South East Coast Ambulance Service
NHS Foundation Trust

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

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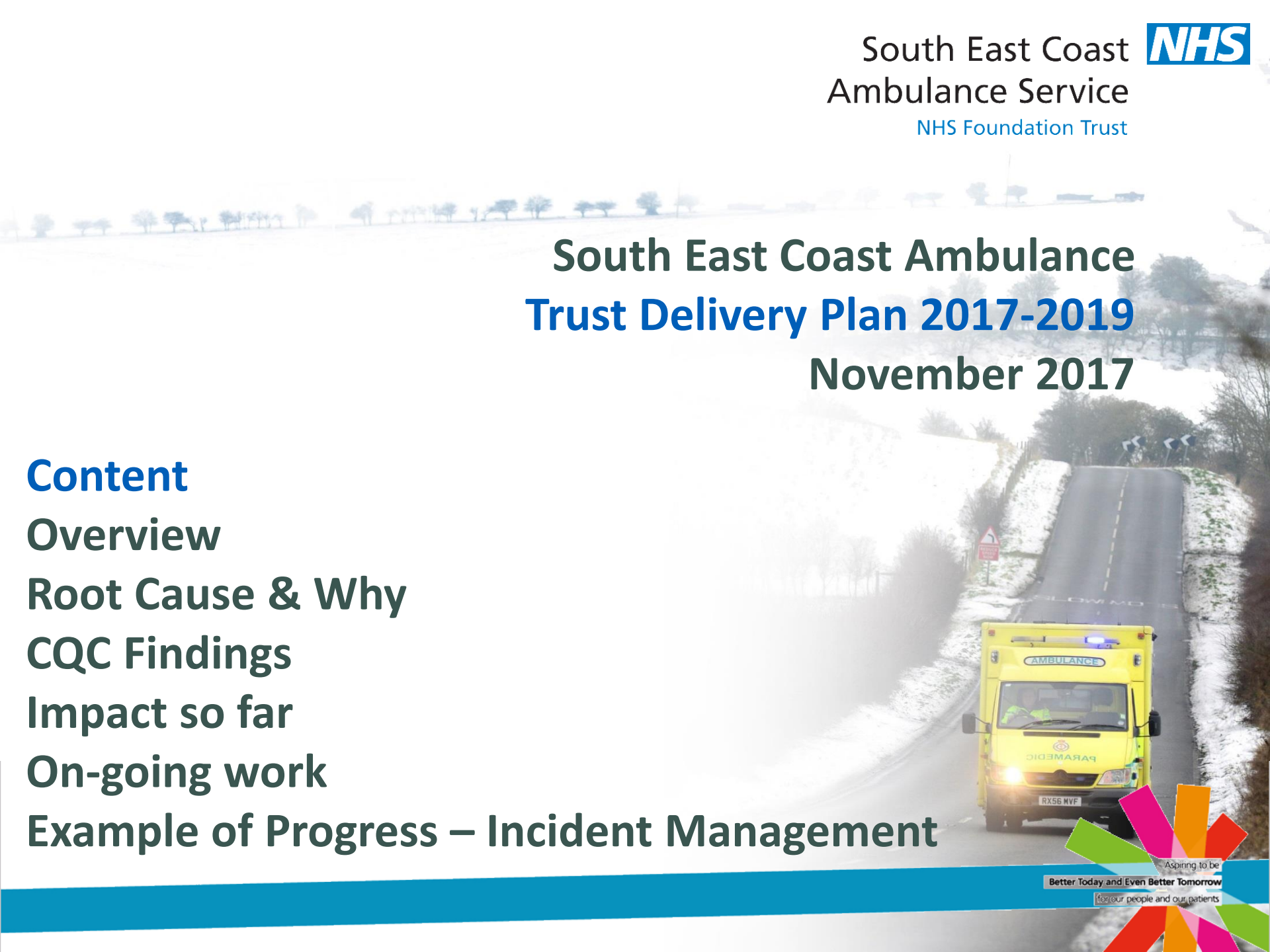
- Root Cause & Why
- CQC Findings
- Impact so far
- On-going work
- Example of Progress – Incident Management



Aspiring to be
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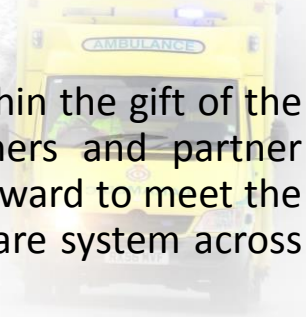
South East Coast Ambulance Service NHS Foundation Trust

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.



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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

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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

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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

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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.

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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”.

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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

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Action

Created a Strategy & Delivery Plan

Strategy (2017-2022)

Delivery Plan (2017-2019)

Strategy	Culture & OD	Compliance	Sustainability	Service Transformation

Enabling Strategies

- Comms and Engagement
- Commercial
- Workforce
- Culture and OD
- Education
- Wellbeing
- Inclusion
- Quality Improvement
- Risk Management
- Safeguarding
- Medicines
- Clinical Equipment
- Research
- LTFM
- Digital
- Fleet
- Estates

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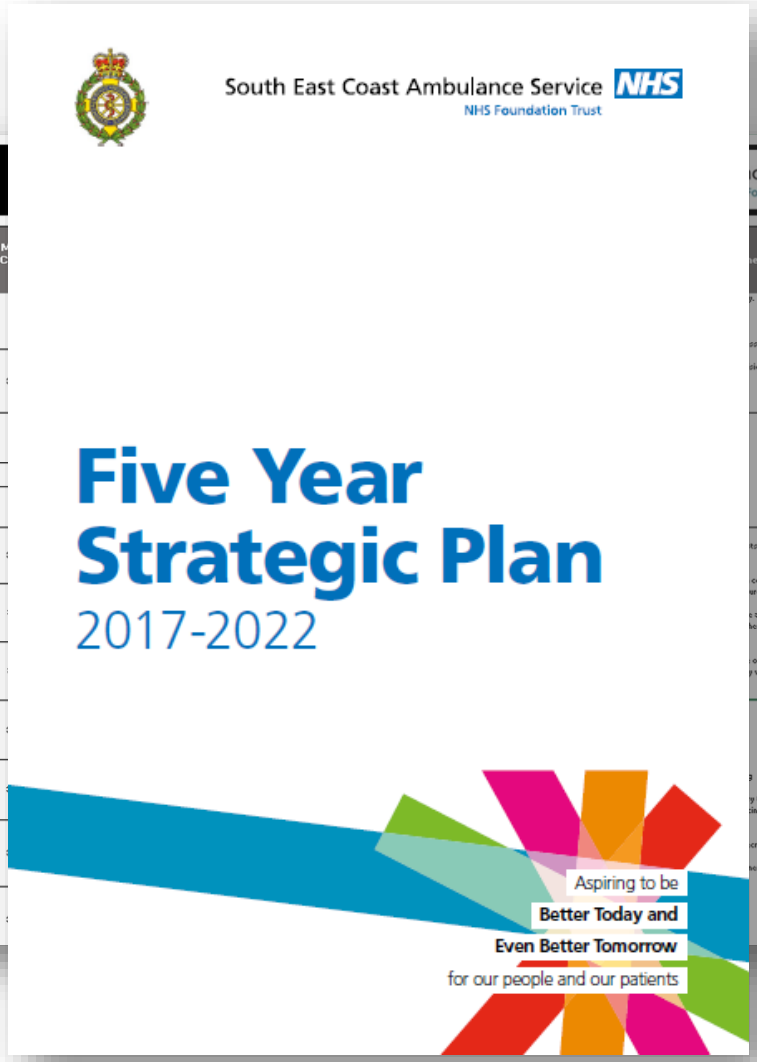
Action

