and high activity forecasts, this will proactively reflect predictive times of pressure or in a more reactive way i.e. erratic call profiles, higher staff non-attendance, surge in demand because of a significant external event etc.

Surge Management Escalation Plan - Dispatch / Operations Escalation Action Cards

8.01 Surge Management Escalation Plan- Dispatch / Operations **GREEN (BAU)**

Level	Rationale / Description
GREEN	Ability to dispatch and respond to meet patient needs as identified in Ambulance Response Programme metrics

8.02 Surge Management Escalation Plan - Dispatch **AMBER (EOCM Actions)**

Level	Trigger	Owner	Actions	Impact 0 = Low 5 = High	Review	De-Escalation
AMBER	• 4x Category 1 unassigned for >5 Minutes • 6x Category 2 unassigned for >8 Minutes • 40 x Category 3 Unassigned for >90 Minutes • 40 x Category 4 unassigned for >150 Minutes	EOCM	Nominate Surge DTL (from the Incident Command Hub (ICH) where possible)	1	Every Hour Documented within CAD Call incident	EOCM Not meeting trigger
		EOCM	Identify Clinical Navigator role in the EOC	1		Not meeting trigger
		EOCM	Notification response capable managers (RCM) via SMS	1		Not meeting trigger
		EOCM	Notify Ashford 111 to inform Surge level and ensure clinical review of all Category 3 and Category 4 incidents before sending to ambulance dispatch	1		Not meeting trigger

	• A combined total of 41 from any of the above Categories.	EOCM - EMA TL	Implement Surge Call Taking Amber script. (***Appendix 3***)	1		Not meeting trigger
		EOCM - EMA TL	Contact Police/Fire informing them of amber surge and no send to incident unless a response is on scene and has contacted EOC via 999 (exception to Category 1)	1		Not meeting trigger
		OM (Tactical)	To liaise with 'On-Call Director' at the relevant hospital with delayed resource availability to notify of escalation and assurance of 'Conveyance Handover and Transfer of Care Procedure' (***Appendix 6***)			
		EOCM	If no OM within Incident Command Hub, EOCM to contact the nearest OTL resource available to attend within EOC, to liaise with on scene crews and review delays on scene			
		EOCM	Non-essential staff to leave EOC	1		Not meeting trigger

8.03 Surge Management Escalation Plan - Dispatch **AMBER (Dispatch Team Actions)**

Level	Trigger	Owner	Actions	Impact 0 = Low 5 = High	Review	De-Escalation
A M		Dispatch Team	Start CAD log (initiate log)	1	DTL will review	DTL

	• 4x Category 1 unassigned for >5 Minutes • 6x Category 2 unassigned for >8 Minutes • 40 x Category 3 Unassigned for >90 Minutes • 40 x Category 4 unassigned for >150 Minutes • A combined total of 41 from any of the above Categories.	Leader (DTL)			current pending dispatch cases continuously and initiate actions to escalate/de-escalate accordingly, once hourly	Not meeting trigger
		DTL	General broadcast on all talk groups informing operational crews of escalation - Thereafter alternate MDT/Airwave broadcasts every 30 minutes	1		Not meeting trigger
		Response Desk Coordinator	SMS all Community First Responders (CFR) to maximise support	2		Not meeting trigger
		Resource Dispatcher (RD)	No SRV back up to be allocated prior to arriving on scene unless confirmed Category 1	2		Not meeting trigger
		RD	OTLs/OMs not to be used for incidents except for Category 1, crew request or scene management	2		Not meeting trigger
		RD	SRVs will be booked available by EOC, 15 minutes after back up arrives. Only exception is if prior contact is made with an appropriate clinical reason	2		Not meeting trigger

			overseen by the Clinical Reviewer in EOC. Escalation to OTL/OM any issues with non-compliance			
		RD	All resources to be booked clear by EOC 15 minutes' post-handover. Non-compliance to be escalated to the OTL/OM	3		Not meeting trigger
		RD	Only Category 1 cross border calls to be allocated.	1		Not meeting trigger
		DTL/RD	Patients over the age of 75 who have fallen and remain on the floor that are a C3 or C4 must be manually upgraded to a C2 response when out of time.	1		

8.04 Surge Management Escalation Plan - Dispatch **AMBER (Operational Team Actions)**

Level	Trigger	Owner	Actions	Impact 0 = Low 5 = High	Review	De-Escalation
AMBER	• 4x Category 1 unassigned for >5 Minutes • 6x Category 2 unassigned for >8 Minutes • 40 x Category 3 Unassigned	Operational Team Leader (OTL) / Operations Manager (OM)	All grade 3 back up requests to be reviewed with on scene clinician and Operational Team Leader (OTL)/Operational Manager (OM) to assess if patient can make own way or convey with SRV	2		OTL Not meeting trigger
		OTL / OM	To review incidents that have more than one resource on scene	2		Not meeting trigger

	for >90 Minutes • 40 x Category 4 unassigned for >150 Minutes • A combined total of 41 from any of the above Categories.		and stand down where possible			

8.05 Surge Management Escalation Plan - Dispatch **AMBER (Clinical Team Actions)**

Level	Trigger	Owner	Actions	Impact 0 = Low 5 = High	Review	De-Escalation
AMBER	• 4x Category 1 unassigned for >5 Minutes • 6x Category 2 unassigned for >8 Minutes • 40 x Category 3 Unassigned for >90 Minutes • 40 x Category 4 unassigned for >150 Minutes • A combined total of 41 from any of the above Categories.	Clinical Navigator	Category 4 calls not to be allocated on prior to a clinical review and a decision to dispatch has been made	4		Clinical Navigator Not meeting trigger
		Clinical Navigator	Incidents to be allocated dependent on clinical needs rather than time order as assessed by the Clinical Reviewer	1		Not meeting trigger
		Incident Command Hub (ICH)	PP emergency visits to be referred for clinical review	1		Not meeting trigger

Surge Management Escalation Plan - Dispatch – **RED (EOCM Actions)**

Level	Trigger	Owner	Actions	Impact 0 = Low 5 = High	Review	De-Escalation
RED	• 6x Category 1 unassigned for >5 Minutes • 14 x Category 2 unassigned for >8 Minutes • 64 x Category 3 Unassigned for >90 Minutes • 64 x Category 4 Unassigned for >150 Minutes • A combined total of 65 from any of the above Categories.	EOCM	Ensure completion of all amber actions	0	EOCM in conjunction with the Clinical Reviewer and DTL review pending dispatch cases continuously and initiate actions to escalate/deescalate accordingly, once an hour	EOCM Not meeting trigger
		EOCM	Create a new log reflecting move to red escalation.	1	Every Hour Documented within CAD Call incident	Not meeting trigger
		EOCM	External communications to be sent relating to pressure on the Trust from EOCM to on-call communications team	1		Not meeting trigger
		EOCM - Production Managers	Scheduling managers to contact all Private Ambulance Services/Volunteer Ambulance Services to request support	1		Not meeting trigger
		EOCM - EMATL	Implement Surge Call Taking Red+ script (***Appendix 3***)	1		Not meeting trigger

8.07 Surge Management Escalation Plan - Dispatch – **RED (Dispatch Team Actions)**

Level	Trigger	Owner	Actions	Impact 0 = Low 5 = High	Review	De-Escalation
RED	• 6x Category 1 unassigned for >5 Minutes • 14 x Category 2 unassigned for >8 Minutes • 64 x Category 3 Unassigned for >90 Minutes • 64 x Category 4 Unassigned for >150 Minutes • A combined total of 65 from any of the above Categories.	DTL	General broadcast and SMS to RCM/CFR groups to red escalation every half an hour	1	Every Hour Documented within CAD Call incident	DTL Not meeting trigger
		RD	Category 3 calls not to be allocated on prior to a clinical review and a decision to dispatch has been made	4		Not meeting trigger
		RD	Ensure Technicians and Associate Practitioners to convey all patients unless patient refuses transport. (All refusals to be managed at scene without speaking to clinical desk and identified within PCR/EPCR)	2		Not meeting trigger
		DTL	MDT type Message to Crew	1		Not meeting trigger

8.08 Surge Management Escalation Plan - Dispatch – **RED (Clinical Team Actions)**

Level	Trigger	Owner	Actions	Impact 0 = Low 5 = High	Review	De-Escalation
RED	• 6x Category 1 unassigned for >5 Minutes	Clinical Navigator	Clinical review of all Category 3 and Category 4 incidents before allocation by dispatcher	4	Every Hour Documented within CAD Call incident	Clinical Navigator Not meeting trigger

	• 14 x Category 2 unassigned for >8 Minutes • 64 x Category 3 Unassigned for >90 Minutes • 64 x Category 4 Unassigned for >150 Minutes • A combined total of 65 from any of the above Categories.	Clinical Navigator	No send on Inter-Hospital transfers For Hospital Transfer 120 (Cat 3) without clinical review	2		Not meeting trigger

8.09 Surge Management Escalation Plan – Dispatch – **PURPLE (EOCM Actions)**

Level	Trigger	Owner	Actions	Impact 0 = Low 5 = High	Review	De-Escalation
PURPLE	• 8x Category 1 unassigned for 5 Minutes • 22x Category 2 unassigned for >8 Minutes • 84 x Category 3 Unassigned for >90 Minutes • 84 x Category4 unassigned for >150 Minutes	EOCM	Ensure all Red actions completed, changing log	0	EOC on call liaise with EOCM to update current situation Every 2-4 hours at discretion of EOC on-call	EOC on Call Not meeting trigger
		EOCM	Review Conveying Assets to include St Johns Ambulance, Red Cross and alternative services	1		Not meeting trigger

	• A Combined total of 85 or more from any of the above Categories	EOCM	To contact EOC on call – informing of purple escalation	0		Not meeting trigger
		EOC on call	To contact strategic on call informing of purple escalation	0		

8.10 Surge Management Escalation Plan – Dispatch – **PURPLE (Dispatch Team Actions)**

Level	Trigger	Owner	Actions	Impact 0 = Low 5 = High	Review	De-Escalation
PURPLE	• 8x Category 1 unassigned for 5 Minutes • 22x Category 2 unassigned for >8 Minutes • 84 x Category 3 Unassigned for >90 Minutes • 84 x Category4 unassigned for >150 Minutes • A Combined total of 85 or more from any of the above Categories	DTL	General broadcast and SMS RCM / CFR groups to Purple escalation every half an hour	1	Every Hour Documented within CAD Call incident	DTL Not meeting trigger
		DTL	Implement no send to all incidents that are not categorised as Category 1 or Category 2 except those that meet the exception criteria purple, ***(Appendix 4)***	5		Not meeting trigger
		RD	Resources on scene with Category 3 or Category 4 calls will be requested to split if Category 1 local	2		Not meeting trigger
		RD	Emergency care support workers (ECSW) or equivalent private providers to convey patients without back up	2		Not meeting trigger

8.11 Surge Management Escalation Plan - Dispatch – **PURPLE (Strategic On-Call Actions)**

Level	Trigger	Owner	Actions	Impact 0 = Low 5 = High	Review	De-Escalation
PURPLE	• 8x Category 1 unassigned for 5 Minutes • 22x Category 2 unassigned for >8 Minutes • 84 x Category 3 Unassigned for >90 Minutes • 84 x Category4 unassigned for >150 Minutes • A Combined total of 85 or more from any of the above Categories	Strategic On-Call Commander	Conference call to be chaired by Strategic Commander with all on call managers/EOCM's	1	Every Hour Documented within CAD Call incident	Strategic On-Call Not meeting trigger
		Strategic On-Call Commander	All on calls should attend their requested workplace as instructed by the strategic on call via the conference call. A gold cell will also be established at EAST/WEST EOC.	2		Not meeting trigger

8.12 Surge Management Escalation Plan - Dispatch – **BLACK (EOCM Actions)**

Level	Trigger	Owner	Actions	Impact 0 = Low 5 = High	Review	De-Escalation
BLACK	Strategic on call to make the decision if and when escalating to black	EOCM	Declaration BCI and invoke plan	2	EOC on call liaise with strategic on-call to update current situation	Strategic On Call Not meeting trigger

		EOCM	Ensure all partner agencies are informed for BCI	0		Not meeting trigger

8.13 Surge Management Escalation Plan - Dispatch – **BLACK (Strategic On-Call Actions)**

Level	Trigger	Owner	Actions	Impact 0 = Low 5 = High	Review	De-Escalation
BLACK	Strategic on call to make the decision if and when escalating to black	Strategic on-call	Ensure all purple actions completed, changing log	0	EOC on call liaise with strategic on-call to update current situation	Strategic On Call Not meeting trigger
		Strategic on-call	Strategic on call to chair conference call, invitation to include call details/agenda, with all on call executives for the acute trusts, within the affected area informing them immediate handover is being implemented	1		Not meeting trigger
		Strategic on-call	Inform on call commissioners and NHS England and Trust Exec on -call	0		

8.14 Surge Management Escalation Plan – Dispatch – **BLACK (Dispatch Team Actions)**

Level	Trigger	Owner	Actions	Impact 0 = Low 5 = High	Review	De-Escalation
BLACK	Strategic on call to make the decision if and when escalating to black	DTL	General broadcast and SMS RCM/CFR groups to black escalation every hour	1	EOC on call liaise with strategic on-call to update current situation	Strategic On-Call Not meeting trigger

		DTL	Implement no send to all incidents that are not categorised as C1 and C2 except those that meet the exclusion criteria black	4		Not meeting trigger

9.0. Surge Management Escalation Plan - Clinical EOC Escalation

The Clinical EOC Escalation plan is to ensure and maintain the capability in supporting EMA's in meeting NHS Pathways use and licence compliancy stipulations, to manage cases directed to the Clinical Team in the EOC within NHS Pathways and ARP national guidelines and to support the apposite dispatch of resources through active enhanced clinical triage.

Surge Management Escalation Plan - Clinical EOC Action Cards

9.01 Surge Management Escalation Plan - Clinical EOC **GREEN (BAU)**

Level	Rationale / Description
GREEN	EOC Clinical capability to support EMA's in meeting NHS Pathways use and licence compliancy stipulations and outcomes, as well as being able to manage cases directed to the Clinical Team within EOC

9.02 Surge Management Escalation Plan - Clinical EOC **AMBER**

Level	Trigger	Owner	Actions	Review	De-Escalation
AMBER	**Staffing** 1 clinician in one EOC and/or 3 or more in other EOC Or 0 clinician in one EOC and 4 in other EOC	Clinical Advice Manager (CAM)	Follow Scheduling Clinical Escalation Plan with Scheduling.	Start of shift or change in shift	Not meeting trigger *(Minimum Clinical Staffing Requirements met)*
		CAM	Arrange for one clinician to move from one EOC to another if appropriate		
		CAM	EMATL to floor walk leaving CS to manage workload/call backs in EOC with one clinician. EMATL to speak to CS in event of question they cannot safely manage		

		CAM	Review CS cover across EAST and WEST using remote cover if possible		
AMBER	**Clinical Call Back's** Twice the number of clinician call backs than there are clinicians across both EOCs. e.g. 4 clinicians across EOC – 8 clinical immediate cases	CAM	Review clinical immediate cases: Identify those that are likely to need operational response and upgrade without call back. Identify calls not needing operational response and ensure calls are marked to remain in clinical call back list	20mins	Not meeting trigger
		CAM	Consider identifying person for Welfare call back (as per procedure) while waiting for clinical input if clinically inappropriate to upgrade and call back time likely to be exceeded		
AMBER	**Dispatch Support** Clinical Navigator liaise with dispatch in EOC that has triggered surge	CAM	Clinical Supervisor to liaise - corresponding re-allocation of CS case load (ODAs)	Every Hour	Not meeting trigger
		CAM	Review CS cover as a result of allocation of Clinical Reviewer		
		CAM	Take account of likely timeframe of SMP escalation		
		CAM	Use actions in Service Surge Escalation Clinician to make sure CS cover maximised		

9.03 Surge Management Escalation Plan - Clinical EOC **RED**

Level	Trigger	Owner	Actions	Review	De-Escalation
RED	**Staffing** 0 clinician in one EOC and/or 3 or less in other EOC or 1 clinician in one EOC and 2 in other EOC	Clinical Advice Manager (CAM)	Review Ops for NHSP clinician to work in EOC. If not possible, arrange for one clinician to move from one EOC to another	Start of shift or change in shift	Not meeting trigger *(Minimum Clinical Staffing Requirements met)*
		CAM	Liaison with Agency to identify if staff available for EMA Clinical Floor support only roles		
		CAM	Identify additional staff for remote support – Including 111 and 'Silo Sites'		
RED	**Clinical Call Back's** Three times the number of clinician call backs than there are clinicians across both EOCs. e.g. 4 clinicians across EOC – 8 clinical immediate cases	CAM	Initiate Welfare Call procedure ***(Appendix 2)***		
		CAM	Identify additional staff for remote support – Including 111 and 'Silo Sites'		
RED	**Dispatch Support** Clinical Navigator liaise with dispatch in EOC that has triggered surge	Clinical Navigator	Clinical review of all Category 3 and Category 4 incidents before allocation by dispatcher		
		Clinical Navigator	No send Emergency Transfer for 120 mins (Cat 3/4) without clinical review		

RED	**Crew Call Back Support** >12 crew call backs stacking across East and West May be a combination of assessment for PP referral and clinical discussion	EOCM	Make sure all Amber actions are being undertaken & Use OTL to support crew call backs		

9.04 Surge Management Escalation Plan - Clinical EOC **PURPLE**

Level	Trigger	Owner	Actions	Review	De-Escalation
PURPLE	**Staffing** 0 clinician in one EOC and/or 2 or less in other EOC Or 1 clinician in one EOC and 1 in other EOC Total Trust cover 2	Clinical Advice Manager (CAM) / EOCM	Operations Manager to identify clinical staff to support within EOC	Start of shift or change in shift	Not meeting trigger *(Minimum Clinical Staffing Requirements met)*
PURPLE	**Clinical Call Back's** Four times the number of clinician call backs than there are clinicians across both EOCs. e.g. 4 clinicians across EOC – 16 clinical immediate cases	CAM	Continue Welfare Call procedure ***(Appendix 2)***	20mins	Not meeting trigger
		CAM	Identify additional staff for remote support – Including 111 and 'Silo Sites'		
PURPLE	**Dispatch Support** Clinical Navigator liaise with dispatch in EOC that has triggered surge	Clinical Navigator	No Send to Category 4 cases with 'Exception Criteria' ***(Appendix 4)***	20mins	Not meeting trigger

		Clinical Navigator	No send for Emergency Transfer without clinical review	20mins	Not meeting trigger

9.05 Surge Management Escalation Plan - Clinical EOC **BLACK**

Level	Trigger	Owner	Actions	Review	De-Escalation
BLACK	**Staffing** No NHSP Clinician across any EOC *(Not NHS Pathways Licence Compliant)*	Clinical Advice Manager (CAM) / EOCM	Operations Manager to identify clinical staff to support within EOC – *(Incident to be logged within Datix)*	Every 60 minutes	Not meeting trigger *(Minimum Clinical Staffing Requirements met)*
BLACK	**Dispatch Support** Clinical Navigator liaise with dispatch in EOC that has triggered surge	Clinical Navigator	No Send to Category 3 cases with 'Exception Criteria' ***(Appendix 4)***	20mins	Not meeting trigger

10.0. Audit and Review

10.1. Initially the SMP document will be reviewed within three months of its introduction by the Trust and/or if any significant Serious Incident arises as a direct result of the SMP not being effective or if significant concerns are formally raised by the Lead Commissioner for the 999 service.

10.2. For any Incident triggering a Surge Black status, a debrief to take place within seven days of the incident, to be chaired by an objective senior manager who will determine staff who will be involved.

10.3. The procedure document will be reviewed at least every year by appropriate working group assigned by the directorate lead; or earlier if required due to change in local/national guidance and/or policy; or as a result of an incident that requires a change in practice.

10.4. The policy will be reviewed at least every year (or sooner if new legislation, national standards or working practices are introduced) by the Senior Operations Leadership Team (SOLT) in conjunction with other stakeholders to ensure compliance.

11.0. Associated Documentation

11.1. Associated Documentation Includes:

11.1.1. Welfare Call Back Procedure

11.1.2. Patient Call Handling and Pre-Dispatch Procedure

11.1.3. Response and Incident Resourcing Policy

11.1.4. Business Continuity Management Policy

11.1.5. SECAmb Major Incident Plan

11.1.6. Emergency Call Compliance and Quality Assurance Procedure

12.0. Appendices

Appendix 1 – Emergency Rule

Emergency Rule Action Card.pptx

Appendix 2 – Welfare Call Back Procedure

Patient Welfare Procedure V0.09.doc

Appendix 3 – Call Taking Surge Scripts

EMA Surge Scripts V0.05.docx

Appendix 4 – Exception Criteria

Regarding the 'no send' element (dispatch/purple and black):

SECAmb No Send Exception Criteria Surge Purple

- <2 and > 74 (Age)
- 3rd party Stakeholder (caller not on scene) when first party contact is not possible
- Advised to call 999 by a HCP or a previously attended member of SECAMB crew staff
- Addison's disease
- Administered diazepam, midazolam or lorazepam or those who are steroid dependent (Any age)
- Back Pain aged over 55 years
- Clinical Review - Blood disorders including:
  - Haemophilia
  - Blood thinners (e.g. Warfarin)
- Currently undergoing Chemotherapy treatment (both during and between cycles / within 4 months of their last cycle)
- Exposed to the extremes of weather
- Fallers (any age) who are alone and confirmed as still on the floor
- Groin pain in males (between 12 and 55 years) where testicular torsion cannot be excluded
- Patients that have been seen by HCPs within the last 2 hours (add to call taking script)
- Calls referred by NHS 111 / integrated urgent care Clinicians
- Neutropenic patients
- Renal Dialysis patients
- Potassium levels (high or low)
- Clinical Review - Patients with a SCA (Specific Course of Action)
- Psychiatric event (presently threatening suicide, has taken overdose etc.)
- Safeguarding issues / concerns
- Clinical Review - Recent surgery including Tonsillectomy (Within the last 7 days) (< 72 hours / 3 days)
- Clinical Review - Patients with chronic neurological muscular conditions i.e. MS or Muscular Dystrophy
- Ante / Post-Partum complications

SECAmb Non Send Exception Criteria Surge Black

- Chemotherapy patients
- Fallers who are alone and confirmed as still on the floor for more than 2 hours
- Addison's Disease – Needs a clinical review
- Administered Diazepam, Midazolam or Lorazepam or those who are steroid dependant (any age)
- Back Pain >55 years – Needs a clinical review
- Exposed to extremes of weather
- Renal Dialysis patients – Needs a clinical review

Project Reference	
Project Title	Surge Mangement Plan

Quality Impact Assessment

ACCOUNTABILITY

Directorate	*Operations*
Exec Sponsor	*Joe Garcia*
Project Lead	*Sue Barlow*
Project Manager	*Scott Thowney*

QIA REQUEST

SG in which QIA requirement raised	Organisational Recovery Steering Group

Individual completing assessment	Scott Thowney
Date of assessment	31.10.2017

PROJECT / SCHEME / INITIATIVE DETAIL

Project Title	**Surge Mangement Plan**
Scheme / Initiative	N/A
Objectives	Potential risk to Quality or Patient Safety to be identified and allocated a score, based upon the likelihood and impact. Identify and implement appropriate mitigations.

SUMMARY QIA

Patient Safety	Details	Likelihood *(1 - 5)*	Consequence *(1 - 5)*	Score
The impact on Patient Safety after the change has occurred	The Surge Management Plan (SMP) is provided to ensure that in times when South East Coast Ambulance Service (referred to from here on as SECAmb or the Trust) is unable to meet operational demand or is likely to experience operational challenges, the Trust prioritises its resources to address those patients with the greatest clinical need. The SMP acknowledges the interdependency i.e. call handling, dispatch and clinical escalation, and the impact that one element of its services has on another part of the Trust and the wider system. The aim of this plan is to demonstrate how SECAmb can manage its demand effectively across the Trust, whilst remaining safe and effective for its patients and service users in relation to those of the highest acuity, through to the lowest acuity in priority of need but to meet the safety of all patients	2	3	6

Clinical Effectiveness	Details	Likelihood *(1 - 5)*	Consequence *(1 - 5)*	Score
The impact on Clinical Effectiveness after the change has occurred	The implementation of the SMP will faclicate the Trusts capacity to meet the needs of the service users within the boundaries of SECAmb in relation to their respective clinical needs and ensure effective use of resources. There is a potential that service users who are identified as lower risk may have to wait for periods exceeding Ambulance Response Programme measures, which will respectively put those patients at risk of deterioration. This is addressed throught the associated patient welfare procedure, which will identify and escalate these service users when appropriate	1	3	3

Patient Experience

Details	Likelihood *(1 - 5)*	Consequence *(1 - 5)*	Score
The impact on Patient Experience after the change has occurred There is a potential that service users who are identified as lower risk may have to wait for periods exceeding Ambulance Response Programme measures and become frustrated with the service delivery and may seek alternative services and lose confidence of the Trusts ability to meet their emergency needs. Implementation of the SMP and associated front end messages and call handling scripts will inform and manage expectationd of service users in line with Ambulance Response Programme (ARP) response targets.	1	2	2

Staff Experience

Details	Likelihood *(1 - 5)*	Consequence *(1 - 5)*	Score
The impact on Staff Experience after the change has occurred The SMP will allow and inform all staff of the specific triggers and actions that may be recognised and initiated through the various stages of escalation/de-escalation. Assigned roles, support and note taking is also stipulated to facilitate audit, governance and assurance to the wider Trust and faciliate reflection and review of escaltion which may be used to inform developments of practice and SMP review. The above factors of the SMP will assure and support staff with their decision making and evidence.	1	1	1

Other
(including impact on Trust reputation, regulatory requirements and local health economy impact)

Details	Likelihood *(1 - 5)*	Consequence *(1 - 5)*	Score
The SMP is an essential aspect of Business continuity for the effective delivery of the service within the Trust and to reflect cpacity and management processes for discussion within the wider healthcare economy and CCG engagement. There is additional Reputational risk related to the policy in higher escalation levels where ambulances may not be dispatched to CAT 3 and CAT 4 patients which may cause harm to patients or raise media attention and public focus	2	4	8

Mitigations

APPROVALS

Deputy Chief Nurse approval

Automatic requirement for a full QIA if any score above is greater than 9

Name	Trevor Hubbard	**Signature**	
Role	Deputy Clinical Director	**Date**	07.11.2017
Comments from Deputy Chief Nurse	*Include reasons for full QIA requirement*		

Full QIA required?	

National Ambulance Resilience Unit

NARU

NHS

JESIP

ACTION CARDS INFORMATION READER BOX

V.1.2 October 2015
OFFICIAL

National Ambulance Resilience Unit
NARU

ASSOCIATION OF AMBULANCE CHIEF EXECUTIVES

INFORMATION READER BOX

Document Name	National Ambulance Resilience Unit (NARU) Action Cards
Document Classification	OFFICIAL
Document Owner	National Ambulance Resilience Unit (NARU)
Purpose	To ensure that we treat those involved, and in the enormity of the situation ensure that we do not lose sight of the individual needs of patients To ensure an effective and coordinated response to an incident To ensure all staff have an understanding of their role in a major incident To describe an effective command structure
Contact for further Information	Robert Flute, Ambulance Advisor - National Ambulance Resilience Unit Email: robert.flute@nhs.net
Related documentation	NARU Command and Control Guidance, CBRN Guidance, Log Book, Operations Order, NHS England EPRR Guidance
Circulation	All UK NHS ambulance service providers
Version	Final 1.2
Approved By	EPRR, NDOG
Implementation Date	October 2015
Review Date	In line with any national changes and/or following a significant incident

Amendment History:

Version	Date of Change	Date of Release	Changed by	Reason for Change
V.1.2	October 2015	October 2015	R J Flute	Alignment with JESIP

National Ambulance Resilience Unit

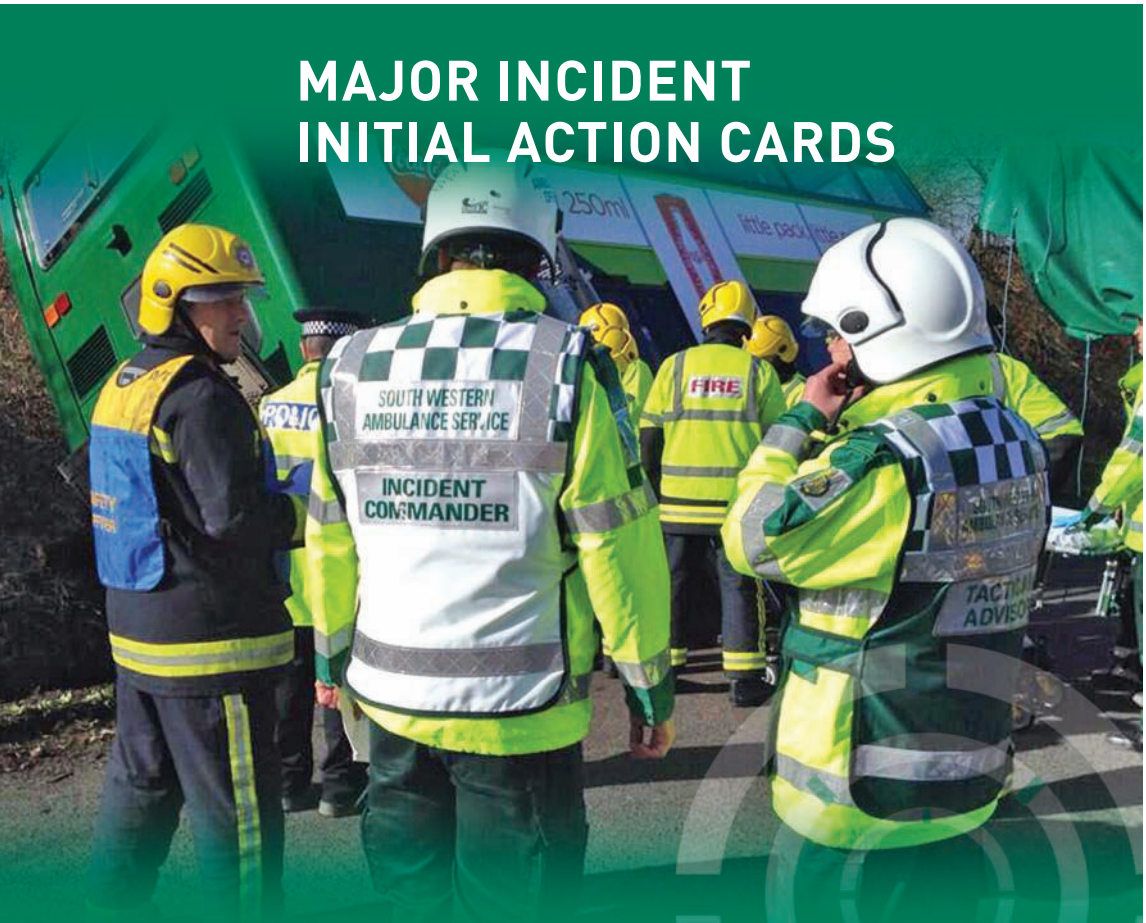
NARU

NHS

JESIP

MAJOR INCIDENT INITIAL ACTION CARDS

MAJOR INCIDENT INITIAL ACTION CARDS



V.1.2 October 2015
OFFICIAL

National Ambulance Resilience Unit
NARU

ASSOCIATION OF AMBULANCE CHIEF EXECUTIVES

Contents

1.0 Structured Approach To Major Incident Management

C - COMMAND:

- **Ambulance Incident Commander (Tactical)** will appoint a **Operational Commander, Primary Triage Officer, Ambulance Parking and Loading Officer** as quickly as possible - co-locate as soon as possible
- Issue Action Cards. Ensure tabards are worn and roles are understood

S - SAFETY:

- Ensure the safety of yourself – don personal protective equipment
- Ensure the safety of the scene – use cordons/barrier tape
- The survivors - remove to place of safety
- Remember **STEP 1 2 3+**

C - COMMUNICATIONS:

- Instigate early communications including **METHANE Report** and make use of Airwave Incident Ground and Interoperable Talk Groups
- Remember to **Start a Log**

A - ASSESSMENT:

- Joint understanding of risk and then carry out an assessment of the incident – requesting resources through a **METHANE Report** to **Emergency Operations Centre (EOC) Duty Manager** as soon as possible

T - TRIAGE:

- Instigate primary triage (sieve) **BEST PRACTICE WORK IN PAIRS** using Triage Cards as soon as possible. Note the numbers of casualties within each priority group
- Consider encouraging self help to control major haemorrhage and basic airway management
- Establish a **Casualty Clearing Station** (with Medical Advisor)

T - TREATMENT:

- Commence extended treatment / stabilisation of patients as soon as the triage sieve is complete

T - TRANSPORTATION:

- Consider the capability, availability and suitability of types of transport as well as the capacity and capability of receiving units

2.0 Major Incident Standard Messages

"MAJOR INCIDENT ALERT / STANDBY"

The term used by any member of staff to prefix messages indicating that an incident with the potential to generate a large number of casualties has or may have occurred.

"MAJOR INCIDENT CONFIRMED / DECLARED"

The term used by any member of staff to prefix a message to confirm that a Major Incident has occurred indicating that the plan should be implemented and a full pre-determined attendance / response is required.

"MAJOR INCIDENT CANCEL"

The term used by a Commander to cancel a Major Incident alert.

"AMBULANCE MAJOR INCIDENT STOP"

The term used by a Commander to indicate that sufficient Ambulance and/or medical resources are available at the scene and that no further assistance is required.

"AMBULANCE MAJOR INCIDENT SCENE EVACUATION COMPLETE"

The term used by a Commander to indicate that the treatment and removal of casualties **from the scene** is complete.

"AMBULANCE MAJOR INCIDENT STAND DOWN"

The term used by a Commander to indicate the conclusion of all ambulance service activity in connection with a declared major incident and a return to normal modes of operation.

The early declaration of a "MAJOR INCIDENT" ensures that the appropriate resources are activated at the earliest opportunity.

PLEASE NOTE:
These messages should be part of a METHANE Report

National Ambulance Resilience Unit
NARU

3.0 Incident Initiation Form

TIME OF CALL: DATE:

ORGANISATION:

NAME OF CALLER: TEL NO:

Major Incident	Declared or Standby (Inc Date & Time of Declaration)	
Exact location	Exact location / geographical area of incident	
Type of Incident	Flooding / Fire / Utility failure / HazMat / Disease outbreak etc	
Hazards	Present and potential	
Access	Effective routes for access and egress / Inaccessible routes / RVPs	
Number of Casualties	Numbers and Types (P1, P2, P3 and dead)	
Emergency Services	Required / On-scene	
(S)tart a log	Intentions / Actions	
	Support / Mutual Aid required	

SIGNATURE (once completed) :

Restricted when complete

National Ambulance Resilience Unit
NARU

4.0 Subsequent Situation Report

TIME OF CALL: DATE:

ORGANISATION:

NAME OF CALLER: TEL NO:

Major Incident	Declared or Standby (Inc Date & Time of Declaration)	
Exact location	Exact location / geographical area of incident	
Type of Incident	Flooding / Fire / Utility failure / HazMat / Disease outbreak etc	
Hazards	Present and potential	
Access	Effective routes for access and egress / Inaccessible routes / RVPs	
Number of Casualties	Numbers and Types (P1, P2, P3 and dead)	
Emergency Services	Required / On-scene	
(S)tart a log	Intentions / Actions	
	Support / Mutual Aid required	

SIGNATURE (once completed) :

Restricted when complete

5.0 Briefing Tool

INITIAL	ITEM	ACTION
I	**Information –** where/what/how many? history (if applicable) use METHANE	
I	**Intent –** why are we here? strategy, tactical & operational plan	
M	**Method –** how are we going to do it? tactical plan, policy, plans	
A	**Administration –** Command /media / dress code / decision logs / welfare / food / individual tasking / timing	
R	**Risk Assessment –** specific threat areas / PPE / filter changes	
C	**Communications –** confirm radio callsigns / indicate other means of communication if required / ensure staff understand inter agency communications	
H	**Human Rights** disclosure details	

SIGNATURE (once completed) :

6.0 Joint Decision Model (JDM)

The mnemonic VIAPOAR will help users remember the key elements of the JDM

Values
Information
Assessment
Powers, Policies and Procedures
Options
Action
Review

Principals of Joint Working

How Interoperability is achieved in the context of an operational response

STATEMENT OF MISSION AND VALUES

The mission of the NHS Ambulance Service is to deliver world class, patient centred care to our communities, whenever and wherever it is needed. We will embrace joint working with emergency responders and other health partners whilst striving to improve health and well-being by preserving life.

Using professional judgement, common sense and a well-trained, empowered workforce to deliver our vision, promoting honesty and openness and respecting diversity, treating everyone as an individual.

We will hold full accountability for our decisions and actions and will embrace comments, criticism and concerns, responding to them in an open minded approach, with a willingness to identify key learning points and embed them into organisational culture.

GATHER INFORMATION AND INTELLIGENCE

During this stage the decision maker defines the situation (ie what is happening or has happened) and clarifies matters relating to any initial information and intelligence.

- **What is happening?**
- **What do I know so far?**
- **What further information (or intelligence) do I want or need?**

Intelligence

Gather continual intelligence from the Tactical Advisor / NILO.

CONTINUED OVERLEAF

ASSESS THREAT & RISK AND DEVELOP A WORKING STRATEGY

This stage involves assessing the situation, including any specific threat, the risk of harm and the potential for benefits.

- Do I need to take action immediately?
- Do I need to seek more information?
- What could go wrong (and what could go well)?
- How probable is the risk of harm?
- How serious would it be?
- Is that level of risk acceptable?
- Is this a situation for the Ambulance Service alone to deal with?
- Am I the appropriate person to deal with this?

Develop a working strategy to guide subsequent stages by asking yourself what you are trying to achieve. Remember that circumstances are constantly changing and so it might be necessary to conduct a Dynamic Risk Assessment *(Appendix A)* at any given stage, according to the principles of the Hierarchy of Control *(Appendix B)*.

CONSIDER POWERS, POLICIES AND PROCEDURES

This stage involves considering what policies and procedures might be applicable in this particular situation.

- What Ambulance resources might be required?
- Is there any national guidance covering this type of situation?
- Do any local organisational policies or guidelines apply?
- What legislation might apply?

As long as there is a good rationale for doing so, it may be reasonable to act outside policy.

IDENTIFY OPTIONS AND CONTINGENCIES

This stage involves considering the different ways to make a particular decision (or resolve a situation) with the minimum risk of harm.

Options

- What options are open to me? Consider the immediacy of any threat, the limits of information to hand, the amount of time available, available resources and support, your own knowledge, experience and skills and the impact of potential actions on the situation and the public.

If you have to account for your decision, will you be able to say it was:

- Proportionate, legitimate, necessary and ethical?
- Reasonable in the circumstances facing you at the time?

TAKE ACTION AND REVIEW WHAT HAPPENED

This stage requires decision makers to make and implement appropriate decisions. It also requires decision makers to review what happened once an incident is over.

ACTION

- Respond – Implement the option you have selected
  - Does anyone else need to know what you have decided?
- Record – Record what you did and why
- Monitor – What happened as a result of your decision?
  - Was it what you wanted or expected to happen?

If the incident is continuing, go through the JDM again as necessary.

REVIEW

- If the incident is over, review your decisions using the JDM
- What lessons can you take from how things turned out?
- What might you do differently next time?

7.0 STEP 1-2-3 PLUS

STEP 1

One person incapacitated with no obvious reason

- Approach using standard protocols

STEP 2

Two people incapacitated with no obvious reason

- Approach with caution using standard protocols

STEP 3

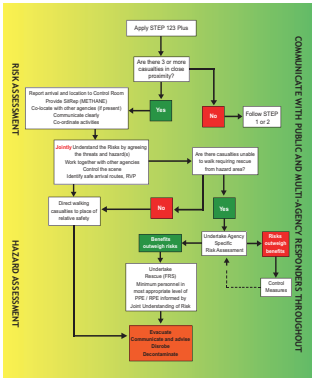
Three or more people in close proximity, incapacitated with no obvious reason

- Use caution and follow **PLUS**

PLUS

PLUS means follow the CBRN First Responder Flow Chart to consider what actions can be undertaken to save life, using the principles below:

- **Evacuate** – Get people away from the scene of contamination.
- **Communicate and Advise** – Give immediate medical advice and reassurance that help is on its way.
- **Disrobe** – Remove clothing.
- **Decontamination** – Dry decontamination should be the default process.



8.0 Dynamic Risk Assessment / Hierarchy of Control Appendix A

DYNAMIC:	RISK:	ASSESSMENT:
Ever changing and evolving. (***HAZARD***: Something with the potential to cause harm.)	Is the likelihood that a hazard will cause loss or harm?	Analysis of information gathered from the incident site and used to implement appropriate safe measures of work.

In order to ensure that staff are protected to the best of ability, dynamic risk assessments must be conducted throughout the incident at all levels. The approach described overleaf will allow information to be processed quickly to provide safe working practices.

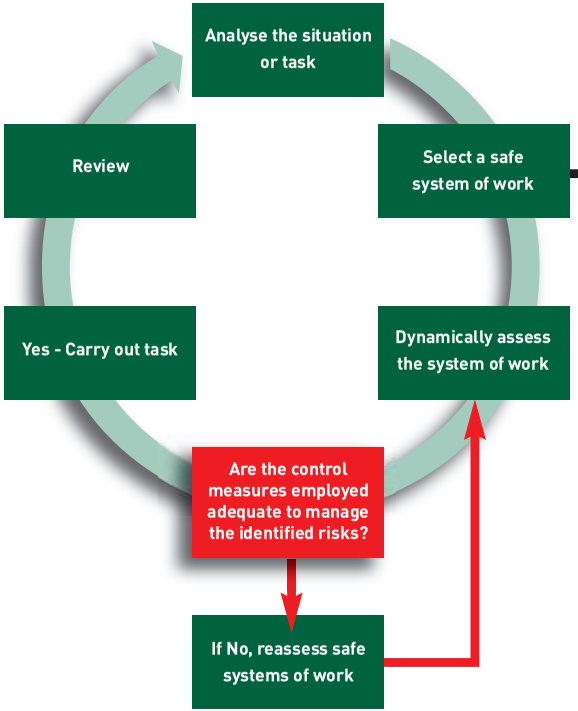
ERICPD

The Control of Substances Hazardous to Health (COSHH) regulations states that "an employer shall not carry on any work which is liable to expose employees or other persons on the premises to any substance hazardous to health unless an assessment of the risks to health and of the steps which need to be taken has been carried out".

The Hierarchy of Control principles are applied to this end, and can also be applied when carrying out a Dynamic Risk Assessment. They can be remembered using the acronym ERIC/PD:

The first four steps ensure that the risk has been reduced as much as possible by starting from the top (removing the hazard altogether) and working down (controlling the risk). These steps will make the site or workplace safer for everyone, whereas the final two steps only serve to protect the individual staff member (see diagram overleaf).

DYNAMIC RISK ASSESSMENT / HIERARCHY OF CONTROL APPENDIX A



ELIMINATE	by complete removal of the hazard - get rid of the hazard; replace it with something less hazardous.
REDUCE	the level of risk by reducing the nature of the hazard eg use small quantities, lower voltage.
ISOLATE	the hazard from people or the people from the hazard.
CONTROL	exposure to the hazard by controlling who has access or use procedure/ protocols limiting exposure time.
PPE	Issue Personal Protective Equipment. Personal Protective Equipment should always be seen as the last resort in order to control a hazard.
DISCIPLINE	Ensuring that employees follow safe systems of work and procedures. Ensure all control measures are monitored, subject to review and enforced.

National Ambulance Resilience Unit
NARU

National Ambulance Resilience Unit
NARU

INITIAL RISK ASSESSMENT

INCIDENT | **DATE** | **TIME**

HAZARD / RISK?

GENERIC HAZARD / RISK	No
Animal attack	
Body fluids (biological)	
Building collapse	
Confined space	
Contamination	
Dangerous machinery	
Drowning	
Electricity	
Entrapment	
Explosion	
Fall from height	
Falling objects	
Fatigue	
Fire	
Fuel (flammable)	
Gas cylinders	
Hazmat	
Heat stress	
Hypothermia	
Lighting	
Manual handling	
Physical assault	
Rapid fire development	
Smoke (vapours / fumes)	
Traffic (moving vehicles)	
Water run off	
Weather conditions	
Other:	

TO WHO?

