PATIENT IMPACT REVIEW

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1. EXECUTIVE SUMMARY

Between December 2014 and February 2015, South East Coast Ambulance Service NHS Foundation Trust conducted a project that involved changing standard operating procedures for handling some NHS 111 calls transferred to the 999 service.

The project did not involve calls identified by NHS 111 as potentially the most life-threatening, but it did include those at the next level of urgency. In response to these calls, the Trust delayed dispatching ambulances to allow paramedic staff to call the patient/caller back to get more information and potentially downgrade or upgrade the call's priority level.

This review considers whether there was benefit or harm to patients calling 999 or 111 during the project. The methodology for the project is described in this report. A review of all the evidence considered found there was no evidence of patient harm but the project cannot completely exclude that any incident of harm occurred.

It was considered that the exercise of contacting all the tens of thousands of people who called during the project to find out about their experience would not add significant value to the findings of the report. Of the cases we examined in detail, in only one case was it not possible to totally exclude harm as a consequence of the project.

In terms of potential benefit resulting from the project, in 89 cases calls were given a higher priority; nine of these cases involved upgrading calls to the most urgent category.

If effective clinical governance arrangements for the project had been in place it would have been easier to measure any positive or negative effects of the project on patients.

We recommend that the Trust reviews and implements effective governance arrangements, ensuring all projects use effective means to measure their impact.

2.   INTRODUCTION

South East Coast Ambulance Service NHS Foundation Trust provides 999 and NHS 111 services to the population of Kent, Sussex and Surrey. Like all ambulance trusts, it experiences fluctuating demand for its service. Peak demand typically occurs in winter, during bank holidays and when GPs start their home visits after morning surgeries. Ambulance response times are also influenced by the time and day of the week, weather and traffic conditions, availability of crews which can depend on handover times at emergency departments and a number of other factors.

Between 20 December 2014 and 24 February 2015, the Trust conducted a project that involved changing standard operating procedures for handling some NHS 111 calls transferred to the 999 service. The project introduced a second review stage for certain calls from the public to NHS 111, to find out whether they required an ambulance. The second review took place after the initial triage by NHS 111 had determined that an ambulance was required. Essentially, this approach allowed a delay in allocating an ambulance to certain calls transferred from 111 to 999.

The Trust devised the project in response to high demand for ambulances and difficulty meeting national response times (for details of call categories and response times, see Box 1). For example, in November 2014 it dealt with 1,035 Red 1 (R1) calls[1] compared to 468 in the previous November[2].

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[1] https://www.england.nhs.uk/statistics/statistical-work-areas/ambulance-quality-indicators/ambulance-quality-indicators-data-2014-15/

[2] https://www.england.nhs.uk/statistics/statistical-work-areas/ambulance-quality-indicators/ambulance-quality-indicators-data-2013-14/

> **Box 1: Call categories and response times**
>
> **Red 1 (R1):** immediately life-threatening conditions where speed of response may be critical in saving life or improving the outcome for the patient – for example, cardiac arrest patients, who are not breathing and do not have a pulse, and other severe conditions such as airway obstruction.
>
> **Red 2 (R2):** serious but not the most life-threatening conditions, such as stroke and fits.
>
> All NHS Ambulance services must respond to 75% of Red calls within 8 minutes and 95% within 19 minutes of an ambulance being requested.
>
> **Green:** non life-threatening conditions that need to be attended quickly, but which will not deteriorate or suffer by a slightly slower response.
>
> **Green 2 (G2):** a response target of 30 minutes.
>
> **Green 4 (G4):** a response target of 60 minutes.
>
> **Green 4 Healthcare Professional (G4 HCP):** responses relate to calls made by doctors and other healthcare professionals requesting an ambulance to attend a patient within 60, 120,180 or 240 minutes depending on the urgency of the situation.

The project did not involve calls identified by NHS 111 as potentially the most life-threatening (R1 calls). But it did include those at the next level of urgency (R2 calls).

These calls were re-categorised as R3, and the project allowed up to an additional 10 minutes for clinical staff to call the patient/caller back to get more information and potentially downgrade or indeed upgrade the call's priority level, (a process referred to as 're-triage').

For G2 calls, which generally require a response within 30 minutes, the project allowed an additional 20 minutes for re-triage. These calls were re-categorised as Green 5 (G5).

These changes did not comply with NHS England's NHS 111 commissioning standards, nor with nationally agreed operating standards that require responses to R2 calls within eight minutes, regardless of location, in 75% of cases.

