



South East Coast Ambulance Service 
NHS Foundation Trust

Presentation to Medway HASC

Geraint Davies, Acting Chief Executive



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CQC Findings

- ✚ CQC report published on 29 September 2016
- ✚ The Trust was found to be 'Inadequate' overall
 - ✚ Safe and well-led being the areas with most concern
- ✚ It is clear from the CQC report that, despite the care shown to patients, there are many systems and processes in place within the Trust which are failing patients and staff and for that I must apologise



Service Ratings

	Urgent and Emergency Care	Patient Transport	Emergency Operations Centre	NHS 111
Safe	●	●	●	●
Effective	●	●	●	●
Caring	●	●	●	●
Responsive	●	●	●	●
Well-Led	●	●	●	●
Overall	●	●	●	●



SECamb Ambition for Change

- ✦ The Trust is already delivering against an ambitious recovery plan which already addresses many of the areas highlighted by CQC
- ✦ We are committed as a Board to delivering focussed change, with rigorous internal and external governance and assurance of delivery
- ✦ This will be a long journey with longer term actions requiring prioritisation within available resources



Response

Recovery plan in place since March 2016 focussed on:

-  Governance
-  Culture
-  Performance
-  Clinical Outcomes
-  Financial Sustainability



Response

- ✦ Recovery Plan addresses quality concerns to improve patient care and safety:
 - ✦ Deloitte Governance Review
 - ✦ CQC warning notice
 - ✦ Commissioner concerns
 - ✦ Internally identified concerns
- ✦ Will address the final CQC report



Principles for Recovery

- ✦ Robust executive leadership with board oversight and challenge
- ✦ Ensure capacity, capability to deliver cultural change
- ✦ Clear Executive portfolios
- ✦ Engaged and empowered senior management team
- ✦ Clear ownership of plans
- ✦ Effective programme management
- ✦ Internal systems of control and assurance
- ✦ External diagnostics, advice and assurance from:
 - ✦ NHS Improvement
 - ✦ South Central Ambulance Service
 - ✦ London Ambulance Service
 - ✦ BOC

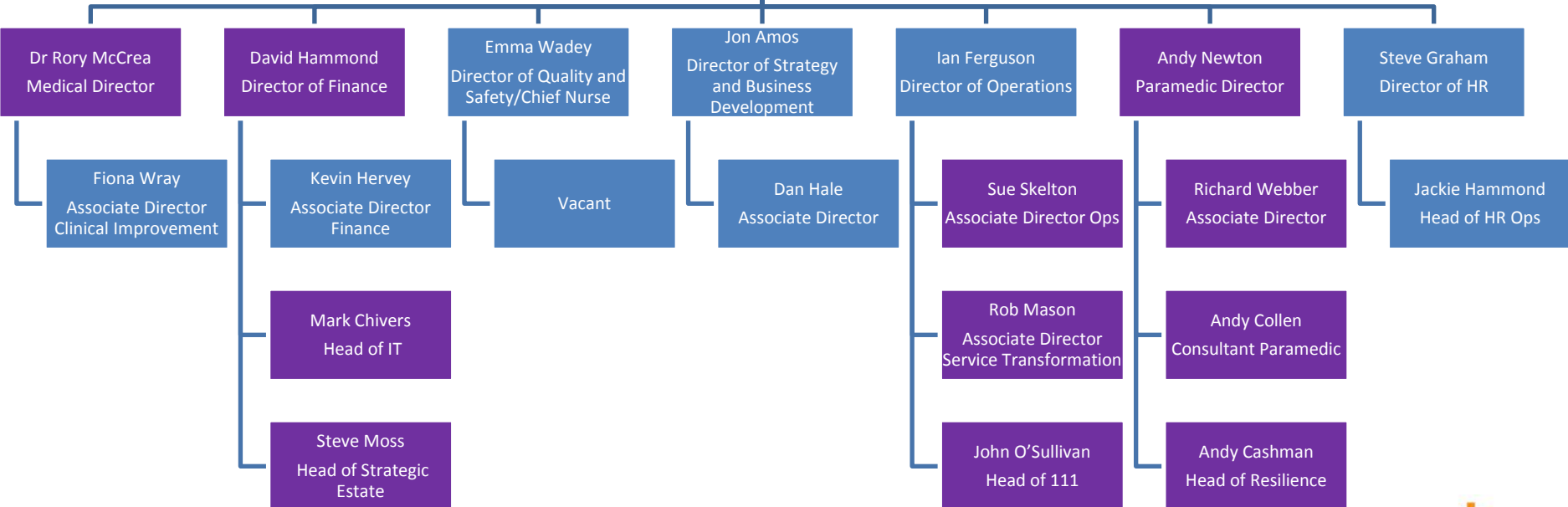


Leadership

Geraint Davies
CEO

Peter Lee
Company Secretary

Janine Compton
Head of Communications





Outstanding Practice

- ✦ Innovative approaches to pathway development in NHS 111 improving outcomes for patients, particularly for end of life care patients and victims of sexual assault
- ✦ Provision of training and support to enhance paramedic roles