AGENCY	✓	SPECIFIC	RELEVANT RISKS
WORKING INSIDE STRUCTURE / HOT ZONE			
FIRE			
POLICE			
AMBULANCE			
AIRPORT FIRE			
COASTGUARD			
PUBLIC			
OTHER			
WORKING WITHIN INNER CORDON / WARM ZONE			
FIRE			
POLICE			
AMBULANCE			
AIRPORT FIRE			
COASTGUARD			
PUBLIC			
OTHER			
WORKING OUTSIDE INNER CORDON / COLD ZONE			
FIRE			
POLICE			
AMBULANCE			
AIRPORT FIRE			
COASTGUARD			
PUBLIC			
OTHER			
ENVIRONMENT			
AIR			
GROUND			
WATER COURSE			
OTHER			

Completed by: PRINT NAME / SIGN

Agreed by:

FIRE		AFRS	
POLICE		COAST	
AMB		OTHER	

9.0 Ambulance Incident Command

DATE: INCIDENT CAD NO:

OFFICER NAME: ISSI NO:

LEVEL	DESCRIPTION	NAME	ISSI	TELEPHONE	SUGGESTED CALLSIGN
OPERATIONAL	FIRST RESOURCE ON SCENE - ATTENDANT				VEHICLE CALLSIGN
	FIRST RESOURCE ON SCENE - DRIVER				VEHICLE CALLSIGN
	SUBSEQUENT AMBULANCE RESOURCES				VEHICLE CALLSIGN
	OPERATIONAL COMMANDER				OPERATIONAL
	SECTOR COMMANDER (1)				SECTOR 1
	SECTOR COMMANDER (2)				SECTOR 2
	SECTOR COMMANDER (3)				SECTOR 3
	SAFETY OFFICER				SAFETY
	PRIMARY TRIAGE OFFICER				PRIMARY TRIAGE
	TRIAGE SIEVE				TRIAGE
	CASUALTY CLEARING OFFICER				CCS
	SECONDARY TRIAGE OFFICER				SECONDARY TRIAGE
	PARKING OFFICER				PARKING
	LOADING OFFICER				LOADING
	EQUIPMENT OFFICER				EQUIPMENT
	PATIENT LIAISON OFFICER				PLO
	HOSPITAL AMBULANCE LIAISON (1)				HALO (AND HOSPITAL NAME)
	HOSPITAL AMBULANCE LIAISON (2)				HALO (AND HOSPITAL NAME)
	HOSPITAL AMBULANCE LIAISON (3)				HALO (AND HOSPITAL NAME)
	CONTROL OFFICER				

National Ambulance Resilience Unit
NARU

LEVEL	DESCRIPTION	NAME	ISSI	TELEPHONE	SUGGESTED CALLSIGN
TACTICAL	AMBULANCE INCIDENT COMMANDER				TACTICAL
	FIRE INCIDENT COMMANDER				TACTICAL
	POLICE INCIDENT COMMANDER				TACTICAL
	MILITARY COMMANDER				TACTICAL
	LOCAL AUTHORITY COMMANDER				TACTICAL
STRATEGIC	AMBULANCE STRATEGIC COMMANDER				STRATEGIC
	POLICE STRATEGIC COMMANDER				STRATEGIC
	FIRE STRATEGIC COMMANDER				STRATEGIC
	MILITARY STRATEGIC COMMANDER				STRATEGIC
	LOCAL AUTHORITY STRATEGIC COMMANDER				STRATEGIC

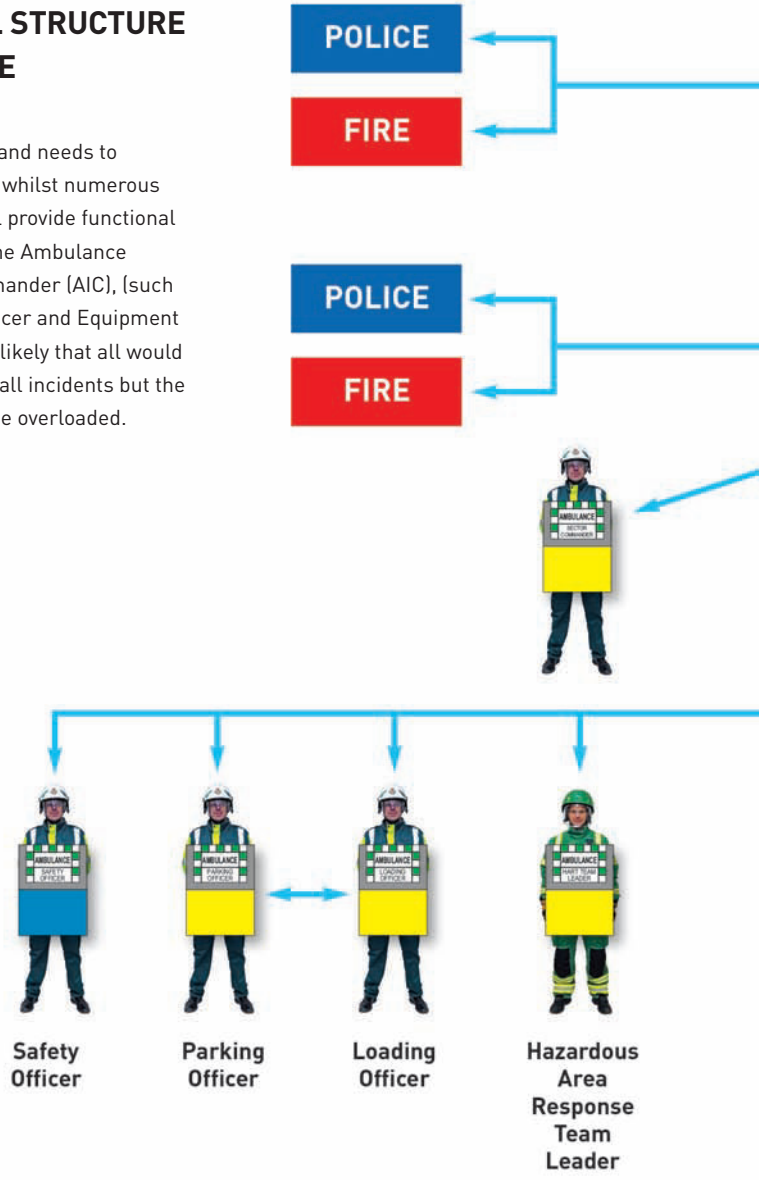
CONTINUED OVERLEAF

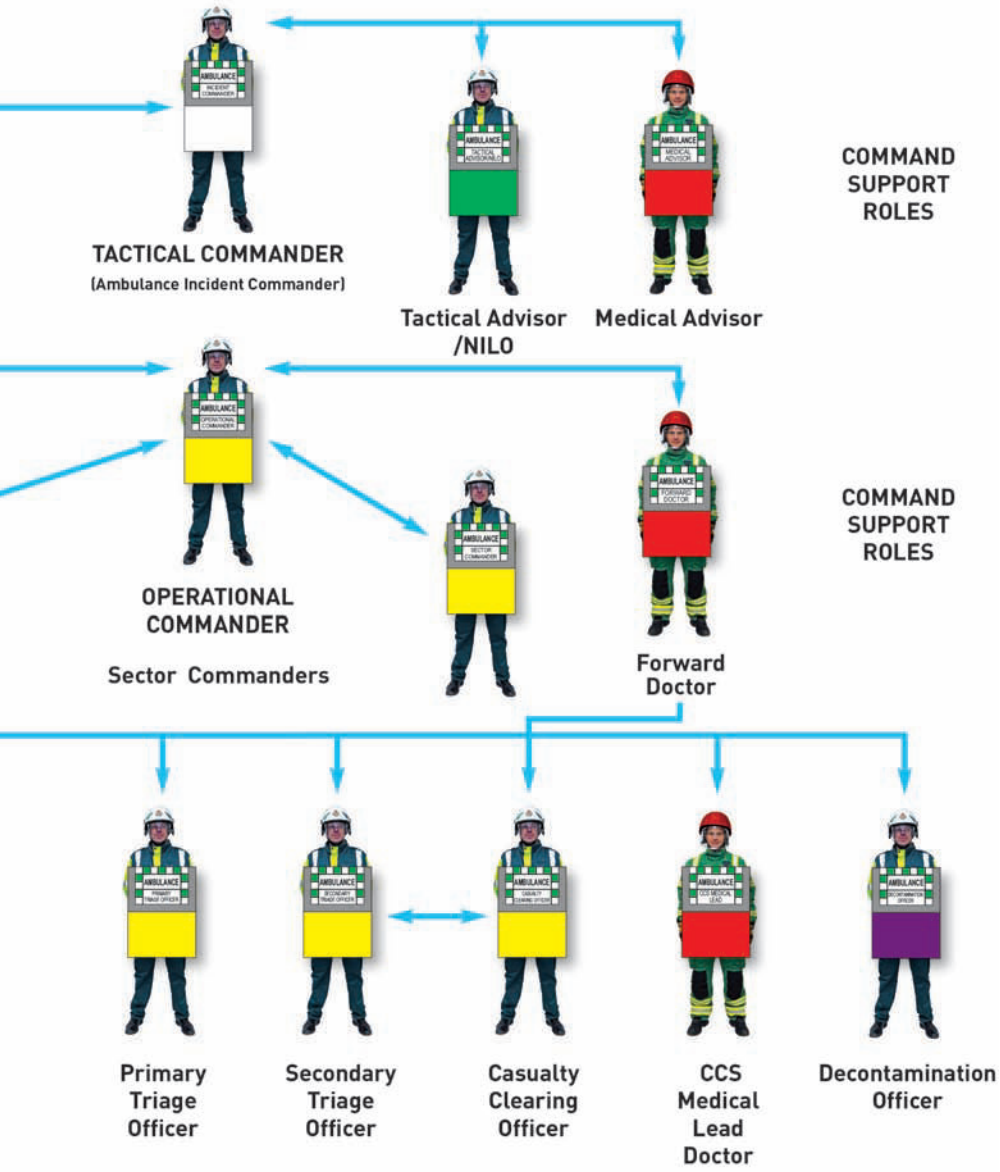
LEVEL	DESCRIPTION	NAME	ISSI	TELEPHONE	SUGGESTED CALLSIGN
COMMAND SUPPORT	AMBULANCE STRATEGIC ADVISOR				SA
	AMBULANCE TACTICAL ADVISOR/NILO				TA
	COMMUNICATIONS OFFICER				COMMS
	HALCO				HALCO
	STAFF OFFICER (S)				STAFF
	LOGISTICS OFFICER				STAFF
INCIDENT LOGGIST	LOGGIST 1				LOGGIST 1
	LOGGIST 2				LOGGIST 2
AIR	AIR ASSET CO-ORDINATOR				
MEDICAL	STRATEGIC MEDICAL ADVISOR				SMA
	MEDICAL ADVISOR				MA
	FORWARD DOCTOR				FORWARD DOCTOR
	CCS MEDICAL LEAD				CCS MEDICAL LEAD

LEVEL	DESCRIPTION	NAME	ISSI	TELEPHONE	SUGGESTED CALLSIGN
VAS / PAS	ST JOHN AMBULANCE				
	BRITISH RED CROSS				
	OTHER (S)				
HART / SORT	HART TEAM LEADER				HART TL
	DECONTAMINATION OFFICER				DECON OPERATIONAL
	DECONTAMINATION TEAM LEADER				DECON TL

MODEL COMMAND CONTROL STRUCTURE GUIDANCE

Span of command needs to recognise that whilst numerous individuals will provide functional command to the Ambulance Incident Commander (AIC), (such as Parking Officer and Equipment Officer) it is unlikely that all would be required at all incidents but the AIC must not be overloaded.




TACTICAL COMMANDER
(Ambulance Incident Commander)
Tactical Advisor /NILO
Medical Advisor
COMMAND SUPPORT ROLES
OPERATIONAL COMMANDER
Sector Commanders
Forward Doctor
COMMAND SUPPORT ROLES
Primary Triage Officer
Secondary Triage Officer
Casualty Clearing Officer
CCS Medical Lead Doctor
Decontamination Officer

10.0 Considerations for using the Hazardous Area Response Team (HART)

INCIDENTS HART SHOULD BE DEPLOYED TO:
Fire and explosives
Water incidents, including rescue
MTFA/firearms incidents
Carbon monoxide poisoning
Multi-casualty incidents
Incidents at height
USAR - unsafe or collapsed structures, or difficult access
Difficult or assisted extractions - MIBS requests/bariatric patients
Road traffic collisions: multi-vehicle, difficult extraction, high mechanism
Hazardous material and chemical, biological, radiological and nuclear incidents
Cave, cliff and mine rescue
Specialist advice, e.g. chemical advice
Suspect packages and vehicles
Explosive devices
Aircraft emergencies
Major Incidents

11.0 Major Incident Standby or Declared - Initial Command Arrangements

TASK	DESCRIPTION	✔	TIME
1	In the event of a **Major Incident Standby or Declared, or Significant Incident,** the **Emergency Operations Centre (EOC) Manager** within a maximum of 5 minutes of the declaration will: ● Mobilise resources including Operational and Tactical Commanders and HART where appropriate ● Allocate Major Incident Talk Group ● In a Marauding Terrorists Firearms Attack scenario, (Operation PLATO), resources should only be deployed following a Tactical Risk Assessment ● Contact the Tactical Advisor/NILO, Tactical and Strategic Commanders, and inform them of the situation using a **METHANE** report ● Mobilise a Medical Advisor if required		
2	Following this contact the **Tactical Advisor** will, within 15 minutes of standby/declaration: ● Deploy to the incident and mobilise a second Tactical Advisor to the co-ordinating EOC ● Mobilise the Strategic Advisor and Loggist to the Strategic Commander ● Confirm the incident is managed on the relevant Airwave Talk Group ● Instigate a **conference call** between the Strategic, Tactical and Operational Commanders, the Tactical and Strategic advisors, Strategic Medical Advisor, on-call Communications Manager and the EOC Duty Manager ● In a Mass (patients in the 100s) or Catastrophic (1000s) casualty situation, please note the local Mass / Catastrophic Casualties action card ● Ensure **EOC** have notified the receiving Acute Trusts on the dedicated MI hospital numbers		

TASK	DESCRIPTION	✔	TIME
3	Following this the **Strategic Advisor** in conjunction with the Strategic Commander will: ● Inform the Strategic Medical advisor and the on-call Media Officer of the situation ● Following the Conference Call, and where appropriate, send a message to all managers informing them of the status of the Trust ● Notify key stakeholders as appropriate ● Under direction of the Strategic Commander inform the CEO and Senior Management Team ● Consider additional managerial support to EOC		
	'Information Only' notifications of a Major, Special or Significant event from another agency, (even if outside of the Trust's geographical area): ● **EOC Manager** must notify the Tactical Advisor who will inform the Strategic Advisor and Strategic Commander		

12.0 Teleconference Generic Action Card

Note: This process is based on use of a recognised British Telecom system

TASK	DESCRIPTION	✔	TIME
1	Pre-alert participants by providing all with the selected telephone number and pincode and ensure they are notified of the date and time of the call. ***Any security arrangements can then be identified.***		
2	Once access is settled, the Chairperson should announce their name and either verbally check the names of the participants or carry out an electronic 'role call'. ***Remember to record names of the participants and ask them to go to mute - also advising that action points will be logged!***		
3	State the actions involved/required to manage, the purpose of the conference call and that an invitation will be made at certain intervals for responses. ***Be prepared for urgent interjections. Remember to advise that they may have to 'un-mute'.*** Suggested Agenda: ● Introduction ● Current situation **(METHANE)** ● Liaison and comms – internal (airwave) and external (media) ● Trust/wider area impact (staffing and resourcing) ● Priorities next 4 hours; horizon scanning ● AOB ● Time/date of next call		
4	Once the main part of the conference call has been completed then allow final questions on a 'round robin' basis. ***A 'silence' on the call will indicate no response.***		
5	Conclude the call by reviewing outstanding **actions** and/or include the **date** and/or **time** of the next conference call. ***Thank all participants and state that the call is now complete.***		

National Ambulance Resilience Unit

NARU

NHS

JESIP

MAJOR INCIDENT INITIAL ACTION CARDS

For further information please contact:

National Ambulance Resilience Unit (NARU)

Website: www.naru.org.uk

V.1.2 October 2015

OFFICIAL

National Ambulance Resilience Unit

NARU

NHS

JESIP

MAJOR INCIDENT OPERATIONAL COMMAND ACTION CARDS

MAJOR INCIDENT OPERATIONAL COMMAND ACTION CARDS

V.1.2 October 2015
OFFICIAL

National Ambulance Resilience Unit
NARU

ASSOCIATION OF AMBULANCE CHIEF EXECUTIVES

Contents

1.0 First Resource On Scene - Attendant

TASK	DESCRIPTION	✔	TIME
1	Park as near to the scene as safety permits, upwind and uphill of the incident and adjacent to Police and Fire Controls if possible.		
2	Assume the role of **Operational Commander** until relieved by an appropriate Ambulance manager.		
3	Don appropriate PPE.		
4	**Stay focussed on your role. DO NOT ATTEMPT RESCUE OR TREATMENT OF CASUALTIES.**		
5	Assess the scene and if determined safe to enter, carry out reconnaissance of the scene and report the following to Emergency Operations Centre (EOC) using **METHANE(S):** **M** Major Incident Declared or Major Incident Standby **E** Confirm exact location of the incident **T** Type of incident with brief details of types and numbers of vehicles, trains, buildings etc **H** Identify hazards present and potential **A** Determine best access/egress routes and RVP **N** Estimate number of casualties eg dead/injured **E** Identify whether other Emergency Services are on scene and what further resources are required **(S)** Start a log book		

CONTINUED OVERLEAF

TASK	DESCRIPTION	✔	TIME
6	Ascertain the requirement for specialist teams eg SORT, MERIT, HART, BASICS, Air Support and specialist equipment.		
7	In liaison with the other **Emergency Services,** initially identify: ● RVP; criteria –avoid objects ie waste bins, check for suspect packages, rotate RVPs –don't always have them at predetermined points ● Ambulance Parking and Ambulance Control Point (normally situated with Police Control and Fire Control) ● Location for a Casualty Triage; collection and clearing points ● Ambulance Loading Point ● Area for decontamination (if appropriate)		
8	On arrival of additional staff designate further roles as required.		
9	Prepare a brief for the first **Ambulance Commander** on scene.		

2.0 First Resource On Scene - Driver

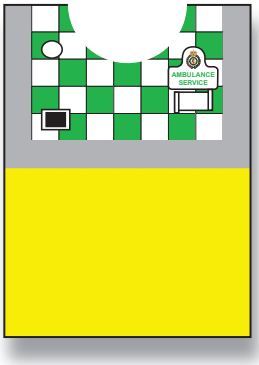
TASK	DESCRIPTION	✔	TIME
1	Park as near to the scene as safety permits, upwind and uphill of the incident and adjacent to Police and Fire Controls if possible.		
2	Leave blue lights on and keys in ignition with engine running. Don appropriate PPE.		
3	Assume the role of communications link between Emergency Operations Centre (EOC) and the attendant.		
4	Instigate a log.		
5	**Remain with your vehicle.** **DO NOT ATTEMPT RESCUE OR TREATMENT OF CASUALTIES.**		
6	Maintain radio contact with Emergency Operations Centre (EOC).		
7	Compile a debrief report of the incident.		

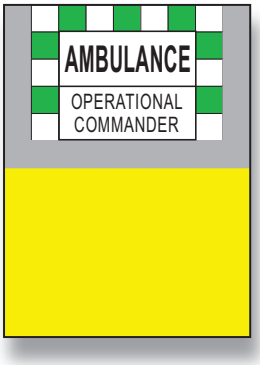
3.0 Subsequent Ambulance Resources

TASK	DESCRIPTION	✔	TIME
1	If tasked to do so by **Emergency Operations Centre**, change to a designated Talk Group.		
2	Don appropriate PPE.		
3	Switch off all blue lights; ensure keys are left in the ignition.		
4	Proceed as instructed to the **Parking Officer** for briefing and tasking. *(If not established – contact Operational Commander.)*		
5	Take a functional role as tasked by the **Operational Commander** in the initial stages of the incident and don appropriate tabard.		
6	Perform role that you are assigned: ● Do not deviate from this role unless otherwise directed by the **Operational Commander**		
7	On leaving the scene: ● Advise the **Ambulance Loading Officer** of departure ● Tear off strip from SMART Triage Card and hand to **Ambulance Loading Officer** ● Confirm the receiving hospital		
8	Remain on allocated Airwave Talk Group unless instructed by the **Emergency Operations Centre.**		

National Ambulance Resilience Unit
NARU

4.0 Operational Commander



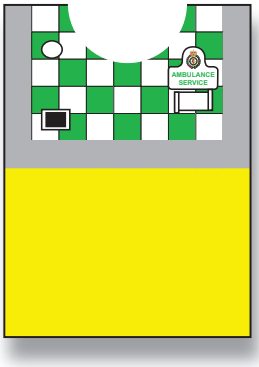


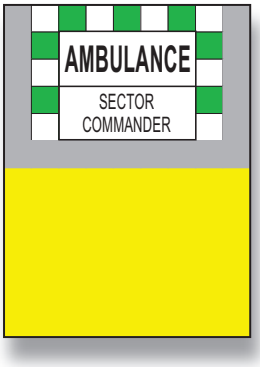
TASK	DESCRIPTION	✔	TIME
1	Don high-visibility tabard inscribed **"Operational Commander"** and protective helmet.		
2	Check communications/radio Talk Group and start a log. Deliver updated METHANE report.		
3	In liaison with, and under the direction of the **Ambulance Incident Commander,** manage and co-ordinate the medical activities of all Ambulance and medical personnel at the forward site or, if directed, at a specific area of the site (Sector).		
4	**Stay focussed on your role. DO NOT ATTEMPT RESCUE OR TREATMENT OF CASUALTIES.**		
5	Identify any hazards and assess risk – present/potential – and in liaison with **Ambulance Incident Commander** assign a **Safety Officer and Sector Commanders** where required, if not already appointed. Using the Joint Decision Model (JDM), develop an operational plan (within the given tactical parameters).		

CONTINUED OVERLEAF

TASK	DESCRIPTION	✔	TIME
6	Direct Ambulance personnel as needed and continually monitor the numbers of staff and resources at the incident site.		
7	Liaise closely with representatives of the other Emergency Services at the forward site as soon as possible.		
8	Liaise where required with **all functional roles** and **Forward Doctor** to monitor and manage initial triage sieve and eventual treatment of patients. Appoint further triage officers if required.		
9	Establish the need for other specialist assets eg BASICS, SORT, Mass Casualty Vehicle, HART, MERIT, Air assets at the incident site.		
10	In liaison with the **Ambulance Incident Commander** ensure action has been undertaken to organise: ● Access and egress routes (sterile route) ● Forward Control Point (and appropriate sector commanders) ● Casualty Clearing Station ● Loading Point ● Parking Point		
11	Continually monitor and manage the performance of Ambulance staff in respect of signs of fatigue and traumatic stress.		
12	Regularly liaise with and brief the **Ambulance Incident Commander** about the situation at scene. Establish regular briefings with other agency commanders.		
13	Compile a debrief report of the incident.		

5.0 Sector Commander



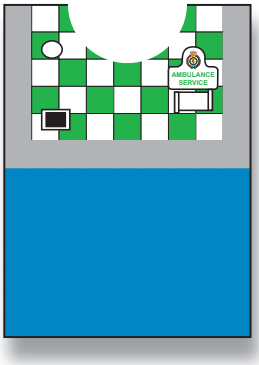


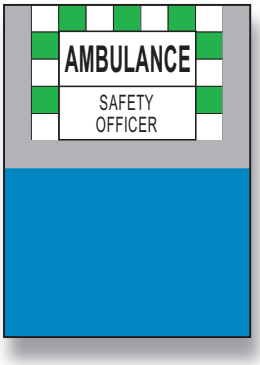
TASK	DESCRIPTION	✔	TIME
1	Don high-visibility tabard inscribed **"Sector Commander"** and protective helmet. Switch to allocated talk group.		
2	Once briefed by Operational commander – collocate with Sector commander from partner agencies		
3	In liaison with and under the direction of the **Operational Commander**, directly manage and co-ordinate the medical activities of all Ambulance and medical personnel at the designated sector.		
4	**Stay focussed on your role. DO NOT ATTEMPT RESCUE OR TREATMENT OF CASUALTIES.**		
5	Identify any hazards and risks present, and inform the **Ambulance Safety Officer.**		

CONTINUED OVERLEAF

TASK	DESCRIPTION	✔	TIME
6	Prior to deployment into respective sector ensure all staff are briefed and wearing appropriate PPE for the task. Maintain a head count as staff enter your allocated sector.		
7	Liaise where required with **Primary Triage Officer and Forward Doctor** to monitor and manage initial triage sieve and eventual treatment of patients. Appoint further triage officers if required.		
8	Consider the need for specialist assets to be assigned to a specific sector and communicate to **Operational Commander.**		
9	Compile a debrief report of the incident.		

6.0 Safety Officer



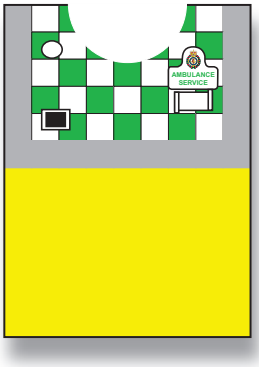


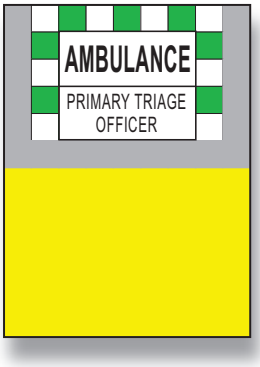
TASK	DESCRIPTION	✔	TIME
1	Don high-visibility tabard inscribed **"Safety Officer"** and protective helmet.		
2	Check communications/radio Talk Group and start a log.		
3	The **Safety Officer** is responsible for ensuring that the environment and working practices of the Ambulance staff, NHS and any support staff are not placed at undue risk. (Eliminate, Reduce, Isolate, Control, PPE, Discipline.)		
4	Collocate with **Safety Officers** from the other agencies, particularly the Fire and Rescue Service.		
5	Identify specific hazards and/or dangers and advise the **Operational Commander/Sector Commander** as to the protective measures required.		
6	Ensure **all** personnel are wearing **appropriate** PPE for the task.		
7	In consultation with the **Parking Officer**, assist with the briefing of staff prior to deployment to the incident site.		

CONTINUED OVERLEAF

TASK	DESCRIPTION	✔	TIME
8	Manage and record the access and egress of all medical personnel to the inner cordon by using the **Safety and Inner Cordon Log.**		
9	Monitor staff for signs of fatigue and/or stress and ensure all staff receive adequate rest and refreshments. Inform the **Operational Commander** or **Sector Commander** to take the appropriate actions.		
10	Advise the **Operational Commander and Sector Commanders** of the need to evacuate the site or sector if required and the agreed signal.		
11	Seek appropriate advice from the **Tactical Advisor/NILO** on correct procedures and treatment in cases of contamination of casualties, Ambulance/medical personnel, vehicles and equipment.		
12	Compile a debrief report of the incident.		

7.0 Primary Triage Officer





Best practice is to carry out TRIAGE SIEVE in pairs

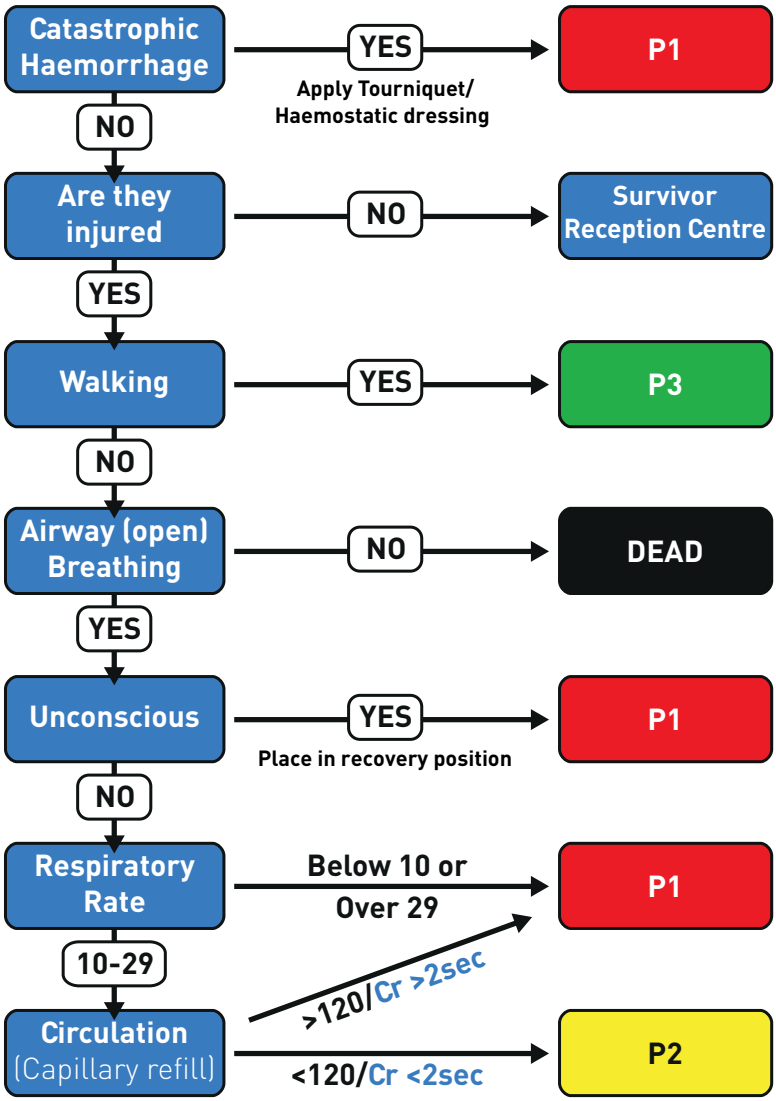
TASK	DESCRIPTION	✔	TIME
1	Don high visibility tabard inscribed **"Primary Triage Officer"** and protective helmet.		
2	Check communications/radio Talk Group.		
3	In liaison with the **Operational Commander** and/or the **Forward Doctor** identify sectors containing patients requiring triage.		
4	**Primary Triage Officer** is responsible for the co-ordination of triage by all resources on scene including HART.		
5	Obtain all triage packs and use priority selection using triage sieve (best practice work in pairs - 1 person to carry out clinical triage, 1 person to record).		
6	Liaise with the **Fire and Rescue Service and HART Team Leader** regarding triage in the inner cordon.		

CONTINUED OVERLEAF

TASK	DESCRIPTION	✔	TIME
7	**Stay focussed on your role. DO NOT ATTEMPT RESCUE OR TREATMENT OF CASUALTIES, with the exception of opening an airway (with adjunct) or stemming catastrophic haemorrhage.**		
8	Place unconscious patients into the recovery position.		
9	Encourage P3 patients to move to an identified holding area.		
10	If the incident involves multiple children use the paediatric triage tape.		
11	Ensure the **Operational Commander/Sector Commander** is notified regularly about the number of casualties remaining, triage categories and those that have been removed.		
12	Co-ordinate the triaged removal of casualties to the Casualty Clearing Station(s) as appropriate. **Remind all Triage staff that they only move the deceased to access a live patient and if possible in the presence of a Police Officer.** **If during triage sieve process a patient is triaged as dead the clinician MUST record location,time and initial the triage card.**		
13	**Re-triage each patient at least every 15 minutes.**		
14	As casualty numbers reduce, redeploy your staff in liaison with the **Casualty Clearing Officer.**		
15	Compile a debrief report of the incident.		

8.0 Triage Sieve

Best practice is to carry out TRIAGE SIEVE in pairs



National Ambulance Resilience Unit
NARU

8.0a Casualty Count

The Triage Sieve flow chart on the reverse should only be used for adults.

For Paediatric Triage (0 to 12 years) use the Smart Tape

Cross out the next number in each priority as you label a new casualty.

PRIORITY 1

1	2	3	4	5	6	7	
8	9	10	11	12	13	14	15
16	17	18	19	20	21	22	
26	24	25	26	27	28	29	30

PRIORITY 2

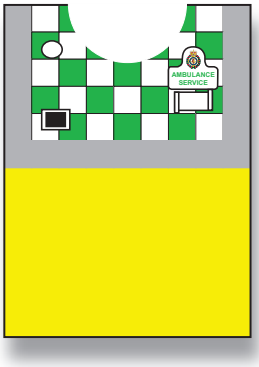
1	2	3	4	5	6	7	
8	9	10	11	12	13	14	15
16	17	18	19	20	21	22	
26	24	25	26	27	28	29	30

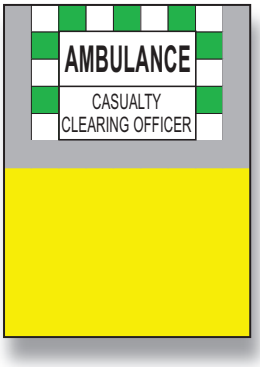
PRIORITY 3

1	2	3	4	5	6	7	
8	9	10	11	12	13	14	15
16	17	18	19	20	21	22	
26	24	25	26	27	28	29	30

DEAD 1 2 3 4 5 6 7 8 9 10

9.0 Casualty Clearing Officer





TASK	DESCRIPTION	✔	TIME
1	Don high-visibility tabard inscribed **"Casualty Clearing Officer"** and protective helmet.		
2	Check communications/radio Talk Group and start a log.		
3	In liaison with the **Operational Commander**, establish an appropriate safe location for the Casualty Clearing Station and Ambulance Loading Point.		
4	**Stay focussed on your role. DO NOT ATTEMPT RESCUE OR TREATMENT OF CASUALTIES.**		
5	In liaison with the **Parking Officer** consider that the Casualty Clearing Station is: ● Close to the ambulance circuit (access, egress) ● On hard standing ● Safe from hazards ● Making use of existing buildings or shelter		
6	If not already on scene or mobile to scene consider requesting temporary shelter.		

CONTINUED OVERLEAF

TASK	DESCRIPTION	✔	TIME
7	Request the appropriate medical assistance within the Casualty Clearing Station and ensure that there is an appropriate level of healthcare professionals for the station.		
8	In liaison with the **Medical Advisor**, brief and manage the medical/Ambulance staff in the Casualty Clearing Station.		
9	Ensure that: ● Adequate protection exists; liaise with **Safety Officer** ● Separate triage area is marked out ● Transportation needs are prioritised ● Records (Patient ID) are kept on patient movements **(Casualty Clearing Log)** via the **Loading Officer**		
10	Request the **Primary Triage Officer** to report how many patients are present and number of each triage category present.		
11	Appoint a **Secondary Triage Officer** to co-ordinate the triage sort and re-triage each patient every 15 minutes within the Casualty Clearing Station.		
12	Maintain regular communication with the **Operational Commander, Medical Advisor** and **Secondary Triage Officer**.		
13	Ensure medical supplies are available from the Incident Support Units and from the Mass Casualty Vehicle, and set up nearby equipment resupply area. **Allocate an Equipment Officer**.		
14	In liaison with the **Secondary Triage Officer** provide separate identifiable areas or sectors for triage categories and ensure the categories are segregated appropriately: ● Red - Immediate First Priority (P1) ● Yellow - Urgent Second Priority (P2) ● Green - Delayed Third Priority (P3) ● White/Black - Dead		

TASK	DESCRIPTION	✔	TIME
15	As patients arrive from the forward incident site to the Casualty Clearing Station ensure that they have been triage sieved **and** have a triage label attached to them.		
16	Ensure that patient documentation is initiated and maintained even if limited details are obtained.		
17	In liaison with the **Loading Officer, Air Support Officer** and **Medical Advisor** agree effective patient transportation to hospital.		
18	Ensure an effective handover of patients to **Loading Officer** for allocation of transportation to hospital.		
19	Ensure appropriate skill levels are available as required for each casualty en route to hospital.		
20	Compile a debrief report of the incident.		

9.0a Casualty Clearing Log

CASUALTY CLEARING LOG

TO BE USED BY THE CASUALTY CLEARING OFFICER TO TRACK PATIENTS

CASUALTY NAME OR NUMBER	ADULT M	ADULT F	CHILD M	CHILD F	CONTAM Y	CONTAM N	TRIAGE CATEGORY 1 2 3 D	TIME IN CASUALTY CLEARING	TIME OUT CASUALTY CLEARING	VEHICLE CALLSIGN	DESTINATION HOSPITAL OR LOCATION

National Ambulance Resilience Unit
NARU

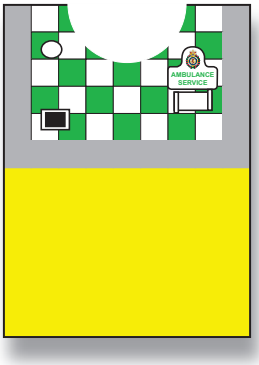
CASUALTY CLEARING LOG

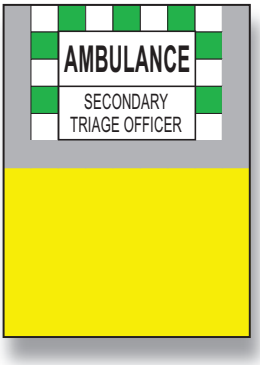
TO BE USED BY THE CASUALTY CLEARING OFFICER TO TRACK PATIENTS

CASUALTY NAME OR NUMBER	ADULT M	ADULT F	CHILD M	CHILD F	CONTAM Y	CONTAM N	TRIAGE CATEGORY 1 2 3 D	TIME IN CASUALTY CLEARING	TIME OUT CASUALTY CLEARING	VEHICLE CALLSIGN	DESTINATION HOSPITAL OR LOCATION

National Ambulance Resilience Unit
NARU

10.0 Secondary Triage Officer





TASK	DESCRIPTION	✔	TIME
1	Don high-visibility tabard inscribed **"Secondary Triage Officer"** and protective helmet.		
2	Check communications/radio Talk Group.		
3	In liaison with the **Operational Commander** and/or the **Medical Advisor** undertake the identification of group(s) of patients requiring triage at the Casualty Clearing Station.		
4	**Stay focussed on your role. DO NOT ATTEMPT RESCUE OR TREATMENT OF CASUALTIES, with the exception of opening an airway (using an adjunct) or stemming catastrophic haemorrhage.**		
5	Ensure **every** patient has a triage card attached and is re-triaged using triage sort.		
6	If the incident involves multiple children use the paediatric triage tape.		

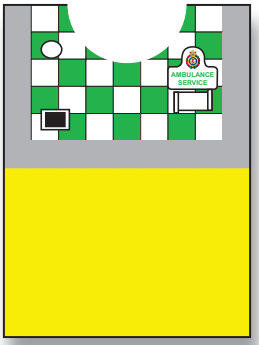
TASK	DESCRIPTION	✔	TIME
7	Treatment of patients will be performed by medical and Ambulance staff – your role is to continually manage the effective triage sort of the casualties.		
8	In the event of a large number of casualties, segregate into triage areas (Priority 1, 2, 3) if practicable.		
9	Liaise with the **Medical Advisor** to ensure that patients delayed on scene are triaged regularly to include injury pattern. **Ensure that all patients are re-triaged at least every 15 minutes.**		
10	Keep a tally of the number of each priority and report this to the **Casualty Clearing Officer**.		
11	As casualty numbers reduce, redeploy your staff in liaison with the **Casualty Clearing Officer**.		
12	Compile a debrief report of the incident.		

SECONDARY TRIAGE (SORT)

Physiological Variable	Measured Value	Score
Respiratory Rate	10 - 29	4
	> 29	3
	6 - 9	2
	1 - 5	1
	0	0
Systolic Blood Pressure	> 90	4
	76 - 89	3
	50 - 75	2
	1 - 49	1
	0	0
Glasgow Coma Scale	13 - 15	4
	9 - 12	3
	6 - 8	2
	4 - 5	1
	3	0

Priority	Triage Revised Trauma Score	
T1	1 - 10	RED
T2	11	YELLOW
T3	12	GREEN
Dead	0	

11.0 Parking Officer



TASK	DESCRIPTION	✔	TIME
1	Don **"Parking Officer"** tabard and protective helmet.		
2	Check communications/radio Talk Group and start a log.		
3	Establish an appropriate safe location to park further resources likely to arrive at the incident and inform **Emergency Operations Centre and Operational Commander**.		
4	Remember that ambulances will leave scene and response cars and other specialist units will probably remain at scene.		
5	Liaise with Police Officers to ensure that the parking location is secure and access and egress is maintained; escalate to **Operational Commander** if required.		
6	Manage the arrival and safe parking of incoming vehicles and brief Ambulance crews on any specific routes to and from the Casualty Clearing Station (Sterile Route).		
7	Brief staff regarding the key locations and any hazards.		

TASK	DESCRIPTION	✔	TIME
8	Ensure that **all** staff attending are wearing the **appropriate** PPE for the incident.		
9	Maintain records of attending staff and callsigns including: • Qualification level – Paramedic/Technician etc • Vehicles – eg type and capacity • Mobile teams, BASICS, HART, MERITs, SORT, VAS		
10	Ensure that blue lights are turned off and vehicles are left unlocked with keys in the ignition.		
11	Direct staff from the parking point to the appropriate **Sector Commander** (if going to scene on foot) or **Loading Officer** (if transporting patents from CCS).		
12	Facilitate the transportation of equipment from the vehicles as required.		
13	Compile a debrief report of the incident.		

National Ambulance Resilience Unit
NARU

11.0a Marshalling/Parking Point Log

MARSHALLING/PARKING POINT LOG

TO BE USED BY THE MARSHALLING/PARKING OFFICER ON ARRIVAL OF VEHICLES

NAME & ORGANISATION	VEHICLE CALLSIGN	TIME OF ARRIVAL	QUALIFICATION	DEPLOYED TO	TIME DEPLOYED

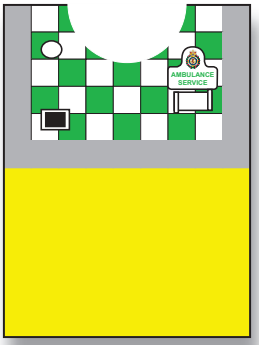
National Ambulance Resilience Unit
NARU

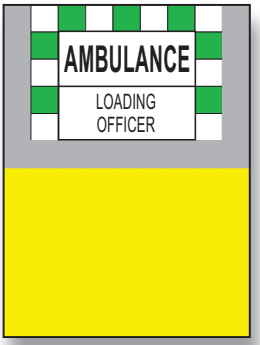
MARSHALLING/PARKING POINT LOG

TO BE USED BY THE MARSHALLING/PARKING OFFICER ON ARRIVAL OF VEHICLES

NAME & ORGANISATION	VEHICLE CALLSIGN	TIME OF ARRIVAL	QUALIFICATION	DEPLOYED TO	TIME DEPLOYED

12.0 Loading Officer





TASK	DESCRIPTION	✔	TIME
1	Don high-visibility tabard inscribed **"Loading Officer"** and protective helmet.		
2	Check communications/radio Talk Group.		
3	The **Loading Officer** is responsible for the management of vehicles and the controlled onward transportation of patients from the Casualty Clearing Station to definitive care.		
4	Establish a Loading Point with consideration to access, egress, hard standing and turning circle – seek Police assistance if required.		
5	In liaison with **Emergency Operations Centre and Parking Officer** ensure an adequate supply of ambulances to the Loading Point.		
6	In liaison with **Casualty Clearing Officer / CCS Medical Lead** organise the packaging, loading and dispatch of casualties in priority order.		

TASK	DESCRIPTION	✔	TIME
7	In liaison with the **CCS Medical Lead**, identify suitable patients for evacuation by air assets.		
8	Ensure that all patients have been triaged and labelled prior to leaving scene.		
9	Ensure a record of patients leaving the Casualty Clearing Station is maintained using the **Loading Point Log** and triage tags.		
10	Arrange for the collection of Ambulance/medical equipment used on site and ensure the return of such equipment to its source.		
11	Compile a debrief report of the incident.		

12.0a Loading Point Log

LOADING POINT LOG

TO BE COMPLETED BEFORE PATIENTS ARE PUT ON TRANSPORT TO HOSPITAL

VEHICLE CALLSIGN	ADULT M	ADULT F	CHILD M	CHILD F	CONTAM Y	CONTAM N	TRIAGE CATEGORY 1 2 3 D	TIME OUT CASUALTY CLEARING	TIME VEHICLE DEPART	CASUALTY NAME OR NUMBER	DESTINATION HOSPITAL OR LOCATION

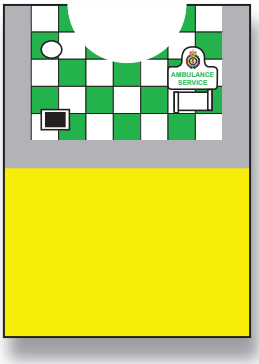
National Ambulance Resilience Unit
NARU

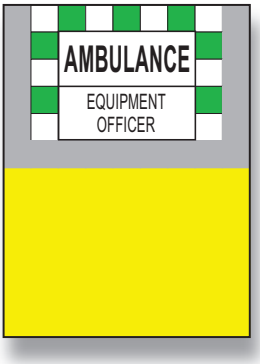
LOADING POINT LOG

TO BE COMPLETED BEFORE PATIENTS ARE PUT ON TRANSPORT TO HOSPITAL

VEHICLE CALLSIGN	ADULT M	ADULT F	CHILD M	CHILD F	CONTAM Y	CONTAM N	TRIAGE CATEGORY 1 2 3 D	TIME OUT CASUALTY CLEARING	TIME VEHICLE DEPART	CASUALTY NAME OR NUMBER	DESTINATION HOSPITAL OR LOCATION

13.0 Equipment Officer





TASK	DESCRIPTION	✔	TIME
1	Don high-visibility tabard inscribed **"Equipment Officer"** and protective helmet.		
2	Check communications/radio Talk Group.		
3	The **Equipment Officer** is responsible for ensuring medical equipment is readily available / resupplied throughout the incident.		
4	Utilise the Incident Support Units and set up the emergency equipment as required.		
5	Establish an appropriate safe location for an equipment dump. Consider: ● Close to the Casualty Clearing Station ● Hard Standing ● Safe from hazards		
6	Issue equipment stored within the Incident Support Units, recording such issues on the **Equipment Officer Log**.		

TASK	DESCRIPTION	✔	TIME
7	Monitor supplies of equipment on site and arrange via **Operational Commander** for additional supplies to be brought to site.		
8	Liaise with **Hospital Ambulance Liaison Officer(s)** at receiving hospitals to return equipment to site.		
9	Consider the mobilisation of the Mass Casualty Vehicle **(via Tactical Advisor/NILO)**.		
10	Following formal "Stand Down" from the **Ambulance Incident Commander, co-ordinate with the Police** to supervise a scene sweep and removal of Clinical Waste and Equipment.		
11	Compile a report of missing equipment.		
12	Compile a debrief report of the incident.		

13.0a Equipment Point Log

EQUIPMENT POINT LOG

TO BE USED BY THE EQUIPMENT OFFICER

ITEM ISSUED	QUANTITY	ISSUED TO	REMAINING STOCK	REMARKS

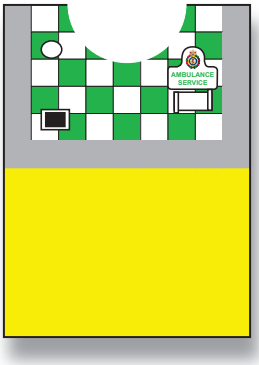
National Ambulance Resilience Unit
NARU

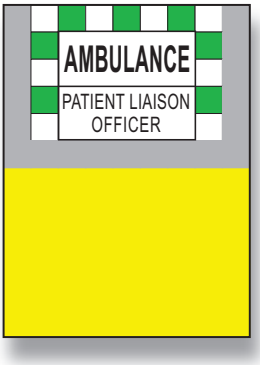
EQUIPMENT POINT LOG

TO BE USED BY THE EQUIPMENT OFFICER

ITEM ISSUED	QUANTITY	ISSUED TO	REMAINING STOCK	REMARKS

14.0 Patient Liaison Officer





TASK	DESCRIPTION	✔	TIME
1	Book on scene with Emergency Control Centre; use designated channel or Talk Group (if established).		
2	Don the appropriate high visibility jacket marked **"Patient Liaison"** and safety helmet. Collect hand portable radio and use callsign "Operational Patients".		
3	Collect a Loud Hailer.		
4	Start your own log.		
5	Liaise with **Ambulance Incident Commander** and agree messages to be communicated to patients.		
6	At a CBRNE incident seek advice from the **Tactical Advisor/NILO** to ensure consistent messaging with staff working in the dirty area of the incident.		
7	Proceed to the incident site and in consultation with **Operational Commander/Forward Doctor** begin issuing information to patients.		

TASK	DESCRIPTION	✔	TIME
8	Maintain a high degree of liaison with representatives from the other Emergency Services to ensure consistent messaging between all agencies.		
9	Ensure emergency dressing pack is available for patients to use if required.		
10	Continue messaging until all patients have left scene.		