Commissioners became fully aware of the project in February 2015. They questioned how it had been developed and implemented, and how the risks to patients were being monitored and managed. At this point the project was halted and a Risk Summit was held on 31 March 2015. Because of concerns, and because the Trust Board and commissioners had been unaware of the full details of the project, the Trust undertook an internal review, with scrutiny by the lead Commissioners' Clinical Quality and Safety team.

NHS England opened a separate investigation, while a further review by Deloitte focused on accountability and governance relating to the project's introduction. It was not the purpose of either of these reviews to identify whether any patient was harmed or to highlight any benefits of the project (see Appendix 1).

On 29 October 2015, Monitor (now NHS Improvement) took enforcement action under section 106 of the Health and Social Care Act 2012 on the basis of the internal and external review findings and after discussions with the Trust. As part of this, in February 2016, NHS Improvement required the Trust to commission an investigator to undertake an independent impact review "to establish whether there has been on balance benefit or harm for patients calling 999 or 111 services provided by the Trust during the implementation of this project". For details of the scope of the review, see Appendix 2.

## 3.	HOW WE UNDERTOOK THIS REVIEW

The original scope of the review included 18 strands of work to assess the impact the project had on patients (for the full list, see Appendix 4).

Desktop reviews

- Review and triangulation with NHSE and Deloitte Reports
- Comparison of like-for-like 111 and 999 SI Reviews
- Independent review of Datix records

Call management data

- Comparison of like-for-like 111 and 999 performance indicators
- Comparison of like-for-like 111 and 999 mortality data
- Comparison of like-for-like 111 and 999 delayed response

Contact with external stakeholders

- Collation of letters from 44 MPs (harm/enhanced safety)
- Consult patient groups (HOSCs and CQC; harm assessment)
- Consult whistleblower views (via NED, Deloitte, CQC and Monitor)
- Consult CCGs Patient Safety Leads (safety issues)

Interviews with staff

- Review and triangulate with Operations and Strategic Delivery Group
- Specialist Paramedic interviews
- Collate feedback from call centre staff

As described in the introduction above it was not possible to undertake all 18 strands of work; we explain the reasons for this below and in our findings in Section 4. For full details of our research methodology and analysis, see Appendix 5.

We used the following approaches:

Desktop reviews of documents

- We reviewed the previous reports from NHS England and Deloitte and corroborated their findings.

- We analysed the seven 'Serious Incidents' identified as potentially related to the project (see Appendix 6) that had been investigated by the Trust and documented in NHS England's report. We consulted the Medical Directors at the hospitals where three of the patients involved were taken.

- We reviewed the Trust's Datix records – software used to record and analyse complaints and safety incidents – for all patients included in the project, and examined whether its decisions about potential or actual patient harm were appropriate.

Call-management data

We analysed the Trust's call-management data within the scope of our review (for more details, see Appendix 2). Problems with data quality included missing data for some calls on:

- 'initial' and 'final' priority classification
- the time calls arrived at 999 emergency operations centres (EOCs)
- the time a response was alerted/allocated by dispatch.

There was contradictory information on the status, priority and response allocated to a substantial number of calls. This included 'initial' and 'final' priority categorisations, and was compounded by the inclusion of 'duplicate' and 'cancelled' calls. For some the 'Cancel Reason' field indicated the call had received a non-ambulance response (such as 'hear-and-treat').

We sought to eliminate these potential sources of error and excluded calls where missing data was evident.

Interviews with staff

We asked Trust staff involved in the project to contact the independent reviewer directly. We interviewed two specialist paramedics, along with call centre staff. We sought whistle-blowers' views through the Trust non-executive director with responsibility for whistle-blowing, as well as through Deloitte, the Care Quality Commission (CQC) and NHS Improvement.

Interviews with callers

We originally planned to interview patients whose calls had been subject to excessive review times. However, we decided against this after discussions with stakeholders, including the Trust's Medical and Nursing Directors, the Deputy Medical Director of NHS Improvement and patient representative groups such as Healthwatch.

The reasons for this included:

- the group from which a sample of patients to be interviewed would have been drawn exceeded 300,000 people who called 111 or 999 during the project

- the length of time that had elapsed would reduce the likelihood of full recollection; in particular, frequent callers to or users of the ambulance service may have had difficulty recalling specific incidents

- it might have been distressing for patients whose condition had worsened in the interim, or for families of patients who had died.

The Trust's Director of Nursing did contact patients or families linked to the seven Serious Incidents to offer on-going support.

Contact with external stakeholders

We analysed letters from the 44 local MPs to identify any cases of patient harm or potentially improved patient safety. We asked for feedback from other organisations, including the local Healthwatch, clinical commissioning groups (CCGs), patient safety leads, local authorities' health overview and scrutiny committees and CQC. We also took account of any reports into patient safety issues at the Trust.