Good Practice

- ✚ Good practice recognised included:
 - ✚ Kindness and understanding
 - ✚ Patient empathy and focus
 - ✚ Well developed links with other services
 - ✚ Support to staff following traumatic events
 - ✚ Planning with commissioners, strategic clinical networks and trauma networks
 - ✚ Engagement with the public including use of social media
 - ✚ Culture of innovation



South East Coast Ambulance Service **NHS**

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● Inadequate ● Requires improvement ● Good

Area	CQC rating	Examples of findings
Safe	●	<ul style="list-style-type: none"> Poor incident reporting culture, processes for reporting and investigating incidents and lack of learning from incidents Weak safeguarding arrangements with a lack of accountability, understanding and appropriate investigations Low attendance at infection control training and poor hand hygiene practices Trust CAD system had not been appropriately updated Low staffing levels
Effective	●	<ul style="list-style-type: none"> Not meeting national performance targets for response time or call answering Policies and procedures had not been updated Inconsistent approaches to appraisal and no tracking system for completion Lack of mental capacity act training and guidance for staff
Caring	●	<ul style="list-style-type: none"> Patient empathy and focus Clear, sensitive and non-judgemental communication and support to patients, relatives and colleagues
Responsive	●	<ul style="list-style-type: none"> Complaint responses not meeting expected target Unequal resource distribution Handover delays led to a major loss of productive ambulance capacity
Well-led	●	<ul style="list-style-type: none"> Lack of clarity on roles and accountability of executive team, particularly the respective roles of the three clinical directors Risks management was not structured in a way that allowed identification and escalation to the board Culture of bullying and harassment Numerous interim post holders at board level



Progress

CQC finding...

‘Poor incident reporting culture’

SECamb action:

- ✓ Backlog of incidents reduced to ensure more timely closure and feedback
- ✓ New Reflections publication to share learning from incidents
- ✓ Plans to make Datix accessible via iPad

CQC finding...

‘Hand hygiene practice was inconsistent’

SECamb action:

- ✓ Awareness campaign
- ✓ Station champions and training
- ✓ Audits as part of new Operating Unit compliance framework



Progress (2)

CQC finding...

‘Appraisals completion below Trust target’

SECamb action:

- ✓ Audit of appraisal quality
- ✓ Revision of appraisal process to develop an approach which is less ‘desk’ based
- ✓ Closer alignment of appraisal with recruitment and induction processes

CQC finding...

‘First level managers pulled into clinical rota’

SECamb action:

- ✓ Operational management restructure under consultation with 50% management time and specialist clinical leadership



Progress (3)

CQC finding...

‘Insufficient staff in NHS 111’

SECAMB action:

- ✓ New recruitment and induction processes in place – learning from which is shared with EOC
- ✓ Performance consistently in line with or above trajectories

CQC finding...

‘Processes not in place to ensure equipment is maintained and secured’

SECAMB action:

- ✓ Audit of oxygen storage by BOC
- ✓ New security strategy
- ✓ New clinical asset register



Progress (4)

CQC finding...

‘Limited understanding of Mental Capacity’

SECamb action:

- ✓ Guidance added to clinical record
- ✓ Staff communications, awareness and review of training design

CQC finding...

‘Inappropriate disposal of controlled drugs’

SECamb action:

- ✓ Updated medicines manual available in all ambulance stations
- ✓ Move to central disposal through the implementation of disposal containers at each location



Single Oversight

- ✚ Clear roles and responsibilities
- ✚ Internal programme governance agreed with weekly Exec scrutiny and assurance through board committees
- ✚ Work underway to move to a single oversight model with CQC, NHSI and CCGs



Stakeholders

- ✦ Some actions are only possible with clear system support and alignment of future operating model with STPs
- ✦ Continued transparency of progress and challenges is essential
- ✦ Engagement with all stakeholders through a range of existing forums



Summary

- ✚ Significant problems have been identified
- ✚ Improvement work is already underway
- ✚ Robust plan in place which is being revised to ensure it addresses and appropriately prioritises CQC and wider issues
- ✚ System support is needed to address demand, capacity and patient pathway issues



Patient Impact Review

- ✚ Patient Impact Review into Red 3 Pilot published on 28th October 2016
- ✚ Commissioned by Trust but led by external, independent clinician
- ✚ Variety of work-streams used
- ✚ No evidence of patient harm attributable to the Pilot identified



Defibrillators/CAD

- ✦ Board has agreed to undertake a focussed review into impact of system issues in consistent identification of defibrillators to aid future learning
- ✦ In light of this and other issues, Board agreed at October meeting to begin the procurement process for a new Computer Aided Dispatch (CAD) system
- ✦ In the meantime, work will continue to rectify urgent, patient safety issues on existing system



999 performance

- ✦ Performance for Red 1, Red 2 and Red 19 remains challenged
- ✦ Demand in September more than 3% above plan
- ✦ Hospital handover delays – up 38% on last year
- ✦ Detailed plan in place to improve productivity and processes, agreed with Commissioners
- ✦ Improvements seen in October
- ✦ Trust successfully implemented ARP on 18th October



NHS 111 performance

- ✚ Weekday performance remains consistently strong against KPIs
- ✚ Room for improvement in week-end performance
- ✚ Focus on operational stability ahead of winter
- ✚ On-going impact of failure of new provider in East Kent to mobilise – SECAmb asked, at short notice, to continue to provide service

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