COMMON MESSAGE SCRIPTS

Use short and concise messages, speak clearly and slowly
Always use "This is the ********* Ambulance Service"

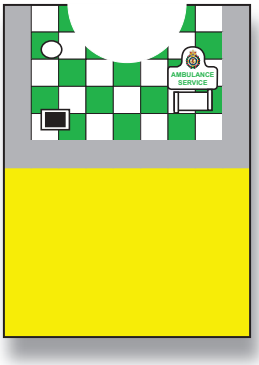
Message Options:
- Help is on the way
- If you are not injured please move towards "Location"
- Please use dressings provided to cover any minor injuries

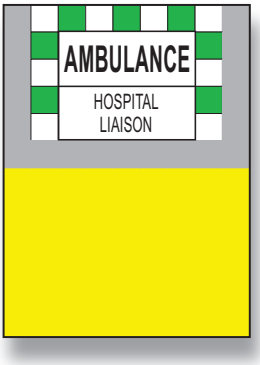
Encourage conscious casualties to:
- If bleeding severely, apply direct pressure to the wound
- Assist any other casualties

CBRNE / HAZMAT Incidents
- Remain where you are
- Face into the wind
- Remove your contaminated clothing
- Refer to IOR Aide Memoire

National Ambulance Resilience Unit
NARU

15.0 Hospital Ambulance Liaison Officer





"HOSPITAL NAME" HALO

TASK	DESCRIPTION	✔	TIME
1	Don high-visibility tabard inscribed **"Hospital Liaison"**.		
2	Report to the designated receiving hospital under the direction of the co-ordinating **Emergency Operations Centre**.		
3	Establish and maintain telephone and/or radio communications between the receiving hospital and the **Emergency Operations Centre**.		
4	Liaise with the **Hospital Emergency Department Officer** and the **Police Casualty Bureau Officer**.		
5	Liaise with the MERIT(s) prior to deployment, if applicable.		
6	Control and direct Ambulance activities to manage a prompt turnaround from hospital back to the incident scene if required.		
7	Ensure release of Ambulance equipment by the hospital and arrange its return to the incident scene if required. Ensure the welfare requirements of staff are met prior to return to the scene.		

TASK	DESCRIPTION	✔	TIME
8	Co-ordinate and log the return of all Ambulance equipment not available for release during the incident.		
9	Maintain a log of patients arriving at the hospital department - **HALO Log**.		
10	Arrange for the availability of consumable Ambulance equipment for Ambulance crews to replenish their vehicles at the hospital department.		
11	Remain at the hospital subsequent to "stand down" to maintain continuing liaison in managing the continuing demands on the hospital and Ambulance resources for discharges/transfers.		
12	Compile a debrief report of the incident.		

National Ambulance Resilience Unit
NARU

15.0a Hospital Ambulance Liaison Log

HOSPITAL AMBULANCE LIAISON LOG

TO BE COMPLETED AT A RECEIVING HOSPITAL

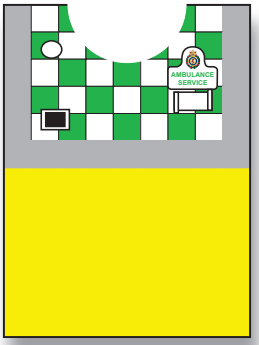
VEHICLE CALLSIGN	ARRIVAL TIME	CASUALTY NAME OR NUMBER	TRIAGE NUMBER	ADULT M	ADULT F	CHILD M	CHILD F	CLEAR TIME	REDEPLOYED SCENE	REDEPLOYED OTHER

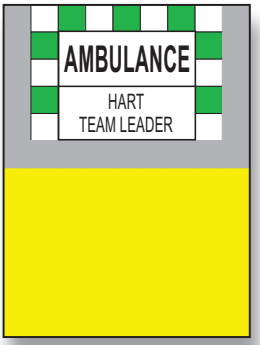
HOSPITAL AMBULANCE LIAISON LOG

TO BE COMPLETED AT A RECEIVING HOSPITAL

VEHICLE CALLSIGN	ARRIVAL TIME	CASUALTY NAME OR NUMBER	TRIAGE NUMBER	ADULT		CHILD		CLEAR TIME	REDEPLOYED	
				M	F	M	F		SCENE	OTHER

16.0 HART Team Leader





TASK	DESCRIPTION	✔	TIME
1	Assume the role of **HART Sector Commander** and report directly to the **Operational Commander** ensuring that the **Operational Commander** is fully aware of the capabilities of the HART response.		
2	Ensure the HART log is started.		
3	Ensure an appropriate **METHANE** report is given to the CCD as soon as possible after arrival.		
4	Where appropriate (either on scene or via telephone) liaise with the **Tactical Advisor/NILO** providing them with specialist information and guidance where necessary around HART capabilities.		
5	Request additional HART management support where necessary.		
6	Ensure attendance at Inter Agency Liaison Meetings to support the **Operational / Incident Commander** in the capabilities of HART.		

TASK	DESCRIPTION	✔	TIME
7	Ensure the HART operatives are briefed and aware of any risks before being deployed forward into a hazardous environment.		
8	Ensure HART operatives work within their Standard Operating Policies.		
9	Where necessary consider the need to request support from the Training Team or mutual aid from a neighbouring Ambulance Trust.		
10	Ensure that, where necessary, an exit plan is in place (and communicated with all other agencies on scene) at: • An incident where there are currently no patients • Where medical cover is being provided • Where there are deceased patients only This will allow the HART team to mobilise to attend a HART specific incident.		
11	Ensure **Emergency Operations Centre** is contacted post incident to ensure sufficient time is allocated to allow staff to rehydrate and that equipment is replenished. The **HART Supervisor** should ensure the vehicles are prepared for future deployment as soon as possible.		
12	Maintain overall awareness of the welfare of HART operatives during the incident, eg knowing the amount of time they have been in gas tight suits etc.		
13	Where still on scene during a hot debrief ensure HART are appropriately represented at this debrief and that this information is fed back to the HART Management Team.		
14	Post incident ensure that notes and learning points are written up and appropriately filed.		
15	For any incident which is protracted over a shift changeover ensure as early as possible a plan is put in place to allow HART to stay at the scene but for replacement staff to be brought to the scene.		

National Ambulance Resilience Unit

NARU

NHS

JESIP

MAJOR INCIDENT OPERATIONAL COMMAND ACTION CARDS

For further information please contact:

National Ambulance Resilience Unit (NARU)

Website: www.naru.org.uk

V.1.2 October 2015

OFFICIAL

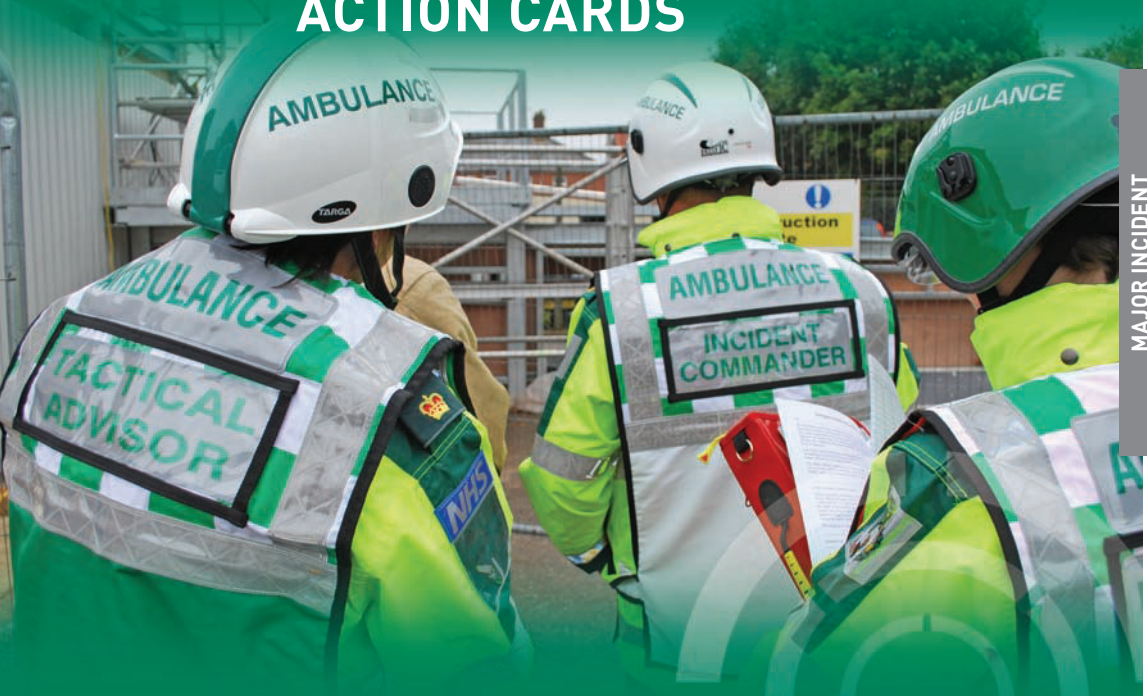
National Ambulance Resilience Unit

NARU

NHS

JESIP

MAJOR INCIDENT TACTICAL COMMAND ACTION CARDS



V.1.2 October 2015
OFFICIAL

MAJOR INCIDENT TACTICAL COMMAND ACTION CARDS

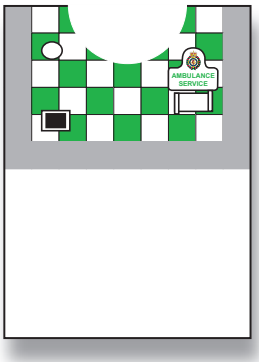
National Ambulance Resilience Unit
NARU

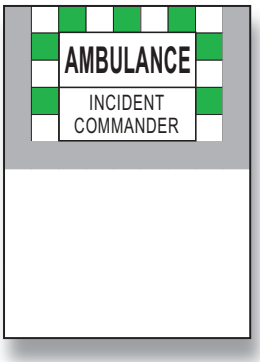
ASSOCIATION OF AMBULANCE CHIEF EXECUTIVES

Contents

MAJOR INCIDENT TACTICAL COMMAND ACTION CARDS

1.0 Incident Commander - Tactical





TASK	DESCRIPTION	✔	TIME
1	Don tabard inscribed **"Ambulance Incident Commander"** and protective helmet. Assume command of all assets operating under the NHS (including Private and Voluntary Ambulance Services). Ensure a log is commenced.		
2	Obtain a full briefing from the **Operational Commander or First Resource on Scene**, and retain as part of your command team.		
3	Check communications/radio Talk Group and inform the **Emergency Operations Centre** of arrival at specific site as well as confirming that you are taking over responsibility for Ambulance command of the incident.		
4	Confirm with **Emergency Operations Centre** that a **Tactical Advisor/NILO** has been deployed to the incident.		
5	Confirm Major Incident 'Declared' or 'Standby' has been received with a **METHANE** report and the cascade instigated.		

CONTINUED OVERLEAF

TASK	DESCRIPTION	✔	TIME
	METHANE(S) **M** "Major Incident Declared" or "Major Incident Standby" **E** Confirm exact location of the incident **T** Type of incident with brief details of types and numbers of vehicles, trains, buildings etc **H** Identify hazards present and potential **A** Determine best access / egress routes and RVP **N** Estimate number of casualties eg dead/injured **E** Identify whether other Emergency Services are on scene and what further resources are required **(S)** Start an Incident Log and request a **Loggist** to assist. Within 15 minutes of Major Incident Declaration/Standby liaise with the Strategic and Operational Commanders, Tactical and Strategic Advisors, and Emergency Operations Centre Manager.		
6	Consider the activation of the Airwave interoperability Talk Groups in line with standard operating procedures.		
7	Following co-location with partner agency commanders develop a tactical plan utilising the Joint Decision Model and Joint Understanding of Risk.		
8	Confirm with EOC the numbers of resources deployed are sufficient and via the **Tactical Advisor** that specialist assets have been considered. Escalate to **Strategic Commander** as appropriate.		
9	Ensure that all **Operational command support roles** have been allocated, and designate other roles eg Air Ambulance Support as necessary.		

TASK	DESCRIPTION	✔	TIME
10	Confirm times of regular Tactical Commander meetings - Tactical Co-ordinating Groups.		
11	Consider the sectorisation of the incident, if required, and ensure they match police/fire service sectors. Allocate **Sector Commanders via the Operational Commander**.		
12	Ensure appropriate staff are allocated and deployed to further establish: ○ The RVP is in place, safe and appropriate ○ An Ambulance Control Point ○ Ambulance Parking ○ Primary Triage ○ Casualty Clearing Station/ Secondary Triage and Treatment ○ Ambulance Loading ○ Ambulance Decontamination (if appropriate) ○ Ambulance Equipment Point ○ Ambulance Air Support (if appropriate)		
13	Ensure all designated officers have established callsigns and radio communications / Talk Group.		
14	Consider the need for other specialist assets eg BASICS, SORT, Mass Casualty Vehicle, HART, MERIT, Air Assets.		
15	Confirm that radio communications between **Emergency Operations Centre** and the site of the incident and receiving hospitals via **Hospital Ambulance Liaison Officer** are established and maintained.		
16	Consider an early request for Mutual Aid support and escalate to Strategic.		
17	Establish regular contact with the **Communications/Media Officer** on site.		

CONTINUED OVERLEAF

TASK	DESCRIPTION	✔	TIME
20	Ensure effective deployment of: Resources Personnel Specialist assets		
21	Liaise with the **Tactical Advisor** to ensure that the Major Incident Plan is being followed and any further specialist advice is followed.		
22	Liaise with **Operational Commander** to ensure functional roles are being undertaken.		
23	Arrange for non-medical transport for non-injured patients via Local Authority and/or other. Consider: Non-emergency/Schedule Transport Service vehicles Buses/coaches		
24	Consider welfare arrangements for yourself, managers and crews if the incident is likely to be protracted.		
25	Agree and initiate "Major Incident-Stand Down" authorisation when appropriate and inform EOC.		
26	Ensure that a "hot debrief" is facilitated immediately after the incident.		
27	Collect and secure all documents relating to the incident and prepare a report for the CEO.		
28	Ensure a debrief of the incident is carried out.		

2.0 Tactical Plan

It is the Tactical Commander's intention to manage the response to an incident in line with the Strategic Command Strategy. Through effective co-ordination, sound planning and good leadership, the Tactical Commander will:

TASK	DESCRIPTION	✔	TIME
1	Maintain public confidence and minimise the impact of this occurrence on core activity by ensuring that the Ambulance Service Provider is responding effectively to the incident.		
2	Implement, manage and support an operational command structure to assist delivery of the Tactical Plan. This includes the following key roles: i **Operational Commander & Sector Commanders** (if appropriate) ii **Casualty Clearing Officer** iii **Loading Officer** iv **Parking Officer** v **Safety Officer** vi **Equipment Officer** vii **Communications Officer** viii **Decontamination/Decontamination Entry Control officer**		
3	Identify the resources required to bring the incident to a satisfactory close as identified within the Strategic Strategy as soon as possible.		
4	Ensure all possible measures including the implementation of the **Ambulance Safety Officer** role and the performing and reviewing of Dynamic Risk Assessments to safeguard the following people under the terms of health and safety have been conducted: Ambulance Service Provider staff and other responders Local communities and patients		
5	In partnership with the Ambulance Service Providers communications team, create a public statement/message and ensure that it is in line and consistent with the multi agency message where appropriate.		
6	Create and maintain a well-documented, auditable plan and decision log for the incident at all levels of command.		

National Ambulance Resilience Unit

NARU

NHS

JESIP

MAJOR INCIDENT TACTICAL COMMAND ACTION CARDS

For further information please contact:

National Ambulance Resilience Unit (NARU)

Website: www.naru.org.uk

V.1.2 October 2015

OFFICIAL

National Ambulance Resilience Unit

NARU

NHS

JESIP

MAJOR INCIDENT STRATEGIC COMMAND ACTION CARDS

V.1.2 October 2015
OFFICIAL

MAJOR INCIDENT STRATEGIC COMMAND ACTION CARDS

National Ambulance Resilience Unit
NARU

ASSOCIATION OF AMBULANCE CHIEF EXECUTIVES

Contents

MAJOR INCIDENT
STRATEGIC COMMAND
ACTION CARDS

1.0 Incident Commander - Strategic

The Strategic Commander is ultimately responsible for determining the strategic objectives that the Tactical and Operational Commanders should follow. Strategic Commanders retain strategic oversight and overall command of the incident or operation.

Management Tasks: Resource allocation, communications, casualty dispersal planning, media management, resource retention and sustainability.

TASK	DESCRIPTION	✔	TIME
1	Assume **STRATEGIC Command** and set strategic objectives using the **Joint Decision Model (JDM).**		

CONTINUED OVERLEAF

TASK	DESCRIPTION	✔	TIME
2	Gain assurance from the **Ambulance Incident Commander** that Risk Assessments have been carried out as appropriate.		
3	**Commence Personal LOG**. Request immediate attendance of **Strategic Advisor, Loggist and Staff Officer** to support **Strategic Command**.		
4	Ensure access to the following policies: ● Trust Major Incident Plan ● Trust Business Continuity Policy, Strategy and Plans ● Trust appropriate policies and procedures ● Relevant Local Resilience Forum Plans		
5	With advice from the **Strategic Advisor** and the **Strategic Medical Advisor** confirm the strategy for the incident and ensure that this is disseminated to the **Ambulance Incident Commander**. Ensure the strategy is documented within the log.		
6	Ensure the Strategic strategy enables the **Ambulance Incident Commander** to make justifiable decisions and implement tactical options that meet the overall strategy.		
7	Ensure the NHS accountable/commissioning body is continuously briefed during the incident and establish a communications pathway. Prepare to deploy personnel to the relevant NHS Command structures as appropriate.		
8	Consider the requirement to cease routine work under force majeure (contractual obligations).		
9	Consider whether Ambulance Service STRATEGIC Command Cell needs to be set up and action as appropriate.		

TASK	DESCRIPTION	✔	TIME
10	Plan beyond the immediate response phase from recovering from the emergency, to returning to or toward a state of normality (consider implementation of Business Recovery Team in conjunction with Business Continuity Plan).		
11	Develop and communicate overall strategy for the Trust response, both internally and externally, which should be recorded and subject to regular review.		
12	Confirm that command structure is in place for the Trust and communicate this to other agencies and internally.		
13	Ensure inter service liaison at the appropriate strategic level.		
14	Ensure an integrated media policy is created via the Communications / Media Officer on call.		
15	Agree the media strategy with other multi agency Commanders and cascade this information to the **Ambulance Incident Commander** and **Trust Comms Lead/On Call**.		
16	Ensure there are clear lines of communication with the AIC.		
17	Ensure the SMA has consulted the **Trauma Network Lead Clinicians**.		
18	Ensure there are longer-term resources and Commander resilience.		
19	Assure that welfare arrangements are in place to identify and respond to any staff welfare needs arising as a result of the incident.		
20	Consider and communicate appropriate changes to REAP level.		

CONTINUED OVERLEAF

TASK	DESCRIPTION	✔	TIME
21	Give consideration to the needs of the wider health economy prioritising demands from a number of sources including mutual aid.		
22	If the incident is or has the potential to be a CBRNE incident consider an early request for Mass CBRN Prophylaxis supply through the NACC.		
23	Ensure that incident debriefs are arranged as necessary: ● Hot debrief immediately for all available staff involved ● Internal debrief and associated action plan within two weeks ● Inter agency debrief as required		
24	Ensure that letters of appreciation are prepared as necessary for: ● Trust Staff ● Partner agencies		
25	Compile a report for the **Chief Executive Officer** and attach all documentation relating to the incident.		

2.0 Strategy

It is our intention to deal with an ongoing incident in an appropriate manner which promotes the saving of life, reduces humanitarian suffering and is compatible with the vision and values of the Trust. Through effective co-ordination, sound planning and good leadership the Strategic Commander will:

TASK	DESCRIPTION	✔	TIME
1	Maintain public confidence and minimise the impact of the occurrence by ensuring that the Trust is responding effectively to the incident.		
2	Ensure that the Trust response is co-ordinated and integrated with the wider health and other responding agencies where applicable.		
3	Maintain effective capacity management within the **Emergency Paramedic Service, Emergency Operations Centre and Planned Care Service**.		
4	Assess and identify any gaps in the response capability of the organisation for dealing with this incident.		
5	Through the identification and use of mutual aid, minimise the impact on the **Emergency Operations Centre, Emergency Paramedic Service and Planned Care**.		
6	So far as is reasonably practicable, take all measures to safeguard the following people under the terms of health and safety legislation: ● Ambulance staff and other responders ● Local communities ● Other NHS responders		
7	Ensure public messages are co-ordinated with other agencies and partners.		

TASK	DESCRIPTION	✔	TIME
8	Ensure effective Business Continuity and Recovery arrangements are in place across the organisation and review where necessary.		
9	Create and maintain a well-documented auditable plan and decision log for the incident at all levels of command.		

3.0 Strategic Liaison Manager

On behalf of the Strategic Commander, act as the liaison in a pre-determined Local Resilience Forum (Strategic Co-ordinating Group) area. Facilitate strategic decisions through the Trust Strategic Commander in a cohesive manner with partner agencies and ensure that decisions and actions are appropriately recorded.

TASK	DESCRIPTION	✔	TIME
1	Assume the role of **Strategic Co-ordination Group (SCG) Liaison Manager**.		
2	Ensure appropriate Risk Assessments have been undertaken – record and action as appropriate.		
3	**Commence Personal LOG.** Request immediate attendance of Loggist and Staff Officer to support.		
4	Communicate overall strategy for the Trust response, both internally and externally, which should be logged (recorded) and subject to regular review.		
5	Communicate that the command structure is in place for the Trust and communicate this (diagram) to other agencies and internally.		
6	Ensure inter-service liaison (undertake appropriate liaison with Strategic Commanders in other agencies).		
7	Support an integrated media policy via the Regional Media Officer on call.		
8	Ensure there are clear lines of communication with the **Strategic Commander** and AIC.		
9	Ensure there is a longer-term resource and expertise for command resilience.		

TASK	DESCRIPTION	✔	TIME
10	Communicate appropriate changes to REAP level.		
11	In close liaison with the **Strategic Commander**, identify and commit Ambulance resources in co-operation with the multi agency forums (SCG and STAC).		
12	Decide on what resources or expertise can be made available for AIC requirements (mutual aid).		
13	Plan beyond the immediate response phase from recovering from the emergency to returning to or toward a state of normality (consider implementation of Business Recovery Team in conjunction with Business Continuity Plan).		
14	Compile a debrief report of the incident.		

National Ambulance Resilience Unit

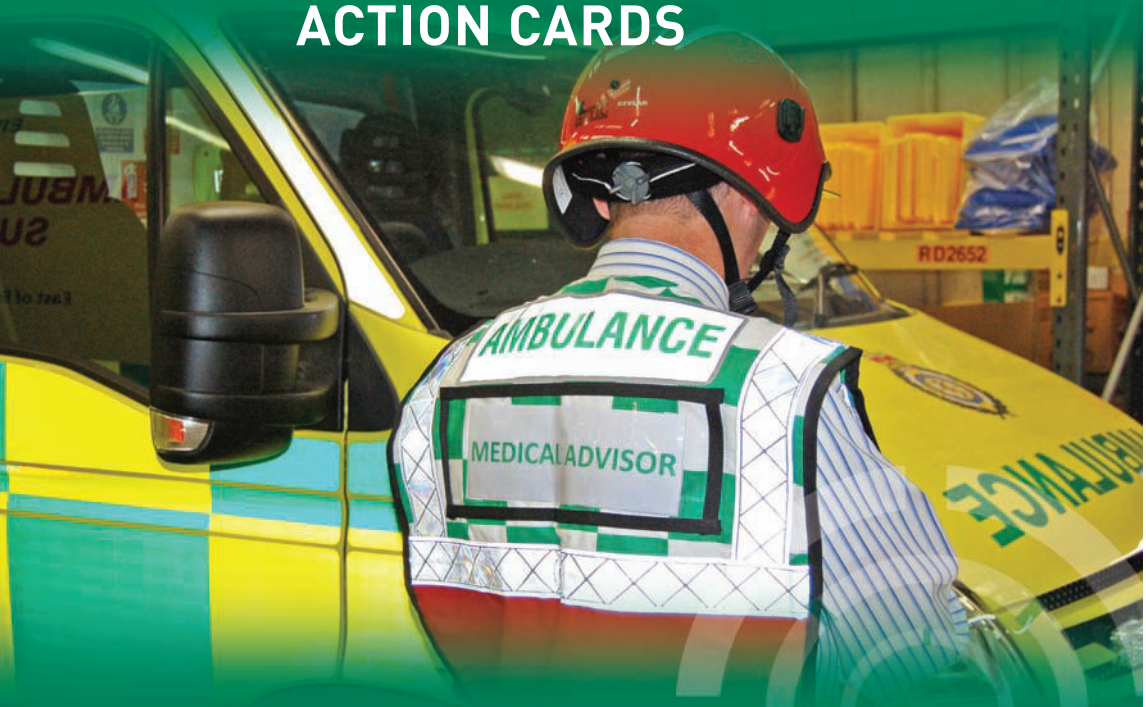
NARU

NHS

JESIP

MAJOR INCIDENT MEDICAL ACTION CARDS

MAJOR INCIDENT MEDICAL ACTION CARDS

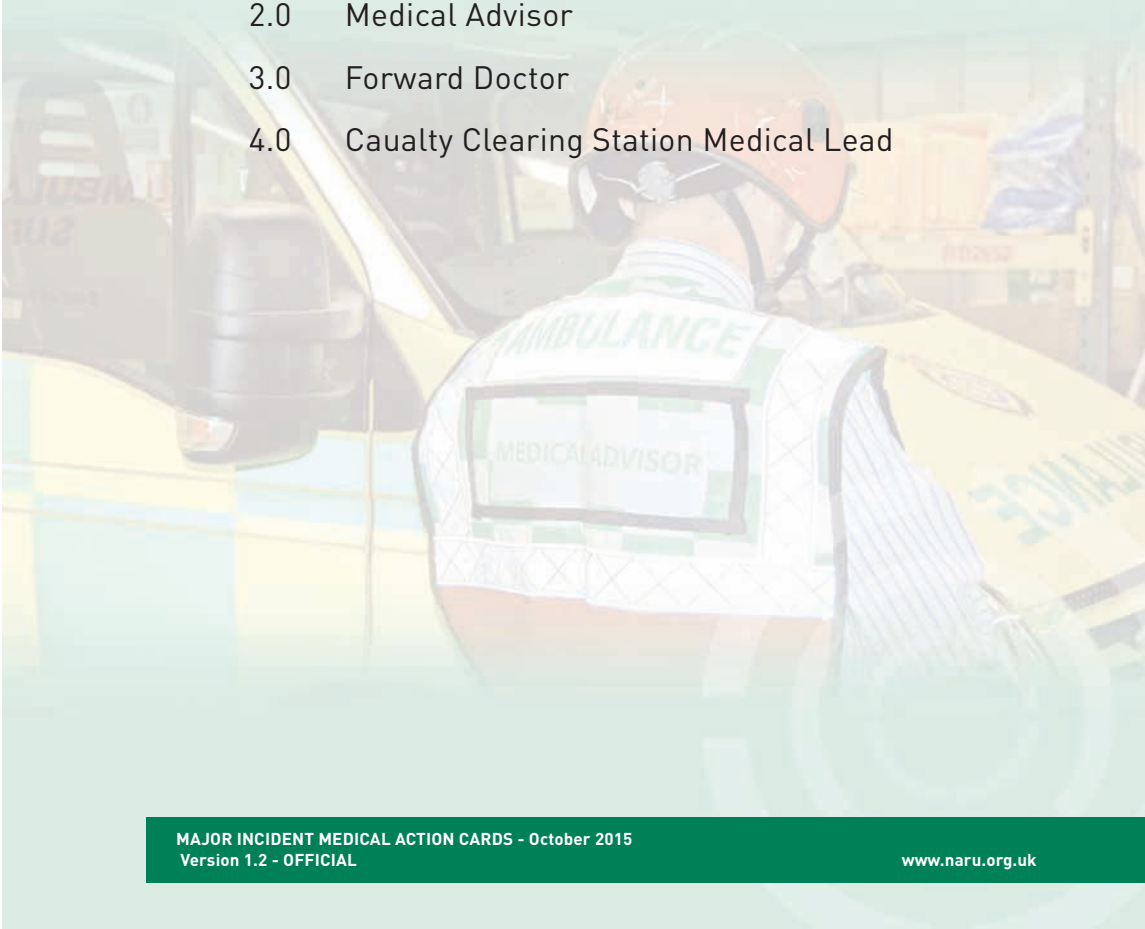


V.1.2 October 2015
OFFICIAL

National Ambulance Resilience Unit
NARU

ASSOCIATION OF AMBULANCE CHIEF EXECUTIVES

Contents



1.0 Strategic Medical Advisor

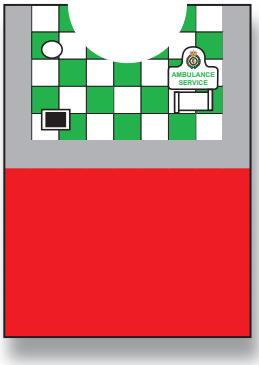
TASK	DESCRIPTION	✔	TIME
1	On notification of a major incident (declared or standby) co-locate with the **Strategic Commander** if requested. Start a log.		
2	In liaison with the **Strategic Commander** establish communication with **Medical Advisor** at scene.		
3	In consultation with the **Strategic Commander and Medical Advisor**, establish the need for additional medical resources (MERIT) on site.		
4	Discuss with **Strategic Commander** the implementation of triage guidelines. Consider the requirement in the event of mass casualties to permit the use of Expectant (P4) category – **this must be authorised by the Trust Medical Director or Associate Medical Director in liaison with the NHS accountable / commissioning body.**		
5	Consider with **Strategic Commander** the requirement to cease routine work under force majeure (contractual obligations).		
6	Wherever possible, the use of the Trauma Network Tool to be used with appropriate casualty regulation. Consider the use of wider casualty regulation outside the region and liaise appropriately.		
7	Interpret STAC/specialist advice for the organisation to enable strategic advice and guidance on PPE and infection control if required.		
8	Arrange relief rota for **Strategic Medical Advisor, Medical Advisor and CCS Medical Lead**.		

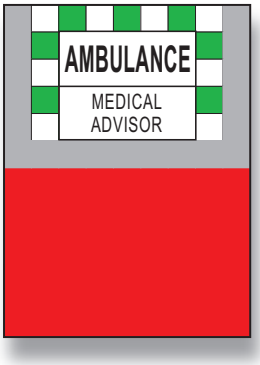
CONTINUED OVERLEAF

TASK	DESCRIPTION	✔	TIME
9	If the incident is or has the potential to be a CBRNE incident consider an early request for Mass CBRN Prophylaxis supply through the NACC.		
10	In liaison with the **Police Incident Commander and DVI Team Manager**, make arrangements for the certification of the deceased and the location of a Body Holding Area. Coroner boundaries must be identified and where possible confirmation of death should only occur in one area.		
11	Compile a report for the CEO and attach all documentation relating to the incident.		

National Ambulance Resilience Unit
NARU

2.0 Medical Advisor



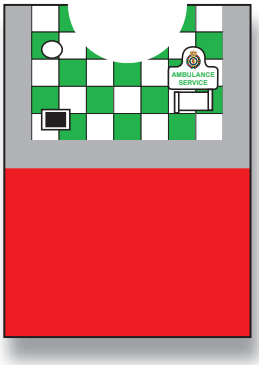


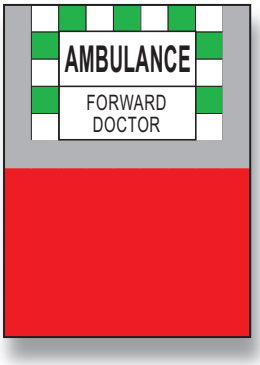
TASK	DESCRIPTION	✔	TIME
1	Don high-visibility tabard inscribed **"Medical Advisor"** and protective helmet.		
2	Check communications/radio callsign and start a log.		
3	Liaise with the **Ambulance Incident Commander** and obtain a full briefing. Work in conjunction with the **Ambulance Incident Commander** for the triage, treatment and transportation of all casualties. Open dialogue with the receiving hospital(s). Request permission from **Strategic Medical Advisor** to invoke expectant (P4) triage category if required or indicated due to mass casualty volume/capacity issues.		
4	Co-locate with the **Ambulance Incident Commander** or **Operational Commander** throughout the incident. Regularly brief the **Strategic Medical Advisor**.		
5	**Stay focussed on your role. DO NOT ATTEMPT RESCUE OR TREATMENT OF CASUALTIES.**		
6	Establish communications between all BASICS doctors operating at the incident.		

CONTINUED OVERLEAF

TASK	DESCRIPTION	✔	TIME
7	Check all doctors' ID Cards, as bogus doctors are not uncommon at incidents.		
8	Appoint doctor(s) to designated Operational areas. ● **Forward Doctor** (to work with **Operational Commander**) ● Casualty Clearing Stations ● Body Holding Area (in order to confirm life extinct)		
9	In conjunction with the **Casualty Clearing Officer**, ensure the effective throughput and evacuation of casualties, remain constantly aware of bed status at the Receiving Hospital(s) and plan the distribution of casualties accordingly.		
10	In consultation with the **Ambulance Incident Commander and Strategic Medical Advisor**, consider all other relevant and available means of evacuation eg Helicopters, buses, coaches.		
11	Ensure that Receiving Hospital(s) are kept informed of the numbers and type of casualties that they are to receive. Monitor bed and acceptance status.		
12	Liaise with the **Ambulance Incident Commander** to identify suitable specialist hospital treatment centres if required.		
13	Arrange for the relief of medical staff as necessary.		
14	Provide technical medical advice to all services and agencies at the site.		
15	In conjunction with **Ambulance Incident Commander**, arrange medical cover for rescue personnel during the recovery phase after all live casualties have been removed.		
16	After consultation with the **Ambulance Incident Commander** stand down **MERIT** and consider welfare requirements.		
17	Ensure all medical staff are included at the hot debrief.		
18	Compile a report for the AIC and attach all documentation relating to the incident.		

3.0 Forward Doctor





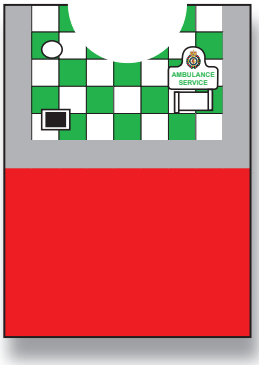
TASK	DESCRIPTION	✔	TIME
1	Don high-visibility tabard inscribed **"Forward Doctor"** and protective helmet. Ensure that your personal protective equipment is suitable for the task.		
2	Present your ID to the **Operational Commander** on scene.		
3	Liaise with the **Operational Commander** and obtain a full briefing. Work in liaison with the **Medical Advisor** for the triage, treatment and transportation of all casualties in the sector allocated.		
4	Check communications/radio callsign and start a log.		
5	Ensure that you have a method of communication between yourself, the **Medical Advisor** and other medical assets on scene. You should be issued with a radio by the Ambulance Service.		
6	Work within sector allocated by the **Operational Commander**. Regularly brief the **Medical Advisor**. **Forward Doctor** may be deployed to: ● Casualty Clearing Station ● Body Holding Area (in order to confirm life extinct) ● Incident Ground		

CONTINUED OVERLEAF

TASK	DESCRIPTION	✔	TIME
7	**Stay focussed on your role. DO NOT BE TEMPTED TO GET INVOLVED IN OVERALL MEDICAL COMMAND.**		
8	If located in the Forward Area, make yourself known to the **Ambulance Sector Commander** and **Primary Triage Officer**.		
9	Work in the Forward Area to ensure the most appropriate medical management of casualties is undertaken and that clinical records are commenced.		
10	If located in the Casualty Clearing Station, work with the **Casualty Clearing Officer** and **Loading Officer** to ensure the effective throughput and evacuation of casualties.		
11	Ensure that casualty treatment records are completed and that all interventions are indicated with their time.		
12	If allocated to the Body Holding Area ensure that the appropriate examinations to recognise life extinct are undertaken and that appropriate records are made.		
13	Indicate to the **Medical Advisor** any casualties who will require a Trauma Centre or specialist intervention eg head injuries and burns.		
14	Identify to the **Medical Advisor** when relief of medical teams might be indicated.		
15	Provide technical medical advice to all services and agencies at the sector in which allocated.		
16	Do not leave the allocated sector without the **Ambulance Sector Commander's** permission.		
17	Attend the hot debrief.		
18	Compile a post incident report and attach all documentation relating to the incident.		

National Ambulance Resilience Unit
NARU

4.0 Casualty Clearing Station Medical Lead



TASK	DESCRIPTION	✔	TIME
1	Don high- visibility tabard inscribed **'CCS Medical Lead'**.		
2	Check communications/radio call sign and start a log.		
3	Liaise with the **Ambulance Incident Commander** and obtain a full briefing.		
4	On arrival at CCS – liaise with **Casualty Clearing Officer** and **Loading Officer** to gain shared situational awareness before commencement of post.		
5	Obtain accurate up to date information regarding capability and capacity of surrounding hospitals (including specialist units).		
6	Consider appropriate facilities such as minor injury units, walk in centres and primary care centres in addition to treat and discharge from scene.		
7	Establish medical lead of the CCS and ensure all staff are aware of the management structure.		
8	Provide oversight and support to medical care and where appropriate treat patients within the CCS.		

CONTINUED OVERLEAF

TASK	DESCRIPTION	✔	TIME
9	Coordinate any extra clinical resources available at the scene (enhanced care teams, Aeromedical teams, BASICs.		
10	Provide specialist guidance and support to ambulance clinicians, in triaging, treating and providing advanced clinical interventions to casualties.		
11	Ensure casualty treatment records are completed with all available information and that all clinical interventions are indicated with their time.		
12	Give clear information to the CCO and Loading Officer regarding casualties who will require transfer to specialist units or those that may benefit from specialist interventions. Ensure appropriate skill mix is maintained during any transfer.		
13	Attend the hot debrief.		
14	Compile a post incident report and attach all documentation relating to the incident.		

National Ambulance Resilience Unit

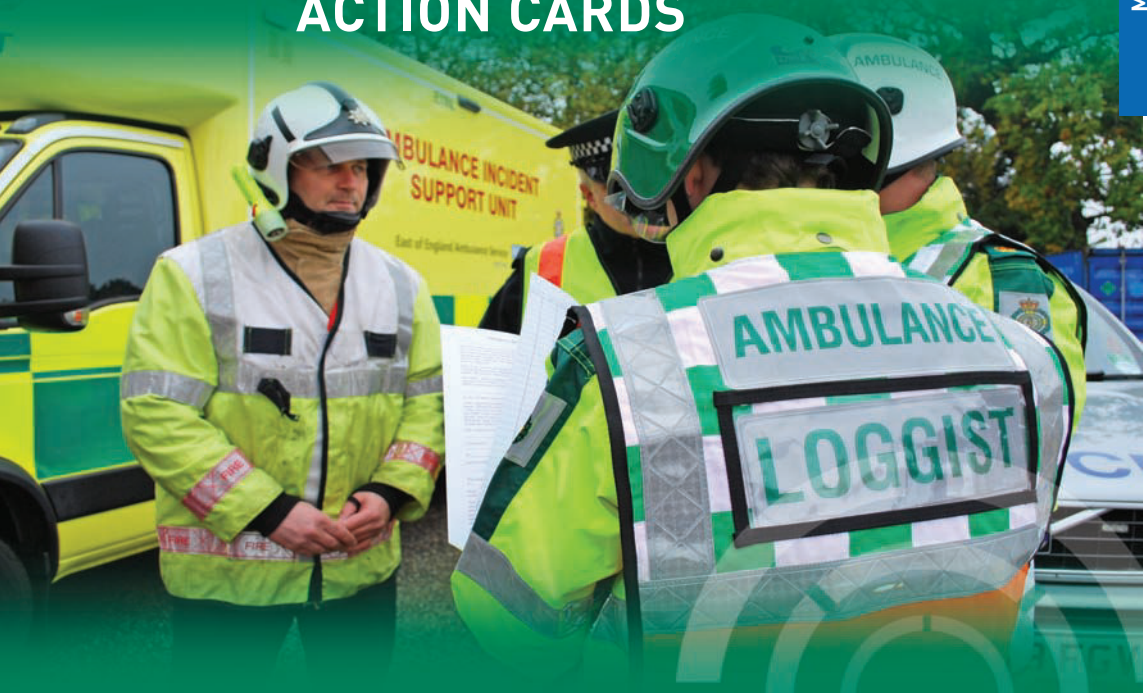
NARU

NHS

JESIP

MAJOR INCIDENT COMMAND SUPPORT ACTION CARDS

MAJOR INCIDENT COMMAND SUPPORT ACTION CARDS

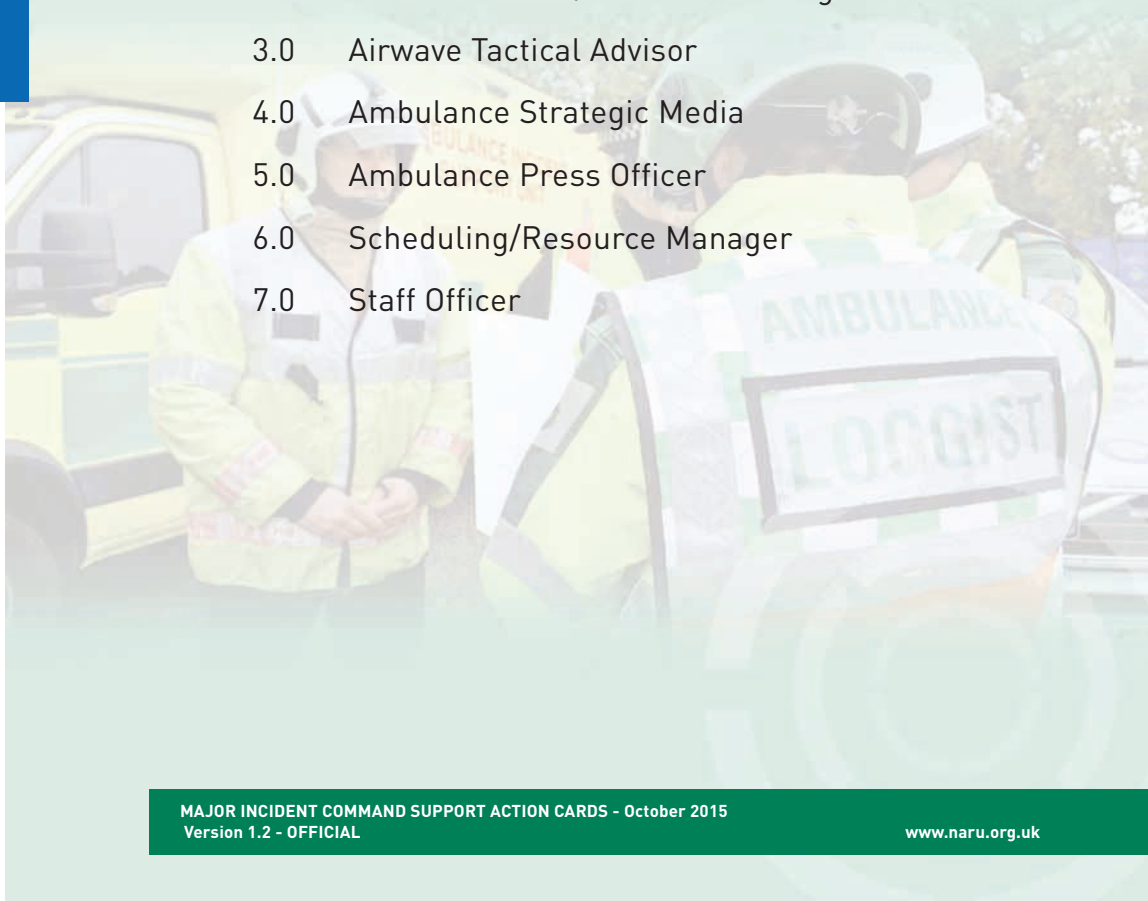


V.1.2 October 2015
OFFICIAL

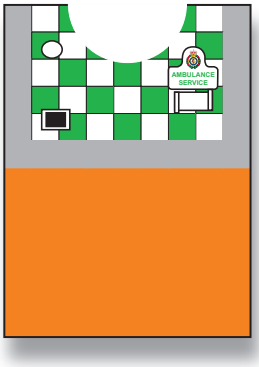
National Ambulance Resilience Unit
NARU

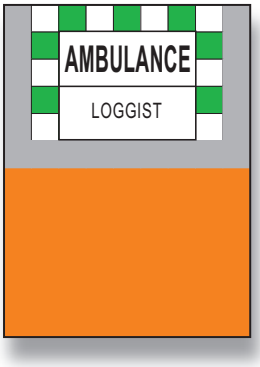
ASSOCIATION OF AMBULANCE CHIEF EXECUTIVES

Contents



1.0 Loggist



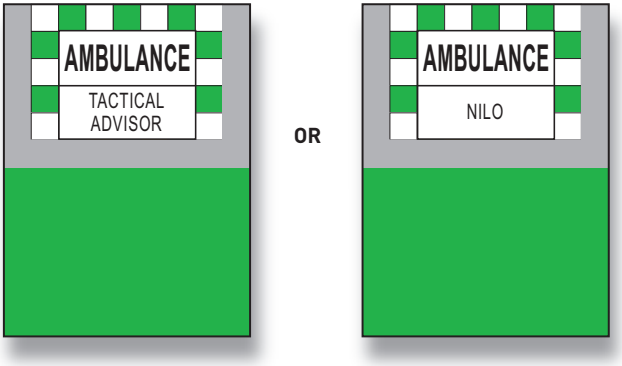


TASK	DESCRIPTION	✔	TIME
1	**Contact Emergency Operations Centre** and confirm mobilisation. Don high-visibility tabard inscribed **"Loggist"** and protective helmet, if required.		
2	If mobilised to a scene, ensure that a safety briefing has been received from the **Ambulance Safety/Parking Officer** before commencing duties.		
3	Ensure you have all equipment required to perform your task. Report to the appropriate Commander for tasking.		
4	The **Loggist** is responsible for capturing key information and decision making and events during an incident.		
5	Remain with the assigned Commander until stood down or re-tasked.		
6	Initial each entry into the log book as well as at the end of your duty period. Ensure any change in the Command and Control structure is logged with date and time. The Commander must sign the log to record completion of the role.		

CONTINUED OVERLEAF

TASK	DESCRIPTION	✔	TIME
7	**FOCUS ONLY ON YOUR ALLOCATED ROLE.**		
8	Before handover of the logs, ensure that all logs have the correct date, time and initials on all entries, and have been signed as a true record of events by the person responsible for the log.		
9	Collate and number (cross referenced to the log) all documentation, drawings, maps, emails, photographs (of dry wipe boards), notes, recordings and computer based material.		
10	Deliver all documentation to the **Tactical Advisor/NILO** within 24 hours.		