4.   FINDINGS

Comparing like-for-like 111 and 999 performance indicators

It was not possible to compare calls like-for-like as originally envisaged, due to differences in the way data was entered for calls at different times. In particular, priority was not recorded for calls arriving via NHS 111 for the period preceding the project. Appendix 5 explains the data issues in more detail.

Comparing like-for-like 111 and 999 mortality data

This data was difficult to analyse. Ambulance trusts are involved in only a small part of a patient's emergency care and treatment, and do not routinely have mortality data for the vast majority of their patients[3].

Ambulance trusts do take part in national clinical audits for some patients, such as those who have had a cardiac arrest. For these, there is survival data. But such patients are almost always identified as R1 at their first call, and therefore would not have been included in the project.

For the few patients identified and followed up due to concerns about their outcomes (see our review of Datix records, below), we did not identify any deaths attributable to the project. This was despite considerable publicity about the project, contacts with MPs and awareness within the NHS, hospitals, GPs and 111 service.

Comparing like-for-like 111 and 999 delayed response

To assess if people waited longer for an ambulance during the project, we compared three datasets:

- 184,140 calls made during the project (20 December 2014 to 24 February 2015)

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[3] Only a small minority of 999 calls are for patients experiencing any threat to life. For the vast majority the ambulance service provides assessment and/or care but does not make a difference to survival.

- 164,336 calls made during the same period the previous year (20 December 2013 to 24 February 2014).
- 176,129 calls made during the two months before the project began (15 October 2014 to 19 December 2014).

For each dataset the key measurement was the time between the call arriving on the 999 dispatch screen and the time that an ambulance was alerted. We compared these intervals for calls originating from NHS 111 with those made direct to 999 for calls that were confirmed as requiring an eight minute or 30 minute response i.e. calls whose initial and final priority categorisation had remained R 2 and G 2, or equivalent, respectively. We also compared them to identify any difference according to how many staff were on duty re-triaging calls. Unfortunately, data on initial priority categorisation was only available for the period of the project, and our analyses were therefore restricted to this data.

Our main findings were that:

- the interval was about eight minutes longer for 111 calls that had been given a Red 2/3 priority level than for 999 calls with the same priority level

- the interval was about 12 minutes longer for 111 calls given a Green 5 30-minute response time than for 999 calls with the same priority level

- the intervals were longer when more clinicians trained to re-triage were on duty, regardless of whether the call came from 111 or 999; this is likely to reflect the higher number of calls re-triaged during those periods when re-triage staff were on duty

- intervals for 111 and 999 calls differed by just under five minutes when no clinicians trained to re-triage were on duty

- when one or two clinicians trained to re-triage were on duty the difference was about seven minutes, indicating an excess of about two minutes for 111 calls when the project was not operating.

Frequency distributions of T_0-T_{Alert} interval data

The following Figures demonstrate the distorted distribution of the time from the call being received to an ambulance being dispatched (T_0-T_{Aler}), The time interval data generated for calls from 111 and 999 with 'initial' and 'final' priority classifications that were both R2 or G2 (or equivalent). These (positively skewed) distributions indicate that the median offers a better approximation of the average interval than the mean

111 R2R2 T0-TAlert >18min (Figure 1)

The CAD records for all 71 outliers were reviewed, there was no evidence of patient harm identified that could be attributed to the project for this group of patients.