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	Fionna 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 QIA 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 35% 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



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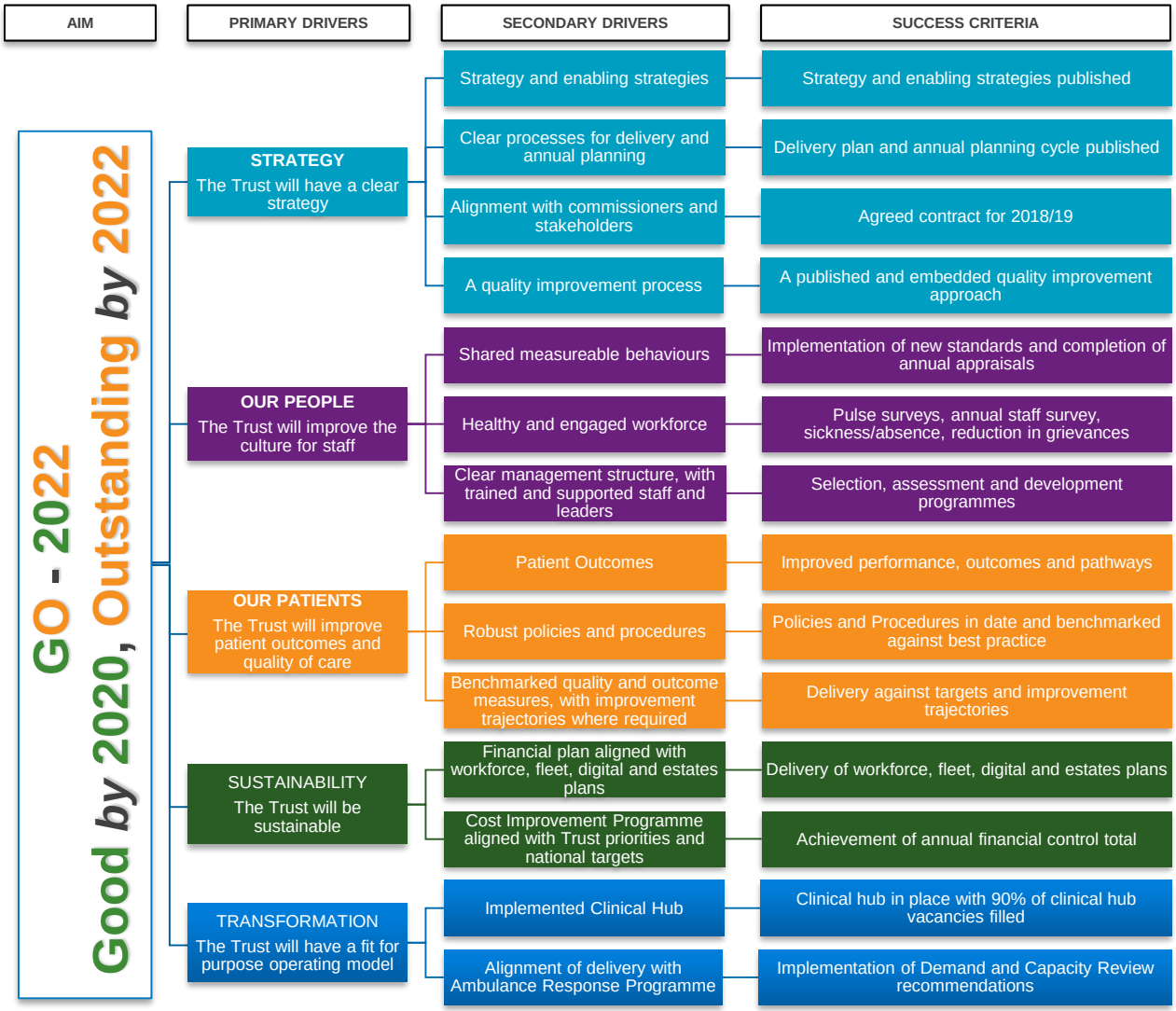
Action

Clear AIM & Driver diagram



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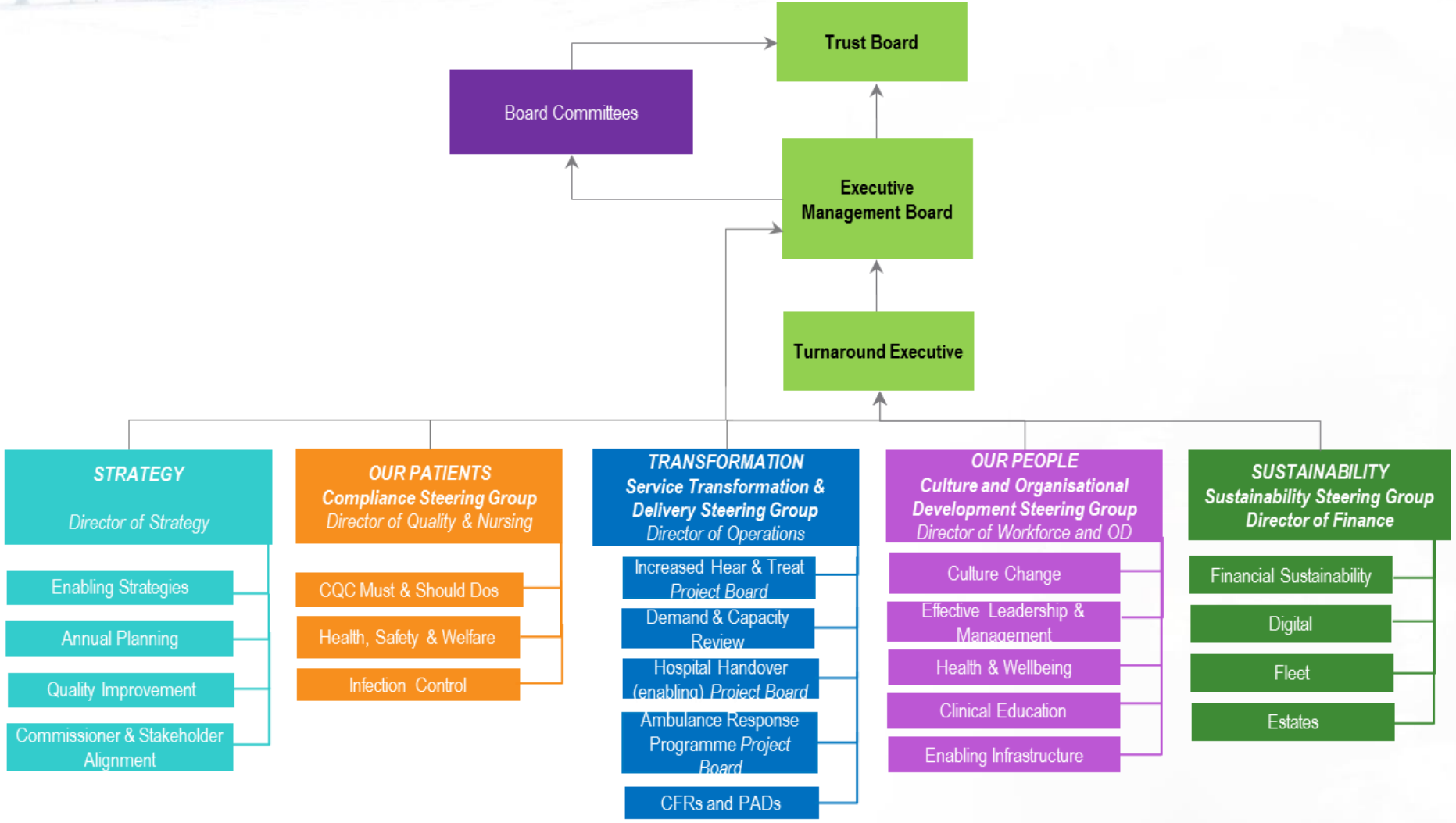
Action