2.0 Tactical Advisor/NILO and Strategic Advisor



TASK	DESCRIPTION	✔	TIME
1	The **Tactical Advisor/NILO** will: ● Activate an additional **Tactical Advisor** as required ● Ensure appropriate command and medical support has been mobilised ● Confirm the incident is being managed on the relevant Airwave Talk Group ● Ensure liaison has taken place between the **Strategic, Tactical and Operational Commanders, On Call Media/ Communications Manager, Strategic advisors** and the **Emergency Operations Centre Manager** ● Ensure relevant Trust policies and plans have been initiated and actioned ● Ensure **Emergency Operations Centre** have notified the receiving Acute Trusts on the dedicated MI hospital numbers		
2	Following this the **Strategic Advisor** in conjunction with the Strategic Commander will: ● Inform the **Strategic Medical Advisor and Senior Communications Manager** of the situation ● Notify key stakeholders as appropriate including National Ambulance Resilience Unit On-Call		

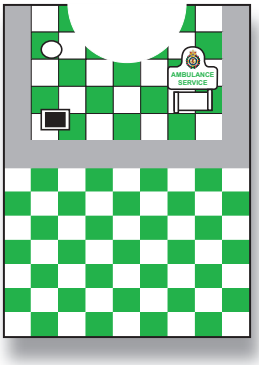
CONTINUED OVERLEAF

TASK	DESCRIPTION	✔	TIME
3	Ensure 'Information Only' notifications of a Major, Special or Significant event from another agency, (even if outside the Trust's geographical area). **Emergency Operations Centre Manager** must notify the **Tactical Advisor** who will inform the **Strategic Advisor and Strategic Commander** as appropriate.		
4	Support the **Tactical / Strategic Commander** providing specialist / specific advice to support the management of the incident. Contact the **Joint Regional Liaison Officer** (HM Armed Forces), where appropriate.		
5	Identify the different organisations and specialities that can provide information on the HAZMAT or CBRNE agents present. Contact the relevant advisory bodies.		
6	Consider early notification to Public Health England if CBRNE/Hazmat suspected. PHE Contact details: Chemical Advice (0900 – 1700 Mon-Fri) **0207 811 7140** Chemical Advice (24 hr) **0844 892 0555** Clinical Advice (24 hr) **0844 892 0111**		
7	Provide **Decontamination Officer** with as much information as possible, utilising intelligence from all agencies.		
8	Consider the activation protocol for the Mass Casualty Vehicle/Incident Support Vehicles.		

TASK	DESCRIPTION	✔	TIME
9	Consider: ● Mutual Aid ● Other specialist advisors ● National Ambulance Co-ordination Centre		
10	Monitor the weather via the Met Office (temperature, wind speed, wind direction, atmospheric pressure, humidity, forecast rain etc) considering its possible affects at the incident.		
11	In conjunction with other agencies obtain the plume distribution, in order to provide safe areas of work at the incident site.		
12	Compile a post incident report including actions identified taken from the formal debrief.		

National Ambulance Resilience Unit
NARU

3.0 Airwave Tactical Advisor



TASK	DESCRIPTION	✔	TIME
1	Ensure contact has been made with Airwave Ambulance desk (0800 4320870) to notify them of the incident.		
2	In liaison with the **Emergency Operations Centre Tactical** mobilise to the co-ordinating Emergency Operations Centre.		
3	**Emergency Operations Centre Manager** to set up the Major Incident Talk Group on the Control Room system.		
4	**Emergency Operations Centre Supervisor** managing the incident to identify all attending units and instruct staff to move onto the assigned Major Incident Talk Group.		
5	**Emergency Operations Centre Manager** to ensure all levels of Command are aware of Major Incident Talk Group. Consider use of interoperability channels.		
6	Throughout the incident, ensure dynamic monitoring of the incident site utilising the INSITE software from Airwave.		
7	Compile a debrief report of the incident.		

4.0 Ambulance Strategic Media Action Card

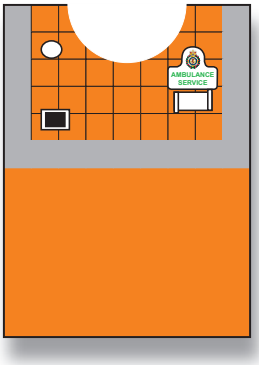
TASK	ACTION	RESPONSIBILITY	COMPLETE (Y OR N)
1	On activation contact Media Officer on call. On-call **Communications Manager** will dial into the initial conference call co-ordinated by the **Tactical Advisor** and activate the Major Incident Message Line post teleconference.	**Strategic Communications**	
2	On activation contact Strategic Communications on call if have not already spoken to each other.	**Media Officer on call**	
3	Establish who is **Strategic Commander**.	**Strategic Communications**	
4	Draft initial holding media statement.	**Strategic Communications or Media Officer on call**	
5	Liaise with host Police force Communications Lead to confirm Ambulance holding statement.	**Media Officer on call**	
6	Get statement approved by the **Strategic Commander**.	**Strategic Communications**	
7	Distribute approved statement to media as requested and put on newsline.	**Media Officer on call**	

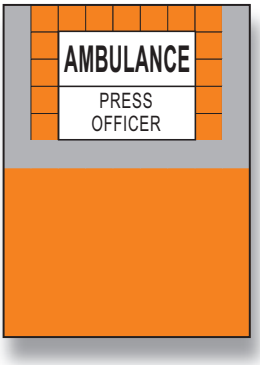
CONTINUED OVERLEAF

TASK	ACTION	RESPONSIBILITY	COMPLETE (Y OR N)
8	Activate Communications Team members and allocate responsibilities. Consider the following: Deploy Strategic Communications on call to Strategic Cell (this could be a virtual deployment in the first instance). On-call Media Officer to establish Media Cell for taking all media calls (this could be a virtual cell in the first instance; consider locating close to the Trust Strategic Cell). Deploy one Media Officer to scene (if appropriate and approved by the **Strategic Commander**). Deploy Media Officers to Media Cell including support.	**Strategic Communications** **Media Officer on call** **Strategic Communications** **Strategic Communications**	
9	Alert communication leads at NHS accountable/commissioning body, lead NHS Trust of the area of incident.	**Strategic Communications**	
10	If virtual media cell initially established, consider requirement to establish permanent media cell depending on the likely length and depth of the incident (consider locating close to Strategic Command if possible).	**Strategic Communications**	
11	If required draft internal message for staff to be circulated by email. Get approved by Strategic Commander.	**Media Officer on call or Strategic Communications**	

TASK	ACTION	RESPONSIBILITY	COMPLETE (Y OR N)
12	Update website with latest statements.	**Media Officer on call**	
13	Provide media statement updates as appropriate, as well as internal communication messages, intranet and website updates.	**Media Officer on call**	
14	Consider staffing requirements for next 12, 24, 48 and 72 hours.	**Strategic Communications**	
15	If required, contact other Ambulance/Health Services for mutual aid.	**Strategic Communications**	
16	Consider welfare needs of staff.	**Strategic Communications**	

5.0 Ambulance Press Officer





TASK	DESCRIPTION	✓	TIME
1	Gather Information from the **Operational Commander's METHANE** report and, in addition: ● Trust resources deployed to incident ● Identity of **Strategic, Tactical and Operational Commanders** ● Expected hospitals to be used ● Medical and other NHS involvement This information can be gathered by dialling into an initial conference call instigated by the **Tactical Advisor/NILO**.		
2	Draft initial press statement for onward approval by **Strategic Commander**. Once approved issue to media as appropriate.		
3	Roles and responsibilities: ● Contact communications colleagues as per MI Communications Toolkit ● Identify roles: - Overall management of the team - Liaison with **Emergency Operations Centre** for information updates - Media liaison at scene/rendezvous point		

TASK	DESCRIPTION	✔	TIME
	- Media liaison at Media Briefing Centre (if different from above) - Attendance at Trust Strategic command - Co-ordination of stakeholder/staff communications - Liaison with partner agency PRs and lead agency PR - Media spokespeople identified and briefed - Website and intranet updated - Media coverage monitored		
4	Cascade alert – contact **Media Officers** at other NHS providers.		
5	**Strategic Command – Strategic Media Officer:** ● To attend or delegate one Media Officer to **Strategic Command** ● Ensure media cell is staffed for incoming media calls or redirected appropriately Where safe, designate Media Officer to Forward Media Liaison Point.		
6	Mutual Aid: ● **Lead Media Officer/Strategic Command Media Officer** to establish contact with communications lead for other services and agencies involved ● Other NHS providers may be able to provide health communications specialists to assist if you need more resources ● If not, Central Office of Information (COI) Communications Officers can be called to assist ● Neighbouring Ambulance Trusts may also be able to provide mutual aid		
7	Compile debrief report of the incident.		

CONTINUED OVERLEAF

Brief Overview of Timescale for Communication:

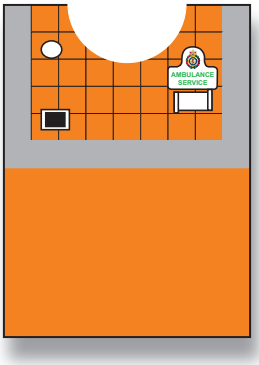
ACTIVITY	TIMESCALE	RESPONSIBILITY
Set up communications log and media monitoring service.	Straight away	**On-call Media Officer/Media Officer**
Issue initial holding statement.	Within 20 minutes	**On-call Media Officer/Media Officer**
Liaise with lead agency and partner agencies.	Within 30 minutes	**Communications Manager**
Brief key internal and external stakeholders.	Within 1 hour	**Media Officer/ Communications Manager**
Establish mutual aid arrangements.	As necessary	**Communications Manager/AD Comms**
Activate emergency warning and informing pages – Internet and Intranet.	Within 1 hour	**Web Editor/on-call Media Officer**
Identify media spokespersons available.	Within 1 hour	**Media Officer**

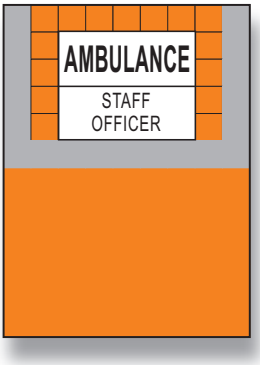
6.0 Scheduling/Resource Manager

Resource Manager – Based within an appropriate department, it is anticipated this role will be carried out by the relevant manager or supervisor of the area. They will be required to provide additional resources as requested by the Emergency Operations Centre for the incident and to ensure that normal day to day operations are dealt with effectively, ensuring any extra staff called to duty are of the appropriate skill level / status, primarily ensuring that the Trust will not encounter staffing problems during the incident and recovery phases.

TASK	DESCRIPTION	✔	TIME
1	Establish a liaison with the **Emergency Operations Centre and Strategic Advisor.**		
2	As necessary inform other scheduling/resource managers within the Trust.		
3	Retain or recall duty staff required to deal with the incident.		
4	Liaise with and inform patient transport service providers and non-operational staff of staff requirements to assist with the incident.		
5	Liaise with the **Emergency Operations Centre** keeping them informed of: – All staff movements – Status of shift cover – Where extra staff are reporting to – Any deficiencies in cover		
6	Carry out any other duties commensurate with the role.		
7	Compile a debrief report of the incident.		

7.0 Staff Officer





The role of the Staff Officer is not to be directly involved in the decision making process but to support the Commander. The relevant Manager will normally request his or her Staff Officer to attend Tactical or Strategic Command with them.

The Staff Officer should/will have an understanding of the Trust's strategic aims and objectives, Major Incident Plan and Major Incident Action Cards, Business Continuity and Incident Recovery.

TASK	DESCRIPTION	✔	TIME
1	To provide support to the **Strategic/Tactical Commander**.		
2	Assist the Commander in ensuring all strategic actions are achieved.		
3	Work alongside the **Strategic/Tactical Advisor/NILO**.		
4	Co-ordinate reports and returns required.		

TASK	DESCRIPTION	✔	TIME
5	Be prepared to act as a log keeper until an appropriately trained member of staff is available.		
6	Be prepared to act as 'gatekeeper' or attend meetings, and field calls on behalf of the Commander.		
7	Arrange transport / driver, accommodation, meals for team.		
8	Ensure systems are in place and liaison is maintained with Human Resources to ensure that concerns and requirements of staff involved directly and indirectly are not overlooked - for example child care and dependents.		

National Ambulance Resilience Unit

NARU

NHS

JESIP

MAJOR INCIDENT COMMAND SUPPORT ACTION CARDS

For further information please contact:

National Ambulance Resilience Unit (NARU)

Website: www.naru.org.uk

V.1.2 October 2015

OFFICIAL

National Ambulance Resilience Unit

NARU

NHS

JESIP

CBRNE INCIDENT ACTION CARDS

CBRNE INCIDENT ACTION CARDS

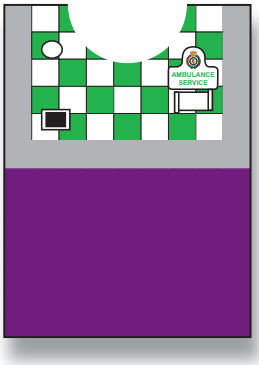
V.1.2 October 2015
OFFICIAL

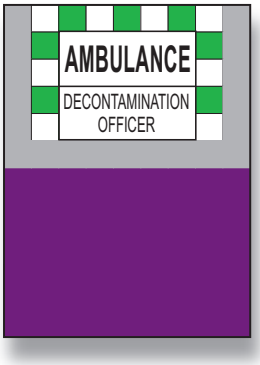
National Ambulance Resilience Unit
NARU

ASSOCIATION OF AMBULANCE CHIEF EXECUTIVES

Contents

1.0 Decontamination Officer



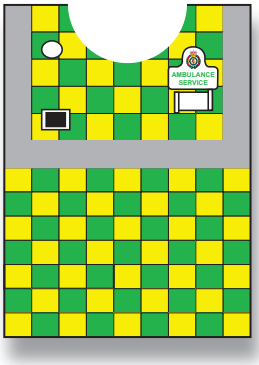


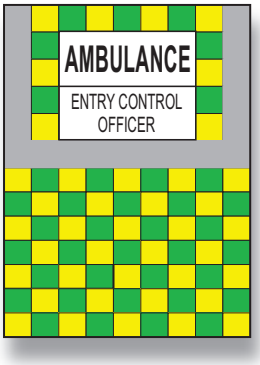
TASK	DESCRIPTION	✔	TIME
1	● Don high-visibility TABARD inscribed **"Decontamination Officer"** and appropriate PPE as required ● Establish communications ● Start Log		
2	Under the direction of the **AIC** or **Tactical Advisor/NILO** manage and co-ordinate the deployment of the **Special Operations Response Team**.		
3	Early consideration to be given to the immediate needs of the casualties: ● Decontamination algorithm ● Improvised decontamination ● Interim decontamination ● Casualty reassurance and information		
4	Prior to the appointment of the **Safety Officer** carry out a joint Dynamic Risk Assessment in conjunction with the Tactical Advisor/NILO, Fire & Rescue and Police Officers; confirm wind direction and zones.		

CONTINUED OVERLEAF

TASK	DESCRIPTION	✔	TIME
5	Appoint appropriately trained staff to undertake the following roles: ● 1 x Entry Control Officer (normal PPE) ● 6 x operatives (PRPS wearers)* ● 1 x Equipment Officer (normal PPE) ● 2 x Warm Zone Rescue Team operatives (PRPS wearers) ● 2 x Forward Triage Officers (PRPS wearers) *Multiple cubicles within a CDU will require additional resources. The host service should determine the equipment levels required.		
6	Ensure the decontamination area is agreed with the AIC and multi agency partners: ● Access and Egress (sterile route) ● Decontamination zones ● Casualty Holding Area ● Clinical Decontamination area and safe undress area for HART/Police (CR1 and/or QDPPE) ● Disrobe and re-robe areas ● Casualty screening area ● Team Rest Area (welfare) ● Casualty Clearing Station		
7	Inform the **AIC** re status of the decontamination facility.		
8	Brief to ensure the safety of all SORT members prior to deployment in PPE.		
9	Liaise with the **Ambulance Incident Commander** via the Tactical Advisor/NILO; consider SORT Mutual Aid.		
10	Advise the **AIC** on completion of patient decontamination.		
11	Compile a report and attach all documentation relating to the incident and send to the Resilience Department.		

2.0 Decon Entry Control Officer





TASK	DESCRIPTION	✔	TIME
1	Under the direction of the **Decontamination Officer (CBRNE Operational Commander)** manage and co-ordinate entry and exit of SORT members to and from the warm zone.		
2	Don the **Decontamination Entry Control Officer** tabard, and appropriate PPE.		
3	Identify in conjunction with multi agency partners suitable site for decontamination footprint taking into account: ● Size of risk area ● Access and egress points ● Physical limitations of site ● Slopes affecting drainage of contaminated water ● Wind direction ● Likely development of incident		
4	Set up an Entry Control Board (ECB) complete with suitable waterproof marker and supplemental information board. Ensure the ECB is manned at all times.		
5	Synchronise clock on Entry Control Board with time on control CAD.		

CONTINUED OVERLEAF

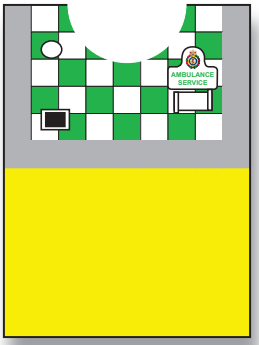
TASK	DESCRIPTION	✔	TIME
6	Ensure each PRPS wearer's details are recorded (name, time, time in) into the warm zone on the ECB. *(Subject to national review.)*		
7	Complete a pre-entry check of PRPS wearers to ensure equipment is correctly worn and fully operational prior to allowing entry into the warm zone.		
8	Conduct a communication pre-entry check with PRPS wearers carrying radios. Nominate a callsign to radio operators. Ensure PRPS wearers are aware of the evacuation signal: 3 loud blasts of a whistle.		
9	Monitor the welfare of PRPS wearers whilst in the warm zone and withdraw staff from warm zone where concerns for their welfare are identified.		
10	Manage the timings of staff within the warm zone and manage the rotation of decontamination team members ensuring replacement teams are in place to ensure continuity of process.		
11	Confirm rescue teams are in situ.		
12	At incidents requiring decontamination involving radiation: in conjunction with **Radiation Protection Supervisor** identify monitoring regime for staff and patients leaving the CDU using RAM GENEs.		
13	In liaison with the **Safety Officer**, monitor the environment for safe working practices.		
14	Maintain effective communications with the **Decontamination Officer (CBRNE Operational Commander)**.		
15	Compile a full report of the incident and attach all documentation relating to the incident.		

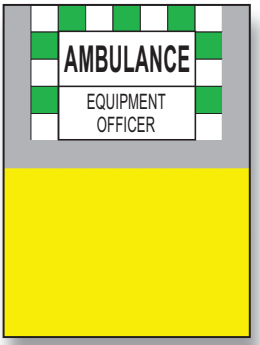
3.0 SORT Operative (Specialist Role)

TASK	DESCRIPTION	✔	TIME
1	Set up the decontamination units as tasked by the **Decontamination Officer**.		
2	Ensure the correct PPE is worn in line with current procedures. Monitor the environment for safe working practices.		
3	If directed by the **Decontamination Officer** to be the rescue team, refer to the Warm Zone Rescue Team Operative action card.		
4	Monitor the welfare and safety of team members and casualties throughout the decontamination process.		
5	Ensure that the clean/dirty line is maintained at all times.		
6	Decontaminate casualties using the **"RINSE, WIPE, RINSE"** method.		
7	Ensure that the quality of decontamination is to the highest possible standard achievable at the time.		
8	**The maximum operating time spent inside a PRPS suit is 1 hour and then decontamination is required.** **Prior to further deployment there must be a minimum of 1 hour stand down.**		
9	Personal decontamination must take place prior to exit from the warm zone.		
10	Upon exit of the unit report to the **Entry Control Officer**.		
11	Attend hot debrief immediately following the official stand down.		
12	Report any feelings of being unwell to the **Decontamination Officer** during and/or post incident.		

National Ambulance Resilience Unit
NARU

4.0 Decontamination Equipment Officer





TASK	DESCRIPTION	✔	TIME
1	Under the direction of the **Decontamination Officer** manage and co-ordinate all equipment requirements for SORT during deployment and post deployment of the CDU.		
2	Don the **Equipment Officer** tabard.		
3	Conduct a communication check with the **Decontamination Officer**.		
4	As directed by the **Decontamination Officer**, co-ordinate the erection of the decontamination structure and gain access to a water supply.		
5	Create an equipment dump to support decontamination operations.		
6	Advise the **Decontamination Officer** when the clinical decontamination unit is ready to commence patient decontamination.		

TASK	DESCRIPTION	✔	TIME
7	Monitor the use of all consumable items and replenish as required.		
8	Advise **Decontamination Officer** of any unforeseen hazards and dangers that may arise and liaise with **Ambulance Safety Officer** regarding any protective measures that can be taken.		
9	Monitor the rate of contaminated water flow from the decontamination process ensuring sufficient containment tanks are available to deal.		
10	Ensure all equipment is regularly checked and refueled as required.		
11	In liaison with the **Decontamination Officer** secure and oversee the disposal of contaminated water in liaison with **Environment Agency**.		
12	Recover all surplus equipment on stand down of the incident.		
13	Prepare an inventory of all equipment and stock used during the incident.		
14	Ensure a full report together with any contemporaneous notes collated during the incident is submitted as soon as possible after the incident.		

National Ambulance
Resilience Unit
NARU

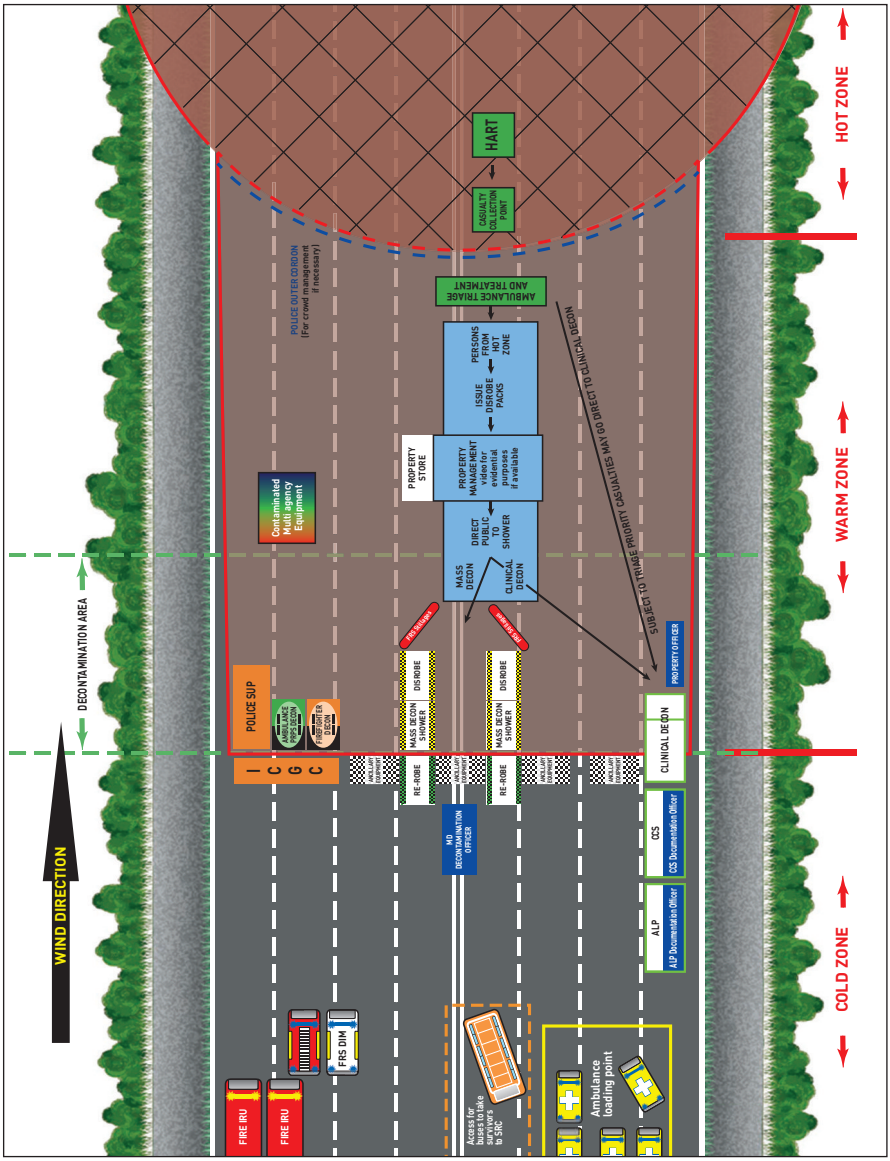
5.0 Decon Forward Liaison Officer

TASK	DESCRIPTION	✔	TIME
1	Ensure the correct PPE is worn in line with current procedures and that safe working practices are utilised.		
2	**The maximum operating time spent inside a PRPS suit is 1 hour and then decontamination is required.**		
3	Under the direction of the **Decontamination Officer**, ensure that the following area is established: ● Warm Zone Triage (inc perimeter)		
4	Receive and manage casualties brought to the decontamination area by HART and/or Fire & Rescue Service. **DO NOT GET INVOLVED IN RESCUE.**		
5	Liaise with HART and FRS to ensure the effective forward movement of casualties.		
6	Update regularly the **Decontamination Officer** with the number and priorities of casualties awaiting decontamination.		
7	Direct decontamination team personnel as to the priorities of casualties for decontamination.		
8	Continue to reassess and dynamically re-triage casualties throughout the entirety of the incident.		
9	Maintain effective communications with the **Decontamination Officer**.		
10	Brief the oncoming **Decontamination Forward Liaison Officer** on their arrival.		
11	Compile a full report of the incident and attach all documentation relating to the incident.		

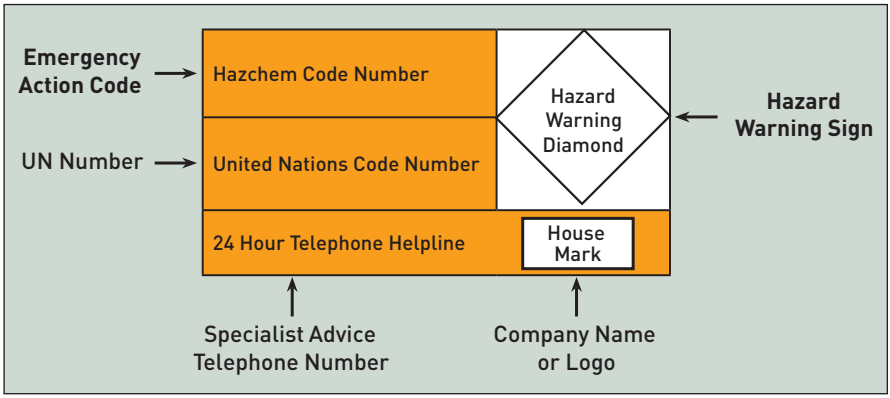
6.0 Warm Zone Rescue Team Operative

TASK	DESCRIPTION	✔	TIME
1	**Following briefing by the Decontamination Officer:** ● Report to the decontamination Entry Control Officer (ECO) and confirm briefing from **Decontamination Officer** ● Confirm with ECO role that will be undertaken ● Don the appropriate PPE for the assigned role		
2	Receive a pre entry safety brief from ECO including evacuation and rescue arrangements and locations of PRPS wearers/zones.		
3	Undertake pre entry check on equipment and communications in conjunction with ECO ready to enter decontamination area if emergency declared.		
4	Identify suitable location to stand by ensuring the team leader is in contact with the ECO and available to immediately enter the decontamination area if a rescue team is required.		
5	When PRPS wearer emergency is identified confirm with ECO that **Decontamination Officer has been informed**.		
6	Ensure each PRPS wearer's details are recorded (name, time, time in) into the warm zone on the ECB. *(Subject to national review.)* The ECO will not enter a time of entry on the board until committed.		
7	Locate and identify PRPS wearer/s requiring rescue; if necessary request further assistance or specialist support to facilitate rescue of PRPS wearer.		
8	Provide an update at the earliest opportunity to the ECO re the PRPS wearer's condition and rescue plan.		
9	On arrival at decontamination unit confirm with ECO if there is a need to re commit to rescue further wearers subject to time available time limits of PRPS, or request second rescue team if required.		
10	Compile a full report of the incident and attach all documentation relating to the incident.		

7.0 Decontamination Schematic



8.0 Hazard Warning Panel and Hazard Warning Diamonds



National Ambulance Resilience Unit
NARU

9.0 Initial Operational Response - STEP 1-2-3 PLUS

STEP 1

One person incapacitated with no obvious reason

- Approach using standard protocols

STEP 2

Two people incapacitated with no obvious reason

- Approach with caution using standard protocols

STEP 3

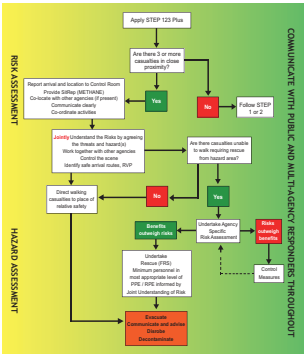
Three or more people in close proximity, incapacitated with no obvious reason

- Use caution and follow **PLUS**

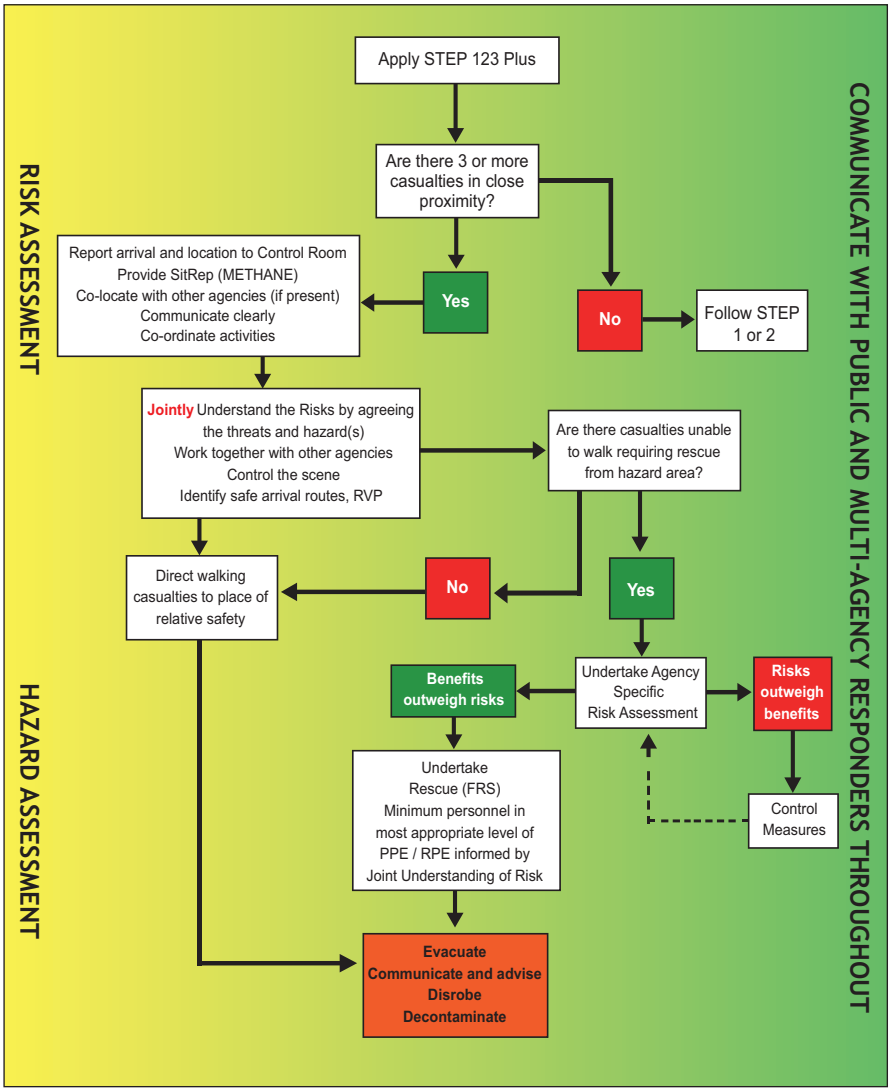
PLUS

PLUS means follow the CBRN First Responder Flow Chart to consider what actions can be undertaken to save life, using the principles below:

- **Evacuate** – Get people away from the scene of contamination.
- **Communicate and Advise** – Give immediate medical advice and reassurance that help is on its way.
- **Disrobe** – Remove clothing.
- **Decontamination** – Dry decontamination should be the default process.



10.0 Initial Operational Response - CBRN First Responder Flow Chart



11.0 Responding To Individual Chemical Exposure (ICE) Events

ICE events are frequently characterised by the use of a chemical or a mixture of chemicals by an individual/s with the intent to self-harm predominantly via ingestion or inhalation. These events commonly occur in sealed or partially sealed environments such as vehicles, residential bathrooms, hotel rooms and other enclosed areas where a small amount of gas can quickly reach lethal concentrations.

INDICATIONS OF AN ICE EVENT

It is important to note that the signs of an ICE event may not be immediately obvious, however there may be certain indications or manifestations at the scene that may alert emergency services personnel to the possibility that an ICE event is on-going.

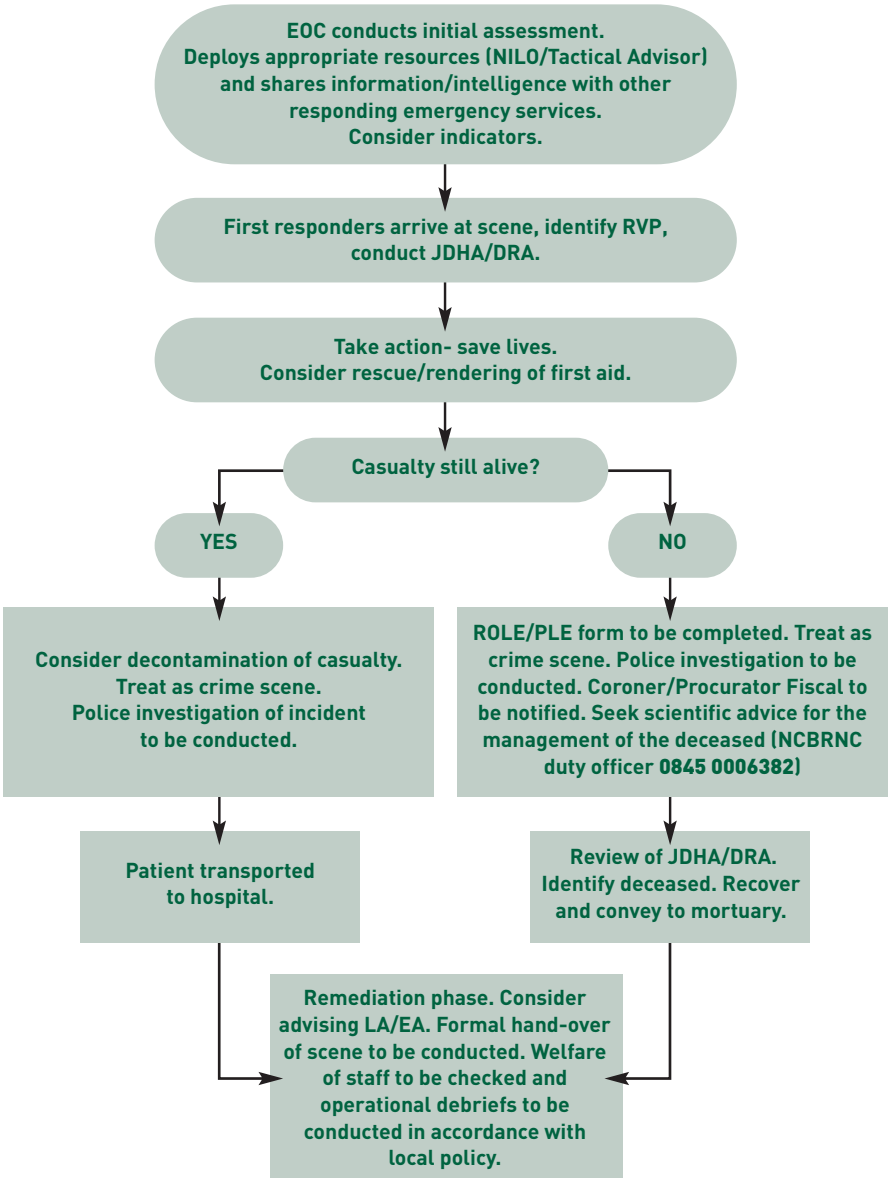
These may include:

- **The incident is taking place in an unusual location e.g. a beauty spot in a rural area or a small enclosed room;**
- **Vehicle occupant/s appears unconscious or unresponsive;**
- **Information has been received (e.g. from a witness) that a person at the scene may be in possession of chemicals or that there is some history or intelligence that suggests the person has attempted to self-harm on a previous occasion;**
- **Warning notes or safety data have been taped to vehicle or house/building windows or doors;**
- **Casualties or emergency responders may be experiencing breathing difficulties and/or have irritation to the eyes and nose.**
- **Duct tape, plastic or towels have been used to cover air vents windows and/or doors in order to produce a sealed environment;**
- **Presence of a 'suicide bag' or hood at the scene;**
- **Suspicious (possibly spilled or empty) containers or cylinders at the scene of an event;**
- **Unexplained vapour in the air or a strong chemical smell present at the scene e.g. the smell of rotten eggs, bitter almonds, garlic or decaying fish;**
- **The presence of a barbecue within a sealed or partially sealed environment;**
- **Disabled smoke alarms and/or carbon monoxide alarms.**

TASK	DESCRIPTION	✔	TIME
1	Deploy appropriate resources relevant to the risks/hazards identified at the scene. (HART) and Fire and Rescue Service (FRS).		
2	Identify and put in place an appropriate command and control structure for the event and notify specialist resources such as HART, National Inter-Agency Liaison Officer (NILO)/ Tactical advisor. Specialist advice can be sought from NCBRNC Operations centre **0845 0006382**.		
3	Consider use of Multi-Agency Interoperability Communication Talk-Group and undertake a **Joint Dynamic Hazard Assessment (JDHA)** in order to identify any hazards associated with the incident.		
4	Unless a suspected ICE casualty can be formally recognised as life extinct by an approved medical professional, the casualty should be assumed to be a potential survivor in need of fast time rescue and lifesaving interventions and appropriate medical care given.		
5	Where necessary, casualties should be de-contaminated at the scene in order to minimise risks to others and avoid contamination of emergency vehicles. Note - Presence of the chemical or contaminated vomit or other bodily fluids on the casualty's skin, hair or clothes.		
6	**Inform receiving hospital that a casualty is potentially contaminated prior to arrival.**		
7	Consider ventilating the enclosed environment and removing the patient from the area of risk (from the source of exposure) to a place of relative safety (into a ventilated space) where either medical treatment/resuscitation can take place.		
8	Undertake an agency specific **Dynamic Risk Assessment (DRA)** reflecting the tasks/objectives to be achieved, their associated risks, and the proposed measures to eliminate or control them. Agree an operational plan, Identifying tasks that are required to be carried out using the JDM.		

TASK	DESCRIPTION	✔	TIME
	If any suspicious devices, packages or equipment are observed at the scene that may indicate an explosive/improvised explosive device (IED) risk then emergency responders should comply with bomb scene management guidelines. Specialist support should then be requested.		
9	Communicate with persons who may be at risk from the incident and direct them away from the main area of contamination into a safe area.		
10	Consider implementing an initial cordon and then, subsequently, an inner and outer cordon Additionally, consider whether hot/warm/cold zones1 should be designated in order that the incident can be controlled and managed as safely as practicable.		
11	Complete a ROLE (Recognition of Life Extinct) or a Pronounced Life Extinct (PLE) form seeking scientific advice for the management of the deceased (NCBRNC duty officer **0845 0006382**) and formal handover to police.		

ICE EVENT FLOW-CHART



National Ambulance Resilience Unit

NARU

NHS

JESIP

CBRNE INCIDENT ACTION CARDS

For further information please contact:

National Ambulance Resilience Unit (NARU)

Website: www.naru.org.uk

V.1.2 October 2015

OFFICIAL

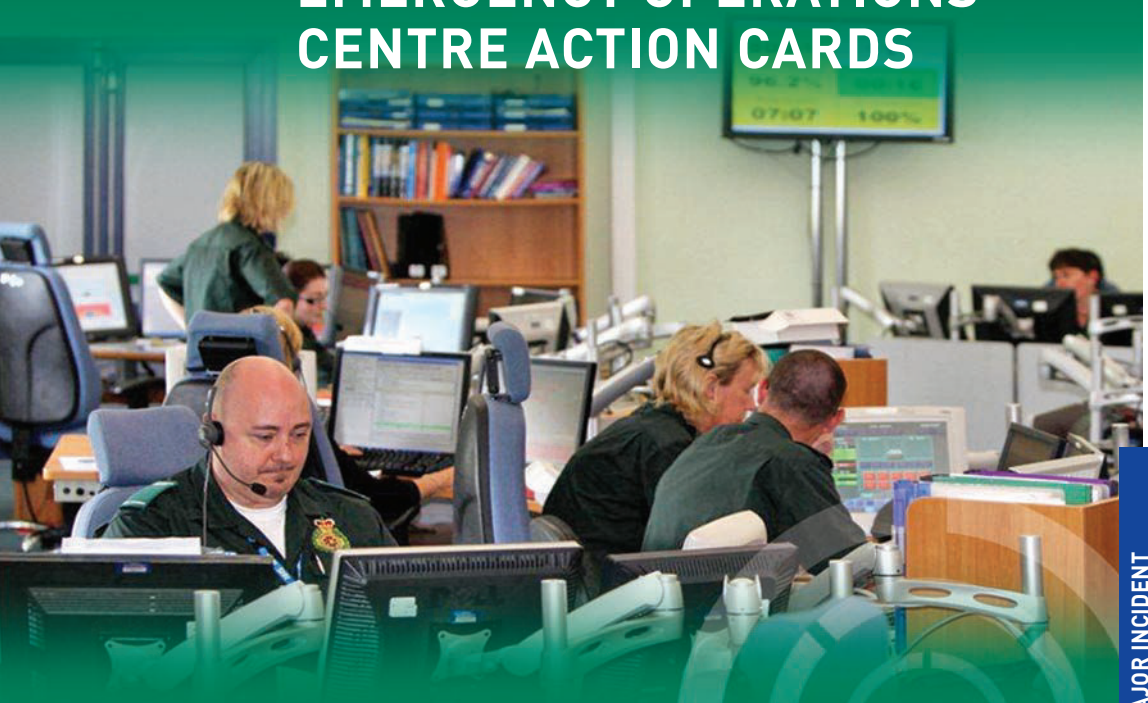
National Ambulance Resilience Unit

NARU

NHS

JESIP

MAJOR INCIDENT EMERGENCY OPERATIONS CENTRE ACTION CARDS



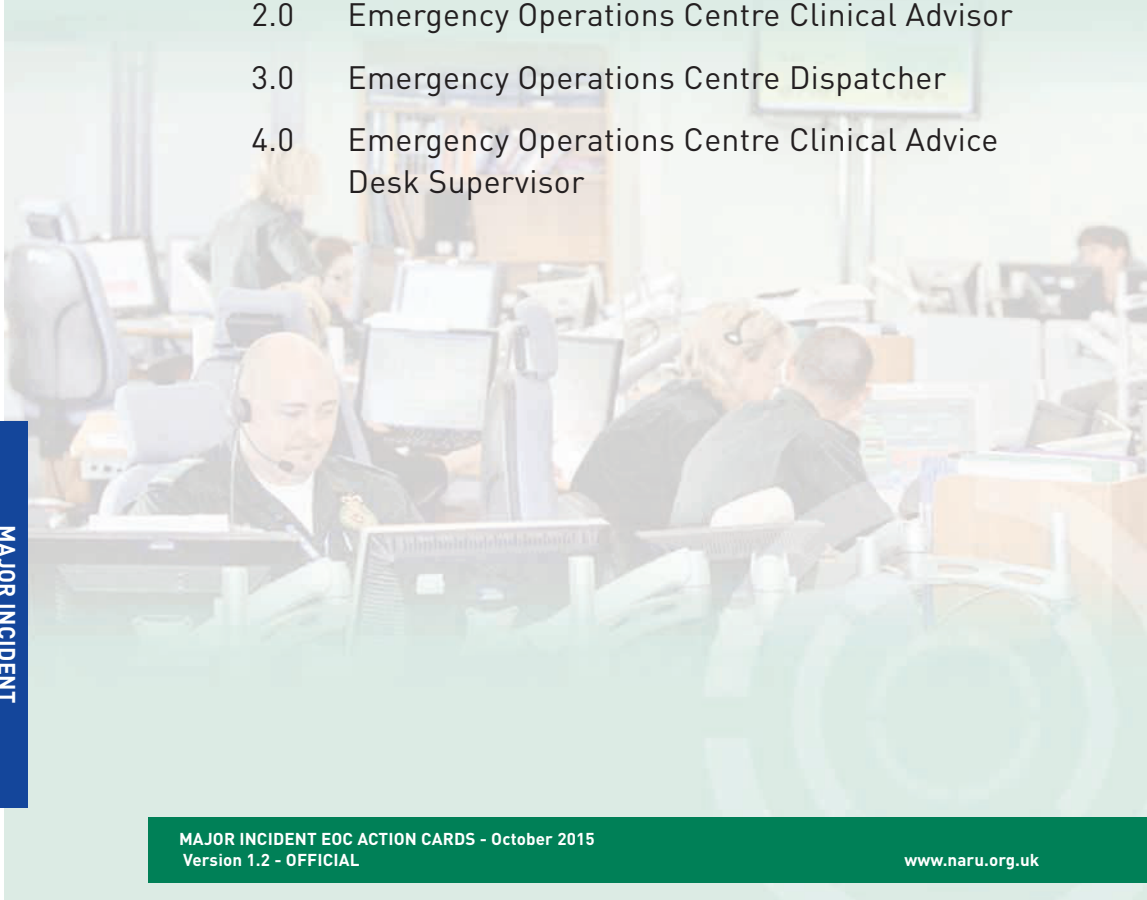
V.1.2 October 2015
OFFICIAL

MAJOR INCIDENT
EMERGENCY OPERATIONS
CENTRE ACTION CARDS

National Ambulance Resilience Unit
NARU

ASSOCIATION OF AMBULANCE CHIEF EXECUTIVES

Contents



MAJOR INCIDENT EMERGENCY OPERATIONS CENTRE ACTION CARDS

1.0 Emergency Operations Centre (EOC) Duty Manager

TASK	DESCRIPTION	✔	TIME
	Primary Actions - This relates to original information received.		
1	Ensure Major Incident details are accurate and reliable.		
2	Ensure appropriate action cards are distributed.		
3	Notify Police and Fire Service that our 'Major Incident' plan has been activated, passing **'METHANE'** report of the incident.		
4	Ensure the **Emergency Operations Centre (EOC) Senior Manager** (Tactical if OOH) is available or called into EOC.		
5	Initiate / maintain Major Incident Control Log using 24 hour format via the CAD.*		
6	Distribute the Trust Major Incident action cards within the EOC.		
7	Notify the nearest receiving hospital(s) **(via METHANE report)** of all the facts and place them on **'Major Incident Standby'**.**		
8	Ensure appropriate senior managers are notified or mobilised.		
9	Inform duty / on-call **Tactical Advisor/NILO**.		
10	Establish emergency communications support (as / if required).		
11	Inform and liaise with other Out of Hours service providers.		
12	Alert neighbouring Ambulance Services that a 'Major Incident' has been declared.		
13	Ensure resources are available to maintain local/urgent cover for the duration of the Major Incident. Consider mobilisation requirements of out of hours vehicles under mutual aid.		