Figure 1: Frequency distribution of T_0-T_{Alert} intervals observed for calls with 'initial' and 'final' priority categorisations of R2 (or equivalent) originating from 111 during the project
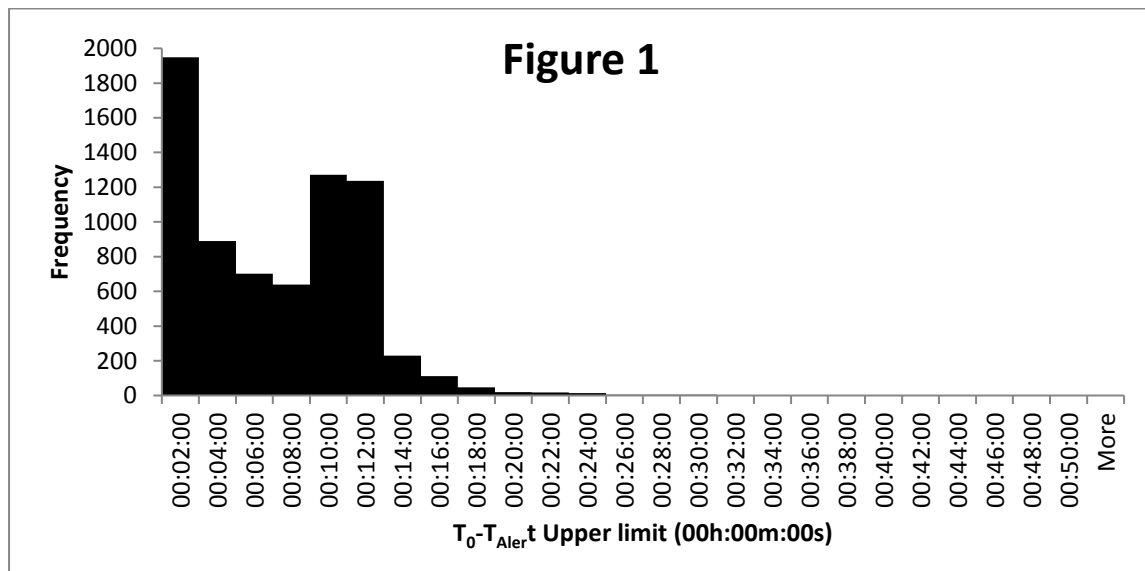
999 R2R2 T0-TAlert >18min (Figure 2)

The CAD records for all 19 outliers were reviewed, there was no evidence of patient harm identified that could be attributed to the project for this group of patients.

Figure 2: Frequency distribution of T_0-T_{Alert} intervals observed for calls with 'initial' and 'final' priority categorisations of G2 (or equivalent) originating from 111 during the project

111 G2G2 T0-TAlert >50min (Figure 3)

The CAD records for all 95 outliers were reviewed, there was no evidence of patient harm identified that could be attributed to the project for this group of patients.

Figure 3: Frequency distribution of T_0-T_{Alert} intervals observed for calls with 'initial' and 'final' priority categorisations of R2 (or equivalent) originating from 999 during the project