Internal Governance



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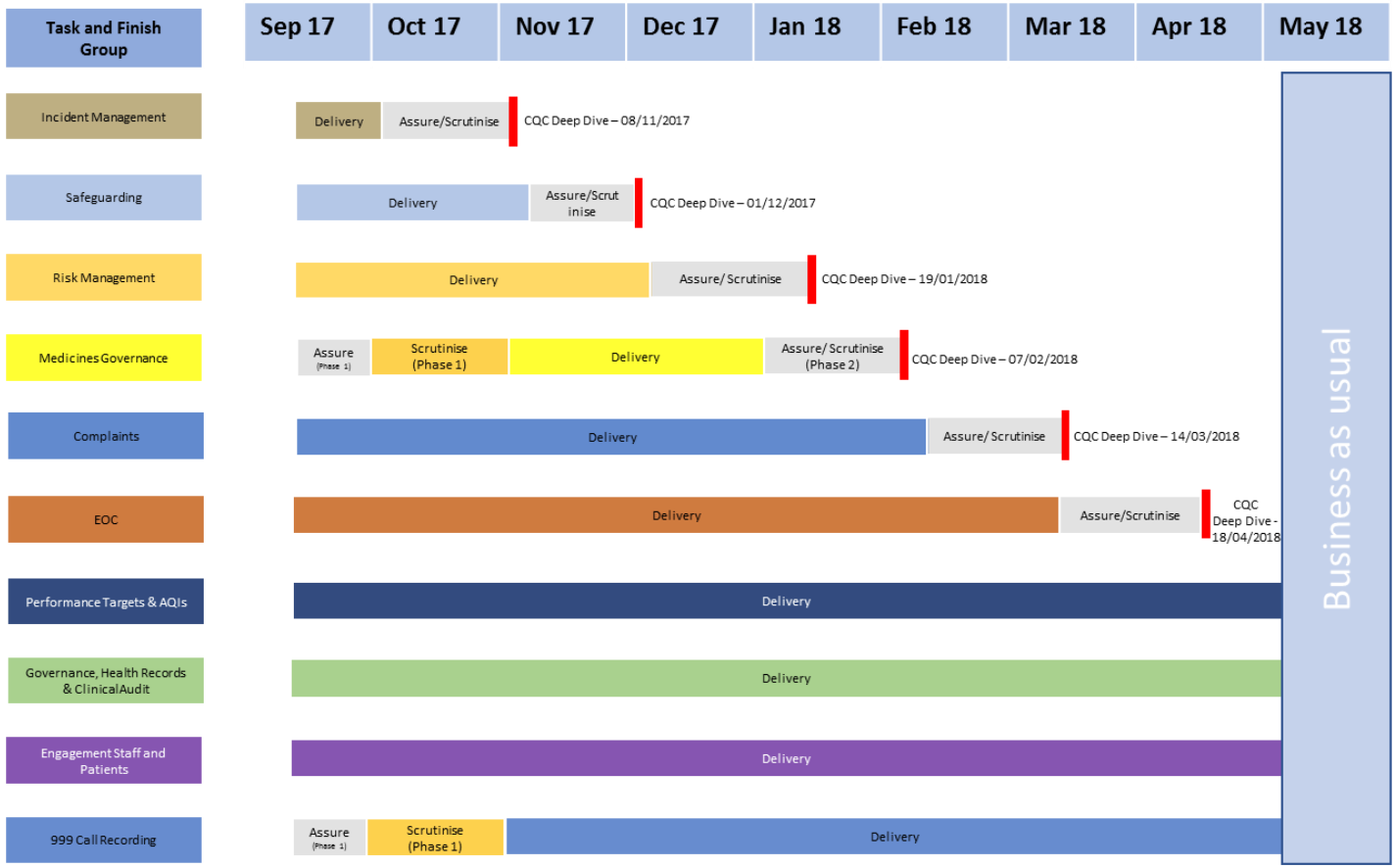
Action

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.

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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							

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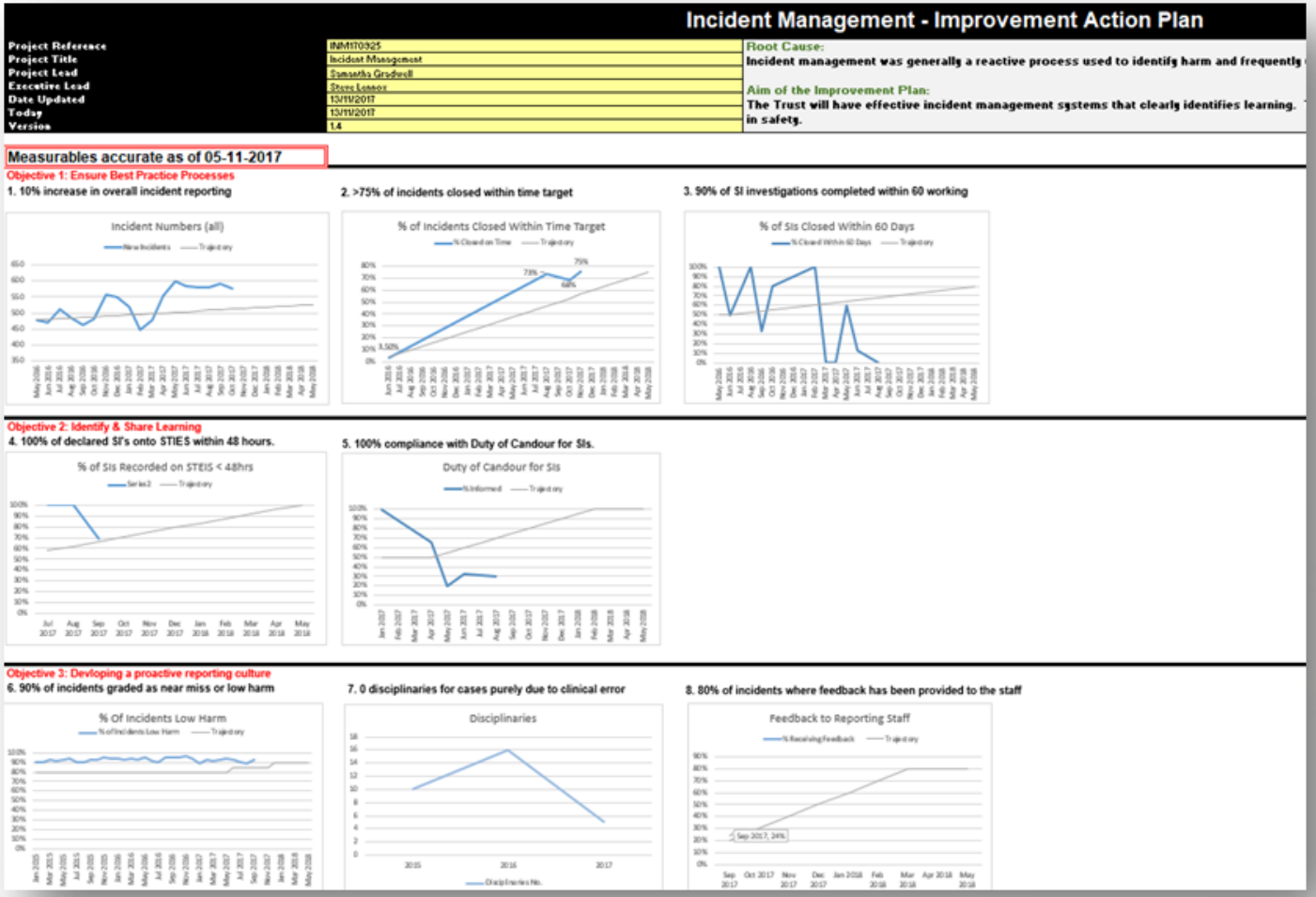
Action