CONTINUED OVERLEAF

TASK	DESCRIPTION	✔	TIME
14	Ensure the Voluntary Aid Societies have been notified that a 'Major Incident' has been declared.		
15	Initiate call out of **Emergency Operations Centre** personnel.		
	Secondary Actions - This relates to updated information received.		
16	Dispatch appropriate managers to the receiving hospital(s) to act as **Ambulance Liaison Officer (HALO).**		
17	If requested arrange for **MERIT** to be transported to the scene.		
18	If CBRNE/HazMat - depending on number of persons affected, arrange for further decontamination teams/SORT/HART to be sent. *** (Guidance should be sought from the **Tactical Advisor/NILO**.)		
19	Confirm bed status of receiving and supporting hospitals.		
20	Inform 'Scheduling/Resources Dept' of the need for 'off duty' personnel to be called in.		
21	Update Voluntary Aid Societies and secure support, giving details of tasks required.		
22	Alert the Occupational Health Dept as required.		
23	Compile a debrief report of the incident.		

NOTE: When the incident is closed by the AIC all agencies who have been alerted for the emergency must be advised and stood down.

* *The information collated within the log may be used as evidence in any subsequent public enquiries and as criminal evidence in a court of law.*

** *If further 'METHANE REPORTS' suggest a Major Incident has been declared the hospital should be updated and informed (via switchboard) of 'Major Incident Declared'. If having instituted 'Major Incident Standby' it is not required, it must be rescinded and the hospital informed (via switchboard) 'Major Incident Cancelled'*

*** *Guidance for numbers of CBRNE trained staff required, in relation to number of casualties, is situated in the CBRNE incident folder within Emergency Operations Centre.*

2.0 Emergency Operations Centre (EOC) Clinical Advisor

TASK	DESCRIPTION	✔	TIME
1	Liaise with **Emergency Operations Centre (EOC) Manager** to identify whether this is a 'Standby' or 'Declared' incident.		
2	Ascertain with the **EOC Manager** the need for additional clinical staff. Contact staff as directed.		
3	Contact the **Team Leader** of the Clinical Desk and inform him/her of the situation.		
4	Ensure that the Clinical Desk is operational and that all support functions, such as TOXbase referral options are available.		
5	If a chemical incident is suspected, access the appropriate TOXbase application and print off all relevant information for retention and onward transmission.		
6	Using enhanced clinical triage provide clinical advice to G1, G2, G3 calls in order to assist in the optimal use of resources.		
7	Provide clinical advice to crews, **Tactical Advisor/NILO and Managers** at scene, if required.		
8	Redirect non-symptomatic callers *(health information type calls)* to the relevant agency.		
9	Monitor trends and nature of calls within the clinical desk and report any unusual findings to the Team Leader of the clinical desk or the EOC Manager.		
10	Be prepared to act as a Clinical resource to the department as a whole and provide direct advice to call handlers whilst not conflicting with their responsibility under AMPDS licence.		
11	Ensure that documentation is maintained and is of a contemporaneous nature.		
12	Compile a debrief report.		

3.0 Emergency Operations Centre (EOC) Dispatcher

TASK	DESCRIPTION	✔	TIME
1	Dispatch nearest suitable Ambulance resource(s)* to the scene.		
2	Dispatch nearest available manager(s)* to the scene.		
3	Request an immediate **'METHANE Report'** from all attending resources or as required.		
4	Notify **EOC Manager** and discuss further 'Trust' notification.		
5	Assess current Ambulance resources and liaise directly with all other dispatch desks to ensure mutual support.		
6	On the receipt of a **'METHANE Report'** and a Major Incident 'Declared' ensure the following information is disseminated and resources mobilised: ● Instruct all Ambulance resources to change to the appropriate designated Talk Group ● Additional Ambulance resources ● Additional officer resources. (Operational positions or as required) ● **Tactical Advisor/NILO** ● CBRNE (SORT) response (as required) ● MA rota		

*** Remember: resources and support are a judgement call based on the information received. Be prepared to initiate a 'Standby' or full 'Major Incident Declaration' only after liaison with the Emergency Operations Centre Duty Manager / Dispatch Team Leader.**

National Ambulance Resilience Unit
NARU

4.0 Emergency Operations Centre (EOC) Clinical Advice Desk Supervisor

TASK	DESCRIPTION	✔	TIME
1	Liaise with the **Emergency Operations Centre Duty Manager** regarding situation and apply judgement regarding additional staffing.		
2	Liaise with other service managers, brief accordingly and ascertain availability if required (Rapid Response / Falls / Admission Prevention Service).		
3	If 'Out of Area' incident, liaise with the **Tactical Advisor/NILO** and discuss potential mutual aid support.		
4	If the incident is 'Within Area', consider mutual aid from neighbouring Ambulance Services to assist with low acuity calls.		
5	Ensure appropriate resources are allocated to the clinical desk in order to facilitate the effectiveness of the team. This includes information resources.		
6	Monitor trends and nature of calls within the clinical desk and report / log any unusual findings.		
7	Be prepared to act as a clinical resource within the control room and clinical support to the **Emergency Operations Centre Manager** if required.		
8	Liaise with GP 'Out of Hours' as directed, to evaluate and provide clinical support to staff as required.		
9	Act as a conduit for clinical support and assistance within **Ambulance Control**.		
10	Compile a debrief report.		

National Ambulance Resilience Unit

NARU

NHS

JESIP

MAJOR INCIDENT EMERGENCY OPERATIONS CENTRE ACTION CARDS

For further information please contact:

National Ambulance Resilience Unit (NARU)

Website: www.naru.org.uk

V.1.2 October 2015

OFFICIAL

National Ambulance Resilience Unit

NARU

NHS

JESIP

AIRPORT INCIDENT ACTION CARDS

V.1.2 October 2015
OFFICIAL

National Ambulance Resilience Unit
NARU

ASSOCIATION OF AMBULANCE CHIEF EXECUTIVES

Contents

1.0 Predetermined Response to an Incident at an Airport Involving Passenger Aircraft

On receipt of notification of an incident / potential incident at an airport involving a passenger aircraft.

Category A: Those aircraft that fall within the scope of CAA airport categories 5, 6, 7, 8, 9 and 10 eg large passenger aircraft, large cargo aircraft (CAT 10 ie A380).

Category B: Those aircraft that fall within the scope of CAA airport categories 3 and 4 eg smaller passenger aircraft, executive type aircraft, large passenger carrying helicopters.

Category C: Those aircraft that fall within the scope of CAA airport categories 1 and 2 eg light aircraft, gliders, small helicopters.

TASK	DESCRIPTION	✔	TIME
1	On receipt of call obtain contact number and name for return calls.		
2	Identify Rendezvous Point or attendance location.		
Cat A	● Mobilise resources: 1 x nearest Manager, 1 x nearest ambulance and crew, 1 x HART ● **In a Marauding Terrorists Firearms Attack scenario (MTFA), resources should only be deployed directly to scene following a Tactical Risk Assessment** ● Notify the Tactical Advisor/NILO		
Cat B	● Mobilise resources: 1 x nearest Manager, 1 x nearest ambulance and crew, 1 x HART ● **In a Marauding Terrorists Firearms Attack scenario (MTFA), resources should only be deployed directly to scene following a Tactical Risk Assessment** ● Notify the Tactical Advisor/NILO		

CONTINUED OVERLEAF

TASK	DESCRIPTION	✔	TIME
Cat C	● Mobilise resources: 1 x nearest Manager, 1 x nearest ambulance and crew ● Consider 1 x HART in consultation with Tactical Advisor ● **In a Marauding Terrorists Firearms Attack scenario (MTFA), resources should only be deployed directly to scene following a Tactical Risk Assessment** ● Notify the Tactical Advisor/NILO		
3	MI declared -minimum of 3 Officers to scene including Tactical (Tactical) Commanders and HART where appropriate. Contact the Tactical Advisor/NILO, Tactical (AIC) and Strategic (Strategic) Commander, and inform them of the situation using a **METHANE** report.		
4	Following this contact the **Tactical Advisor** will, within 15 minutes of Standby/Declaration: ● Activate an additional **Tactical Advisor** as required ● Contact the **Tactical Commander** ● Mobilise the **Strategic Advisor and Loggist** to the **Strategic Commander** and a **Loggist to the Tactical Commander** ● Confirm the incident is managed on the relevant Airwave Talk Group ● Instigate a **conference call** between the **Strategic, Tactical and Operational Commanders**, the **Tactical and Strategic advisors** and the **EOC Duty Manager** **Tel –** ● Mobilise a **Medical Advisor (MA)** to scene if required ● In a Mass (patients in the 100s) or Catastrophic (1000s) Casualty situation, please note the Mass/Catastrophic Casualties action card ● Ensure **EOC** have notified the receiving Acute Trusts on the dedicated MI hospital numbers		

TASK	DESCRIPTION	✔	TIME
5	Following this the **Strategic Advisor** in conjunction with the **Strategic Commander** will: ● Inform the **Strategic Medical Advisor** and the **on-call Media Officer** of the situation ● Following the conference call, and where appropriate, send a message to all managers informing them of the status of the Trust ● Notify key stakeholders as appropriate ● Under direction of the **Strategic Commander** inform the CEO and senior management team ● Consider additional managerial support to EOC		
	'Information Only' notifications of a Major, Special or Significant event from another agency, (even if outside the Trust's geographical area): ● **EOC Duty Manager** must notify the **Tactical Advisor/NILO** who will inform the **Strategic Advisor and Strategic Commander**		

2.0 Predetermined Aircraft Attendance

PREDETERMINED ATTENDANCE TO AN INCIDENT AT AN AIRPORT INVOLVING PASSENGER AIRCRAFT

INCIDENT TYPE	CATEGORY A	CATEGORY B	CATEGORY C
	Those aircraft that fall within the scope of CAA airport categories 5, 6, 7, 8, 9 and 10 eg large passenger aircraft, large cargo aircraft (CAT 10 ie A380).	*Those aircraft that fall within the scope of CAA airport categories 3 and 4 eg smaller passenger aircraft, executive type aircraft, large passenger carrying helicopters.*	*Those aircraft that fall within the scope of CAA airport categories 1 and 2 eg light aircraft, gliders, small helicopters.*
AIRCRAFT ACCIDENT When an accident has occurred or is inevitable on, or in the vicinity of, the Airport. An aircraft which travels off the dedicated runway/taxi-way will be treated as an accident.	1. Mobilise 2 x nearest DMAs to the RVP and ensure further 4 x DMAs are mobile to the RVP using blue lights if necessary. 2. Mobilise nearest Operational Commander and **request Sit Rep within ten minutes of arrival.** 3. Mobilise HART. 4. Mobilise nearest Tactical Commander. 5. Mobilise local Resilience Manager/NILO. 6. Instigate Major Incident Standby and cascade. 7. Place local hospital on Major Incident Standby. 8. Start an Incident Log.	1. Mobilise 2 x nearest DMAs to the RVP and ensure further 4 x DMAs are mobile to the RVP using blue lights if necessary. 2. Mobilise nearest Operational Commander and **request Sit Rep within ten minutes of arrival.** 3. Mobilise HART. 4. Mobilise nearest Tactical Commander. 5. Mobilise local Resilience Manager/NILO. 6. Instigate Major Incident Standby and cascade. 7. Place local hospital on Major Incident Standby. 8. Start an Incident Log.	1. Mobilise nearest DMA to the RVP. 2. Mobilise nearest Operational Commander and **request Sit Rep within ten minutes of arrival.** 3. Mobilise HART. 4. Inform nearest Tactical Commander. 5. Inform local Resilience Manager/NILO. 6. Start an Incident Log.

National Ambulance Resilience Unit
NARU

PREDETERMINED ATTENDANCE TO AN INCIDENT AT AN AIRPORT INVOLVING PASSENGER AIRCRAFT

INCIDENT TYPE	CATEGORY A	CATEGORY B	CATEGORY C
	Those aircraft that fall within the scope of CAA airport categories 5, 6, 7, 8, 9 and 10 eg large passenger aircraft, large cargo aircraft (CAT 10 ie A380).	*Those aircraft that fall within the scope of CAA airport categories 3 and 4 eg smaller passenger aircraft, executive type aircraft, large passenger carrying helicopters.*	*Those aircraft that fall within the scope of CAA airport categories 1 and 2 eg light aircraft, gliders, small helicopters.*
AIRCRAFT IMMINENT Air crash is imminent.	1. Mobilise 2 x nearest DMAs to the RVP and ensure a further 4 x DMAs are mobile to the RVP using blue lights if necessary. 2. Mobilise nearest Operational Commander and **request Sit Rep within ten minutes of arrival.** 3. Mobilise HART. 4. Mobilise nearest Tactical Commander. 5. Mobilise local Resilience Manager/NILO. 6. Instigate Major Incident Standby and cascade. 7. Place local hospital on Major Incident Standby. 8. Start an Incident Log.	1. Mobilise 2 x nearest DMAs to the RVP and ensure a further 4 x DMAs are mobile to the RVP using blue lights if necessary. 2. Mobilise nearest Operational Commander and **request Sit Rep within ten minutes of arrival.** 3. Mobilise HART. 4. Mobilise nearest Tactical Commander. 5. Mobilise local Resilience Manager/NILO. 6. Instigate Major Incident Standby and cascade. 7. Place local hospital on Major Incident Standby. 8. Start an Incident Log.	1. Mobilise nearest DMA to the RVP. 2. Mobilise nearest Operational Commander and **request Sit Rep within ten minutes.** 3. Mobilise HART. 4. Inform nearest Tactical Commander. 5. Inform local Resilience Manager. 6. Start an Incident Log.

CONTINUED OVERLEAF

PREDETERMINED ATTENDANCE TO AN INCIDENT AT AN AIRPORT INVOLVING PASSENGER AIRCRAFT

INCIDENT TYPE	CATEGORY A	CATEGORY B	CATEGORY C
	Those aircraft that fall within the scope of CAA airport categories 5, 6, 7, 8, 9 and 10 eg large passenger aircraft, large cargo aircraft (CAT 10 ie A380).	*Those aircraft that fall within the scope of CAA airport categories 3 and 4 eg smaller passenger aircraft, executive type aircraft, large passenger carrying helicopters.*	*Those aircraft that fall within the scope of CAA airport categories 1 and 2 eg light aircraft, gliders, small helicopters.*
AIRCRAFT GROUND INCIDENT An aircraft on the ground is known to have an emergency situation, other than an accident, which requires the attendance of the Emergency Services (eg cardiac arrest on board prior to take off but aircraft is on the runway).	1. Mobilise 1 x DMA and nearest Manager dependent on type of call/call grading.	1. Mobilise 1 x DMA and nearest Manager dependent on type of call/call grading. .	1. Mobilise 1 x DMA and nearest Manager dependent on type of call/call grading.

National Ambulance Resilience Unit
NARU

PREDETERMINED ATTENDANCE TO AN INCIDENT AT AN AIRPORT INVOLVING PASSENGER AIRCRAFT

INCIDENT TYPE	CATEGORY A	CATEGORY B	CATEGORY C
	Those aircraft that fall within the scope of CAA airport categories 5, 6, 7, 8, 9 and 10 eg large passenger aircraft, large cargo aircraft (CAT 10 ie A380).	*Those aircraft that fall within the scope of CAA airport categories 3 and 4 eg smaller passenger aircraft, executive type aircraft, large passenger carrying helicopters.*	*Those aircraft that fall within the scope of CAA airport categories 1 and 2 eg light aircraft, gliders, small helicopters.*
FULL EMERGENCY When it is known that an aircraft is, or is suspected to be in such difficulty that an accident is possible.	1. Mobilise 2 x nearest DMAs to the RVP and ensure a further 4 x DMAs are mobile to the RVP using blue lights if necessary. 2. Mobilise nearest Operational Commander and **request Sit Rep within ten minutes of arrival.** 3. Mobilise HART. 4. Mobilise nearest Tactical Commander. 5. Mobilise local Resilience Manager/NILO. 6. Instigate Major Incident Standby and cascade. 7. Place nearest hospital on Major Incident Standby. 8. Start an Incident Log.	1. Mobilise 2 x nearest DMAs to the RVP and ensure a further 4 x DMAs are mobile to the RVP using blue lights if necessary. 2. Mobilise nearest Operational Commander and **request Sit Rep within ten minutes of arrival.** 3. Mobilise HART. 4. Mobilise nearest Tactical Commander. 5. Mobilise local Resilience Manager/NILO. 6. Instigate Major Incident Standby and cascade. 7. Place nearest hospital on Major Incident Standby. 8. Start an Incident Log.	1. Mobilise nearest DMA to the RVP. 2. Mobilise nearest Operational Commander and **request Sit Rep within ten minutes of arrival.** 3. Mobilise HART. 4. Inform nearest Tactical Commander. 5. Inform local Resilience Manager/NILO. 6. Start an Incident Log.

CONTINUED OVERLEAF

PREDETERMINED ATTENDANCE TO AN INCIDENT AT AN AIRPORT INVOLVING PASSENGER AIRCRAFT

INCIDENT TYPE	CATEGORY A	CATEGORY B	CATEGORY C
	Those aircraft that fall within the scope of CAA airport categories 5, 6, 7, 8, 9 and 10 eg large passenger aircraft, large cargo aircraft (CAT 10 ie A380).	*Those aircraft that fall within the scope of CAA airport categories 3 and 4 eg smaller passenger aircraft, executive type aircraft, large passenger carrying helicopters.*	*Those aircraft that fall within the scope of CAA airport categories 1 and 2 eg light aircraft, gliders, small helicopters.*
LOCAL STANDBY When an aircraft approaching the airport is known to have or is suspected to have developed some defect which should not prevent the pilot landing the aircraft safely.	1. Inform Resilience Manager/ NILO. 2. Mobilise HART **(Cold Response)**. 3. Inform local Tactical Commander. 4. Identify the closest DMA resource and consider holding them in a state of readiness.	1. Inform Resilience Manager/ NILO. 2. Mobilise HART **(Cold Response)**. 3. Inform local Tactical Commander. 4. Identify the closest DMA resource and consider holding them in a state of readiness. .	1. Inform Resilience Manager/ NILO. 2. Mobilise HART **(Cold Response)**. 3. Inform local Tactical Commander. 4. Identify the closest DMA resource and consider holding them in a state of readiness.

PREDETERMINED ATTENDANCE TO AN INCIDENT AT AN AIRPORT INVOLVING PASSENGER AIRCRAFT

INCIDENT TYPE	CATEGORY A	CATEGORY B	CATEGORY C
	Those aircraft that fall within the scope of CAA airport categories 5, 6, 7, 8, 9 and 10 eg large passenger aircraft, large cargo aircraft (CAT 10 ie A380).	*Those aircraft that fall within the scope of CAA airport categories 3 and 4 eg smaller passenger aircraft, executive type aircraft, large passenger carrying helicopters.*	*Those aircraft that fall within the scope of CAA airport categories 1 and 2 eg light aircraft, gliders, small helicopters.*
AIRCRAFT SECURITY ALERT An aircraft on the ground, or in the air, is known to be or suspected of having an emergency situation arising from a suspect package, device or person on board.	1. Mobilise 1 x DMA and nearest Operational Commander. 2. Inform nearest Tactical Commander. 3. Mobilise local Resilience Manager/NILO. 4. Mobilise HART **(Cold Response)**. 5. Following liaison with Resilience Manager/NILO consider instigating Major Incident Standby and cascade.	1. Mobilise 1 x DMA and nearest Operational Commander. 2. Inform nearest Tactical Commander. 3. Mobilise local Resilience Manager/NILO. 4. Mobilise HART **(Cold Response)**. 5. Following liaison with Resilience Manager/NILO consider instigating Major Incident Standby and cascade.	1. Mobilise 1 x DMA and nearest Operational Commander. 2. Inform nearest Tactical Commander. 3. Mobilise local Resilience Manager/NILO. 4. Mobilise HART **(Cold Response)**. 5. Following liaison with Resilience Manager/NILO consider instigating Major Incident Standby and cascade.

THE AGREED PDA SHOULD BE FOLLOWED INITIALLY; DOWNGRADING OF THE RESPONSE WILL BE MADE BY THE AMBULANCE INCIDENT COMMANDER (TACTICAL) IF APPROPRIATE. ALL RESPONDING VEHICLES MUST ATTEND THE RVP INITIALLY.
IF THE INCIDENT IS SUSPECTED TO BE AN OPERATION PLATO CALL – DO NOT SEND ANY RESOURCES TO THE RVP UNTIL IT IS CONFIRMED AS SAFE BY THE POLICE.

National Ambulance Resilience Unit

NARU

NHS

JESIP

AIRPORT INCIDENT ACTION CARDS

For further information please contact:

National Ambulance Resilience Unit (NARU)

Website: www.naru.org.uk

V.1.2 October 2015

OFFICIAL

National Ambulance Resilience Unit

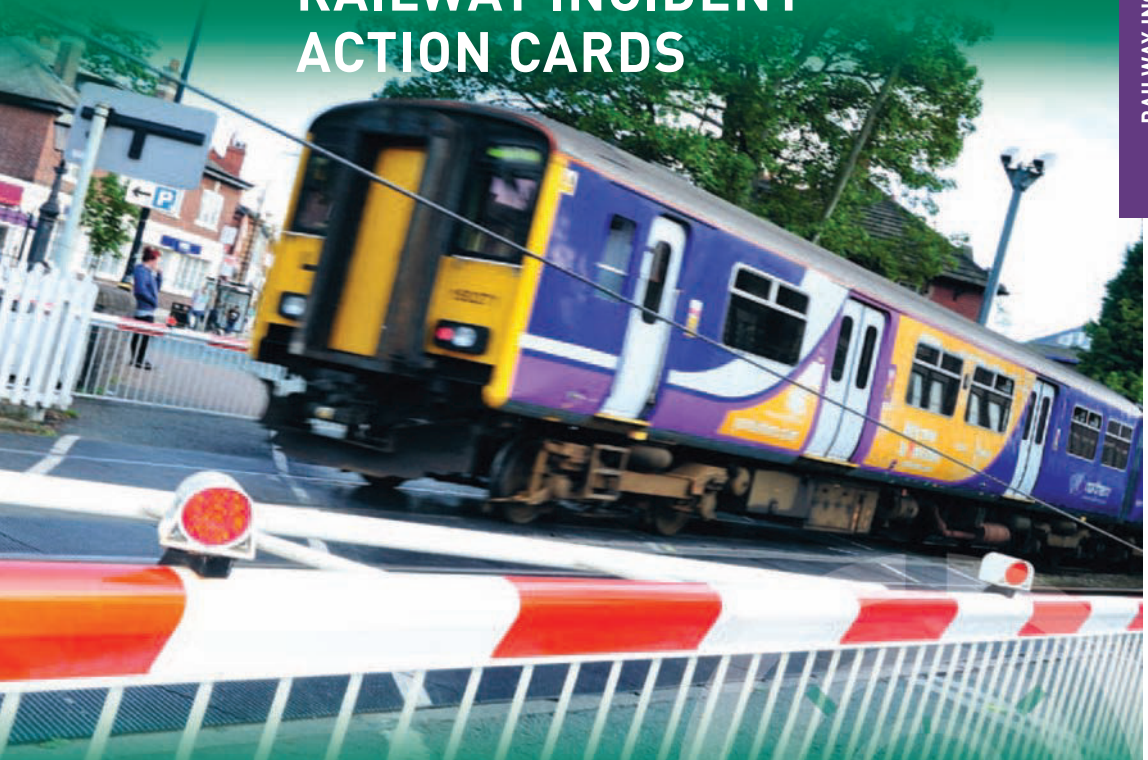
NARU

NHS

JESIP

RAILWAY INCIDENT ACTION CARDS

RAILWAY INCIDENT ACTION CARDS



V.1.2 October 2015
OFFICIAL

National Ambulance Resilience Unit
NARU

ASSOCIATION OF AMBULANCE CHIEF EXECUTIVES

Contents

1.0 Railway Incidents

INTRODUCTION

The Ambulance Service is called to respond to many incidents each year which require operational ambulance staff, officers and HEMS/medical staff to enter the railway trackside environment in order to access injured patients.

Trackside refers to the Network Rail infrastructure encompassing the general 'National Rail' systems in the UK and any other rail systems/environments in the UK.

GENERAL GUIDELINES

Do not approach the track until power off and trains stopped is confirmed.

Use the mnemonic POWER:

P	**P**ower off and trains stopped confirmed by authorised person when in doubt, contact EOC
O	**O**ff the tracks unless the patient appears viable
W	**W**ear your personal protective equipment (minimum Hi-vis jacket and helmet)
E	**E**nsure EOC and Ambulance Commander knows you are entering or leaving trackside
R	**R**apidly remove viable patient and treat in the safest, agreed area off tracks

POWER OFF / TRAINS STOPPED confirmation is provided face to face on scene or via EOC—if in doubt, contact EOC

2.0 Railway Incidents - HAZARDS

TRAINS

Approaching trains are **very quiet** and may appear from either direction on the track. **At speeds up to 125mph, they can cover 55 metres (60 yards) in a second and take over a mile to stop.**

- Do not go on the track unless authorised to
- Get help from railway staff
- Always be vigilant for yourself and colleagues

TRIPPING AND SLIPPING

The most common cause of accidents on the track is tripping or slipping on cables, sleepers, rails and other loose objects.

- Step over rails and sleepers
- Walk on the ballast / rocks / sleepers
- Do not walk on top of cable trunking
- Keep vigilant

TRAPPING YOUR FEET

Points are a particular hazard because they are likely to move unexpectedly.

- Do not step within the moving blades of points
- Do not walk on top of rails

TRAIN CONSTRUCTION MATERIALS

Some vehicles, especially older ones, may contain hazardous material such as asbestos.

- Ask Network Rail Control for specific information

EOC must immediately inform Network Rail Control of any attendance to the railway by the emergency services. Network Rail Control will immediately advise EOC of all incidents requiring the ambulance service, giving details of the circumstances, access location, and known hazards. Network Rail Control will inform British Transport Police of all incidents involving the emergency services. Control rooms will keep each other updated of all relevant information and messages coming from the incident.

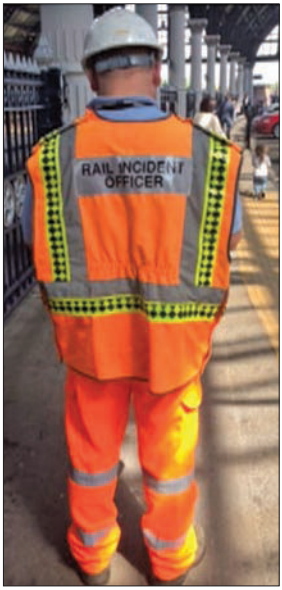
Network Rail will dispatch a Rail Incident Officer (RIO) to all incidents where the emergency services are attending trackside and give an estimated time of arrival for the RIO.

Network Rail Control and EOC will agree a site identification name and an incident number of which the emergency services are in attendance.

Upon arrival at the incident, each emergency service will inform their respective control of the rendezvous point location.

Where possible, the emergency services will await the arrival of the RIO before entering the track area and otherwise, will only do so to save life.

At all incidents the RIO will be the lead railway representative, coordinating the rail industry input and providing site-specific information. The RIO will be readily identifiable and make themselves known to any agency/scene commanders.



Following an assessment of the situation on site all requests for:

- Trains to run at caution or
- Trains to be stopped or
- Traction current/power to be switched off and any subsequent isolation will only be made by the emergency services to Network Rail Control via EOC, unless the RIO is on site and assumes that responsibility. Network Rail will confirm once power is switched off and trains have been stopped.

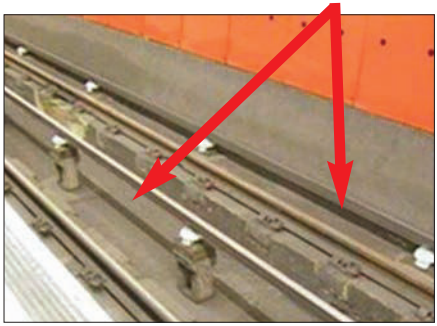
3.0 Railway Incidents - Electrical Supply

Ground level mains power must be switched off before working on or near the track.

LIVE RAIL

Some lines have a third conductor rail energised to between 650 & 750 Volts DC.

LIVE RAILS



On London Underground Lines, all rails carry power but the main 'positive' power rail is located furthest away from the platform edge and carries 420 Volts DC. The centre rail is the 'negative' live rail and carries 200 Volts.

LIVE CABLES

Overhead Line Equipment is energised to 25,000 volts AC and is not routinely switched off unless working adjacently. Do Not Touch or approach within 2.75 meters of live overhead lines.

4.0 Persons Ill On Trains

Every day across the UK, the Service is called to respond to incidents at railway stations. Any incident that affects the movement of trains risks secondary incidents because other trains are stranded. The longer the trains are not moving, the greater the likelihood of casualties on-board other trains.

Whenever a crew arrives on scene and the patient is on-board a train, the priority must be to rapidly assess the patient and remove them from the train as soon as practical. If the patient is in cardiac arrest, CPR and ALS should be commenced and removal from the train should take place as soon as practical. Chest compressions should be continued if possible during removal, with minimal interruptions.

At larger stations, railway staff will seek to close a platform if requested, or to provide screening so that patient management can continue unhindered. It is important not to inadvertently create a multiple casualty incident through the rail network being brought to a standstill when some simple swift actions can prevent trains building up. Use the mnemonic HEAT:

H	**Health Impact** Consider potential impact on NHS; Consider Major or Significant Incident.
E	**EPRR** Contact the on call Tactical Advisor/NILO via EOC for site specific risks.
A	**Arrival Procedures** Maintain contact with EOC and use Incident Action Cards.
T	**Triage Sieve** Consider the possibility of multiple casualties and prepare for triage.

HEAT Mnemonic created by London Ambulance Service Trust

5.0 Managing Escalating Rail Incidents

INTRODUCTION

Ambulance Services may be called to stranded trains. In the majority of calls trains are moving again relatively quickly and the incident can be stood down but there remains the potential for multi-casualty incidents. These can include trains stranded in hot conditions or where it is necessary to evacuate passengers along the trackside.

GENERAL GUIDELINES

- Wear Hi-Viz PPE always
- Take primary response kit and triage pack and report to station control room / supervisors office
- Obtain update from the railway staff and contact EOC with a report
- Report to RIO via RVP
- Obtain from railway staff – (M)ETHANE

QUESTIONS FOR RAILWAY STAFF

- Number of trains affected?
- How full are the trains?
- Is air conditioning or heating working?
- Are trains underground or in 'hot spots'?
- How long has each train been stranded?
- What is the plan for railway staff to resolve the incident?

Further Actions

- Deploy staff to platform areas when trains are due to arrive to provide a visible presence
- Brief responders on use of Triage Sieve should this be needed
- Ask EOC to contact the Tactical Advisor/NILO if you need advice on procedures
- Once all trains have been dealt with, provide a new update to EOC to cancel any resources that have not arrived

National Ambulance Resilience Unit

NARU

NHS

JESIP

ROAD AND MOTORWAY INCIDENT ACTION CARDS

V.1.2 October 2015
OFFICIAL

ROAD AND MOTORWAY INCIDENT ACTION CARDS

National Ambulance Resilience Unit
NARU

ASSOCIATION OF AMBULANCE CHIEF EXECUTIVES

Contents

1.0 Road Incidents - C L E A R

CLEAR

The CLEAR keep traffic moving document outlines the roles and responsibilities of the key organisations involved in traffic incident management on the strategic road network, setting out a joint outcome.

Congestion on the strategic road network is estimated to cost the economy £3 billion each year, 25% of which is caused by incidents.

Congestion can also lead to further collisions and could lead to exacerbation of chronic medical conditions especially during extreme weather events.

Collision	Lead	Evaluate	Act	Re-opened
Collisions and other incidents can close carriageway lanes which adverseley affects the economy	Effective leadership needs to be established to coordinate the incident response	Understanding the scale of the incident ensures a proportionate response	All incident responders act in partnership, recognising differing organisational priorities	Carriageway lanes are re-opened ASAP to reduce the impact of incident closures on road users and the economy

AMBULANCE SERVICE ACTIONS

Work with other responding agencies to resolve the incident.

Consider positioning of ambulance service vehicles to minimise disruption especially on routes being used as diversions away from the incident site.

Provide realistic timescales for casualty treatment and extraction.

Ambulances should minimise delays in clearing scene and moving off the motorway especially where patients don't travel to hospital.

2.0 Road Incidents

INTRODUCTION

The potential for collision is always present when working on roadways and is influenced by road conditions, visibility and traffic.

Further hazards will be presented by Dual Fuel and battery powered vehicles, supplementary restraint devices and other hazardous substances.

Large amounts of freight are moved each day across the UK, when involved in a collision or fire some of these substances can be hazardous.

GENERAL GUIDELINES

- Blue lights and hazard warning lights should be left ON. (Unless the scene has been secured and a Major Incident has been declared).
- Ensure Hi-Vis PPE is worn, consider helmet to provide protection from debris and during any extrication.
- Approach from the rear of the incident at low speed.
- Identify hazards, consider parking position and identify safe area of work.
- Request police / Highways England if not present.
- Follow the flow of traffic unless directed otherwise by police or Highways England.
- Do not stop on the non-incident carriageway to gain access to an incident on the opposite side irrespective of how urgent the situation appears on the affected carriageway nor the distance to the next junction or crossing point.
- In multiple vehicle RTC's it may be necessary to sectorise the scene to promote understanding and aid communication.

ACTIONS ON ARRIVAL

- Ensure the road is closed or restricted.
- First vehicle should park before the incident and additional vehicles should park beyond it creating a boundary for a safe working area. (Except on Motorways where all vehicles should park beyond the incident in the obstructed lane)
- Exit the vehicle on the side away from moving traffic.
- Liaise with police, Highways England and fire service.
- Ascertain number and location of casualties trapped or injured and report to EOC.
- Ensure an Operational Commander is appointed to coordinate ambulance resources and stand back to liaise with other agencies.
- Prioritise extrication and request further resources if required.
- Establish an inner and outer circle around the scene of operations.
- Keep the working area clear by creating an equipment dump.
- Treat all non-activated SRS devices as live, high voltage electrical systems should all be treated as live even when engine is not running.
- Fires in an LPG powered car will be treated by the fire service as a cylinder incident.

INCIDENT LOCATION	LANE CLOSURES REQUIRED
Two way local roadway	Both Lanes
Hard Shoulder of the Motorway or similar	Hard shoulder and lane 1
Lane 1 of 3 lane roadway	Hard shoulder and lane 1 and 2
Lane 2 of 3 lane roadway	Lanes 1,2 and 3
Lane 3 of 3 lane roadway	Lanes 2 and 3
Across the central reservation	Lanes 2 and 3 of both carriageways

LEAVING THE INCIDENT

- Do not move any vehicles especially those providing the fend off protection before consulting with the other emergency services.
- Maintain high visibility when moving away from the incident, rejoining traffic flows. Use warning lights until clear of the incident.

ALL LANE RUNNING

Some sections of motorway may be utilised for All Lane Running, on these sections the hard shoulder area may be used for live traffic at certain times. On these sections lanes are described as Lane 1 - 4.

INCIDENTS IN TUNNELS

- Attending resources should consider entering from both directions.
- Utilise both bores of the tunnel if possible, confirm that traffic has stopped.
- Utilise the non incident bore for casualty treatment and loading if appropriate.
- Ensure that all responders are aware when operations are utilised in the non incident bore.
- Consider fume build up in a protracted incident.

National Ambulance Resilience Unit
NARU

3.0 Emergency Operations Centre action card for receipt of a call to Motorway incidents

RECEIPT OF A CALL ON A MOTORWAY including SMART (ALL LANE RUNNING) MOTORWAYS

When receiving a call on a motorway especially where the location is given as on a 'Smart Motorways All Lane Running (ALR) ' –– the location must be *immediately* confirmed with the local Highways England Regional Control Centre :

A CAD warning will highlight affected sections of Motorway where All lane running is in place as follows:

"Smart Motorways All Lane Running in Operation"

A summary of actions required by ambulance control will then be included.

Call Taker Actions:

It is very important that the call taker asks the caller if the incident is on the main carriageway or on a slip road.

If on main carriageway:

- Which junctions are they between?
- Which carriageway is the incident on (i.e. what direction are they travelling)?
- Which lanes are affected?
- Is the incident between the slip off and slip on at a junction? (This will affect the access point for the responding vehicle)
- Are there any marker signs visible with letters and numbers on or numbers on an emergency roadside telephone?

If on a slip road:

- Which junction is the slip road at?
- Are they entering or exiting the main carriageway?
- Take extra care in gathering details for an incident on a slip road between different motorways – think about how the responding vehicle is going to reach them.

If you are still unsure as to the incident location or how to accurately zone it, seek advice from a Team Leader immediately.

Contact Highways England, Police and Fire Services as required.

Dispatcher / Team Leader Actions:

Ensure that the Highways England RCC has been contacted and the location has been verified.

Consider which / how many lanes have been affected:

- If all lanes are affected, avoid committing more than one resource to the same carriageway as the incident e.g. with flow (they are very likely to be caught up in the traffic tail-back and be delayed in reaching the patient).
- Liaise with Highways England as to the best point of access. If all lanes are affected they are likely to need to instigate 'reverse' access. If only a few lanes are affected they can close relevant lanes on the same carriageway to allow improved access through the traffic.
- Ensure that all responding crews are clear as to the point of access they need to utilise and give them as much information as possible to help them locate the incident quickly.
- **REVERSE ACCESS** If 'reverse access' is implemented by Highways England, crews should be given appropriate instruction on where to access the incident e.g. RVP at a Junction.

- Crews should be told not to commit to Motorway unless specifically authorised to do so by Ambulance Control or Highways England representative at the access point. This authorisation may come directly to the crew or via the Ambulance Control or from Highways England RCC.
- Once reverse access is agreed the crew should be given specific instruction on entering the motorway and which lane to travel to and from the incident in as per the action card for reverse access.
- Ambulance crews should notify control when entering the motorway under reverse access and when clear of the motorway on leaving the scene. Ambulance Control should update Highways England RCC of all vehicle movements on and off the motorway.

RENDEZVOUS POINTS

The Highways England may request vehicles to attend an RVP where exact location of incident is unknown, these have been predetermined locally.

Ambulance vehicles should park safely on the junction or just off the junction ready to enter the motorway when required. Communication with Ambulance Control should be maintained at all times

Police or Highways England may send an officer to the RVP to provide co-ordination where resources allow.

CO-ORDINATION

Current responsibilities for incident locations remain unchanged between Ambulance Service controls, however close co-operation is required to maintain a robust response to incidents.

National Ambulance Resilience Unit
NARU

4.0 Emergency Operations Centre action card for Implementing Reverse Access to Motorway incidents

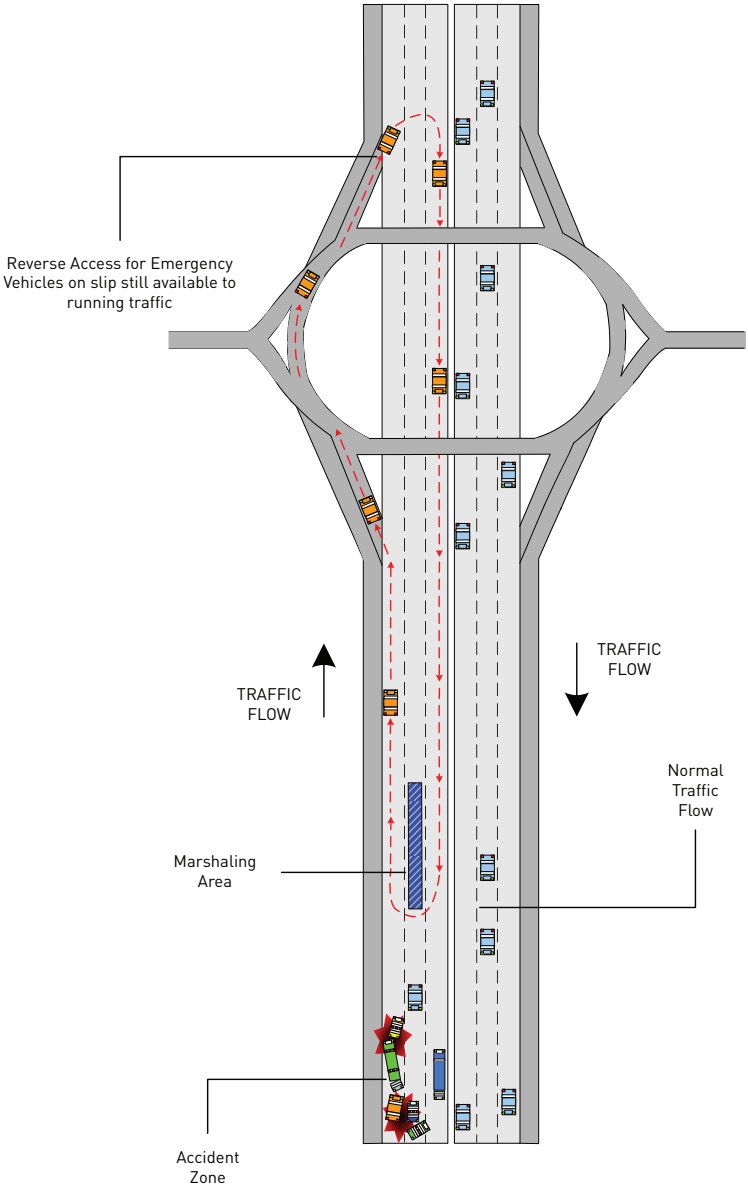
- Resources to RVP at the Junction above the incident (downstream)
- Regular communication to be maintained with Highways England RCC and other emergency services control rooms
- Highways England RCC to confirm Highways England, Fire or Police Operational Commander is at the head of the incident and has control of the traffic.
- Crews only to access the motorway once closure confirmed by Highways England RCC
- Crews to inform ambulance control when entering the motorway
- Access via the on slip road and turn across the carriageway into lane 4 to access the incident.
- Crews to run along lane 4 in the reverse direction to the incident and park safely at the scene allowing other vehicles space to move
- Crews to return from the incident with flow in lane 1 and inform the Highways England operational commander and Ambulance Control when leaving the Motorway.
- The proposed exit junction should also be advised especially if the vehicle will pass through the reverse access entry junction.
- Ambulance Control to advise Highways England RCC when all resources are clear of the motorway.

Note – no access by ambulance crews from the opposite carriageway unless this also is closed by Police or Highways England.

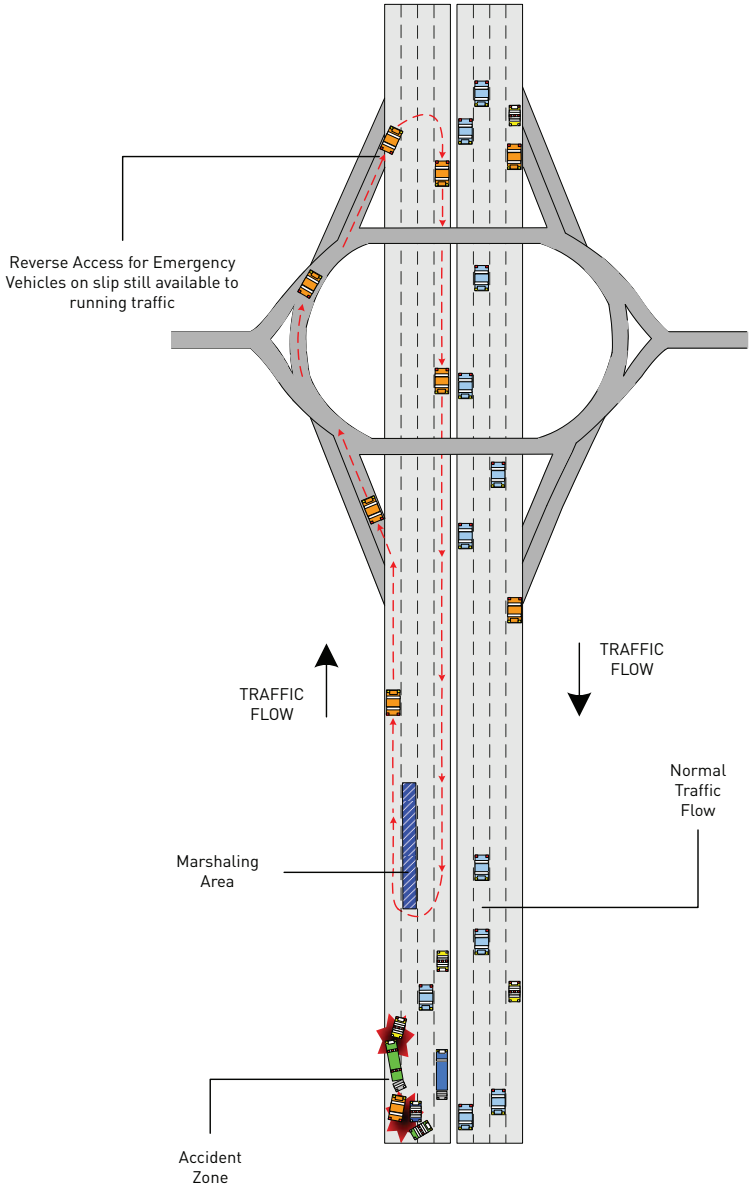
Remember that attending ambulance crews and response vehicles will require specific instructions from Ambulance Control to undertake this procedure.

Verification of understanding should be sought at every stage for the safety of all responders.

Reverse access on a motorway with a hard shoulder



Reverse access on a motorway without a hard shoulder



National Ambulance Resilience Unit

NARU

NHS

JESIP

RESPONDING TO PUBLIC SAFETY AND PUBLIC ORDER EVENTS ACTION CARDS

V.1.2 October 2015
OFFICIAL

RESPONDING TO PUBLIC SAFETY AND PUBLIC ORDER EVENTS ACTION CARDS

National Ambulance Resilience Unit
NARU

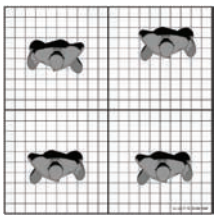
ASSOCIATION OF AMBULANCE CHIEF EXECUTIVES

Contents

RESPONDING TO PUBLIC SAFETY AND PUBLIC ORDER EVENTS ACTION CARDS

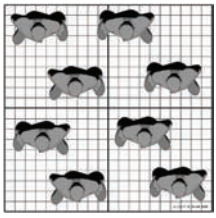
Crowd Density and Behaviour Guide

V
VERY LOW DENSITY CROWD



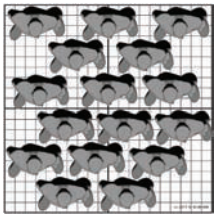
VERY LOW DENSITY CROWD: approx. 4 persons per 4m² (2m x 2m). People move extremely freely.