999 G2G2 T0-TAlert >50min (Figure 4)

The CAD records for all 111 outliers were reviewed, there was no evidence of patient harm identified that could be attributed to the project for this group of patients.
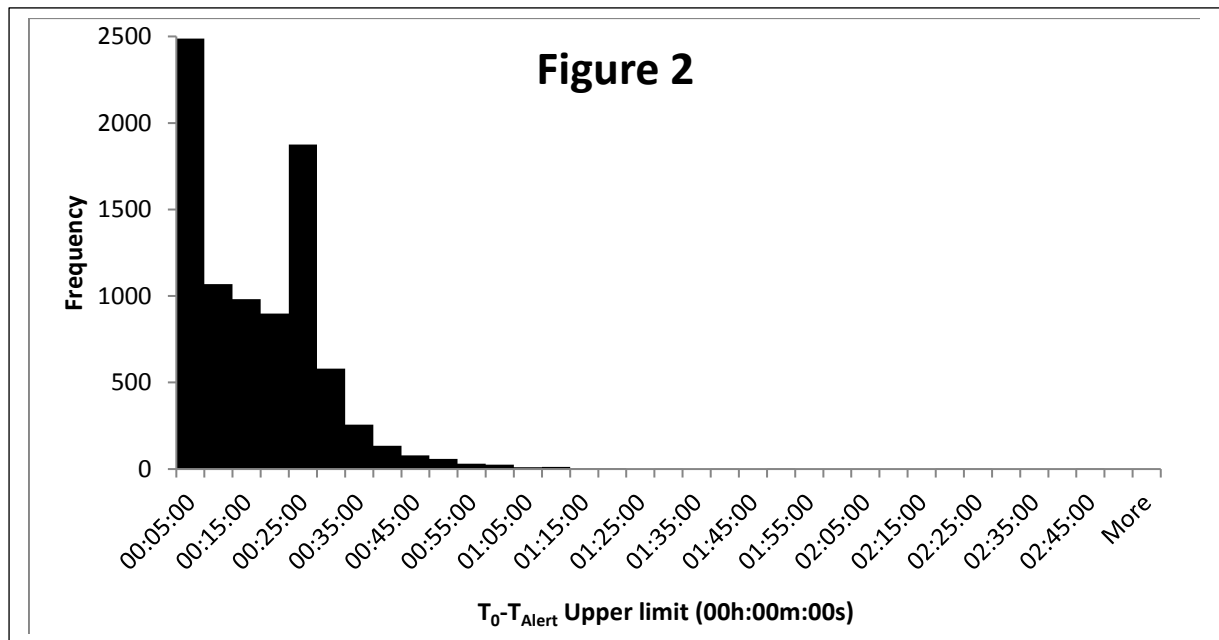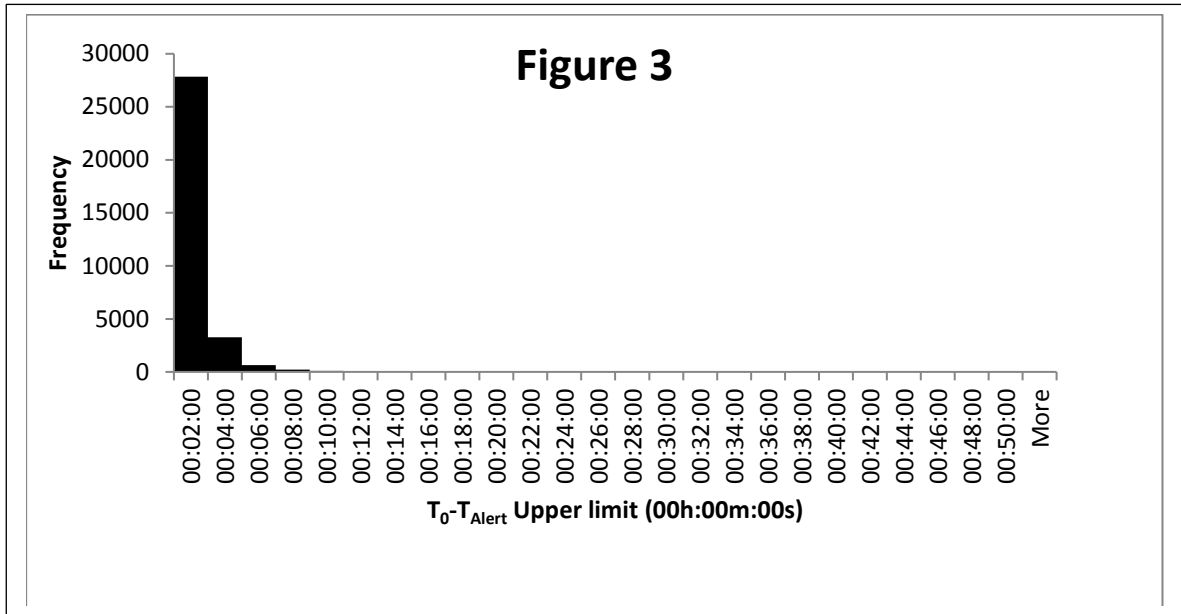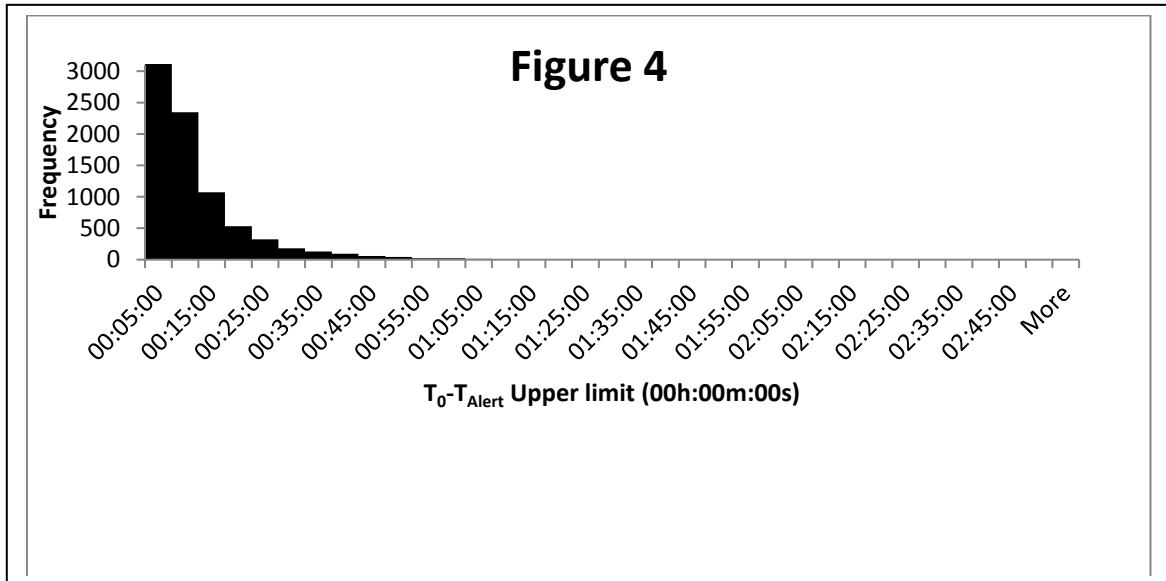
Figure 4: Frequency distribution of T_0-T_{Alert} intervals observed for calls with 'initial' and 'final' priority categorisations of G2 (or equivalent) originating from 999 during the project