Benchmarked measurement of Improvement Journey



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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

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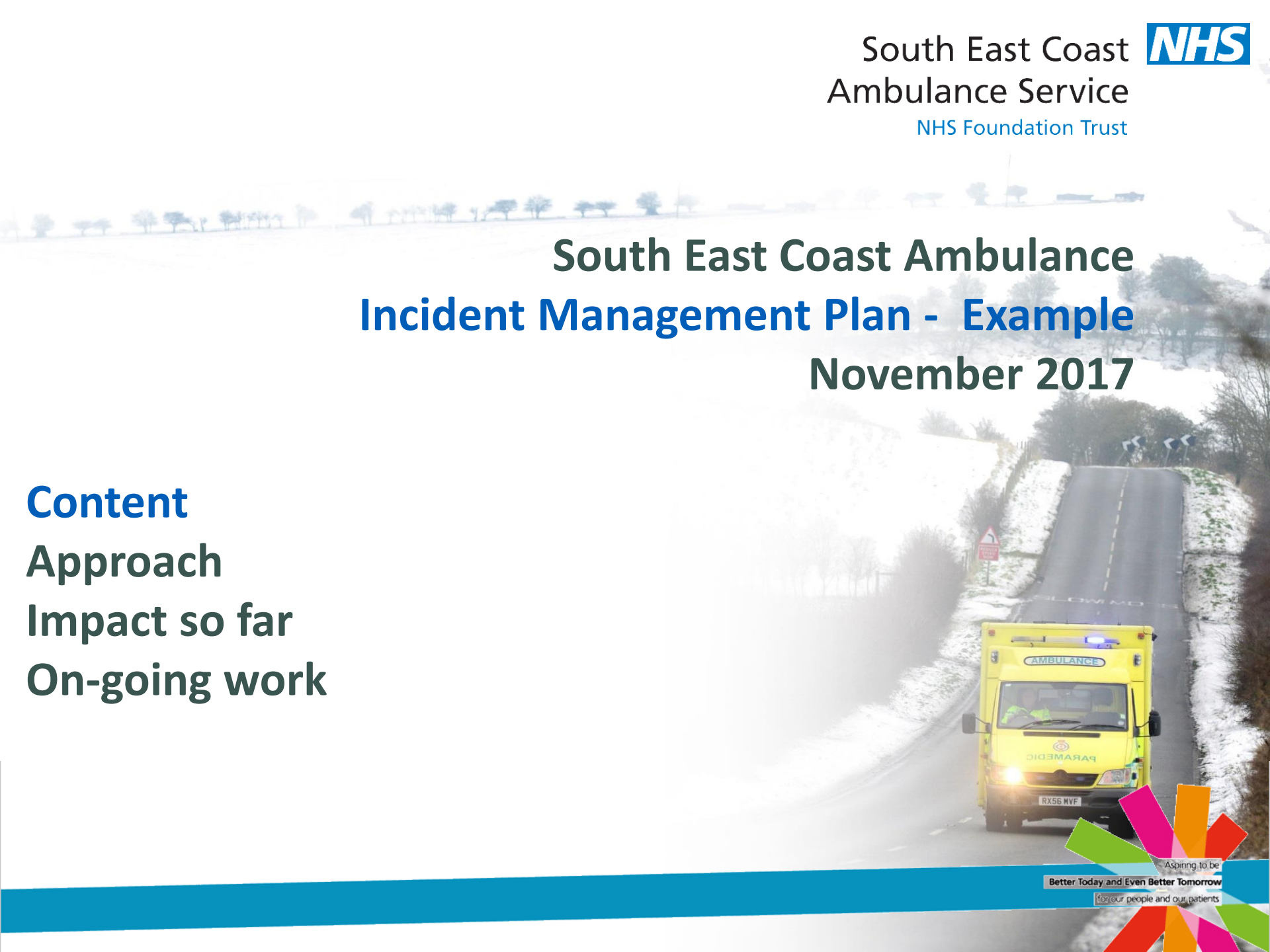
Incident Management Plan - Example
November 2017

Content

Approach

Impact so far

On-going work



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Example – Incident Management

Identified Objectives

Objective 1: Ensure Best Practice Processes

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

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Example – Incident Management