L
LOW DENSITY CROWD



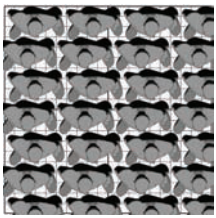
LOW DENSITY CROWD: approx. 8 persons per 4m² (2m x 2m). People move freely although crowd numbers can inhibit some movement.

M
MEDIUM DENSITY CROWD



MEDIUM DENSITY CROWD: approx. 16 persons per 4m² (2m x 2m). People still free to move although movement through crowd is difficult. Can be very dense in areas.

H
HIGH DENSITY CROWD



HIGH DENSITY CROWD: approx. 24 persons per 4m² (2m x 2m). Tightly packed together. Almost impossible to move through the crowd.

1	**CASUAL** People coming and going; not organised but may be in a loose group situation. Will accept direction by authority. Well behaved.
2	**COHESIVE** Crowd assembled for a specific purpose or reason. No leadership.
3	**EXPRESSIVE** Crowd gathered for a common purpose. Under loose leadership or following particular motive. Not aggressive, but sections of crowd behaviour becoming mildly anti-social. May require active involvement by authority.
4	**ANTI-SOCIAL** Crowd engaged in acts of civil disobedience or direct action. Some sections may be aggressive and violent while other sections continue with other activities.
5	**INCIDENT** Crowd reacting to or retreating from a dangerous situation. Panic situation caused by serious anti-social behaviour or emergency situation.

National Ambulance Resilience Unit

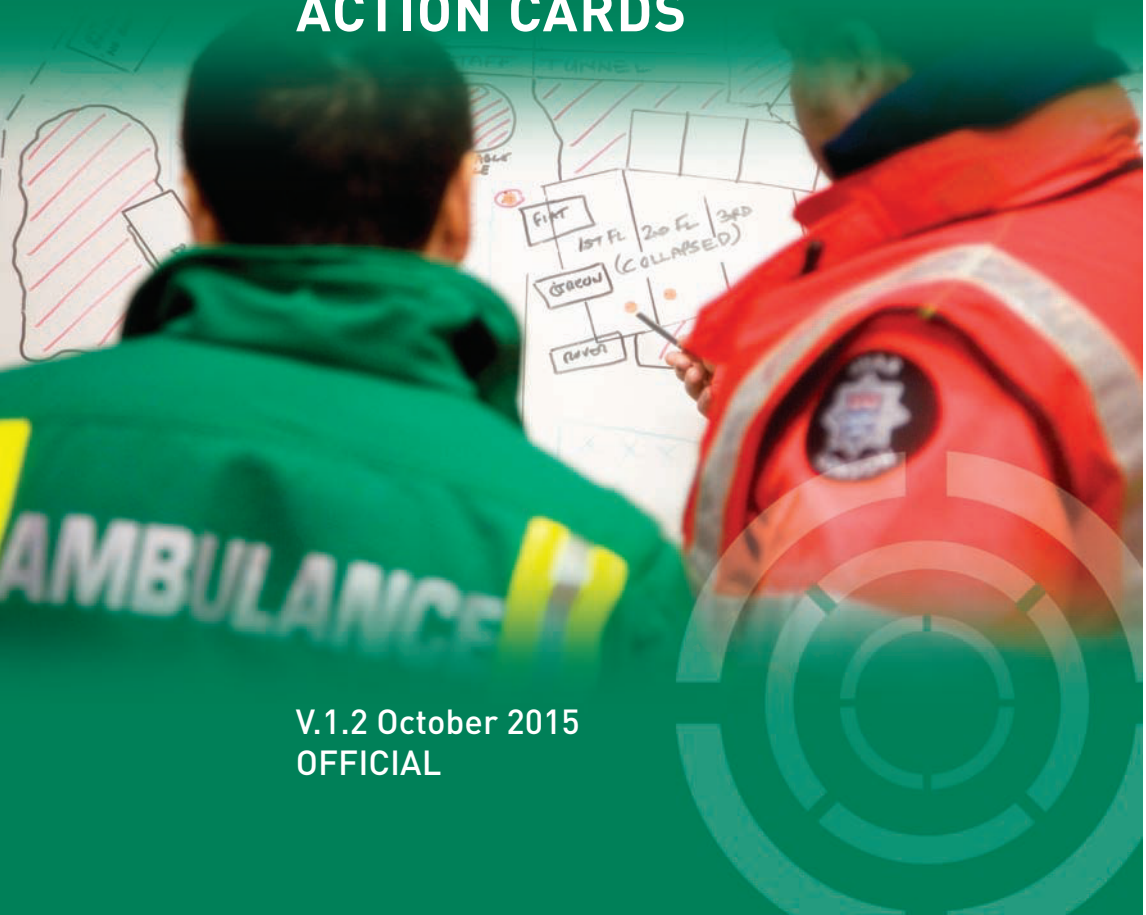
NARU

NHS

JESIP

MAJOR INCIDENT SPECIALIST ACTION CARDS

MAJOR INCIDENT SPECIALIST ACTION CARDS



V.1.2 October 2015
OFFICIAL

National Ambulance Resilience Unit
NARU

ASSOCIATION OF AMBULANCE CHIEF EXECUTIVES

National Ambulance Resilience Unit

NARU

NHS

JESIP

MAJOR INCIDENT LOCAL ACTION CARDS

MAJOR INCIDENT LOCAL ACTION CARDS

V.1.2 October 2015
OFFICIAL

National Ambulance Resilience Unit
NARU

ASSOCIATION OF AMBULANCE CHIEF EXECUTIVES

MAJOR INCIDENT LOCAL ACTION CARDS

South East Coast Ambulance Service NHS
NHS Foundation Trust

Agenda No	131/17

Name of meeting	Trust Board
Date	29 November 2017
Name of paper	Strategic Risks
Responsible Executive	Executive Team
Author	Peter Lee, Company Secretary
Synopsis	This paper sets out the principal risks to the Trust achieving its strategic goals; through its 16 corporate objectives. The risks include the controls currently in place, any gaps, and the actions to be taken. It also describes the assurances, and confirms the current risk rating, and the target risk score post treatment.
Recommendations, decisions or actions sought	The Board is asked to; 1. Consider this version 3 of the strategic risks, and confirm it is content with the controls and mitigating actions, and its tolerance of the target risk scores. 2. Confirm it is content with the risk treatment (tolerate) of objectives 12 and 15.

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**

1. Background

In June, the Board of Directors approved the trust's five-year strategic goals and the related two-year objectives (Appendix 1). This paper sets out the principal risks to achieving the 16 objectives, and is structured to enable the Executive and Board of Directors to focus on these risks and to seek assurance that adequate controls are in place to manage the risks appropriately.

The risks are quantified in accordance with the risk score matrix in Figure 1 below:

Risk Score Matrix					
	Likelihood:				
Consequence:	Remote (1)	Unlikely (2)	Possible (3)	Likely (4)	Almost Certain (5)
Insignificant (1)	1	2	3	4	5
Minor (2)	2	4	6	8	10
Moderate (3)	3	6	9	12	15
Major (4)	4	8	12	16	20
Catastrophic (5)	5	10	15	20	25

Low	Moderate	High	Extreme

Figure 1

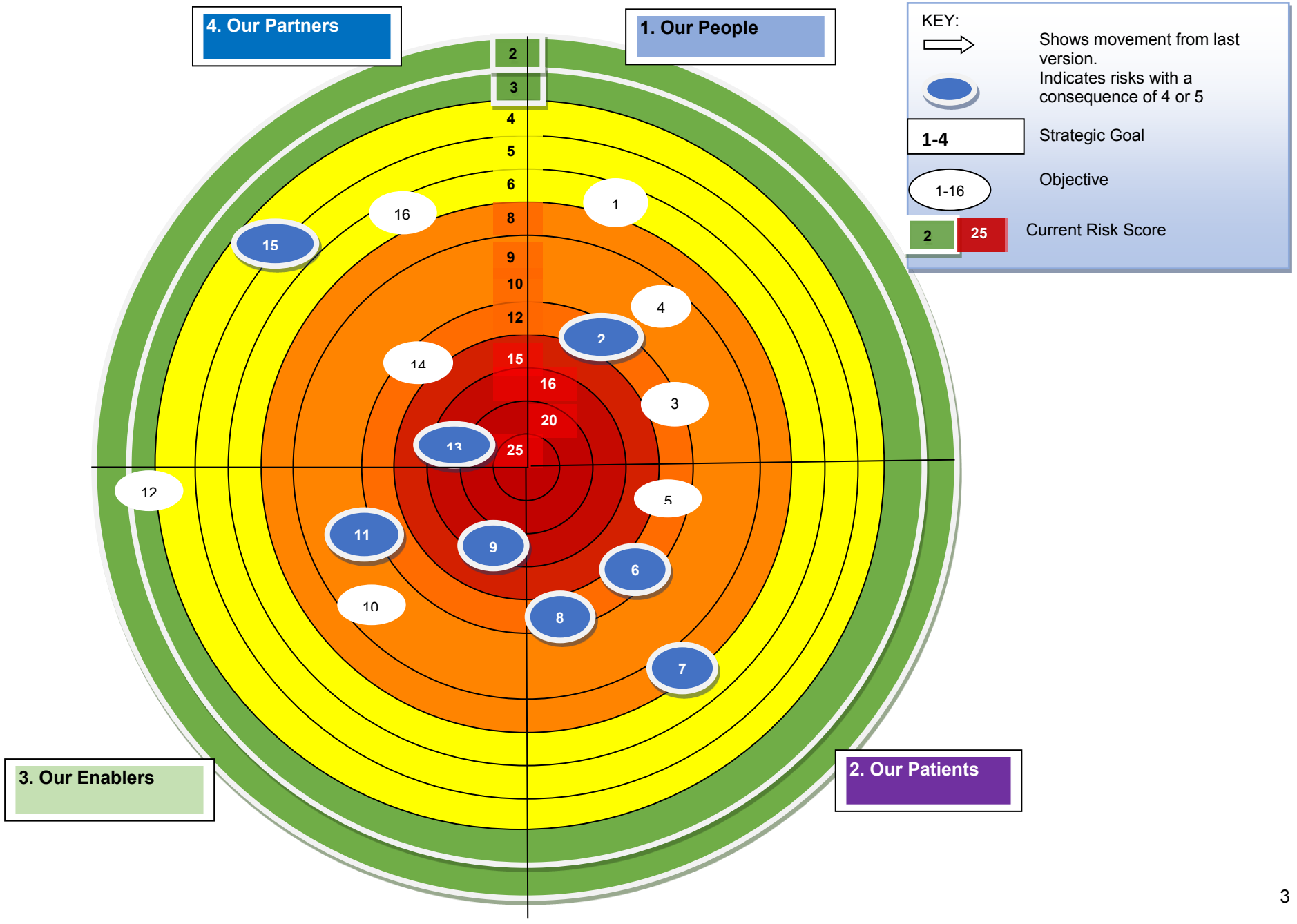
2. Overview

As illustrated in Figure 1, risks are categorised from low to extreme.

In consideration of the strategic risks, last reviewed by the executive leads during November 2017, the Executive has considered it appropriate to tolerate the current risks identified against objectives 12 and 15.

'Capacity' is a theme across several of the objectives and this is consistent with discussions at recent Board meetings about the need to ensure robust prioritisation.

The Risk Radar below illustrates the risk score (with controls) for each objective. There has been no movement in risk since version 1 was considered by the Board in July 2017, which is not unexpected given we are at month 6 of 24-month objectives.


4. Our Partners
1. Our People
3. Our Enablers
2. Our Patients
2
3
4
5
6
8
9
10
12
15
16
20
25
1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
KEY:
Shows movement from last version.
Indicates risks with a consequence of 4 or 5
1-4
Strategic Goal
1-16
Objective
2
25
Current Risk Score

3. Deep Dives

Objective 8 (High)
Improve clinical outcomes and operational performance, with a particular focus on life threatening emergencies

At its meeting in July there was a challenge by the Board relating to objective 8, asking whether the controls are such that they realistically reduce the risk score from 20 (extreme) to 12 (high), especially given the work still outstanding on funding.

The Executive has considered this and believes that the controls currently in place, in particular the positive impact of the initiatives to improve efficiencies, such as call cycle time and resources per incident and the high degree of specialist practice education to minimise the volume of patients transported to hospital, can be reasonably judged as to reduce the risk of not achieving this objective. The judgement is that the consequence remains the same (4/major) but the likelihood reduces from a 5/certain (to not meet the objective) to a 3/possible. This is therefore still considered a high risk.

Objective 9 (Extreme)
Ensure our services are efficient and sustainable and that they are supported by appropriate levels of funding

The achievement of this objective will likely continue to be at significant risk, given the link to ensuring appropriate levels of funding, and the associated internal efficiencies the Trust needs to make; £15.1m CIP in 2017/18 which is over 7% of the budget.

Objective 13 (Extreme)
Work with STPs to achieve the best care for our patients through emerging local out of hospital care systems

The achievement of this risk is currently extreme primarily due to issues of capacity and an ability to engage and influence given such a high number of different pathways. The gaps in control illustrate this and the high target risk score reinforces the difficulty in achieving this objective.

4. Recommendation

The Board is asked to consider the risks to the achievement of the Trust's objectives, as set out in this paper, and confirm the extent to which it believes that;

i. They adequately describe the principal risks to achieving the Trust objectives
ii. They accurately reflect the risk scores with the stated controls in place
iii. They include sufficient actions to help meet the target risk score
iv. The target risk score is tolerable and stretching
v. It is reasonable to tolerate the risks relating to objectives 12 and 15.

5. Strategic Risks

5.1 Our Strategic Goals

Our People	Our Patients	Our Enablers	Our Partners
We will respect, listen to and work with our staff and volunteers to provide development and support that enables them to provide consistent, quality care to our patients	We will develop and deliver an integrated clinical model that meets the needs of our communities whilst ensuring we provide consistent care which achieves our quality and performance standards	We will develop and deliver an efficient and sustainable service underpinning by fit for purpose technology, fleet and estate	We will work with our partners in STPs and blue light services to ensure that our patients receive the best possible care, in the right place, delivered by the right people

5.2 Strategic Risk Dashboard

Objectives		Principal risk(s) to achievement of objectives		Initial Score		Current Score		Target Score		Target Date
				C	L	C	L	C	L	
1	With the support and engagement of staff and volunteers, refresh the Trust values and behaviours	Lack of engagement from staff / volunteers		3	3	3	2	3	1	31.03.2019
2	Develop effective leadership and management at all levels, through our new selection, assessment and development processes	Not following the NHS leadership academy framework for all appointments. Inability to support development plans.		4	4	4	3	4	2	31.03.2019
3	Ensure all staff and volunteers have clear objectives, and a plan for their development, set through regular appraisal	Management capacity and lack of workforce engagement		4	4	4	3	4	2	31.03.2019
4	Improve staff and volunteer health and wellbeing	Insufficient resources to deliver on aspects of the strategy, e.g. wellbeing hub. Lack of awareness and understanding of how to access the support available, e.g. OH services		3	4	3	3	3	2	31.03.2019
5	Develop and deliver a clinically led process to prioritise patient need at the point of call, increasing referral	Capacity in the clinical hub. Inability to consistently manage call handling times.		3	5	3	4	3	3	31.03.2019

	to alternative services where clinically appropriate									
6	Further integrate and share best practice between NHS 111 and 999 services, striving for Integrated Urgent Care service where this is considered viable	111 leadership capacity to help drive the integration and sharing of best practice.		4	4	4	3	4	2	31.03.2019
7	Further improve and embed governance and quality systems across the organisation, building capacity and capability for continuous improvement	Insufficient capacity and competing priorities through the whole cascade of governance. Resourcing for IT infrastructure to allow reliable data collection from multiple sources.		4	3	4	2	4	1	31.03.2019
8	Improve clinical outcomes and operational performance, with a particular focus on life threatening emergencies	Inability to provide enough hours to meet demand within the current systems and resources available		4	5	4	3	4	2	31.03.2019
9	Ensure our services are efficient and sustainable and that they are supported by appropriate levels of funding	CIP target is over 7% of the budget. Insufficient capacity to deliver this stretching CIP target in the context of recovery etc. (most acute within operations). Current residual commissioners gap. Capacity within PMO to support once EY exit.		5	5	5	4	5	2	31.03.2019
10	Develop and deliver a digital plan which supports integration with the health system and enables the clinical model and our approach to continuous improvement	Prioritising between internal and external requirements and maintaining delivery within scope.		3	4	3	3	3	2	31.03.2019
11	Ensure that our fleet is fit for purpose and supports the clinical model	Investment needed and ability of vehicle manufacturers and converters to deliver in a timely manner. Introduction of ARP will change the vehicle mix required; more DCAs and less cars.		4	3	4	2	4	1	31.03.2019
12*	Ensure that our estate is fit for purpose and supports the clinical model	Financial investment needed to implement our estates strategy (future investment in estate will need to come from disposals of surplus locations).		3	2	3	1	3	1	31.03.2019
13	Work with STPs to achieve the best care for our patients through emerging local out of hospital care	Capacity and ability to engage and influence given such a high number of different pathways		4	5	4	4	4	3	31.03.2019

	systems									
14	Work with STPs to design and deliver generalist and specialist care pathways for patients requiring an acute hospital attendance	Capacity to ensure proactive engagement Insufficient influence		3	4	3	4	3	3	31.03.2019
15*	Work with education and STP partners to develop career pathways that support our staff to make effective clinical decision making	Insufficient internal capacity to design and deliver appropriate modules. A reduction in external resource		4	3	4	1	4	1	31.03.2019
16	**Work with blue light partners to ensure collaboration supports patient outcomes and efficient service delivery**	**Desire between partners to collaborate**		**3**	**2**	**3**	**2**	3	1	31.03.2019

*Risk Tolerated

Objective 1	**With the support and engagement of staff and volunteers, refresh the Trust values and behaviours**

Our People			
Principal Risk	Non-engagement from staff & volunteers	**Director responsible**	**Director of HR**
		Initial Risk	C3xL3 = 9
Potential Impact	Lack of ownership of the values and behaviours and, therefore, insufficient impact.	**Current rating**	C3xL2 = 6
		Risk Treatment (tolerate, treat, transfer, terminate)	**Treat**
		Target risk score	C3xL1= 3

Controls in place (what are we doing currently to manage the risk)

Completed a number of focus groups following the Prof. Lewis report which helped to obtain staff feedback on the types of behaviours they would expect. This has informed the behavioural expectations, currently agreed in draft, for consultation starting next week.
Executive approved the behavioural change plan.
Created a barometer group to test the impact of the changes we are making

Gaps in Control

barometer group yet to meet for first time

Assurance: Positive (+) or Negative (-)	Gaps in assurance
None	Values and Behaviours Project Plan (part of Culture and OD steering group) yet to report through the steering group

Mitigating actions planned / underway	Progress against actions (including dates, notes on slippage or controls/ assurance failing.
1. Engagement with staff (survey monkey / in person) 2. Plan to collate feedback and seek Board approval for the final behavioural expectations	1. To be completed by mid-December 2017 2. Scheduled for January Board meeting

Update	23.11.2017	Last considered by the Board	25.07.2017 04.09.2017 (Audit Committee)

Objective 2 Our People	Develop effective leadership and management at all levels, through our new selection, assessment and development processes		
Principal Risk	Not following the NHS leadership academy framework for all appointments. Inability to support development plans	**Director responsible**	**Director of HR**
		Initial Risk	C4xL4 = 16
Potential Impact	Lack of understanding of staff development needs. Not supporting their leadership development, which will affect staff morale.	**Current rating**	C4xL3 = 12
		Risk Treatment (tolerate, treat, transfer, terminate)	**Treat**
		Target risk score	C4xL2 = 8

Controls in place (what are we doing currently to manage the risk)

We have assessment centres established, and recruitment tools, which are based on the NHS leadership academy framework
The system 'Actus' has been introduced to support managers identify development needs and establish associated plans
The Actus Project Plan has begun, with the aim of ensuring consistent use of this system
Limited internal and external capacity is in place to support some interventions, such as coaching / mentoring
Leadership development programme has started

Gaps in Control

Additional internal and external capacity is required to ensure demand is met to support interventions, such as coaching and mentoring
Actus is not fully embedded / used by staff
The performance management culture needs to be improved

Assurance: Positive (+) or Negative (-)	Gaps in assurance
(-) Data on career conversations / objective setting (- & +) Pulse surveys	Staff survey (results scheduled for Q4)

Mitigating actions planned / underway	Progress against actions (including dates, notes on slippage or controls/ assurance failing.
1. Development of a leadership programme 2. Procurement of the support needed to increase internal / external capacity to support interventions 3. Implementing the Actus Project Plan, which includes training managers to hold career conversations.	1. It is in place, but needs to be reviewed against the new behaviour expectations. 2. Still have gaps – plan to recruit by end of December 2017 3. On-going

Update	23.11.2017	Last considered by the Board	25.07.2017 04.09.2017 (Audit Committee)

Objective 3 Our People	Ensure all staff and volunteers have clear objectives, and a plan for their development, set through regular appraisal		
Principal Risk	Management capacity and lack of workforce engagement	**Director responsible**	**Chief Executive**
		Initial Risk	C4xL4 = 16
Potential Impact	Lack of clarity of role and therefore accountability Motivation and morale due to lack of recognition and reward	**Current rating**	C4xL3 = 12
		Risk Treatment (tolerate, treat, transfer, terminate)	**Treat**
		Target risk score	C4xL2 = 8

Controls in place (what are we doing currently to manage the risk)

Actus is in place – all staff have log-ins and training has taken place. Aim is to encourage both line manager and employee to take responsibility by enabling through Actus ability to set 1:1s and objectives.
Project plan is monitored by the Steering Group, aimed at increasing the numbers of career conversations.

Gaps in Control

None

Assurance: Positive (+) or Negative (-)	Gaps in assurance
(- +) Steering Group/monthly reports although showing numbers of completed career conversations is increasing it is still currently below the Trust target.	Staff Survey (due to report in Q4)

Mitigating actions planned / underway	Progress against actions (including dates, notes on slippage or controls/ assurance failing.
1. Project Plan delivery	1. Aim to ensure 80% of career conversation by April 2018 – currently at just over 50%

Update	23.11.2017	Last considered by the Board	

Objective 4 Our People	Improve staff and volunteer health and wellbeing		
Principal Risk	Insufficient resources to deliver on aspects of the strategy, e.g. wellbeing hub. Lack of awareness and understanding of how to access the support available, e.g. OH services	**Director responsible**	**Director of HR**
		Initial Risk	C3xL4 = 12
Potential Impact	If materialised these risks will increase the time for staff to access the right intervention(s).	**Current rating**	C3xL3 = 9
		Risk Treatment (tolerate, treat, transfer, terminate)	**Treat**
		Target risk score	C3xL2 = 6

Controls in place (what are we doing currently to manage the risk)

The H&W strategy and delivery plan is in place (approved by the Board)
We have re-tendered OH services - Communication / engagement to staff has included posters etc. on the services available
Management training has been provided on how to access services / request referrals
We have approved a 12-month dedicated resource to support implementation of the strategy
HEKSS funding is in place to support implementation of TrIM – the trauma management programme
Initiatives introduced such as Pilates.
Increased focus on minimising shift over-runs and ensuring meals breaks
Mental Health Nurse Consultant supports the triage of staff experiencing mental health issues
Business Case for the wellbeing hub approved by executive in September.

Gaps in Control

Wellbeing hub is not yet implemented – scheduled for January 2018
Further development is needed to increase healthy activities across trust, such as Pilates which is in place at Crawley HQ.

Assurance: Positive (+) or Negative (-)	Gaps in assurance
(+) Referrals to OH (+) Referrals to TrIM (+) Reduction in shift over runs and increase in (uninterrupted) meal breaks	Progress against the H&W strategy yet to be reported. It will be overseen by management via the HR Group and on behalf of the Board by the WWC.

Mitigating actions planned / underway	Progress against actions (including dates, notes on slippage or controls/ assurance failing.
1. Implementation of the wellbeing hub	1. Planned for January 2018

Update	23.11.2017	Last considered by the Board	25.07.2017 04.09.2017 (Audit Committee)

Objective 5 Our Patients	Develop and deliver a clinically led process to prioritise patient need at the point of call, increasing referral to alternative services where clinically appropriate		
Principal Risk	Capacity in the clinical hub. Inability to consistently manage call handling times.	**Director responsible**	**Executive Medical Director**
		Initial Risk	C3 X L5 = 15
Potential Impact	Slower response times and adverse impact on quality and/or patient safety	**Current rating**	C3 X L4 = 12
		Risk Treatment (tolerate, treat, transfer, terminate)	**Treat**
		Target risk score	C3 x L3 = 9

Controls in place (what are we doing currently to manage the risk)
NHS Pathways is clinically-led; quality assurance is in place Education and supervision of call handlers Recruitment & Focus on retention, e.g. diamond pod introduced to support newly qualified call handlers

Gaps in Control
Currently no decision software support, available to (hear and treat) clinicians ARP – which will help respond to fewer Cat A patients giving more resource for lower priority patients and more time to identify patients suitable for hear and treat. Going live 22.11.2017 Surge Management Plan under development

Assurance: Positive (+) or Negative (-)	**Gaps in assurance**
(-) complaints and incidents data – response times (-) Call handling behind target (-) % patient for hear and treat low (+) low non-conveyance rates	Not completing non-conveyance audit

Mitigating actions planned / underway	**Progress against actions (including dates, notes on slippage or controls/ assurance failing.**
1. Recruitment to the clinical hub 2. Decision support tool with QA 3. LAS support for staff 4. Audit non-conveyed patients (not yet started – although have head of clinical audit) 5. Planning to use alternative clinicians from a group not previously considered. 6. Surge Management Plan	1. Ongoing 2. Ongoing – considering Manchester Triage System 3. Continue to receive the support of a senior manager to support EOC 4. Substantive Head of Clinical Audit appointment due early December 5. No progress made yet - still in planning phase 6. Aim to introduce 29.11.2017

Update	20.11.2017	**Last considered by the Board**	25.07.2017 04.09.2017 (Audit Committee)

Objective 6 Our Patients	Further integrate and share best practice between NHS 111 and 999 services, striving for Integrated Urgent Care service where this is considered viable		
Principal Risk	111 leadership capacity to help drive the integration and sharing of best practice.	**Director responsible**	**Executive Director of Operations**
		Initial Risk	**C4xL4 = 16**
Potential Impact	Quality control of 999 call handling would deteriorate, as audits are led by 111. Anticipated volume of hear and treat activity would not be realised, as recruitment of clinicians and their education and training is currently led by 111.	**Current rating**	C4xL3 = 12
		Risk Treatment (tolerate, treat, transfer, terminate)	**Treat**
		Target risk score	4x2 = 8

Controls in place (what are we doing currently to manage the risk)
Expanded remit of the head of quality to include both 111 and 999 services. The substantive appointment of a senior clinical operations manager has been made. The quality audit team within 999 is being maintained and strengthened by leadership through the 111 service. We have added one WTE post within the training team to provide additional capacity given increased training we are undertaking.

Gaps in Control
None

Assurance: Positive (+) or Negative (-)	**Gaps in assurance**
(+) There has been a significant increase in 999 call handling audits, and subsequent increase in quality / compliance. (- / +) Audit feedback is being provided to 999 call handlers, which is positive, but some staff are negative about the feedback, indicating a need to improve delivery of the feedback. (-) increase in 999 referrals from 111 (reported as a percentage against a national target) – currently trend is above national average. But still better than other ambulance trusts providing 111 services for KMSS. However, recent call routing changes between our partner provider, Care UK, are starting to show increase in ambulance referrals.	Should receive less referrals back to 111 (not yet reporting)

Mitigating actions planned / underway	**Progress against actions (including dates, notes on slippage or controls/ assurance failing.**
1. Recruitment to the senior clinical operations manager 2. Recruitment to 44 clinician posts 3. Exploring opportunity to employ an external provider to reduce backlog of outstanding audits.	1. Due to start in August (now complete – see control) 2. Due to start end of Q2 (started but progression is slow; 12 of 44 appointed, while losing 6 to attrition in the same period) 3. Currently negotiating with a potential provider

4. Ongoing work to enhance clinical pool by integrating other clinical services in to the same working environment such as midwifery and mental health nurse			4. Training is due in January 2018, with aim to have in place during March 2018
Update	22.11.2017	**Last considered by the Board**	25.07.2017 04.09.2017 (Audit Committee)

Objective 7 Our Patients	Further improve and embed governance and quality systems across the organisation, building capacity and capability for continuous improvement		
Principal Risk	Insufficient capacity and competing priorities through the whole cascade of governance. Resourcing for IT infrastructure to allow reliable data collection from multiple sources.	**Director responsible**	**Executive Director of Nursing & Quality**
		Initial Risk	C4xL3 = 12
Potential Impact	The pace of improvement will be slower	**Current rating**	C4xL2 = 8
		Risk Treatment (tolerate, treat, transfer, terminate)	**Treat**
		Target risk score	C4xL1 = 4

Controls in place (what are we doing currently to manage the risk)
Succession plan in place to ensure all key posts are filled (currently there is a mixture of vacancies and interim appointments) PMO support is helping to ensure focus and priority of the actions to support improvement plan Funding from NHSI as a result of being in special measures is supporting improvement work, for example incident management. Datix Manager is in post to ensure this system is maximised to support continuous improvement
Gaps in Control
Some key posts are currently vacant and some are filled on an interim basis. Clarity and informed cross-directorate decision making in competing priorities; for example, the abstraction needed to ensure appropriate training versus the need to ensure improved performance.

Assurance: Positive (+) or Negative (-)	Gaps in assurance
(- / +) IPR / Quality and Patient Safety Report currently shows a mixed-picture (- / +) CQC findings – the initial feedback from the recent inspection was positive about some of the improved systems of governance and weaknesses in others. (+) CQC unannounced inspection in September demonstrated improvement in medicines governance (- +) QPS monthly dashboard (- +) KPMG external Governance Review.	A review is being completed which sets out the critical posts and related succession plan to give assurance that plans are in place when posts become vacant.

Mitigating actions planned / underway	Progress against actions (including dates, notes on slippage or controls/ assurance failing.
1. Vacant posts are being recruited to 2. The quality management group structure is being re-focussed around standards; practice and; effectiveness. 3. Improving the use of Datix	1. On-going 2. This has completed its first cycle 3. Had a review by Datix and options paper will be considered by executive in December.

Update	22.11.2017	Last considered by the Board	25.07.2017 04.09.2017 (Audit Committee)

Objective 8 Our Patients	Improve clinical outcomes and operational performance, with a particular focus on life threatening emergencies		
Principal Risk	Inability to provide enough hours to meet demand within the current systems and resources available.	Director responsible	Executive Director of Operations
		Initial Risk	C4 x L5 = 20
Potential Impact	Adverse impact on patient safety	Current rating	C4 x L3 = 12
		Risk Treatment (tolerate, treat, transfer, terminate)	Treat
		Target risk score	C4 x L2 = 8

Controls in place (what are we doing currently to manage the risk)

Secured additional £1.3m for support during the winter period.
Internal initiatives to minimise lost hours, such as call cycle time and resources per incident.
External initiatives with partners to minimise lost hours, such as hospital handover delays, and exploration of alternative pathways.
High degree of specialist practice education to minimise the volume of patients transported to hospital (relatively high see and treat ratio).
Proprietary forecasting tool used to help understand the required resource to meet demand.
Continued investment in specialist practitioners
Initiated a daily focus on resourcing in order to maximise hours available and scrutiny of performance.

Gaps in Control

Outcome of demand and capacity review which will inform future funding levels
Hospital handover delays not improving in a sustainable way

Assurance: Positive (+) or Negative (-)	Gaps in assurance
(+) Low conveyance rates (-) call cycle time had shown a sustained improvement since January 2017 but since August a slight increase in cycle time (+) resources per incident (-) actual activity is not consistently as predicted (- & +) Ambulance Quality Indicators	Data capture means we aren't properly measuring all Ambulance Quality Indicators correctly.

Mitigating actions planned / underway	Progress against actions (including dates, notes on slippage or controls/ assurance failing.

1. Conclude negotiations with commissioners to agree appropriate levels of funding 2. Continue working with partners on initiatives such as hospital delays 3. Continue focus on call cycle time 4. Improve forecasting model (seeking external support end of Q2)			1. Demand and Capacity review to conclude during March, with early indication in January 2018. 2. On-going with additional support from NHSI with dedicated senior lead on secondment from another provider Trust. 3. On-going as part of deliver plan and specific CIP 4. External Support now provided by a senior manager on secondment from another ambulance Trust.
Update	22.11.2017	**Last considered by the Board**	25.07.2017 04.09.2017 (Audit Committee)

Objective 9 Our Enablers	**Ensure our services are efficient and sustainable and that they are supported by appropriate levels of funding**		
Principal Risk	CIP target is over 7% of the budget. Insufficient capacity to deliver this stretching CIP target in the context of recovery etc. (most acute within operations). Current residual commissioners gap.	**Director responsible**	**Executive Director of Finance & Corp. Services**
		Initial Risk	C5xL5 = 25
Potential Impact	Adverse impact on performance. Adverse impact on quality / patient safety/experience. Sustainability of the improved governance we have introduced through the PMO and delivery of CIP.	**Current rating**	C5xL4 = 20
		Risk Treatment (tolerate, treat, transfer, terminate)	**Treat**
		Target risk score	C5xL2 = 10

Controls in place (what are we doing currently to manage the risk)

We have identified CIP schemes circa £20m to deliver the target of £15.1m. These are now all fully validated and have been developed within a robust governance process with support of PM0 and following the established QIA process.
Process of regular reviews of the QIAs given the risk associated with the 7% efficiency target.
A Financial Sustainability Steering Group (FSSG) is well-established and meets at least weekly, to ensure grip and focus.
Transitional funding received of £1.3m for Q3.

Gaps in Control

We haven't concluded the mediation process with commissioners (superseded by the demand and capacity review)

Assurance: Positive (+) or Negative (-)	**Gaps in assurance**
(+) FSSG is providing positive assurance on the governance supporting the development and implementation of CIP schemes. (+/-) NHSI have been very close to the detail of our CIP development and are assured with the process, but concerned about the risks and size of the target (+) M7 on track to meet control total/CIP	Outcome of the demand and capacity review Unpredictable winter – resource v demand

Mitigating actions planned / underway	**Progress against actions (including dates, notes on slippage or controls/ assurance failing.**
1. CIP for 2018/19 being established 2. Demand and capacity review	1. To be approved by the Board in February / March 2. Due to conclude in March with early indications in January 2018

Update	21.11.2017	**Last considered by the Board**	25.07.2017 04.09.2017 (Audit Committee)

Objective 10 Our Enablers	Develop and deliver a digital plan which supports integration with the health system and enables the clinical model and our approach to continuous improvement		
Principal Risk	Prioritising between internal and external requirements and maintaining delivery within scope.	**Director responsible**	**Executive Director of Strategy & Business Development**
		Initial Risk	C3xL4 = 12
Potential Impact	Inadequate or inaccurate information to inform decision making. Information governance breaches. Additional resources and costs.	**Current rating**	C3xL3 = 9
		Risk Treatment (tolerate, treat, transfer, terminate)	**Treat**
		Target risk score	C3xL2 = 6

Controls in place (what are we doing currently to manage the risk)
CAD project implemented. CQUIN delivery plan has been agreed I-Pads have been rolled out to over 99% of operational staff, improving access to a number of systems. Agreement with STPs to a regional digital approach; rather than eight separate local digital plans.

Gaps in Control
The scope of the digital plan is to be defined. There are currently some gaps in the informatics team. EPCR project implementation has taken longer than anticipated and on 17.11.2017 we stopped the use of ECPR due to software issues. The aim is to resume early December.

Assurance: Positive (+) or Negative (-)	**Gaps in assurance**
(+) CAD Project Board providing positive assurance in its implementation of the new CAD. (-) Up to 17.11.2017, only 10% use of electronic patient care records	We are still unable to provide detailed information to local teams

Mitigating actions planned / underway	**Progress against actions (including dates, notes on slippage or controls/ assurance failing.**
1. CQUIN plan is being delivered 2. The Digital enabling strategy to be developed which defines the scope of the digital plan 3. Recruit to six vacant posts in Informatics team 4. Approved Informatics Business Case to purchase a new data warehouse	1. Commissioners review plan each quarter 2. No progress to date 3. Two posts are covered on interim basis. Two recruited on a substantive basis. 4. Aim to implement the new data warehouse by April 2018

Update	21.11.2017	**Last considered by the Board**	25.07.2017 04.09.2017 (Audit Committee)

Objective 11 Our Enablers	Ensure that our fleet is fit for purpose and supports the clinical model		
Principle Risk	Investment needed and ability of vehicle manufacturers and converters to deliver in a timely manner. Introduction of ARP will change the vehicle mix required; more DCAs and less cars.	**Director responsible**	**Executive Director of Operations**
		Initial Risk	C4 x L3 = 12
Potential Impact	Vehicles breakdowns / weight capacity of aged fleet. Increased running costs. Inability to meet peak demand requirements of DCA fleet	**Current rating**	C4 x L2 = 8
		Risk Treatment (tolerate, treat, transfer, terminate)	**Treat**
		Target risk score	C4 x L1 = 4

Controls in place (what are we doing currently to manage the risk)

Agreed the business cases to; replace 42 of the oldest vehicles; purchase 53 end of lease vehicles (purchased); purchase an additional 43 DCA for 2018/19; and purchase an additional 16 van conversions for delivery by April 2018.
Through engagement with staff, we are considering different manufactures / types of vehicle to increase availability and reduce costs of conversion

Gaps in Control

Decisions to be made on the fleet strategy in light ARP and demand and capacity review, although plan is to work to 80/20 split.
Investment strategy to meet the needs of the new fleet replacement programme
42 new vehicles ordered won't be ready until the end of Q4 2017/18

Assurance: Positive (+) or Negative (-)	Gaps in assurance
(-) Aging fleet (+) business cases approved by FIC/Board (+) vehicle weight issues identified are all now rectified	None

Mitigating actions planned / underway	Progress against actions (including dates, notes on slippage or controls/ assurance failing.
1. Fleet replacement programme (exec options paper)	1. Recommendation to be considered by the executive in December 2017
2. Placed orders for 42 new DCAs [see above]	2. Due in Q4 2017/18
3. 43 new DCAs being ordered	3. Due 2018/19
4. 16 Van conversion ordered	4. Due by April 2018

Update	22.11.2017	Last considered by the Board	04.09.2017 (Audit Committee)

Objective 12 Our Enablers	Ensure that our estate is fit for purpose and supports the clinical model		
Principal Risk	Financial investment needed to implement our estates strategy (future investment in estate will need to come from disposals of surplus locations).	**Director responsible**	**Executive Director of Finance & Corp. Services**
		Initial Risk	C3xL2 = 6
Potential Impact	Inability to invest in our estate	**Current rating**	C3xL1 = 3
		Risk Treatment (tolerate, treat, transfer, terminate)	**Tolerate**
		Target risk score	C3xL1 = 3

Controls in place (what are we doing currently to manage the risk)

We currently have an estate that is fit for purpose, which includes 8 MRCs and a new HQ, plus significant investment in ambulance community response posts.
Estates team continue to manage the estate via external contractors, ensuring the key requirements of compliance / maintenance.
Where opportunities arise we will consider 'land-banking', such as in Brighton where couldn't afford the build costs, but bought the land.
The HQ Project Board Phase 2 is working through the plans for Coxheath and Banstead

Gaps in Control

The Estate Strategy is not yet developed

Assurance: Positive (+) or Negative (-)	Gaps in assurance
(+) Estates Return Information Collection return provides positive assurance re the condition of our estate	Until the Estates Strategy is in place we can't monitor the implementation plan.

Mitigating actions planned / underway	Progress against actions (including dates, notes on slippage or controls/ assurance failing.
1. The Estates Strategy to be approved / implemented.	1. The aim was to approve this by November 2017; the director of finance and director of operations are working during November/December to establish the next iteration for executive consideration.

Update	21.11.2017	Last considered by the Board	25.07.2017 04.09.2017 (Audit Committee)

Objective 13 Our Partners	Work with STPs to achieve the best care for our patients through emerging local out of hospital care systems		
Principal Risk	Capacity and ability to engage and influence given such a high number of different pathways.	**Director responsible**	**Executive Director of Strategy & Business Development**
		Initial Risk	C4xL5 = 20
Potential Impact	Crews longer on scene seeking non-conveyance pathways or increased conveyance through lack of pathway.	**Current rating**	C4xL4 = 16
		Risk Treatment (tolerate, treat, transfer, terminate)	**Treat**
		Target risk score	C4xL3 = 12

Controls in place (what are we doing currently to manage the risk)

We are engaged through account managers and local operations managers in STP meetings.
County-level pathway review workshops have been held.
Increased provision of hear and treat as per the delivery plan.
We are leading a number of regional work-streams, e.g. mental health and digital to address pathways on a once for the region basis

Gaps in Control

We are not always able to provide the right person at each of the STP meeting.
We don't have all the detailed data, e.g. delays in accessing pathways and in evidencing potential gaps in a pathway, such as those in primary care.
We aren't using the directory of services for see and treat, but are exploring the ability to do this via i-Pads
Further increase needed as planned, in the provision of hear and treat

Assurance: Positive (+) or Negative (-)	Gaps in assurance
(+) The current data demonstrated positively conveyance rates (-) on-scene times not decreasing as expected	None

Mitigating actions planned / underway	Progress against actions (including dates, notes on slippage or controls/ assurance failing.
1. Review how we engage with STP-leads to ensure we are more proactive and use conversations to build consistency across the region. 2. Use of directory of services 3. Increasing hear and treat	1. Proactive approaches on a number of pathways, e.g. mental health and digital 2. We have piloted the use of directory of services on iPads, and are now exploring alternative systems with commissioners. 3. Project underway as part of the delivery plan

Update	21.11.2017	Last considered by the Board	25.07.2017 04.09.2017 (Audit Committee)

Objective 14 Our Partners	Work with STPs to design and deliver generalist and specialist care pathways for patients requiring an acute hospital attendance		
Principal Risk	Capacity to ensure proactive engagement. Insufficient influence.	**Director responsible**	**Executive Director of Strategy & Business Development**
		Initial Risk	C3xL4 = 12
Potential Impact	Geographical spread / no funding for additional journey times. Misalignment of plans. We don't plan the right capacity to respond to reconfigured services and do not secure associated funding.	**Current rating**	C3xL4 = 12
		Risk Treatment (tolerate, treat, transfer, terminate)	**Treat**
		Target risk score	C3xL3 = 9

Controls in place (what are we doing currently to manage the risk)
We are engaged through account managers and local operations managers in STP meetings. Improved alignment of engagement between operations, clinical and strategy teams, with STPs

Gaps in Control
We don't have timely availability of clinical outcomes data.

Assurance: Positive (+) or Negative (-)	**Gaps in assurance**
(+) We are being relied upon to provide data which demonstrates STP understanding of the role we have. (+) Clinical outcomes data we do have is used to review and measure the impact of changes to pathways	We only have outcomes data for some of the pathways

Mitigating actions planned / underway	**Progress against actions (including dates, notes on slippage or controls/ assurance failing.**
1. Review how we engage with STP-leads to ensure we are more proactive and use conversations to build consistency across the region. 2. Review of clinical outcomes data we are able to provide.	1. Proactive approaches on a number of pathways, e.g. stroke 2. Medical Director has reviewed cardiac arrest data and now awaiting national direction for stroke, heart attack and sepsis.

Update	21.11.2017	**Last considered by the Board**	25.07.2017 04.09.2017 (Audit Committee)

Objective 15 Our Partners	Work with education and STP partners to develop career pathways that support our staff to make effective clinical decision making		
Principal Risk	Insufficient internal capacity to design and deliver appropriate modules. A reduction in external funding.	**Director responsible**	**Director of HR**
		Initial Risk	C4xL3 = 12
Potential Impact	Inadequate training for clinical staff	**Current rating**	C4xL1 = 4
		Risk Treatment (tolerate, treat, transfer, terminate)	**Tolerate**
		Target risk score	C4xL1 = 4

Controls in place (what are we doing currently to manage the risk)

We currently have fully staffed, established and costed clinical education team, including a consultant paramedic providing input.
We have a programme designed for each module across all relevant career pathways.
We have facilities in place to deliver the modules / training.
Funding from HEKKS is in place for next two years.

Gaps in Control

None

Assurance: Positive (+) or Negative (-)	Gaps in assurance
(+) Clinical education group	Workforce strategy which shows career pathway flow chart

Mitigating actions planned / underway	Progress against actions (including dates, notes on slippage or controls/ assurance failing.
None (all controls in place)	NA

Update	23.11.2017	Last considered by the Board	25.07.2017 04.09.2017 (Audit Committee)

Objective 16 Our Partners	Work with blue light partners to ensure collaboration supports patient outcomes and efficient service delivery		
Principal Risk	Desire between partners to collaborate	**Director responsible**	**Executive Director of Operations**
		Initial Risk	C3 x L2 = 6
Potential Impact	Adverse patient experience by not using co-responding schemes, e.g. fire service. Missed opportunities to improve efficiencies.	**Current rating**	C3 x L2 = 6
		Risk Treatment (tolerate, treat, transfer, terminate)	**Treat**
		Target risk score	C3 x L1

Controls in place (what are we doing currently to manage the risk)

We are working in collaboration, in particular via the emergency services collaboration programme for Sussex and Surrey. The aim is to standardise fleet servicing across the region using a hub and spoke workshop model.
Director of Operations engaged with emergency services in Kent via Fire Services.

Gaps in Control

No decision point agreed with the Surrey and Sussex collaboration.
No formal programme in Kent.
Fire service union withdrawn first responders due to pay dispute.