Table 1: Time between call arrival and response alert during the project

Call origin:	NHS 111		999 emergency operations centres	
Call response categorisation:	8 minutes	30 minutes	8 minutes	30 minutes
Number	7,047	8,404	32,149	35,400
Median	00:06:09	00:13:31	00:00:55	00:01:10
Maximum	00:44:28	02:42:03	00:33:35	02:46:24
Minimum	00:00:01	00:00:01	00:00:00	00:00:00

The median values in Table 1 show that during the project, irrespective of how many staff were on duty to re-triage calls, alerts for:

- NHS 111 calls prioritised for an 8-minute response took about 5 minutes longer (00:05:14) than those from 999

- NHS 111 calls prioritised for a 30-minute response took around 12 minutes longer (00:12:21) than those from 999.

We concluded that 111 calls did wait longer than 999 calls with the same priority level during the project. The times were longer when more staff were on duty to re-triage the calls, regardless of whether the call came from 111 or 999.

Comparing like-for-like 111 and 999 Serious Incident reviews

The NHS uses the term 'Serious Incident' to identify occasions when patients' poor outcomes require investigation to identify if the NHS could or should have done anything differently.

Seven Serious Incidents were identified as potentially related to the project (see Appendix 6). The Trust had investigated them, while NHS England reviewed and documented them in its report.

For three of the seven Serious Incidents where it was considered the project may have had an adverse impact on the patient we asked for the views of the Medical

Directors at the hospitals that treated the patients involved. They said the delay in providing treatment to two of these patients had no impact on the patient's outcome. They concluded that the third patient, who had suffered a stroke and experienced a delay in being taken to hospital, was not suitable for anti-thrombolytic agents, which have to be given as soon as possible: their scan showed too much irreversible damage. It is not possible to determine if the delay of 11 minutes attributable to the project would have made a difference to their clinical outcome or the ability to use more active treatment in this case.

Reviewing Datix records

These records revealed 25 incidents related, however tenuously, to the project. The Trust considered seven of these to be Serious Incidents (see above). There is no evidence that the project was responsible for these patients' outcomes and we did not identify any deaths as being associated with the project itself. For a summary of the 25 incidents, see Appendix 7.

Consulting MPs

The Trust wrote to MPs in the 44 constituencies it serves, asking them to draw to its attention any concerns raised by their constituents. No MPs identified any such concerns.

The Trust's Chief Executive and Director of Nursing met about 12 MPs or their representatives at the House of Commons on 16 November 2015. The Chief Executive and Director of Nursing gave a presentation describing the project and answered MPs' questions. None attending raised any specific concerns on behalf of patients within their constituencies.

Interviews with specialist paramedics

To assess patient safety issues, we interviewed two specialist paramedics involved in re-triaging calls during the project. Most information from these interviews related to the conduct of the project and not directly to whether patients experienced harm or benefit.

Those interviewed felt confident in their ability to make safe, appropriate clinical decisions, but had concerns about the amount of training and briefing they received before taking part in the project. They could not provide a consistent view about the number of calls that might be in the "stack" (on the screen) at various times. In those instances where they found that they could not re-contact callers they would confirm that NHS 111 call proritisation catogorisation and these calls were allocated the response time therewith. They said that although G5 calls were considered less urgent than R3 calls, they could take more time to re-triage because of their complexity, which could delay re-triage of any R3 calls waiting longer.

While these interviews confirmed others' comments about the preparation for, governance and management of the project, they did not provide any specific or general concerns about patient harm. The interviewer speaking to these staff found them all to be extremely 'risk-averse'.

Reviewing and cross-checking with NHS England and Deloitte reports
We identified no evidence that adds to or contradicts the reviews by NHS England or Deloitte.

Feedback from call centre staff
Notices in all three of the Trust's emergency operations centers encouraged staff to contact the independent reviewer by either email or telephone to share their views about the project in confidence. Six staff did so.

They described the pressure that the ambulance service was experiencing before the project began. They gave examples of calls from 111 that, in their view, did not need an ambulance response. They supported the project and how it was run, and said it helped with managing calls and providing appropriate patient care. They shared the view that more patients may have benefited than suffered from the project. The interviewer speaking to these staff found them all to be extremely 'risk-averse'.