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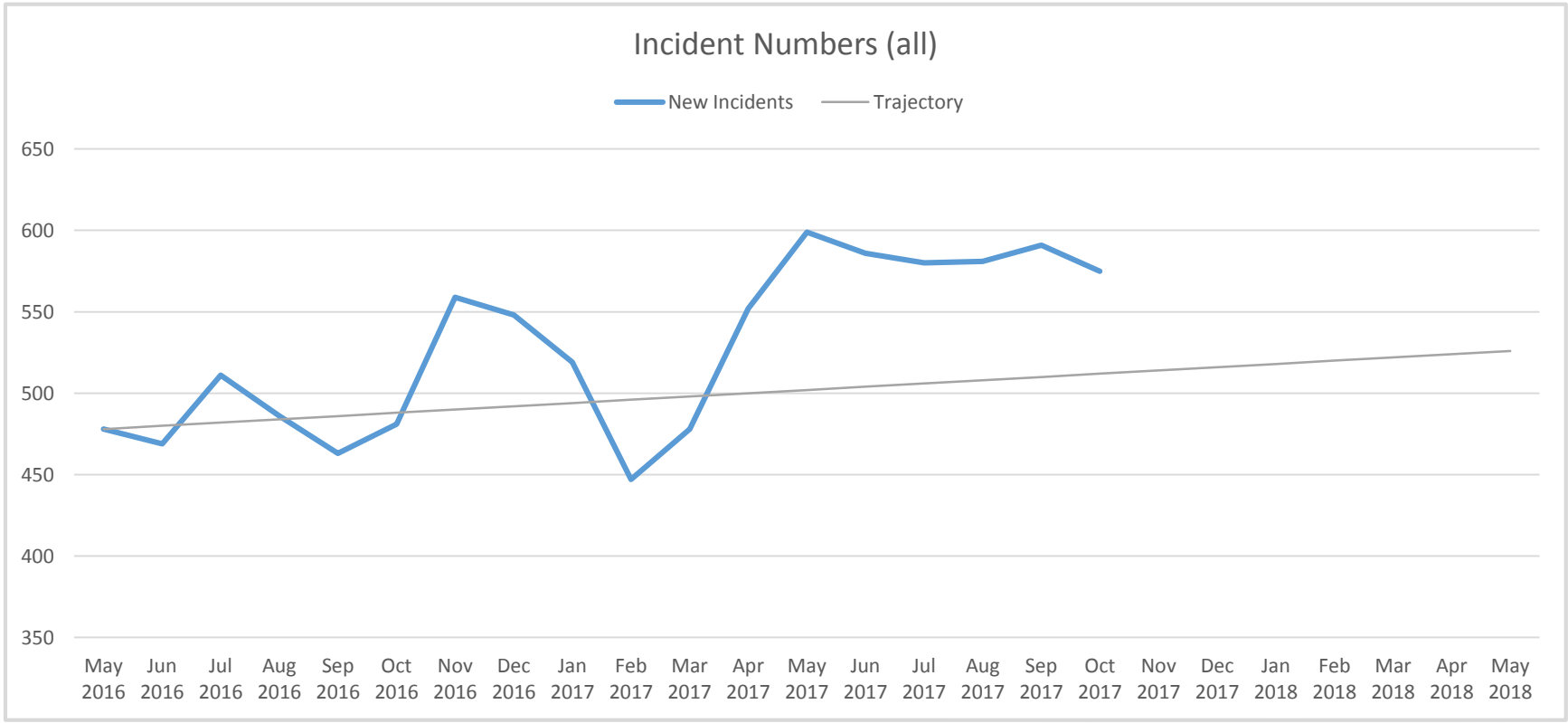
Impact

Impact so far

Objective 1: Ensure Best Practice Processes

10% increase in overall incident reporting



Increase of 20% Since May 2016

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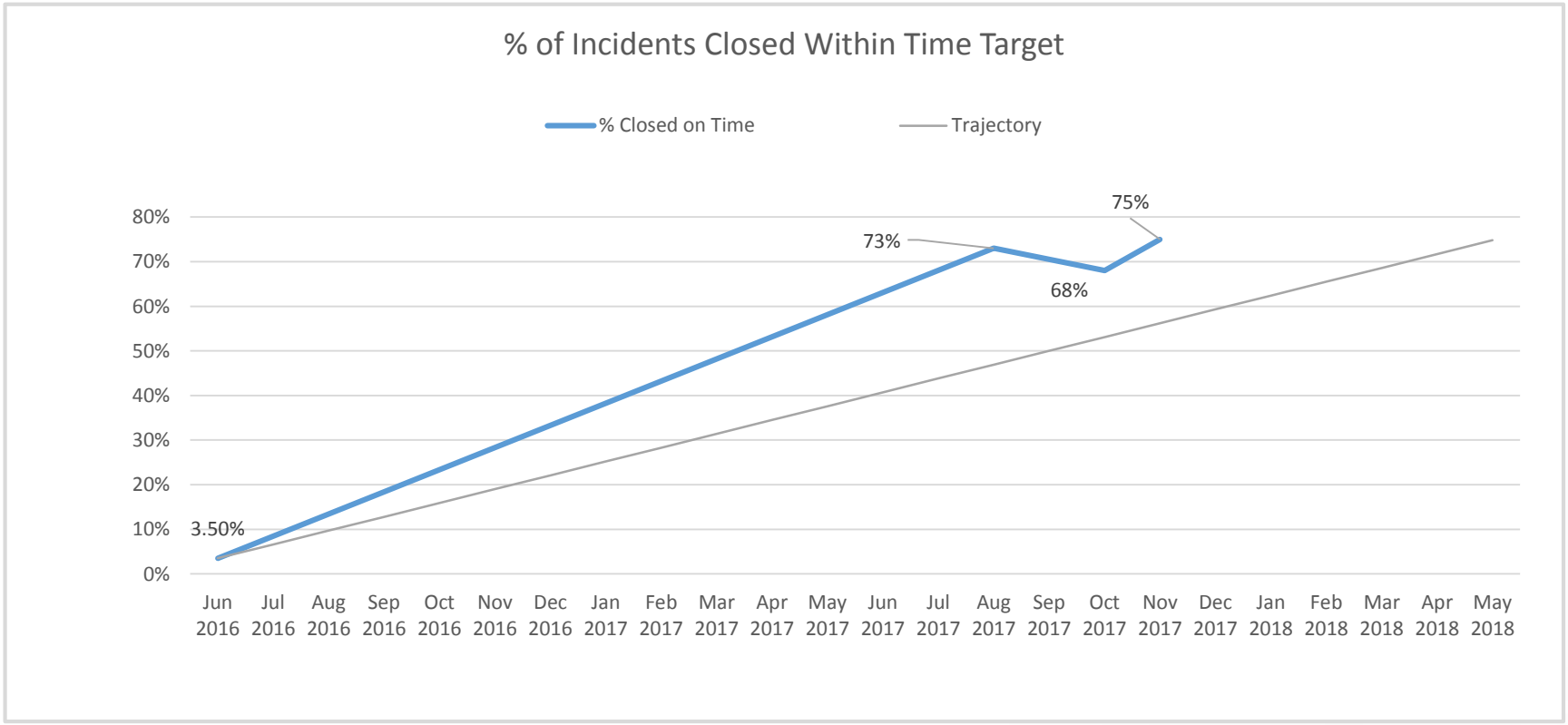
Impact