Assurance: Positive (+) or Negative (-)	Gaps in assurance
(+) exec and senior management attendance at strategic coordinating group in Sussex and Surrey (-) fire service not acting as first responders across the region	None

Mitigating actions planned / underway	Progress against actions (including dates, notes on slippage or controls/ assurance failing.
1. Develop strategic options through the Surrey and Sussex collaboration programme 2. Standardise fleet servicing across the region using a hub and spoke model	1. Still in early stages 2. Still in early stages

Update	21.11.2017	Last considered by the Board	04.09.2017 (Audit Committee)

Our Themes	Our People	Our Patients	Our Enablers	Our Partners
Our five year goals	We will respect, listen to and work with our staff and volunteers to provide development and support that enables them to provide consistent, quality care to our patients	We will develop and deliver an integrated clinical model that meets the needs of our communities whilst ensuring we provide consistent care which achieves our quality and performance standards	We will develop and deliver an efficient and sustainable service underpinning by fit for purpose technology, fleet and estate	We will work with our partners in STPs and blue light services to ensure that our patients receive the best possible care, in the right place, delivered by the right people
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 generalist 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 clinical 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 patient outcomes and efficient service delivery

South East Coast Ambulance Service
NHS Foundation Trust

Integrated Performance Dashboard

November 2017 Board Meeting

SECAmb Integrated Performance Report

Contents

SECAmb Regulation Statistics

Use of Resources Metric (Financial Risk Rating)	3
CQC Compliance Status	Trust: Inadequate (Special Measures) 111 Service: Good
IG Toolkit Assessment	Level 2 - Satisfactory
REAP Level	3

Data Notes

Chart Key:

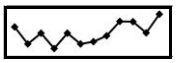
Data Point	This represents the value being measured on the chart
Run of 8 above average	These points will show on a chart when the value is above or below the average for 8 consecutive points. This is seen as statistically significant and an area that should be reviewed.
Run of 8 below average	
Above UCL	When a value point falls above or below the control limits, it is seen as a point of statistical significance and should be investigated for a root cause.
Below LCL	
AVERAGE	This line represents the average of all values within the chart.
UCL	These lines are set two standard deviations above and below the average.
LCL	
Target	The target is either and Internal or National target to be met, with the values ideally falling above or below this point.

SECAmb Clinical Safety Scorecard

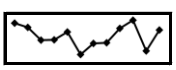
Cardiac ROSC - Utstein

	Apr-17	May-17	Jun-17	12 Month's
Actual %	62.1%	56.8%	44.8%	
Previous Year %	61.1%	61.3%	44.4%	
National Average %	54.8%	48.1%	52.4%	

Cardiac ROSC - ALL

	Apr-17	May-17	Jun-17	12 Month's
Actual %	28.0%	22.8%	28.1%	
Previous Year %	26.3%	26.4%	31.4%	
National Average %	30.2%	28.7%	31.2%	

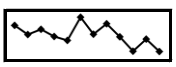
Cardiac Survival - Utstein

	Apr-17	May-17	Jun-17	12 Month's
Actual %	33.3%	30.3%	17.9%	
Previous Year %	25.7%	33.3%	22.6%	
National Average %	31.1%	22.6%	28.4%	

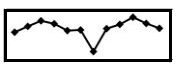
Cardiac Survival - All

	Apr-17	May-17	Jun-17	12 Month's
Actual %	8.1%	6.3%	5.9%	
Previous Year %	6.2%	8.0%	7.9%	
National Average %	9.1%	8.5%	9.7%	

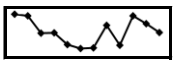
Acute STEMI Care Bundle Outcome

	Apr-17	May-17	Jun-17	12 Month's
Actual %	59.6%	57.5%	70.5%	
Previous Year %	69.1%	66.7%	65.3%	
National Average %	76.7%	78.4%	76.6%	

Acute STEMI receiving primary angioplasty within 150 minutes

	Apr-17	May-17	Jun-17	12 Month's
Actual %	87.9%	91.7%	88.2%	
Previous Year %	94.2%	88.2%	91.0%	
National Average %	87.6%	86.4%	85.5%	

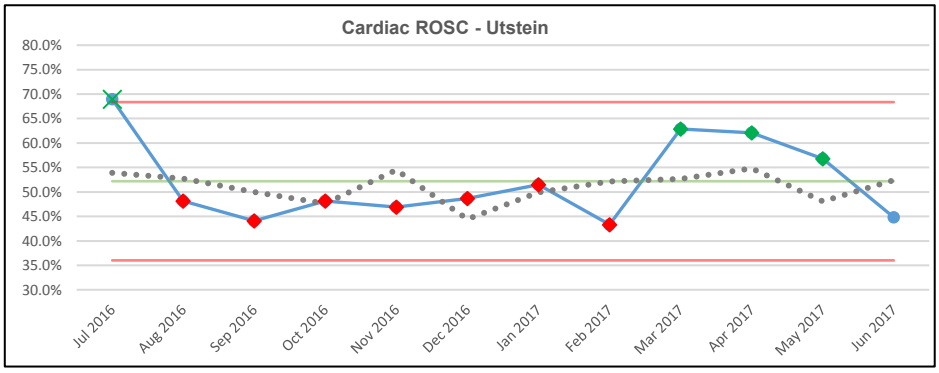
FAST Id'd Stroke - arriving at a hyperacute stroke unit within 60 minutes

	Apr-17	May-17	Jun-17	12 Month's
Actual %	66.8%	64.9%	62.7%	
Previous Year %	76.4%	67.0%	61.9%	
National Average %	58.7%	55.2%	57.0%	

Stroke - assessed F2F receiving care bundle

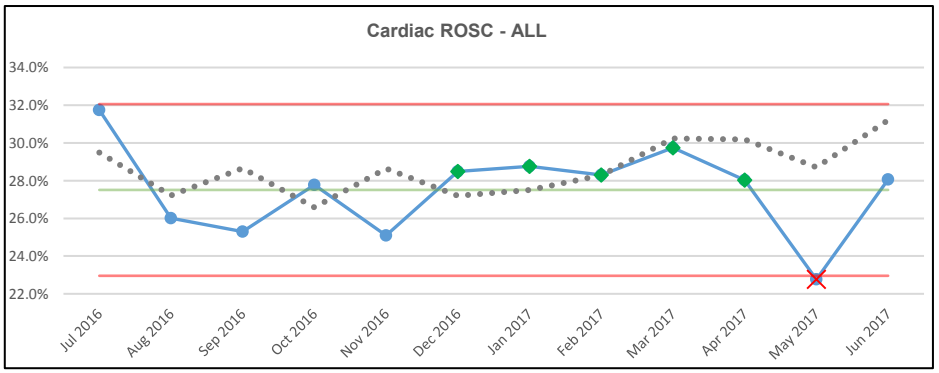
	Apr-17	May-17	Jun-17	12 Month's
Actual %	94.1%	92.3%	94.4%	
Previous Year %	95.8%	95.7%	98.2%	
National Average %	97.3%	96.6%	97.4%	

SECAmb Clinical Safety Scorecard

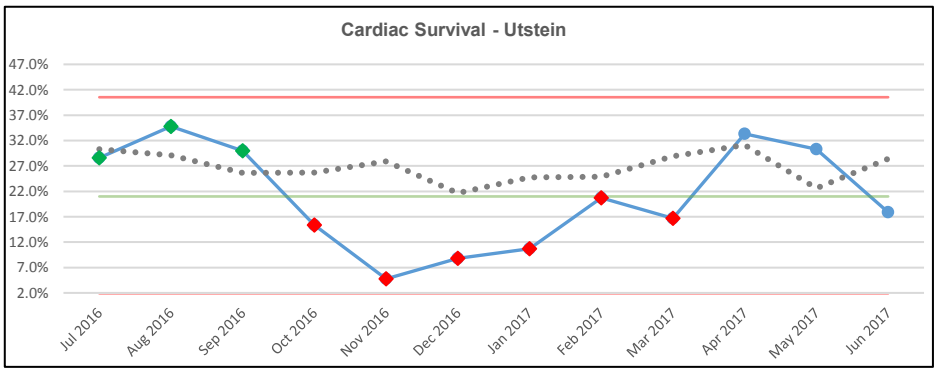


Performance for the cardiac arrest ROSC indicator for the Utstein group for June 2017 declined for a third consecutive month and was below the national average for the first time since February 2017.

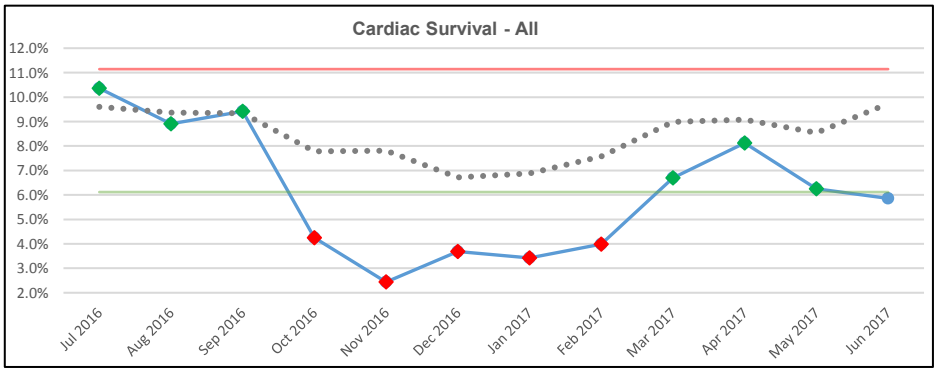
A contributing factor to this decline in performance is our response to Red 1 calls in this period. Monthly meetings continue to explore the quality of data.



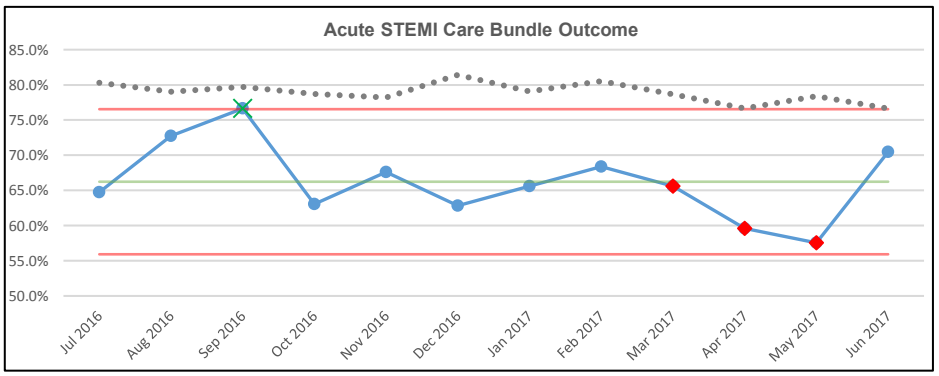
Following last month's decline in performance which was attributed to a high number of non-returns of outcome data from receiving Trusts, our performance is now in line with previous months.



In June 2017 whilst survival to discharge for the Utstein group decreased in relation to the previous two months, performance is higher than the period October 2016 to January 2017 when we saw a decline.
Monthly meetings continue with representation from Clinical Audit, Consultant Paramedic and the Medical Director to review the quality of data and identify areas for improvement prior to submission internally and nationally.

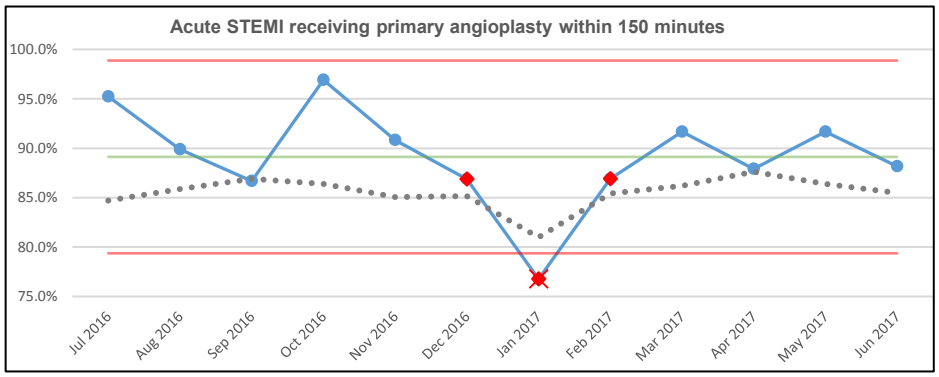


Cardiac survival rates were similar to the previous month but higher than performance recorded during October 2016 to February20 17 when performance previously declined.

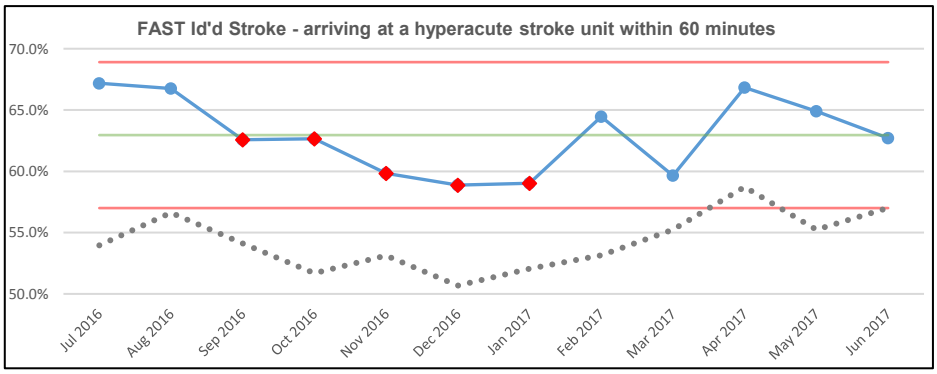


Performance for June 2017 increased to 70%, a level not achieved since September 2016. It was noted that the most frequent elements of the care bundles not fully completed were the recording of two pain scores and administration of analgesia. To address this we will be reviewing performance at OU level to identify high levels of compliance and provide additional education and support in respect of non compliance.

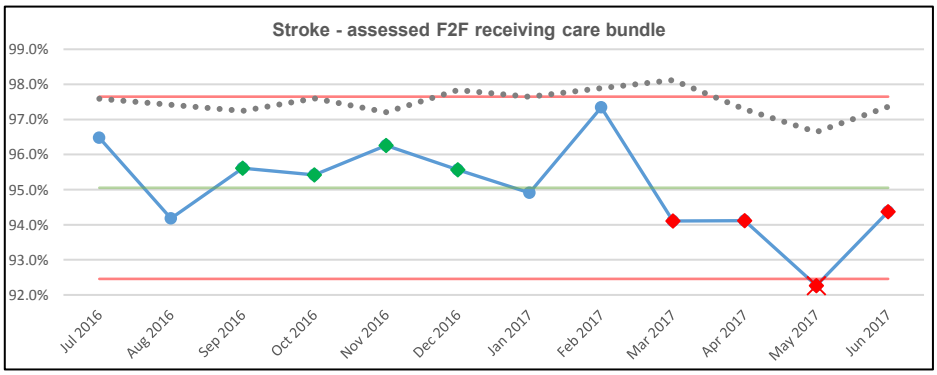
SECAmb Clinical Safety Additional Information



June 2017 performance was slightly lower than May 2017 however remains above the national average.



For June 2017 performance for FAST positive patients potentially eligible for stroke thrombolysis arriving at a hyper acute stroke unit within 60 minutes was 5% above the national average and SECAmb were rated the second best preforming ambulance trust nationally. A contributing factor to our decline in performance over the past two months is a failure to meet our Red 2 performance targets.



Compliance with the stroke care bundle has improved . The area of non-compliance with this care bundle was failure to record blood glucose which was recorded in 96.2% of cases. To address non compliance OU level performance will be reviewed to identify areas of good practice and additional education and support to address non compliance.

Analysis of Cardiac Arrest Data - June 2017

Number of cardiac arrests identified 288 (incl. 13 DNACPR/38 DOA/ 9 No Resus by SECAmb)

Number of resuscitation attempts identified 228 (79%)

Utstein definition
Bystander Witness Arrest
Presenting Rhythm - VF
Arrest - Cardiac in Origin

Utstein Data = 29 (13%)

ROSC sustained to hospital = 13 (45%)

Non ROSC Definition transported to

Patients transported to hospital in cardiac arrest with resuscitation still in progress

Overall (incl. Utstein) = 228 (100%)

ROSC (incl. Utstein) sustained to hospital = 64 (28%) + 6 Non ROSC

Outcomes for ROSC at Hospital and Non ROSC at Hospital Patients		
Utstein	Details	Overall
5	Patient survived to discharge	13
7	Patient died in hospital	51
1	Patient still in hospital*	1
0	Patient not found by hospital*	0
0	No reply from hospital*	5 (incl. 4 x St. Peters)
0	Awaiting reply from NHS Spine*	0

Survival to discharge is calculated as a percentage of the overall Utstein figure minus any missing patient outcomes as detailed * above

Survival to Discharge = 5 (18%)

Survival to discharge is calculated as a percentage of the overall figure minus any missing patient outcomes as detailed * above

Survival to Discharge (incl. Utstein) = 13 (6%)

Additional Information - Resuscitation Attempts

Cardiac Rhythm	Overall Totals	ROSC at Hospital	Non ROSC at Hospital
Asystole	105	16	4
PEA	65	19	2
VF	46	25	0
Non-shockable	7	1	0
Not recorded	5	3	0
CPR Bystander	137		
EMS Witnessed arrest	37		

140 Cardiac Arrest downloads received for June 2017
129 Cardiac Arrest download reports sent to crews for June 2017

SECAmb Clinical Quality Scorecard

Number of Incidents Reported

	Aug-17	Sep-17	Oct-17	12 Month's
Actual	579	585	615	
Previous Year	493	466	512	

Number of Incidents Reported that were SI's

	Aug-17	Sep-17	Oct-17	12 Month's
Actual	10	11	6	
Previous Year	4	0	1	

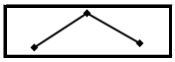
Duty of Candour Compliance (SIs)

	Aug-17	Sep-17	Oct-17	12 Month's
Actual %	30%	64%	83%	
Target	100%	100%	100%	

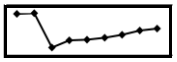
Number of Complaints

	Aug-17	Sep-17	Oct-17	12 Month's
Actual	105	132	129	
Previous Year	144	121	98	
Complaints Timeliness (All Complaints)	47.1%	42.4%	40.1%	
Timeliness Target	95%	95%	95%	

Hand Hygiene

	Aug-17	Sep-17	Oct-17	12 Month's
Actual %	77%	85%	78%	

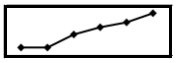
Safeguarding Training Completed (Adult) Level 2

	Aug-17	Sep-17	Oct-17	12 Month's
Actual %	34.06%	45.22%	50.82%	
Previous Year %				
Target	42%	50%	58%	

Safeguarding Training Completed (Children) Level 2

	Aug-17	Sep-17	Oct-17	12 Month's
Actual %	35.99%	46.62%	50.00%	
Previous Year %				
Target	42%	50%	58%	

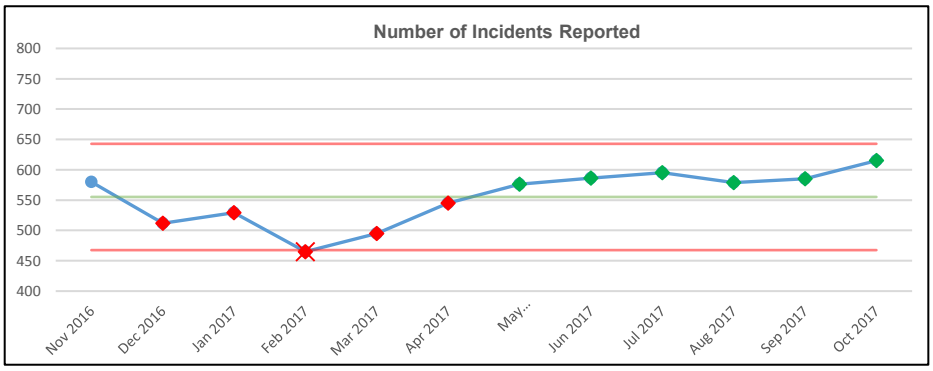
Safeguarding Training Level 3 (Adult/Child)

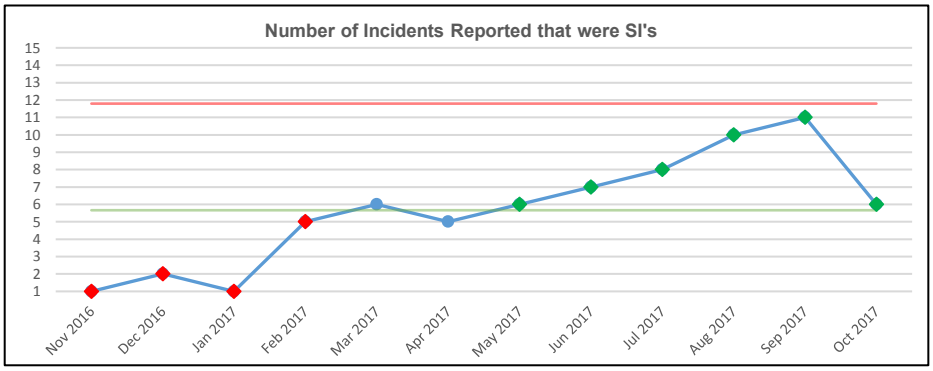
	Aug-17	Sep-17	Oct-17	12 Month's
Actual %	23.75%	26.06%	30.52%	

Medicines Management

	Aug-17	Sep-17	Oct-17	12 Month's
Actual				
Target				

SECAmb Clinical Quality Scorecard

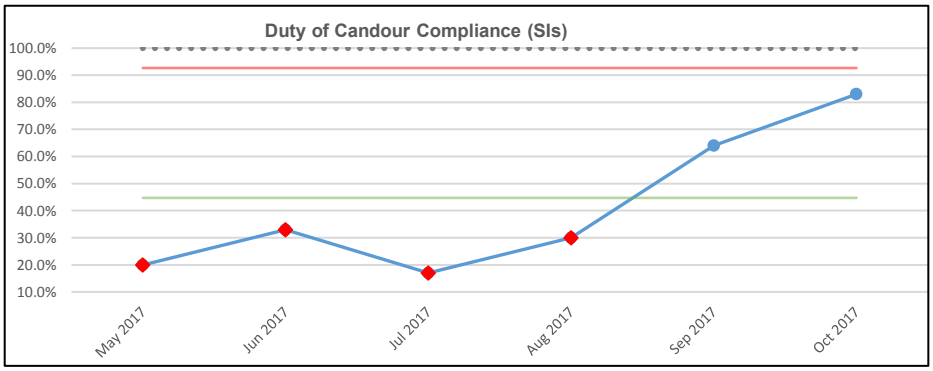




There were 13 Serious Incidents in total for the month of September.

6 were regarding delayed dispatch in EOC. 3 were regarding triage or call answering and 2 regarding a delay in call answering.

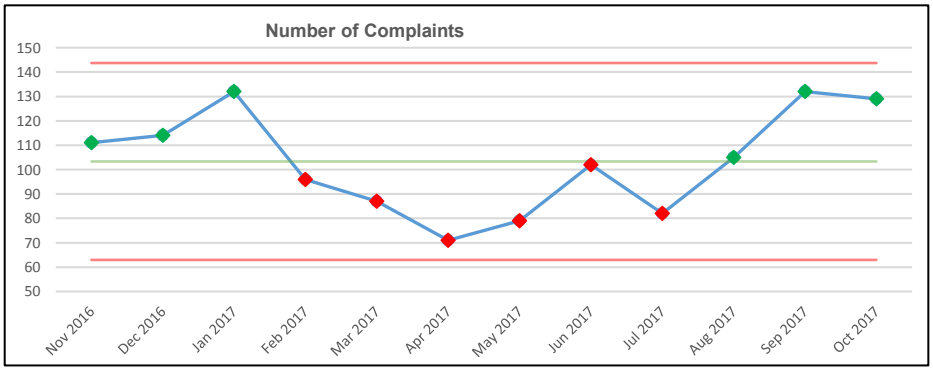
The remaining 2 incidents were within the 111 service and were regarding triage



The improved compliance for Duty of Candour is reflective of the focussed attention being paid to this aspect of care.

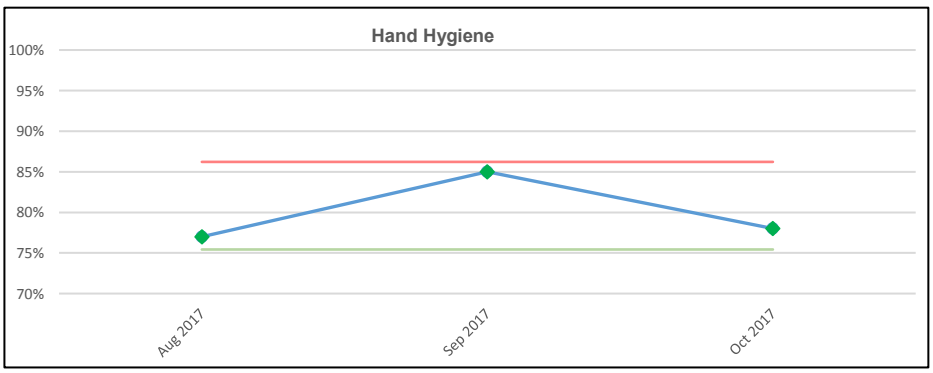
Within the month all staff involved in leading Duty of Candour attended a workshop to ensure everyone who gives advice on candour is consistent in their advice.

In addition, the Lead and the Manager for Serious incidents has been undertaking the responsibility when there has been a delay in assigning an investigating manager.



The number of complaints received has increased significantly this month as a result of two factors. Firstly, there has been an increase in complaints about NHS111 as a result of a spate of complaints from a particular out-of-hours provider (27 total complaints in September compared to 16 in August) . SECAmb's senior NHS111 management team have made contact to discuss this influx, as it was felt that some of the complaints may be spurious.

Secondly, and of more significance, is an exponential rise in complaints about ambulance delays. Thirty-seven were received in July, 52 in August and 73 in September. The average monthly figure for 16/17 was 36.



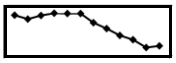
Compliance to hand hygiene is based on the 'Five Moments for Hand Hygiene' audit tool and the figures shown come from local audits carried out at each Operating Unit (OU).

Each OU is required to complete at least ten audits per month and the only OU not to have achieved this for October was Guildford. The IPC Lead will be seeking assurances from the OUM that this is rectified for November.

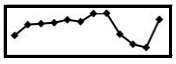
The audit tools will soon be on the I-Pads which will make the process easier for staff to complete these. Once this is in place it will allow the IPC Team to drill down into the areas of non-compliance which can then be used to raise awareness and educate staff.

SECAmb 999 Operations Performance Scorecard

Call Handling

	Aug-17	Sep-17	Oct-17	12 Month's
5 Sec EOC Performance	58.3%	48.6%	50.7%	
Previous Year	70.9%	72.4%	82.6%	
National Target	95%	95%	95%	
Average Call Pick Up Time (secs)	9.0	19.1	17.6	
Call Pick Up Time 95th Percentile (Secs)	170	190	230	

Dispatch

	Aug-17	Sep-17	Oct-17	12 Month's
Average Allocation Time - Red 2 (Secs)	116.6136	148.61	142.33	
Allocation Ratio	1.61	1.60	1.67	
Response Ratio	1.13	1.10	1.13	

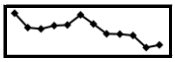
Red 1 8 Minute Performance

	Aug-17	Sep-17	Oct-17	12 Month's
8 Minute Response	59.4%	50.8%	53.9%	
Previous Year	64.6%	62.6%	64.7%	
95th Percentile Response Time (mins)	16.9	18.7	17.9	
Cardiac/Resp Arrest 8 Minute Performance	63.4%	59.1%	63.7%	

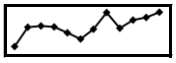
Red 2 8 Minute Performance

	Aug-17	Sep-17	Oct-17	12 Month's
8 Minute Response	46.5%	39.9%	40.9%	
Previous Year	52.5%	52.8%	53.5%	
95th Percentile Response Time (mins)	25.4	27.2	26.7	
Call Volume %	39.5%	42.7%	42.9%	

Green 2 30 Minute Performance

	Aug-17	Sep-17	Oct-17	12 Month's
30 Minute Response	48.4%	37.0%	39.6%	
Previous Year	75.3%	74.0%	71.3%	
95th Percentile Perf Time (hours:mins)	02:29	03:28	03:28	

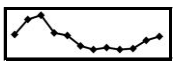
Incident Outcome (Contract)

	Aug-17	Sep-17	Oct-17	12 Month's
See & Convey Total	54.6%	54.6%	54.2%	
See & Treat	32.1%	31.7%	31.5%	
Hear & Treat	13.4%	13.7%	14.3%	
S&C HCP	16.6%	16.7%	16.2%	
S&C 999	83.4%	83.3%	83.8%	

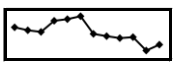
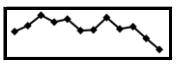
Demand/Supply

	Aug-17	Sep-17	Oct-17	12 Month's
Call Volume	96596	87520	86300	
Incidents	61011	59512	59901	
Transports	33009	31639	33342	
Staff Hours Provided Against Forecast (UHU)	102%			

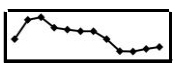
Call Cycle Time

	Aug-17	Sep-17	Oct-17	12 Month's
Clear at Scene	72.24	73.82	74.58	
Clear at Hospital	105.2	105.9	105.9	
Hours Lost at Hospital	5242	5253	5482	

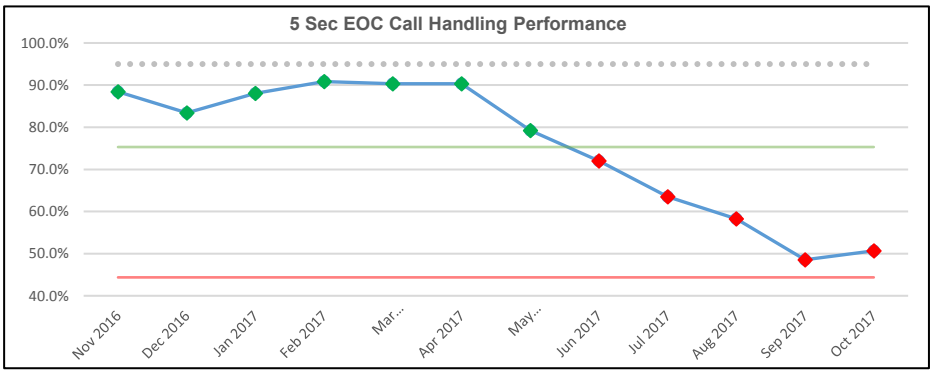
Unique Contribution to Performance

	Aug-17	Sep-17	Oct-17	12 Month's
CFR (Reds)	0.9%	0.8%	0.8%	
PAP (Reds)	1.6%	0.9%	1.2%	
Fire Responder (Red 1)	1.6%	0.9%	0.3%	

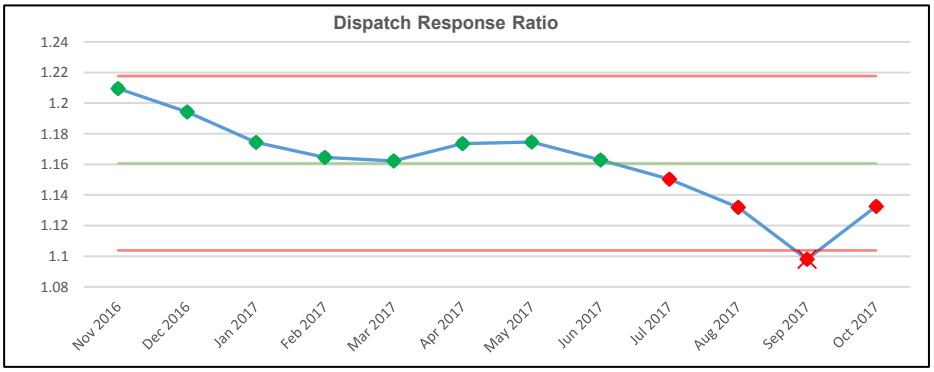
Community First Responders

	Aug-17	Sep-17	Oct-17	12 Month's
Volume of incidents Attended	1110	1189	1246	
Red 1 Attendences	112	118	122	
Hours Provided	24233	20411	20543	

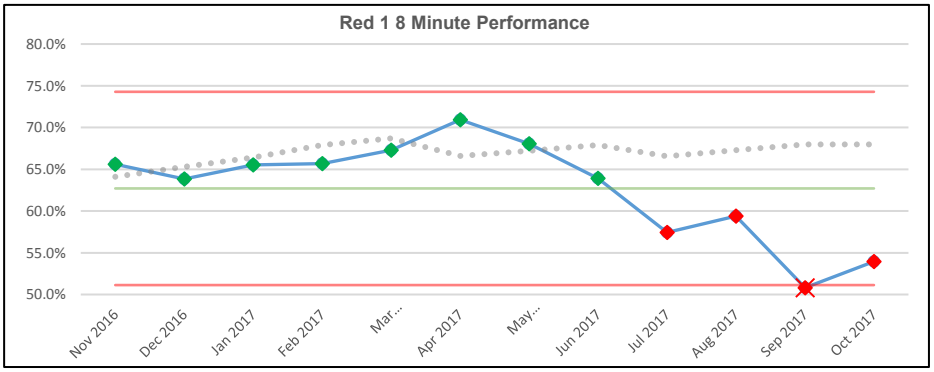
SECAmb 999 Operations Performance Scorecard



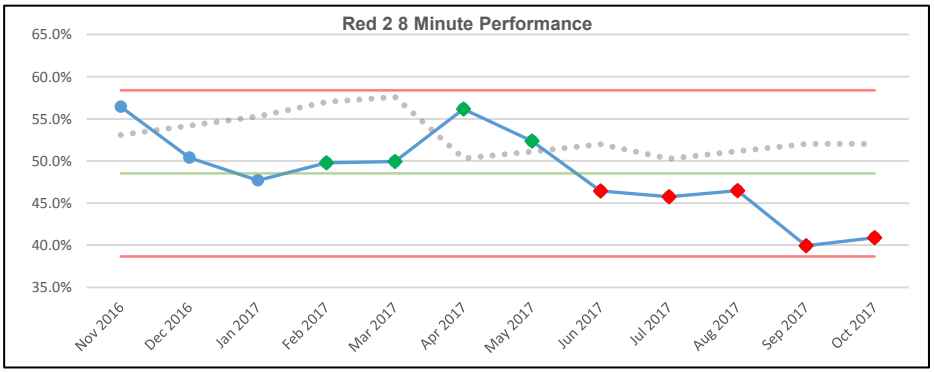
Call handling performance has started to increase over the last month. Call pick up performance is now included in the EOC action plan to address the CQC requirement of improving AQI, recruitment and staff retention. There has also been daily conference calls to drive an immediate improvement to performance which we are already seeing a significant positive impact on for call answer as well as Red 1 & 2 performance.



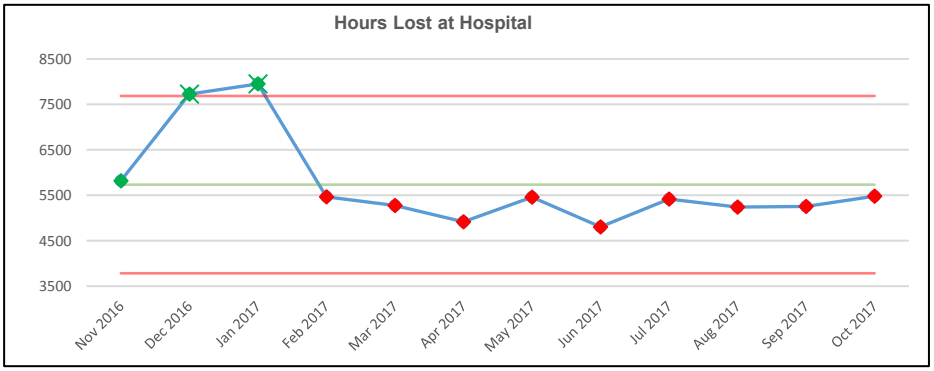
Response ratio has increased, which correlates with the increase in performance.



Red 1 performance has increased to 53.9% for October 2017. A review by AACE is currently being undertaken with the aim of identifying the key areas for improvement. The report should be available shortly on this. The increase in performance is directly correlated to the increase to the call pick up performance.



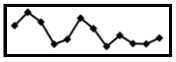
Red 2 performance also increased to 40.9% for October 2017. Whilst call pickup would have had a factor to play in this, it wouldn't have been as significant as the impact to Red 1. The biggest impact to this for September was the increase in abstractions required to meet the university requirements. Work is being undertaken to review all abstractions, with the aim of maximising the number of operational hours that can be deployed within the current budget.



Handover delays continue to apply a significant pressure to SECAmb, with over 5200 hours lost through handover delays. Work is being undertaken in conjunction with the CCGs by the strategy team to reduce these delays, returning hours back in to the system.

SECAmb 111 Operations Performance Scorecard

Calls Offered

	Aug-17	Sep-17	Oct-17	12 Month's
Actual	80524	80053	84639	
Previous Year	90429	86765	98849	

Calls answered in 60 Seconds

	Aug-17	Sep-17	Oct-17	12 Month's
Actual %	93.5%	80.2%	75.3%	
Previous Year %	91.4%	83.7%	83.9%	
Target %	95%	95%	95%	

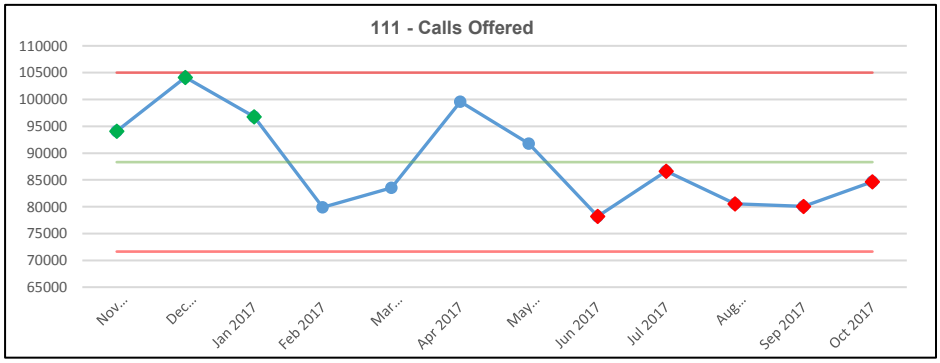
Calls abandoned - (Offered) after 30secs

	Aug-17	Sep-17	Oct-17	12 Month's
Actual %	0.6%	2.0%	2.8%	
Previous Year %	0.9%	2.5%	2.2%	
Target %	2%	2%	2%	

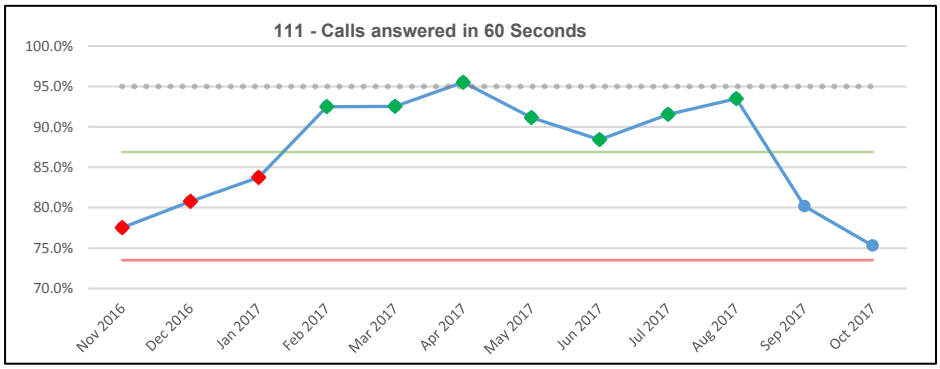
Combined Clinical KPI

	Aug-17	Sep-17	Oct-17	12 Month's
Actual %	80.1%	69.5%	78.2%	
Previous Year %	82.2%	78.1%	68.7%	
Target %	90%	90%	90%	

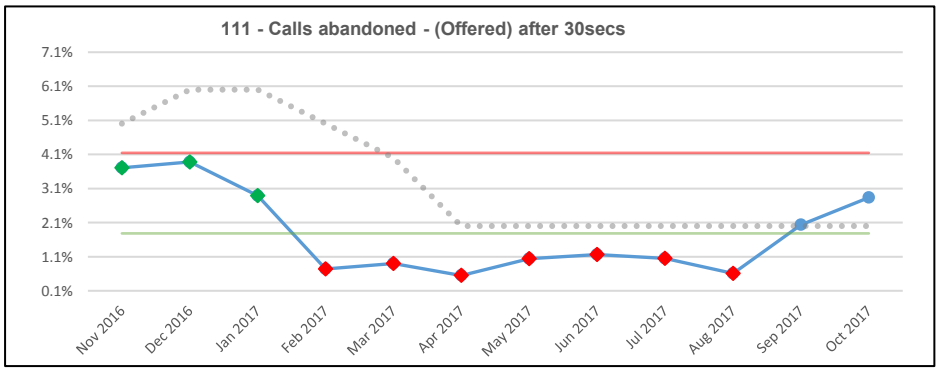
SECAmb 111 Operations Performance Scorecard



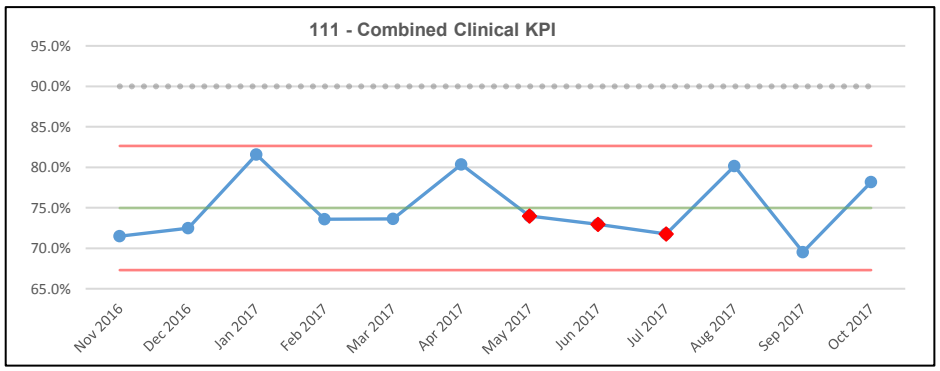
84639 Calls offered in October: up 5.7% vs previous month.



The “Answered in 60” KPI dropped to 75.29%, and the “Average Speed to Answer” increased to 46 seconds.
Operational challenges due to rota incongruence, will be fully resolved before Christmas.



Abandonment rate up to 2.83% but still broadly in line with the national average for October (2.72%).



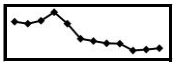
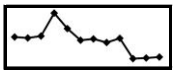
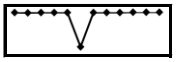
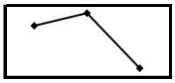
Clinical performance back up to 78.18%, this is 12% better than the national 111 clinical performance. The service has focused on clinical rotas and effective queue management and prioritisation.

SECAmb 111 Operations Performance Additional Information

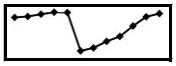
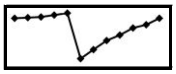
The KMSS 111 Clinical In-line Support (CIS) validation process helped to mitigate the Ambulance referral rate, which at 11.09% was significantly better than the NHS E national average (11.77%) and supported the emergency care system. Despite the strong 999 performance, the service's ED referral rate of 7.69% was also good (the two measures are inversely proportional in terms of disposition outcome) and aligned to the national rate (7.68%).

SECAmb Workforce Scorecard

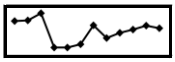
Workforce Capacity

	Aug-17	Sep-17	Oct-17	12 Month's
Number of Staff WTE (Excl bank & agency)	3033.4	3038.0	3043.3	
Number of Staff Headcount (Excl bank and agency)	3310	3313	3318	
Finance Establishment (WTE)	3509.12	3525.24	3525.24	
Vacancy Rate	477.9	490.0	476.4	
Vacancy Rate Previous Year		346.7	318.2	
Adjusted Vacancy Rate + Pipeline recruitment %	9.29%	9.77%	7.70%	

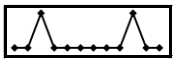
Workforce Compliance

	Aug-17	Sep-17	Oct-17	12 Month's
Objectives & Career Conversations %	34.06%	46.24%	50.66%	
Statutory & Mandatory Training Compliance %	59.99%	65.46%	76.06%	
Previous Year %	67.60%	73.40%	74.60%	

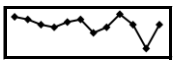
Workforce Costs

	Aug-17	Sep-17	Oct-17	12 Month's
Annual Rolling Turnover Rate %	17.51%	17.77%	18.17%	
Previous Year %	16.90%	16.30%	16.10%	
Annual Rolling Sickness Absence %	4.90%	4.99%	4.93%	

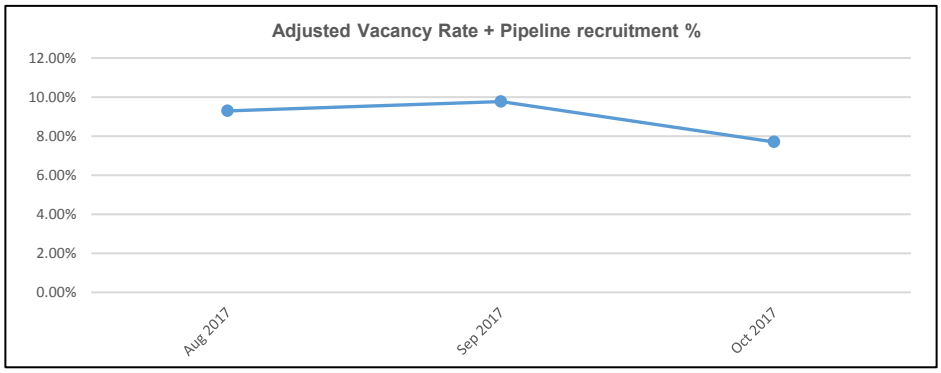
Employee Relations Cases

	Aug-17	Sep-17	Oct-17	12 Month's
Disciplinary Cases	9	4	5	
Individual Grievances	1	8	6	
Collective Grievances	1	0	0	
Bullying & Harrassment	0	1	2	
Bullying & Harrassment Previous Yr	0	0	4	
Whistleblowing	1	0	0	
Whistleblowing Previous Year	0	0	1	

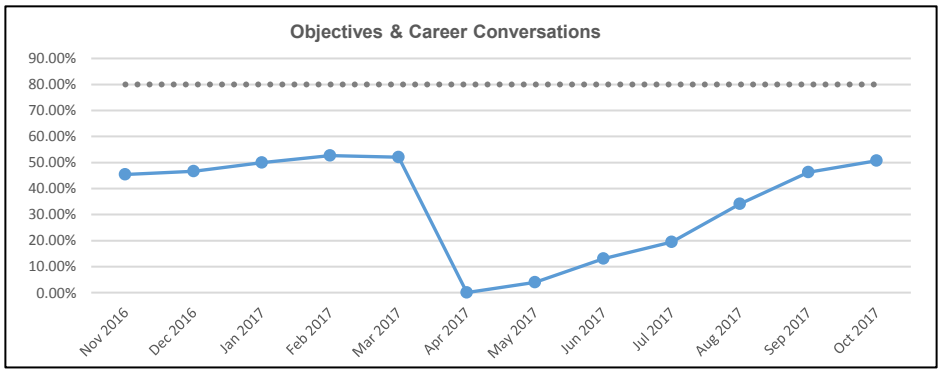
Physical Assaults (Number of victims)

	Aug-17	Sep-17	Oct-17	12 Month's
Sanctions	1	1	0	
Actual	17	8	17	
Previous Year	18	26	18	

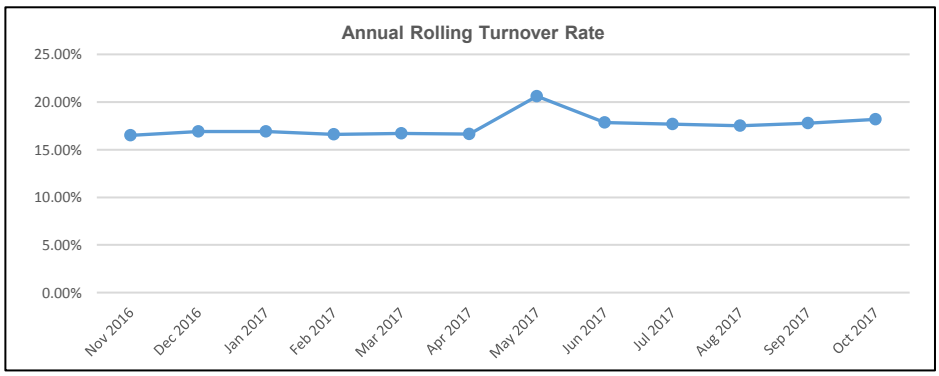
SECAmb Workforce Scorecard



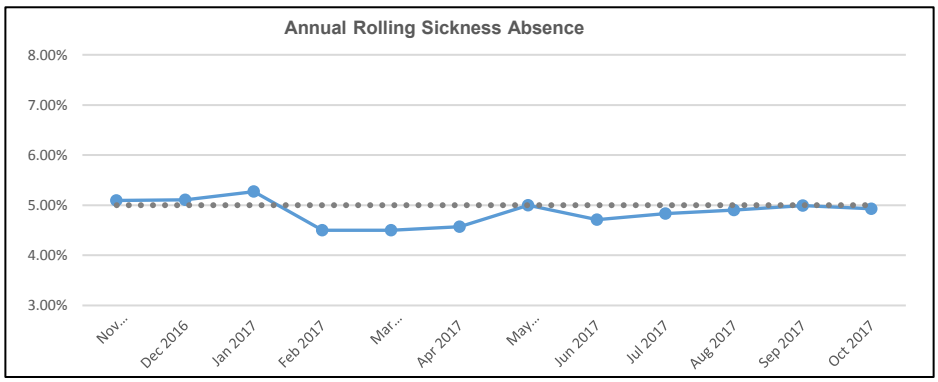
The significant decrease in pipeline vacancy rate is due to repeated and sustained recruitment initiatives, focusing mainly on EOC and 111 roles as these have been historically our hard to fill roles. New approaches include web based job boards, increased visibility locally and attendance at careers events. We are mindful of the starters and leavers monthly ratio and are looking to develop our recording and reporting capabilities.