Consulting patient groups

The Trust made considerable effort to contact members of the public who may have called 111 or 999 during the project, to make it easy for them to raise any concerns. For a full report of the Trust's actions, see Appendix 8.

The Trust's Chief Executive made presentations to six local authority health overview and scrutiny committees between 3 December 2015 and 29 January 2016. No patient safety concerns were raised at or following these meetings.

Consulting whistleblowers

We contacted the Trust's non-executive lead for whistleblowing, who reported in confidence to the Trust Board in January 2016. No individual whistleblower issue or whistleblowing theme was related to concerns about patient safety arising from the project.

No other external review of the project, or any other organisation whose views were canvassed, came forward with either general or specific examples of patient harm.

C8 - Consult CCGs Patient Safety Leads (safety issues)

The CCG Patient Safety Leads who were contacted in order to seek the views and comments they made to the Trust in advance of the publication of NHS England's report.

The patient safety leads were not aware of any patient safety issues relating to the project, but did express the view that 'no harm identified' cannot completely exclude any incident of harm occurring.

Reviewing and cross-checking with the Operations and Strategic Delivery Group

Nothing has come to light in preparing this report that adds to or contradicts NHS England's or Deloitte's reviews.

5. CONCLUSION

This independent review looked retrospectively at the project's impact on patient safety. It aimed to identify any patient harm or benefit.

Through the work stands undertaken in this report there was no evidence of patient harm.

It is not possible to completely exclude the possibility that there may have been an incident or incidents of patient harm due to the review's retrospective nature and the difficulties of contacting a large number of patients. However, the review used a range of approaches to look at the project period and population in question, to reduce the likelihood that any serious incident of patient harm may have been missed.

In only one case was it not possible to totally exclude harm as a consequence of this project. In terms of possible patient benefit, during the project, nine R2 calls were identified as probable cardiac arrest or peri-arrest as a consequence of earlier clinical triage and were upgraded to R1 status accordingly. In addition, 80 Green calls were identified as requiring a higher priority response following earlier clinical intervention and were upgraded to R2 status.

The changes involved in the project were not in line with NHS England's NHS 111 Commissioning Standards (June 2014, page 12, point 3.2) which state that:

> *"NHS 111 must be able to identify potentially life threatening problems and dispatch an ambulance without any delay or re-triage, and support the patient prior to the vehicle arriving."*

The changes did not comply with nationally agreed operating standards that require R2 calls to receive an emergency response within 8 minutes, irrespective of location, in 75% of cases.

It is evident that if effective clinical governance arrangements had been in place it would have been easier to measure any positive or negative impacts of the project, including patient harm.

6.   RECOMMENDATIONS

- The Trust needs to review and implement effective governance arrangements.

- All projects should have an identified matrix to measure their impact; this should be completed during the planning stage.

- The Ambulance Response Project (ARP) documentation should be used to inform best practice, as this work has been carried out since the project. ARP has also been co-ordinated nationally through the Association of Ambulance Chief Executives, the National Ambulance Service Medical Directors and the National Directors' Operational Group.

- Clinicians who are expected to re-triage any calls must be trained to the required standard.

APPENDIX 1: PREVIOUS INTERNAL AND EXTERNAL REVIEWS OF THE PROJECT

R3/G5 Internal investigation (published on 12 June 2015)

This is an internal report requested by the Trust's commissioners and prepared by an external Medical Director and the Trust's Director of Nursing, who had not been present in the Trust when crucial decisions had been made about the project.

Its key finding was that, while a review of individual patients' clinical journeys continued, initial investigation showed that, as far as could be determined, the project did not result in harm to any individual.

This investigation highlighted pockets of good frontline practice in clinical reviews. But it was apparent that the Trust did not follow its formal risk management processes in its desire to implement the solution.

The Trust Board and Commissioners' lack of awareness of the project indicated that the current formal reporting and joint oversight and governance processes required review, and possibly simplification, to be able to manage a project with complex staging, and which required multiple interconnected decisions.

The project implementation had focused solely on minimising community risk to the South East. There was a lack of focus on the impact on the individuals who would be affected by this change in practice.

Regional Chief Nurse for NHS England South (published November 2015)

This report was commissioned by members of the Risk Summit held on 31 March 2015 and was published after the Risk Summit process had ended.

The key findings were that the project involved changing the national operating standard and it had been introduced without proper governance and decision making within the Trust.

Once the change to the national operating standard had been identified and the CCG stopped the project, a detailed assessment of the Trust's incident reporting system was undertaken; Serious Incidents associated with the project were subject to the Trust's usual Serious Incident review process.

The report made recommendations that the Trust has begun to act on.