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

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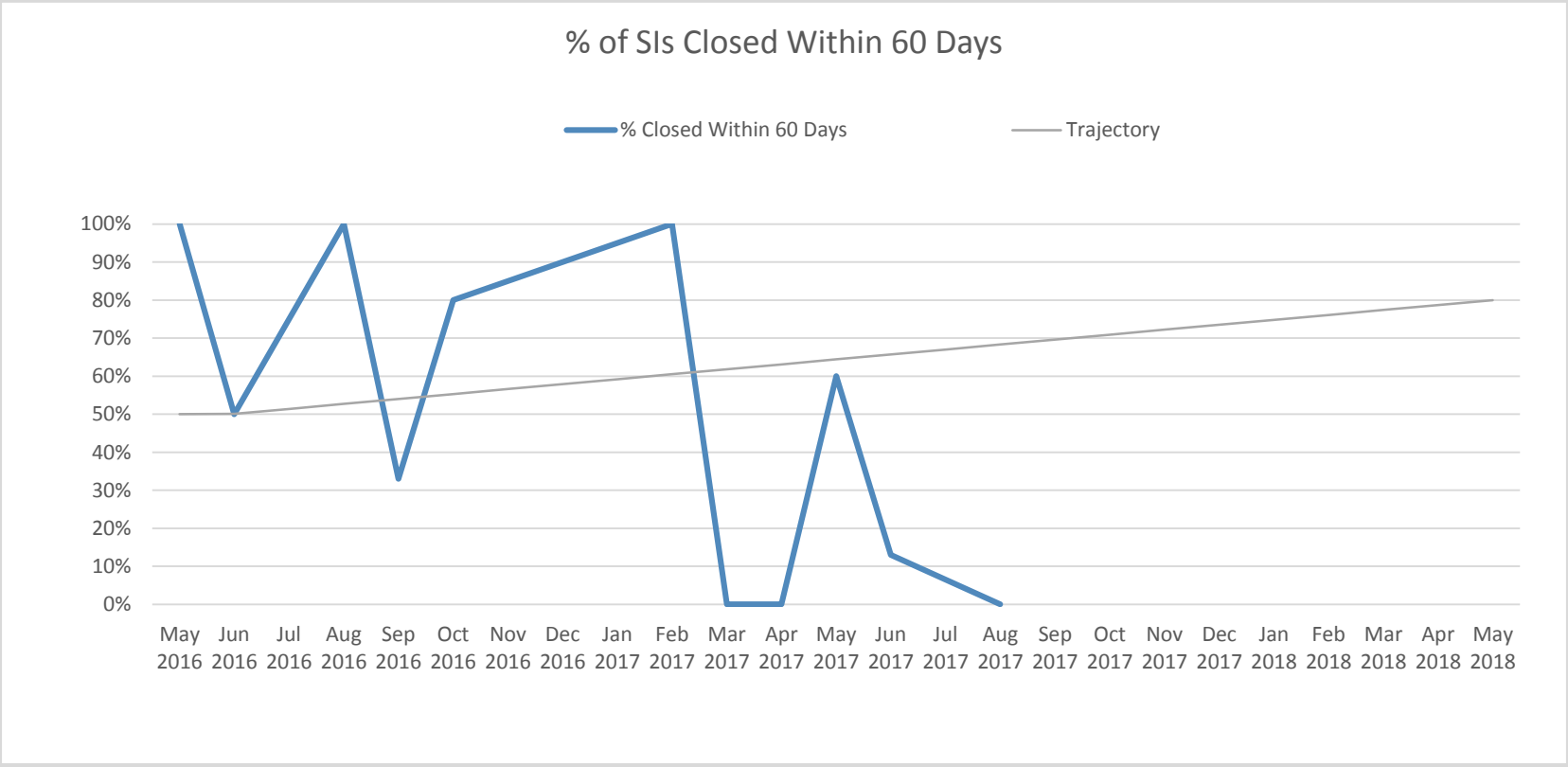
Impact

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

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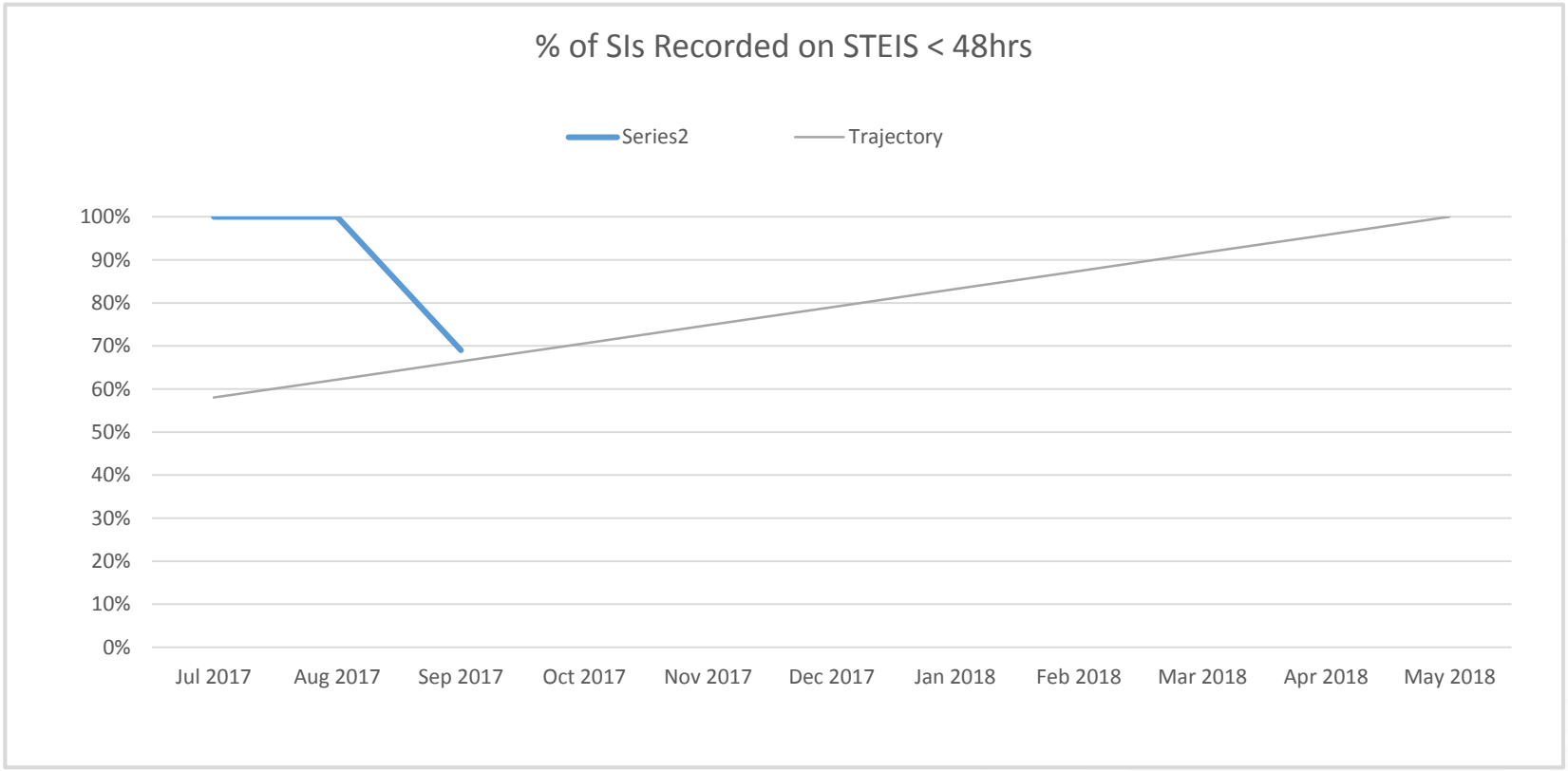
Impact