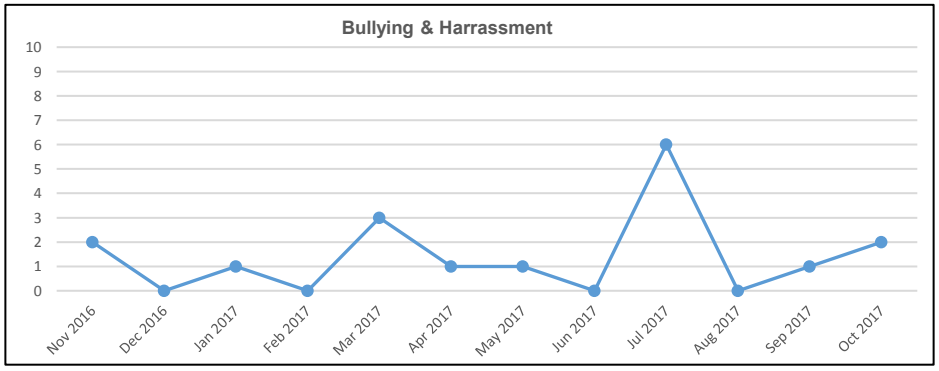
We have had a 4% month on month increase in career conversations recorded in Actus and a 31% increase in the period July - October; momentum is picking up as more staff are trained in the system – over 500 staff (mainly managers) have now been trained. Managers will continue to challenge at a local level to complete their appraisals and career conversations in coonjunction with continued Actus training.



The Trust turnover rate remains constant. However there is currently a high turnover rate in EOC, being addressed via the EOC Task and Finish Group.



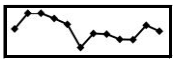
This has remained stable. This is due to the close working relationship between the HR Advisors and Managers. This is being supplemented by additional, more immediate, reporting and monitoring capabilities i.e. weekly not monthly in arrears, as agreed in the AQI Task and Finish Group.



There has been an increase month on month in B&H reports which we would attribute to the ongoing Trust B&H initiatives. There are currently 7 live cases with the longest open case being 3 months.
We will be working on a B&H action plan based on the outcomes of the Focus Groups that were shared recently with the Executive.
We have procured an external trainer to deliver investigation skills training to line managers to increase the number of available investigators, speading up case management.

SECAmb Finance Performance Scorecard

Income

	Aug-17	Sep-17	Oct-17	12 Month's
Actual £	£ 15,756	£ 16,716	£ 16,329	
Previous Year £	£ 16,354	£ 16,198	£ 16,370	
Plan £	£ 16,403	£ 15,892	£ 16,602	

Expenditure

	Aug-17	Sep-17	Oct-17	12 Month's
Actual £	£ 16,461	£ 17,319	£ 16,623	
Previous Year £	£ 17,335	£ 17,095	£ 17,655	
Plan £	£ 17,108	£ 16,506	£ 16,913	

Capital Expenditure

	Aug-17	Sep-17	Oct-17	12 Month's
Actual £	£ 225	£ 450	£ 375	
Previous Year £	£ 1,410	£ 1,054	£ 701	
Plan £	£ 855	£ 855	£ 1,865	

Cost Improvement Programme (CIP)

	Aug-17	Sep-17	Oct-17	12 Month's
Actual £	£ 1,491	£ 1,330	£ 1,304	
Previous Year £	£ 537	£ 588	£ 558	
Plan £	£ 1,293	£ 1,302	£ 1,332	

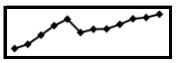
CQUIN (Quarterly)

	Q1 2017	Q2 2017	Q3 2017
Actual £	£ 848	£ 848	£ 282
Previous Year £	£ 952	£ 1,019	£ 716
Plan £	£ 848	£ 848	£ 848

Surplus/(Deficit)

	Aug-17	Sep-17	Oct-17	12 Month's
Actual £	-£ 705	-£ 603	-£ 294	
Actual YTD £	-£ 3,081	-£ 3,685	-£ 3,979	
Plan £	-£ 705	-£ 614	-£ 311	
Plan YTD £	-£ 3,098	-£ 3,712	-£ 4,023	

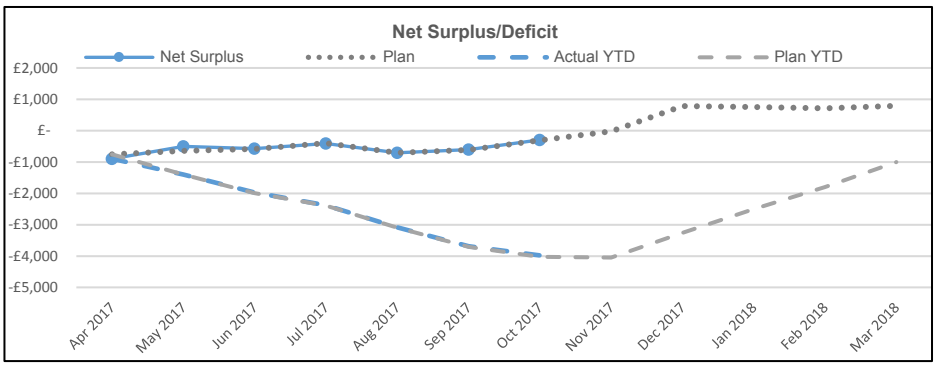
Cash Position

	Aug-17	Sep-17	Oct-17	12 Month's
Actual £	£ 13,146	£ 13,482	£ 14,327	
Previous Year £	£ 10,951	£ 9,847	£ 7,117	
Plan £	£ 5,757	£ 5,413	£ 5,219	

Agency Spend

	Aug-17	Sep-17	Oct-17	12 Month's
Actual £	£ 226	£ 182	£ 127	
Previous Year £	£ 671	£ 556	£ 561	
Plan £	£ 337	£ 336	£ 334	

SECAmb Finance Performance Scorecard



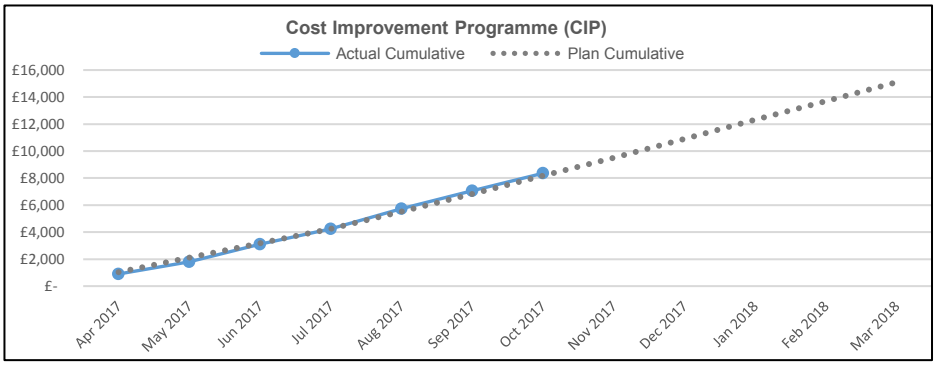
The Trust remains on plan in month and year to date.

Overall Income is £1.6m less than plan, mainly through lower A&E Activity.

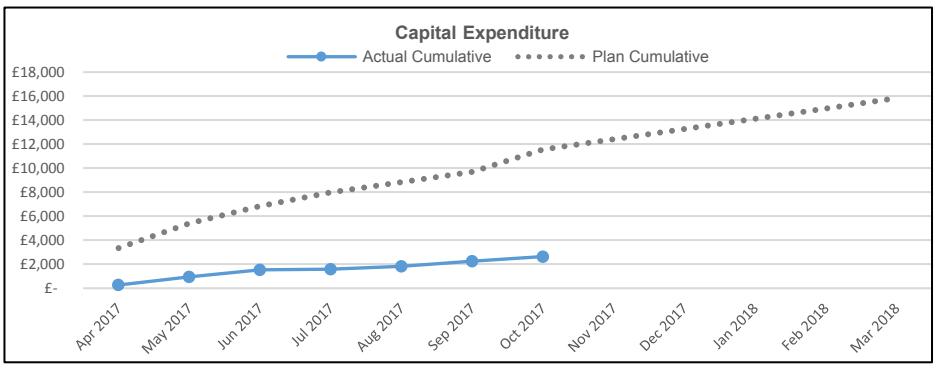
Expenditure has decreased to offset this fall in Income. Again this is mainly through managing frontline hours to match activity.

Further explanation is given below.

We are still expecting to meet our Financial Control Total for 2017/18.

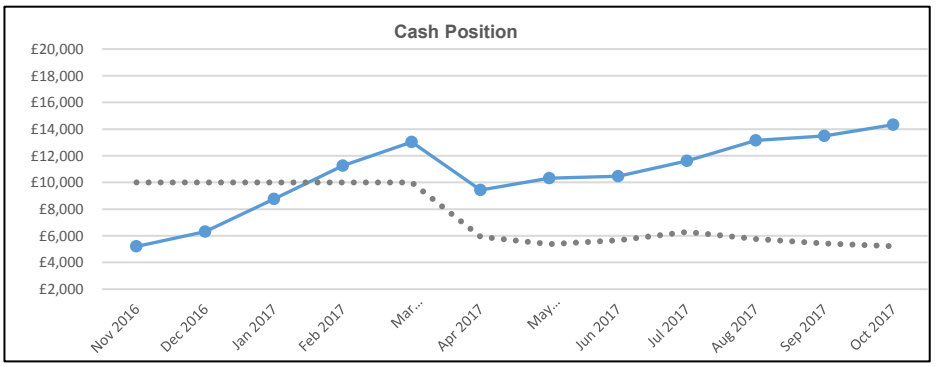


CIP schemes to the value of £15.7m have now been identified, exceeding the target of £15.1m. The latest forecast is to deliver savings of £14.9m, which is just £0.2m below target. The PMO team is continuing to identify and work up additional schemes.



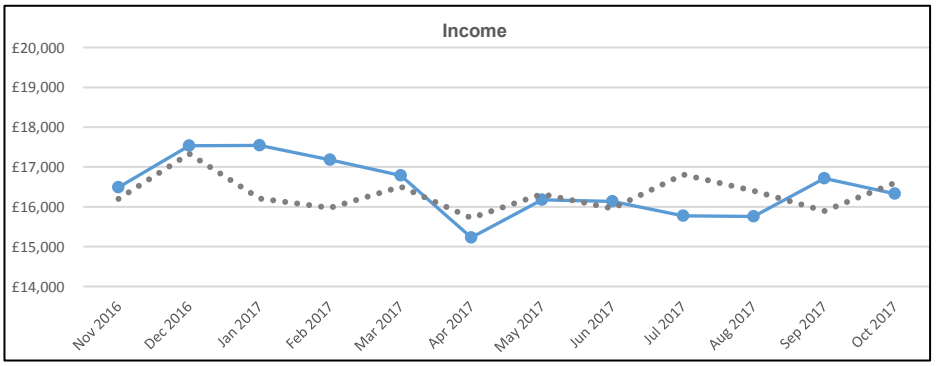
Forecast spend on the capital programme is £7.5m against a plan of £15.8m.
The projected underspend of £8.3m is entirely the result of accounting for vehicle replacement on operating leases, rather than finance leases.

The projected spend includes an element of re-prioritisation for the current year, due to underspending on certain planned schemes. This includes the purchase of 16 ambulances at a cost of £2.3m, which the Board approved in October.



The cash balance at the end of October was £14.3m.

The working capital loan remains at £3.2m, drawn from a total facility of £15m.

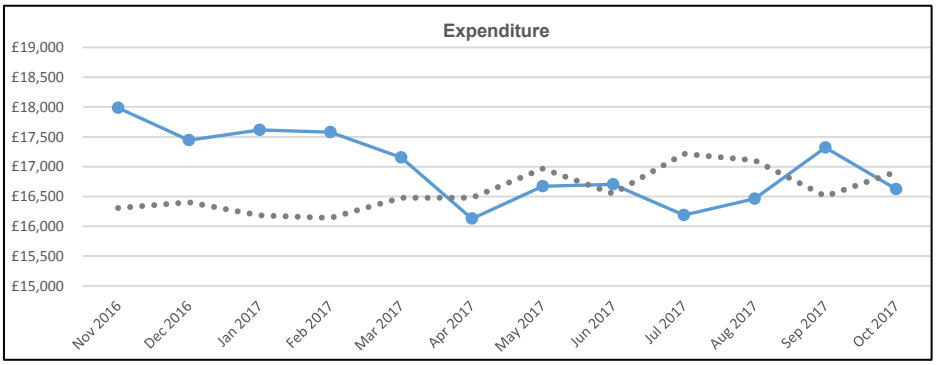


A&E activity in October was 4.3% down against commissioned plan and is 3.4% down year to date. A&E contract income for October was £0.7m or 4.8% below plan in the month and is £3.7m or 3.7% down after 7 months.

111 Income is above plan by £0.3m year to date due to a contract variation to support clinical development.

Other income sources have helped to limit the overall income shortfall to £1.6m for the year to date.

SECAmb Finance Performance Additional Information



The Trust made a positive EBITDA of £0.6m and a deficit of £0.3m in the month. EBITDA for the year to date now stands at a positive £1.9m and the deficit after financing costs is £4.0m, in line with plan.

Pay continues to underspend due to low activity and vacancies. The favourable variance year to date is £1.2m Operational hours remain below plan year to date.

There has been a further catch-up in non-pay expenditure but this remains underspent by £0.2m year to date.

South East Coast Ambulance Service NHS Foundation Trust

Item No	133/17

Name of meeting	Trust Board
Date	29 November 2017
Name of paper	Learning
Executive sponsor	Steve Lennox, Director of Nursing & Quality
Author name and role	Steve Lennox, Director of Nursing & Quality
Synopsis, including any notable gaps/issues in the system(s) you describe (up to 150 words)	At its meeting in May 2017, the Board asked for a paper setting out how the Trust is ensuring learning from complaints, incidents, SIs etc. This paper outlines the steps taken, so far, to move towards a learning culture across the Trust and to move away from a culture that is perceived as blaming. This cultural move is central to many of the Trust's Improvement plans and informs the cultural transformation of the organisation. The paper identifies a number of initiatives that reinforce this transformation. They are not exhaustive as this work will develop and as the work-streams become more advanced other opportunities will be identified for supporting this approach.
Recommendations, decisions or actions sought	The paper is brought to Trust Board for information.

A Learning Organisation

In 1990 a bright 24-year old medical school graduate started his first job in medicine. He was a pre-registration house officer looking forward to a glowing career in surgery.

In his first month he was attending to a 16-year old boy undergoing palliative chemotherapy. The boy needed two different injections, one intravenously and a second by lumbar puncture into the spine.

The intravenous drug was highly toxic – indeed fatal - if administered to the spine. But it arrived on the ward in a nearly identical syringe to the other injection. Both syringes were handed to the young doctor for the lumbar puncture procedure and both injected into the patient's spine.

As soon as the doctor realised what had happened, frantic efforts were made to flush out the toxic drug from the boy's spine. But it was to no avail and tragically he died a week later.

So what happened next?

You might think the most important priority would be to learn from what went wrong and make sure the mistake was never repeated. But instead the doctor was prosecuted and convicted for manslaughter. He and a colleague were given suspended jail terms.

In this case the convictions were eventually overturned at the Court of Appeal. But the real crime was missed: as the legal process rumbled on, exactly the same error was made in another NHS hospital and another patient died because our system was more interested in blaming than learning.

The Rt Hon Jeremy Hunt MP, 2016

Trust Board Update - November 2017

Introduction

1.1. The above extract from the speech by the Secretary of State for Health to the Global Patient Safety Summit on Improving Safety Standards in Healthcare (delivered on 3 March 2016) does illustrate how an absence of learning can inform a negative culture.

1.2. The Trust recognises the need to undertake cultural transformation. Work has already commenced on creating a comprehensive plan. It is clear from the above example that a learning culture is an essential piece of this transformation.

1.3. Additionally, in both the 2016 and the 2017 Care Quality Commission highlighted the need for the Trust to become more focussed on learning. It was a theme that run through both the Inspection Reports with a specific emphasis on complaint management and incident management. At the time of the inspections the Trust was simply not able to demonstrate sufficient evidence that learning took place and when learning was identified it wasn't sufficiently communicated across the Trust to ensure as many staff as possible learnt from the experience.

1.4. It is evident from the extract from the speech and the Care Quality Commission's findings that the Trust needs to ensure that learning becomes a priority.

1.5. This is still a work in progress for the Trust but a number of initiatives have already commenced. This paper informs the Board of progress made so far.

Developing a Learning Culture

An Honest Mistake

2.1. There are a number of improvement plans falling under the compliance work-stream that identify learning as one of the actions for improvement. The most significant is the Improvement Plan associated with Incident Management which identifies the following objective;

> Incident Improvement Plan Objective 3. Develop a proactive reporting culture which will ensure the Trust has a culture which promotes reporting of incidents without fear of blame, and encourages learning from incidents.

2.2. In order to measure success a number of indicators have been developed. One of these is an indicator that monitors the number of staff under disciplinary investigation for making an "honest mistake".

2.3. A definition of an "honest mistake" has been created and presented to the Executive Committee to help define the situation. The aim is that this will enable the organisation to develop a culture where staff are praised for raising incidents where they have made a mistake. The organisation wants to promote a culture where operating units with a greater numbers of incidents reported are viewed positively as they are considered to have a greater level of patient safety awareness.

2.4. This is a considerable transformation and is supported through training for the Operational Managers and the Unit Operational Managers on Human Factors and cultural awareness. This has been delivered to 38 members of staff to date (Nov 21) and the plan is to capture all of the senior operational team over the coming months.

2.5. This is supported by a review of existing policies to ensure the current suite are supportive of this initiative.

2.6. In addition, incidents regarding clinical error are now routinely discussed with the two clinical directors before any decisions on action are taken. This has already started to make a difference in the way the Trust approaches error.

Identifying and Sharing Learning

2.7. Stronger emphasis has already been placed on identifying learning. This is mainly evident in the Serious Incident portfolio where a closure assessment had been created in order to ensure learning has been identified and that the identified actions/recommendations are in alignment with the learning.

2.8. Each serious incident investigation report is then shared with the membership of the Serious Incident Group to ensure the whole report is of high quality.

2.9. Similarly, the Non-Serious Improvement Plan, the Complaint Improvement Plan and the Safeguarding Improvement Plan all have objectives or actions that ask for a greater emphasis on learning and dissemination of learning. These are;

Incident Improvement Plan Objective 2. By the 01/08/18 the Trust will have implemented sustainable processes that allow the Trust to identify and share learning.

Safeguarding Improvement Plan Action Point 2.06 Develop a clear process to disseminate learning from Serious Case Reviews. Serious Adult Reviews and Domestic Homicide Reviews.

Complaint Improvement Plan Objective 2. By 31/01/18 the Trust will be able to provde evidence of learning from at least 95% of complaints that are upheld in any way ad this will drive improvements to our service.

Complaint Improvement Plan Objective 3. By 31/01/18 the Trust will have improved the sharing of learning from complaints.

2.10. All these objectives or actions have a set of measurable that allow the Improvement Lead and the supporting Task & Finish Groups to oversee improvements. As this is the start of this improvement work the base line values are in the process of being established.

Co-ordinating the Learning

2.11. A new senior post is being developed that sits between the two clinical directors. This needs to go through the Trust's processes for approval but a job description has been written and this has been through the grading/evaluation procedure. This post will bring together the Clinical Audit, Complaints and Incident Management teams under a single lead. This post is provisionally titled Head of Effectiveness and Evaluation and will act as the point for identifying overlaps for learning. For example, currently the Trust could experience a rise in complaints and incidents over a single issue but miss the triangulation of the evidence. This post will help identify the themes and trends and task Clinical Audit with making further enquiry.

2.12. The Head of Effectiveness & Evaluation will then also attend the various forums and meetings so that learning can be a shared rapidly across operational teams.

Establishing Forums & Mechanisms

2.13. A number of initiatives are being established that will help the corporate teams share the learning with operational staff. There are currently;

a. A suite of operational meetings where learning can be shared. At the highest level Area Governance Meetings have been established across the West Area, East Area, 111, EOC and Central Operations. The first round of meetings have completed and these have each been adopted by a member of the Clinical Directors teams in order to share learning.

b. A local team meeting structure has been proposed where the information from the Area Governance Meetings can be shared.

c. A weekly telephone call with Team Leaders is being established for Thursdays. The Executive team will identify three main messages to disseminate through this new process at the weekly Executive Committee meeting.

d. A new monthly Quality & Patient Safety Report has been completed where the main themes arising from complaints and serious incidents can be recorded down to operational unit level. This report will be shared upwards to Quality & Patient Safety Committee, Executive Committee and also at the new Area Governance Committees. The report will also be shared with commissioners.

Accountability

2.14. Finally, the Trust recently issued its first "New Generation Clinical Instruction". The Clinical Directors are of the view that the senior team need to strengthen the explanation afforded to staff. Historically, Clinical Instructions were issued with little explanation as to why the instruction had been developed.

2.15. This new generation has been rebranded as Clinical Bulletin and the first issue has been regarding the conveyance of young people under the age of 1. This has been linked to the supporting evidence and the learning that has taken place across the organisation in order to issue the guidance.

2.16. This is a significant change in style.

Conclusion

2.17. This paper has outlined the steps taken, so far, to move towards a learning culture across the Trust and move away from a culture that is perceived as blaming.

2.18. As the work-stream focussing on cultural transformation becomes advanced other opportunities will be identified for developing this approach.

South East Coast Ambulance Service NHS
NHS Foundation Trust

Agenda No	134/17

Name of meeting	Trust Board
Date	29 November 2017
Name of paper	'Deep Dive' on Ambulance Clinical Quality Indicators Outcomes
Responsible Executive	Dr Fionna Moore – Executive Medical Director
Author	Mark Whitbread – Consultant Paramedic, Critical Care & Resuscitation, Kirsty Booth – Business Support Manager, Dr Fionna Moore, Medical Directorate
Synopsis	This report provides a critical overview on the clinical outcomes data reported to NHS England: how we collate and use this data to inform quality improvements and the changes being implemented to improve both data quality, completeness, accuracy and improve clinical practice.
Recommendations, decisions or actions sought	The Board is asked to note this report.

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 Outcomes

1. Introduction

1.1. In common with all English Ambulance Services SECAmb reports 4 clinical outcomes to the Department of Health on a monthly basis. These are 2 cardiac arrest indicators (Return of Spontaneous Circulation - ROSC - for all out of hospital cardiac arrests, the Utstein subset, and survival to discharge for both groups) as well as a series of ST elevation myocardial infarction (STEMI) and Stroke indicators. Unlike the performance indicators, the clinical indicators are reported three months in arrears, to allow information on survival to discharge to be collected.

1.2. This report will look at clinical outcome data from January to June 2017 to highlight areas which require additional focus to ensure accuracy of data capture and consider how we may improve performance against each of the ACQIs.

1.3. The review is based on information collected from Patient Report Forms (PCRs), both paper and electronic (for a proportion of STEMI and stroke patients) and outcome data obtained from the hospitals to which the patients were conveyed. The Trust responds to approximately 300 out of hospital cardiac arrests, 110 STEMI and 510 suspected strokes each month.

2. Data collection.

2.1. Patient data is collected on both paper and electronic PCRs. Currently over 90% of incidents are recorded on paper PCRs, though the number of ePCRs is gradually increasing. The Trust is committed to rolling out the ePCR and currently over 95% of frontline staff have been supplied with personal issue iPads.

2.2. A number of PCRs (13.8%) are not matched to incidents, for example of the 58,247 PCRs returned during August 8,038 were not matched to an incident. Inaccurate coding is one of the reasons for this mismatch.

2.3. Historically the Trust has required both a specific cardiac arrest form, as well as a PCR to be completed for cardiac arrests, leading to duplication of documentation. The cardiac arrest form has variable completion, can be scanned but is not currently linked to the relevant incident, but is available on request from the health records team. ePCRs are not currently completed for these patients.

2.4. Prior to submission to Trust Board and the DH monthly data is scrutinised for completion and accuracy.

2.5. Fig 1 shows the ACQI data for all the clinical outcomes for all Ambulance Trusts and the Trust from January 2017 to June 2017.

		Cardiac Arrest - ROSC		Cardiac Arrest - StD		STEMI 150		Stroke	
		All patients	Utstein comparator group	All patients	Utstein comparator group				
		Proportion of those who were resuscitated who had return of spontaneous circulation on arrival at hospital	Proportion of those who were resuscitated who had return of spontaneous circulation on arrival at hospital, where the arrest was bystander witnessed and the initial rhythm was VF or VT	Number of patients who had resuscitation commenced/continued by ambulance service following an out-of-hospital cardiac arrest, who were discharged from hospital alive	Number of patients who had resuscitation commenced/continued by ambulance service following out-of-hospital cardiac arrest of presumed cardiac origin, where the arrest was bystander witnessed and the initial rhythm was VF or VT, who were discharged from hospital alive	Number of patients with initial diagnosis of definite STEMI for whom primary angioplasty balloon inflation occurred within 150 minutes of emergency call connected to ambulance service, where first diagnostic ECG performed is by ambulance personnel and patient was directly transferred to a designated PPCI centre as locally agreed	Proportion with suspected STEMI confirmed on ECG who received an appropriate care bundle	Number of FAST positive patients (assessed face to face) potentially eligible for stroke thrombolysis within agreed local guidelines arriving at hospitals with a hyperacute stroke centre within 60 minutes of call connecting to the ambulance service	Proportion of suspected stroke or unresolved transient ischaemic attack patients assessed face to face who received an appropriate care bundle
England	Jan-17	27.5%	49.9%	6.9%	24.8%	81.0%	79.1%	52.1%	97.6%
Trust		28.8%	51.5%	3.4%	10.7%	76.8%	65.6%	59.0%	94.9%
England	Feb-17	28.1%	52.3%	8.0%	25.8%	85.3%	80.8%	53.2%	97.9%
Trust		28.8%	45.2%	6.8%	23.3%	86.9%	72.3%	64.6%	97.3%
England	Mar-17	30.3%	52.8%	9.1%	29.2%	86.1%	78.7%	55.2%	98.1%
Trust		31.5%	67.5%	7.5%	19.4%	91.7%	65.6%	59.6%	93.9%
England	Apr-17	30.2%	54.8%	9.1%	31.1%	87.6%	76.7%	58.7%	97.3%
Trust		28.0%	62.1%	8.1%	33.3%	87.9%	59.6%	66.8%	94.1%
England	May-17	28.7%	48.1%	8.5%	22.6%	86.4%	78.4%	55.2%	96.6%
Trust		22.8%	56.8%	6.3%	30.3%	91.7%	57.5%	64.9%	92.3%
England	Jun-17	31.2%	52.4%	9.7%	28.4%	85.5%	76.6%	57.0%	97.4%
Trust		28.1%	44.8%	5.9%	17.9%	88.2%	70.5%	62.7%	94.4%

Figure 1 Shows the Trusts position in comparison to National data for January to June 2017

3. Improving survival from Out of Hospital Cardiac Arrest (OHCA).

3.1. The Medical Directorate has completed a deep dive into out of hospital cardiac arrest data using information from April to June. The findings and a series of recommendations were presented to the Executive Management Team in August 2017.

3.2. The review identified a number of areas of excellent practice as well as some requiring attention: these have been split into short, medium and long term objectives.

3.2.1. The Trust continues to attend approximately 300 cardiac arrests per month

3.2.2. The monthly data submitted to DH, is now presented to the Trust Board, with supplemental flow chart which explains the analysis of the data and how overall survival rates are calculated. **Appendix A** shows the analysis of cardiac arrest data for May 2017 as an example.

4. Downloads from Defibrillators

4.1. All SECAmb LifePak 12s and 15s are fitted with a modem which will allow cardiac arrest data to be transmitted to Clinical Audit. Approximately 50% of Cardiac Arrests are currently transmitted; this provides a huge advantage in promoting high quality Resuscitation and is currently not replicated in any other UK Ambulance Service.

4.2. Data is reviewed using CodeStat software version 9.2. We are in the process of upgrading our software to version 10, which will enable the team to analyse ECGs more accurately.

4.3. The review of downloads is undertaken by three members of the clinical audit team. Sharing the analyses with front line staff will be re-introduced, with a focus on highlighting good practice and encouraging reflection on areas for improvement. We will encourage downloads to be transmitted for **all** resuscitation attempts.

5. Driving up clinical performance

5.1. Two members of the Medical Directorate team have attended a Resuscitation Academy during the past 12 months. This is a course, developed in Seattle, which examines in detail the ten steps to improve Out of Hospital Cardiac Arrest (OHCA) survival developed by the Global Resuscitation Alliance(GRA). The Medical Directorate are looking how to implement the principles illustrated in figure 2 into Trust practice. (Medium term objectives).

5.2. Implementing change: Measuring performance and driving up standards. An excellent example is time from arrival of the first response to delivering a defibrillatory shock.

AREA	Turn on to 1st Shock	1st shock to 2nd shock
Sussex	2 minutes 56 Secs	4 minutes 56 Secs
Kent	2 minutes 55 Secs	3 minutes 17 Secs
Surrey	3 minutes 21 Secs	4mins 36 secs
TARGET	**< 2 minutes**	**2 minutes**

Table 1 Shows a three-month period (January - March 2017) and for patients whose first rhythm was shockable

5.3. An area of concern identified by some other ambulance services is that fine ventricular fibrillation (VF) is sometimes not recognised and treated as asystole with a delay in delivering a shock. This is likely to be an issue in our service, and has led to a change in resuscitation protocols which is being delivered through local training (see short term objectives).

5.4. Education for staff: An update on Resuscitation Guidelines, incorporating the best practice guidelines from the Association of Ambulance Chief Executives (AACE) and endorsed by the Medical Directors Group (NASMeD) and the Lead Paramedic Group (ALPG) has been circulated to Clinical Tutors, Operational Team Leaders (OTLs) and Senior Operational Managers for onward dissemination. Elements of these guidelines will be included in the Key Skills courses rolled out from April 2018.

Figure 2 Shows the GRA 10 steps to improving OHCA

6. Defibrillators

6.1. The Trust currently has the following defibrillators (numbers supplied by logistics and the defibrillator manufacturer)

6.1.1. Total main devices 738 (148 LP12s without ETCO2 capability, 214 LP12s with ETCO2 capability and 376 LP15 are all manual defibrillators i.e. operated by the clinician, all with ETCO2 capability. * ETCO2 measures exhaled carbon dioxide levels from the lungs

6.1.2. Total AEDs 615 (200 LP 1000, 412 FR2, 1 Zoll X-Series – HART, 25 LP 500, CFR AEDs) * Automated External Defibrillator automatically diagnoses the heart rhythm without clinical knowledge

6.2. A defibrillator replacement programme in under development which will address both the replacement of AEDs and the introduction of the next generation of monitor/defibrillators.

6.3. Progress to date:

6.3.1. **Defibrillators:** The Trust is in the process of removing all LP12 without End Tidal CO2 waveform monitoring capacity. The remaining, more modern LP12s, are suitable for use on DCAs, SRVs and Response Capable Managers' cars.

6.3.2. Fleet and Logistics are working together to ensure that all DCAs are fitted with a LP15 by the end of March 2018; the replacement will take place during servicing to minimise the downtime of vehicles. A project plan is under development to ensure that we can track the progress of this key action.

7. Other important initiatives in improving survival from OHCA

7.1. Community First Responders

7.1.1. The Trust currently has 100 CFR teams with a total of 652 responders (approximately 237 in Kent, 250 in Sussex and 165 in Surrey) who on average provide >200,000 hours of cover and attend around 20,000 incidents per year.

7.1.2. Last year CFRs attended 256 cardiac arrests, suggesting that tasking could be improved.

7.1.3. This represents a huge potential resource for the Trust. A review of training and deployment is currently underway. (see short term actions).

7.1.4. The community responder lead is currently working with other agencies i.e. St John Ambulance to recruit additional responders.

7.2. Public Access Defibrillation

7.2.1. There are currently >3000 PAD sites across the Trust (Sussex 1500, Surrey 937, Kent 600) a number of the PAD defibrillators (G3 Power Heart) will require replacement due to having lead batteries.

7.2.1.1. All PAD sites notified to the Trust are being checked; details on over 1000 sites are being verified and registration on the new CAD system will follow after implementation of the Ambulance Response Programme work.

7.3. GoodSam

7.3.1. GoodSam is a platform that alerts doctors, nurses, paramedics and those trained in basic life support to emergencies around them.

7.3.2. It currently has two elements; GoodSam alerts trained volunteers to Cardiac Arrests and is integrated with the CAD system. In ambulance services it currently holds a data base of >28,000 AEDs and over 19,000 volunteers registered GoodSam Pro dispatches staff and co-responders to emergencies, again it is part of the CAD system it allows staff to book on/off duty and records hours and is highly customisable.

7.3.3. The app is endorsed by the Resuscitation Council UK. There is a cost which is approximately £15K, this is to align the App to the CAD system with an additional cost if enhanced features are wanted i.e. video footage.

7.3.4. The Medical Directorate will work with the PAD team to consider the benefits of introducing this to the Trust. (see medium term objectives).

7.4. Lucas 2 Mechanical Devices

7.4.1. The LUCAS 2 is a mechanical device which delivers high quality, reproducible chest compressions. Although there is no evidence these devices improve survival they can be immensely helpful in freeing members of the team to undertake other important actions during a resuscitation attempt. They can also deliver high quality chest compressions while a patient is being conveyed to hospital and reduces the risk of crew injury while standing in a moving ambulance. The Trust currently has 12 LUCAS 2 devices. These are carried by the CCP teams.

7.4.2. All PPCI centres (centres that specialise in heart conditions) within the SECAmb catchment area use mechanical devices.

8. Short term objectives: delivery by end November 2017.

8.1. Review the Trust wide resuscitation guidelines in line with JRCALC, RC(UK) and AACE best practice statements.

8.2. Brief CCP Practice Leads, Education and Development and Operational Area leads.

8.3. Review the monthly cardiac arrest data for formal sign off.

8.4. Staff in Clinical Audit to undergo defibrillator download training to facilitate review and reporting.

8.5. Undertake an assessment against the Resuscitation Academy check list.

8.6. Review training and deployment of CFRs

9. Medium term Objectives: delivery end March 2017

9.1. Develop a defibrillator replacement strategy.

9.2. Develop a business case for an additional 10 LUCAS devices

9.3. Withdraw the specific cardiac arrest form and collect all the relevant information on an updated and revised PCR.

9.4. Plan a Resuscitation Academy in SECAmb (2018)

9.5. Implement the Global Resuscitation Alliance 10 steps to Improving OHCA

9.6. Implement the GoodSam App

9.7. Resuscitation Best practice principles training as part of key skills 2018

10. Long term strategy: deliver in 2018/2019

10.1. Roll out new defibrillators (from 2018/19)

10.2. Run a Resuscitation Academy in SECAmb (2018)

10.3. Demonstrate improved ACQI returns in survival from OHCA

11. STEMI

11.1. Ambulance Clinical Quality Indicators: The Trust consistently performs below the national average in the STEMI care bundle which assesses performance against four elements; the administration of aspirin, GTN (drug used in certain cardiac conditions), the recording of two pain scores and administration of appropriate pain relief. Although our time from call to balloon is within national parameters, our poor performance on the care bundle is due to the second of two pain score not being completed.

12. STROKE

12.1. The Trust consistently performs below the national average in the Stroke Care Bundle, due to failure to record a blood glucose score, the overall score is in excess of 90%. We are looking at areas in the Trust where through geographical issues, patients may experience a long delay from call to hospital, to try and improve the overall time to specialist review

12.2. Due to the reconfiguration of Stroke services in the Surrey area the Trust has worked with our hospitals to ensure that patients are conveyed to the most appropriate hospital for their location. We are also working closely with our colleagues and partners in the Kent area to ensure that the reconfiguration of stroke services there meets the needs of our patients.

12.3. The Trust is working closely with Kent Surrey Sussex Air Ambulance Trust to facilitate the rapid transfer of patients who require emergency thrombectomy (clot extraction) at either King's College or St George's Hospital.

13. Reporting to NHS England

13.1. All ACQI data that is submitted to NHS England is reviewed at meetings held on a monthly basis, chaired by our Consultant Paramedic (Critical Care & Resuscitation) and approved by the Executive Medical Director and Assistant Director – Medical before submission to ensure accurate reporting. With the introduction of the Ambulance Response Programme the indicators may change. It is likely that additional indicators for sepsis and elderly fallers will be added to the existing suite of indicators and care bundles.

14. Clinical Education

14.1. A full briefing on the new Trust resuscitation guidelines has been delivered to the clinical education department and these will be included on all new courses with immediate effect.

14.2. CCP Practice Leads have been briefed on the new guidelines so that they may start the cascade of information to staff along with clinical education.

15. Addressing specific concerns

15.1. Care Bundles

15.1.1. This month has seen articles in both the weekly bulletin and Clinical Newsletter emphasising the importance of completing the care bundles. A copy of the Article from the clinical newsletter can be found at **Appendix B.**

15.1.2. The Trust has approved the introduction of iCPG, this is the Clinical Practice Guidelines (JRCALC) App, work is progressing to ensure this is implemented with the 'classic view' (Core JRCALC Guidelines) by end of Q3 with further work on local content to be developed.

15.1.3. We are working with our communications team to develop a communication strategy for informing all staff of changes to clinical practice. This will include using social media, webinars and videos.

15.2. Airway Management

15.2.1. CCPs currently use the iGel supraglottic device for advanced airway management, as an alternative to endotracheal intubation. Paediatric sizes have now been introduced

15.2.2. A business case is being developed for iGELs to replace the Laryngeal Mask Airway (LMA).

15.2.3. Revision of airway management highlighting the benefits of basic airway management techniques including using a supra glottis device (SGA) in a cardiac arrest. Where an advanced airway is placed, either a SGA or endotracheal tube the Trust now mandates the use of ET CO2 monitoring. From February 2018 bougies will be available and mandated for use by paramedics undertaking endotracheal intubation.

16. Summary

16.1. This report has highlighted areas for improvement in all of the six ACQIs.

16.2. The report also shows areas of good practice that should be further developed and shared to improve our overall compliance and performance.

16.3. Out of Hospital Cardiac Arrest outcomes remain a key priority for the Trust, with targeted work led by our Consultant Paramedic – Critical Care & Resuscitation.

16.4. Improving our performance against the STEMI and Stroke care bundles is a priority, as both measure areas of significant concern to both patients and clinicians. Previous efforts at highlighting these issues have had a very limited

impact, so other ways of communicating the importance of these elements of patient care are under development. These will involve better use of hand held technology.

16.5. The Operating Unit performance dashboard will be introduced to give front line clinicians a more accurate view on the impact of their care.

16.6. The Medical Directorate has developed a series of objectives for delivery by the end of November, and over the coming 6 to 12 months

16.7. The Board is asked to note this report.

APPENDIX A – Analysis of Cardiac Arrest Data – June 2017

Number of cardiac arrests identified 288 (incl. 13 DNACPR/38 DOA/ 9 No Resus by SECAmb)

Number of resuscitation attempts identified 228 (79%)

Utstein definition
Bystander Witness Arrest
Presenting Rhythm - VF
Arrest - Cardiac in Origin

Utstein Data = 29 (13%)

Non ROSC Definition
Patients transported to hospital in cardiac arrest with resuscitation still in progress

Overall (incl. Utstein) = 228 (100%)

ROSC sustained to hospital = 13 (45%)

ROSC (incl. Utstein) sustained to hospital = 64 (28%) + 6 Non ROSC

Outcomes for ROSC at Hospital and Non ROSC at Hospital Patients		
Utstein	Details	Overall
5	Patient survived to discharge	13
7	Patient died in hospital	51
1	Patient still in hospital*	1
0	Patient not found by hospital*	0
0	No reply from hospital*	5 (incl. 4 x St. Peters)
0	Awaiting reply from NHS Spine*	0

Survival to discharge is calculated as a percentage of the overall Utstein figure minus any missing patient outcomes as detailed * above

Survival to Discharge = 5 (18%)

Survival to discharge is calculated as a percentage of the overall figure minus any missing patient outcomes as detailed * above

Survival to Discharge (incl. Utstein) = 13 (6%)

Additional Information - Resuscitation Attempts

Cardiac Rhythm	Overall Totals	ROSC at Hospital	Non ROSC at
Asystole	105	16	4
PEA	65	19	2
VF	46	25	0
Non-shockable	7	1	0
Not recorded	5	3	0
CPR Bystander	137		
EMS Witnessed arrest	37		

140 Cardiac Arrest downloads received for June 2017
129 Cardiac Arrest download reports sent to crews for June 2017

Number of cardiac arrests identified 288 (incl. 13 DNACPR/38 DOA/ 9 No Resus by SECAmb)

Number of resuscitation attempts identified 228 (79%)

Utstein definition
Bystander Witness Arrest
Presenting Rhythm - VF
Arrest - Cardiac in Origin

Utstein Data = 29 (13%)

Non ROSC Definition
Patients transported to hospital in cardiac arrest with resuscitation still in progress

Overall (incl. Utstein) = 228 (100%)

ROSC sustained to hospital = 13 (45%)

ROSC (incl. Utstein) sustained to hospital = 64 (28%) + 6 Non ROSC

Outcomes for ROSC at Hospital and Non ROSC at Hospital Patients		
Utstein	Details	Overall
5	Patient survived to discharge	13
7	Patient died in hospital	51
1	Patient still in hospital*	1
0	Patient not found by hospital*	0
0	No reply from hospital*	5 (incl. 4 x St. Peters)
0	Awaiting reply from NHS Spine*	0

Survival to discharge is calculated as a percentage of the overall Utstein figure minus any missing patient outcomes as detailed * above

Survival to discharge is calculated as a percentage of the overall figure minus any missing patient outcomes as detailed * above

Survival to Discharge = 5 (18%)

Survival to Discharge (incl. Utstein) = 13 (6%)

Additional Information - Resuscitation Attempts

Cardiac Rhythm	Overall Totals	ROSC at Hospital	Non ROSC at
Asystole	105	16	4
PEA	65	19	2
VF	46	25	0
Non-shockable	7	1	0
Not recorded	5	3	0
CPR Bystander	137		
EMS Witnessed arrest	37		

140 Cardiac Arrest downloads received for June 2017
129 Cardiac Arrest download reports sent to crews for June 2017

APPENDIX B

Aspiring to be
Better Today and
Even Better Tomorrow
for our people and our patients

STEMI and STROKE CARE BUNDLES – WHAT ARE THEY AND WHY DO THEY MATTER?

Care bundles are groups of interventions which we must provide our Stroke and STEMI patients to give them the best evidence-based treatment. We have to audit our care bundle delivery every month and submit these figures to NHS England, where they are published and compared to other ambulance trusts. If you want to see all the Ambulance Quality Indicators (AQIs), and how we compare, visit: **www.ambulancestats.co.uk/index.php**

The care bundles are:

STEMI:

1. Aspirin given (unless refused or contraindicated)
2. GTN given (unless refused, contraindicated or no chest pain).
3. Two pain scores recorded (unless refused, unable or unconscious)
4. Appropriate analgesia given (morphine, Entonox, or paracetamol, unless refused, contraindicated or not in pain).

All these must be in place (or documented why not) to comply.

STROKE:

1. FAST + assessed and recorded (unless unable or refused)
2. Blood Glucose recorded (unless refused)
3. Blood pressure recorded (unless refused, or time critical features (ie, airway problems, reduced consciousness).

All these must be in place (or documented why not) to comply.

Although SECAmb performs well on the STROKE care bundle, we are still below the national average (about 96% as compared to 98%). We're not doing well on our STEMI care bundle delivery – only about 66% as compared to a national average of 79%. The main aspects we are not doing or documenting is pain relief and two pain scores.

If you can't deliver one aspect of the care bundle, document why not (see the exceptions above), and it will still be marked as completed for audit purposes.

Any questions?

Email: claire.hall@secamb.nhs.uk
or ask one of the clinical team.

Claire Hall (Clinical Education Lead)