Impact so far

Objective 2: Identify & Share Learning

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



Within trajectory

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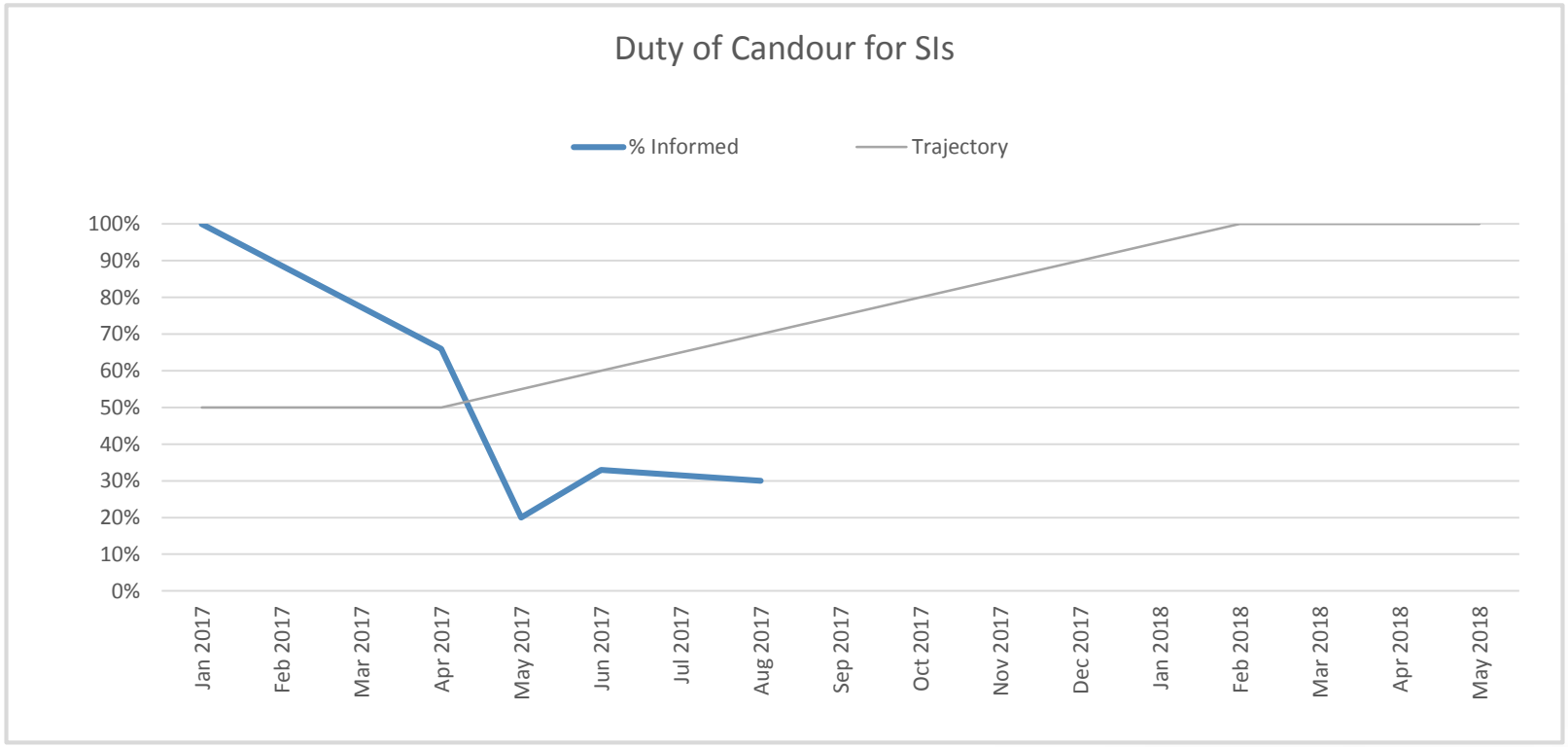
Impact

Impact so far

Objective 2: Identify & Share Learning

100% compliance with Duty of Candour for Serious Incidents



Changed processes to ensure recovery

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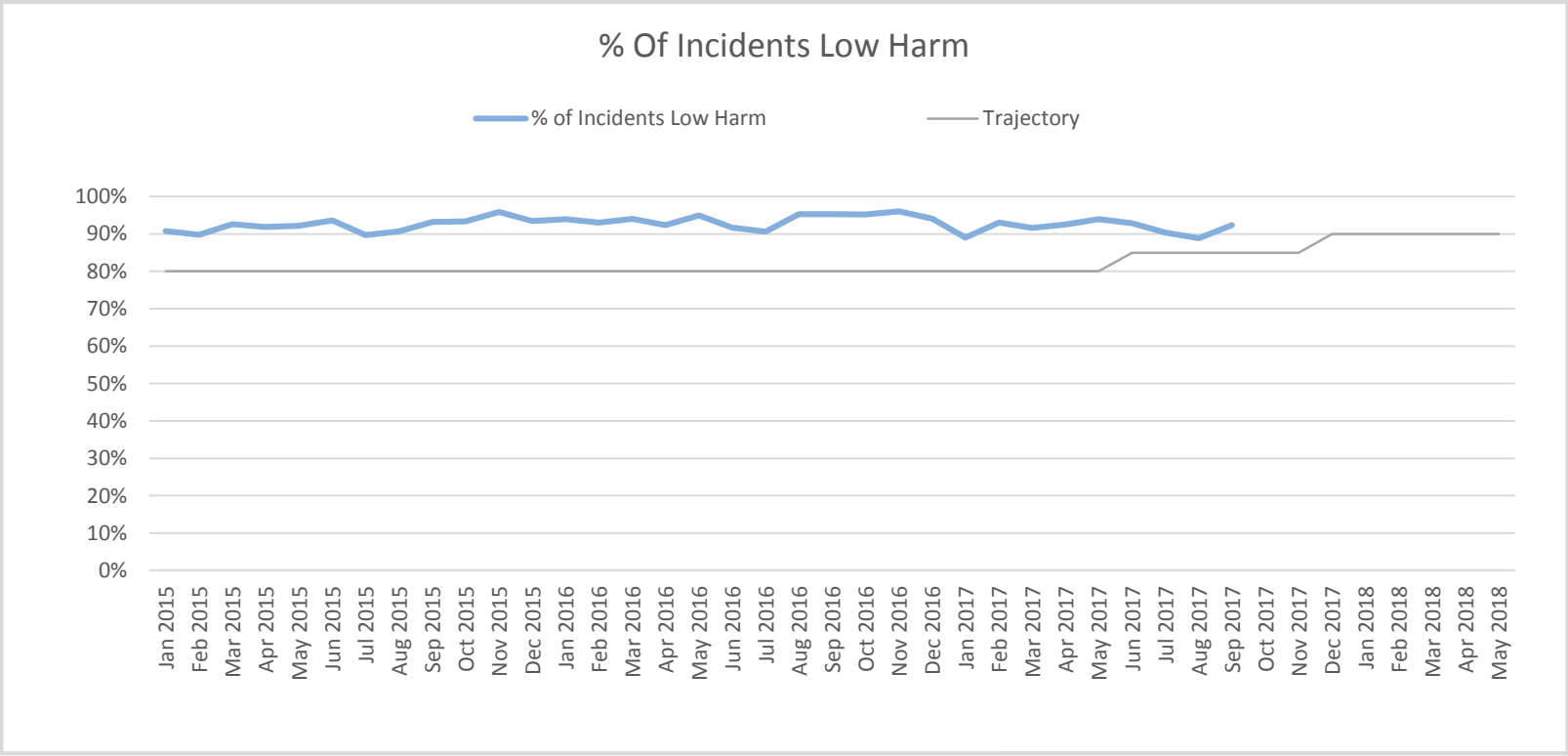
Impact

Impact so far

Objective 3: Positive Incident Culture

90% of incidents graded as near miss or low harm



Above trajectory

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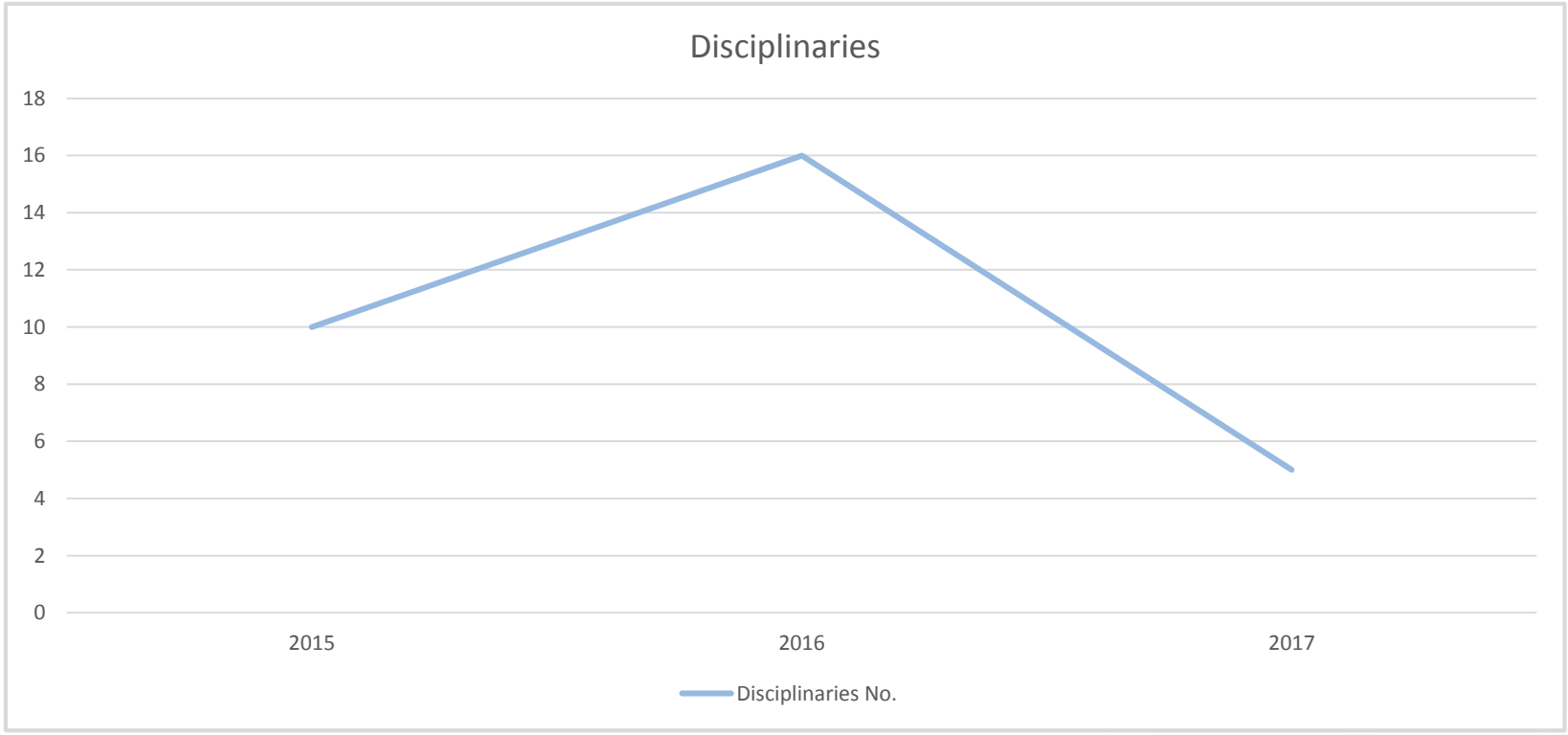
Impact

Impact so far

Objective 3: Positive Incident Culture

0 disciplinary cases that are purely clinical error



New process for deciding disciplinary

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Impact

Impact so far

Objective 3: Positive Incident Culture

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

Targeted improvement

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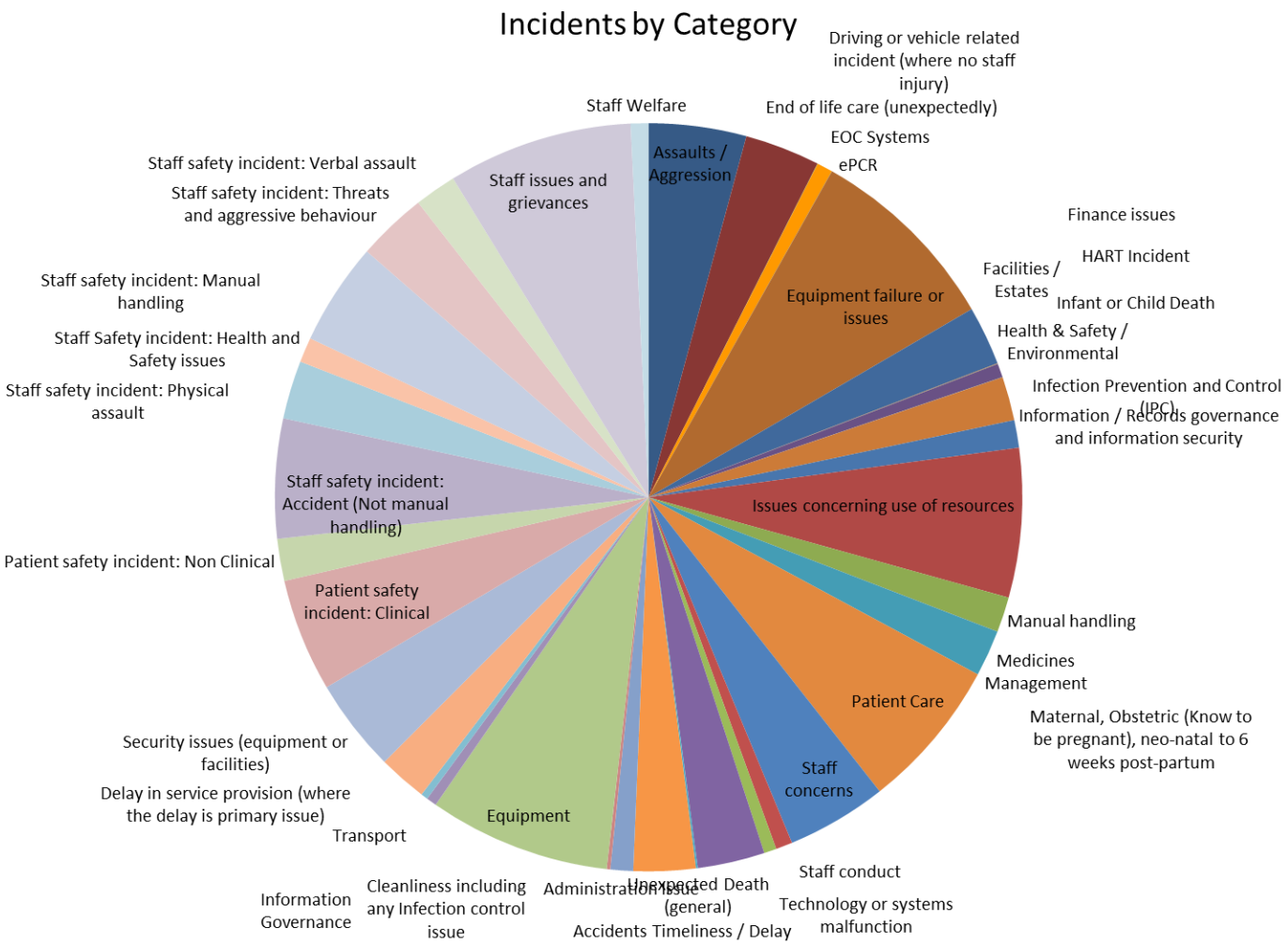
Themes

Of Incidents



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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