NHS England report (September 2015)

This external investigation into the project was carried out by NHS England.

It had wide-ranging terms of reference, which included understanding the project's context and implementation, communication within the Trust and externally to partners and patients, how risks were assessed and managed, and how complaints and incidents were investigated.

Key findings were that the project may have been instigated with good intentions but, due to lack of due diligence, good governance and board leadership it was allowed to proceed without effective risk management. The Executive Directors acknowledged that many of the processes involved in the project were inadequate and there was a distinct lack of accountability. No conclusions could be made about the project's safety and efficacy.

Deloitte report (March 2016)

This report looked at how the project came about, how it was managed and governed, and who was or was not involved in the key decisions.

The key finding was that fundamental failings in governance at the Trust resulted in implementing a high risk and sensitive project without adequate clinical assessment or appraisal by the Board, Commissioners or the NHS 111 service.

APPENDIX 2: SCOPE FOR PATIENT IMPACT REVIEW

The review will be overseen by an independent expert and will consider both patient harm and benefit to patients calling 999 or 111 during the implementation of the project.

The following investigation reports were made available to the independent expert appointed for the Impact review.

1. NHS England investigation report;

2. Trust investigation report; and

3. Lead commissioner's commentary on the Trust investigation.

Scope of Patient Impact Review

Due to the sensitivity of the issues, the independent expert will be expected to ensure appropriately high levels of confidentiality in undertaking the work. The independent expert will be expected to share the information, emerging findings and views and reports (draft as well as final) with the Trust and with NHS Improvement at the same time, and make himself available to NHS Improvement for queries or clarifications as the work progresses. The report will be addressed to the Trust and to NHS Improvement on the basis that NHS Improvement may use it for its statutory functions.

The review should clearly establish whether, in examining the wider question of patient delay and interruptions to care in the process from call to A&E handover, on balance and in the opinion of the independent expert there has been benefit or harm for patients calling 999 or 111 during the implementation of this project. The review should provide a response to this question, reflecting and reporting on the scope specified in section (B) and providing a response to the specific points for consideration in section (A).

The independent expert should make recommendations arising from the review to address any deficiencies in the Trust's corporate governance, operational and

clinical management, operational control and reporting arrangements that may have been identified during the review. In addition, the independent expert should make recommendations arising from the review to highlight any wider learning for the system that may have been identified during the review.

The findings of this review may impact on future governance review(s), for example on clinical governance. The Trust and NHS Improvement reserve the right to share any report and underlying material from this exercise with the party or parties carrying out any such future governance review(s).

Overall question review is seeking to answer

To establish whether, in examining the wider question of patient delay and interruptions to care in the process from call to A&E handover, there has been, on balance, benefit or harm for patients calling 999 or 111 services provided by the Trust during the implementation of this project. Benefit or harm for patients is to be assessed both in terms of a) aggregate impact across the populations served by the Trust and also b) the impact for individual patients.

A. Specific points for consideration

1. During the Period, when a patient called the 111 or 999 services provided by the Trust, was the clinical or the ambulance response as effective (taking into consideration performance against national response time targets, levels of complaints and incidents) as that provided by the Trust on average in the past three years, taking into account seasonal variations in demand?

2. Did more people who called the 111 or 999 services provided by the Trust die during the Period compared to previous years and, if so, was this increase, on balance and in the independent expert's opinion, attributable to the project?

3. In addition to the cases reviewed using the SI system, were there other patients who called the 999 or 111 services provided by the Trust whose ambulance response was extensively delayed during the Period (taking into

account extreme events or unexpected incidents) compared to the average in the past three years?

4. Were ambulance response times significantly different for the Period compared to the same period in the previous year and, if so, was this change, on balance, attributable to the project?

Limitations to scope

This review will not seek to contact every case that passed through the system during the period of the project, due to the high volume of patients this would involve and the apparently small number of members of the public who have contacted the Trust, MPs and Healthwatch etc., about their experience of the project in spite of considerable media coverage. The following caveats will therefore accompany the final report:

1. Attempts will be made to identify cohorts of patients that would have been put most at risk of harm by the additional triage time introduced under the project;

2. A subset of these cohorts of patients will be selected by random sample generation to identify subjects to be contacted and interviewed to try to identify patient harm or benefit arising from the project; and

3. Patient interviews will be conducted independently through the three Healthwatch organisations covering the geographical area served by the Trust.

Timescale and deliverables

The independent expert is responsible for ensuring that this focused review is undertaken according to appropriate professional standards and in a timely fashion. On completion of fieldwork, the independent expert will provide to NHS improvement and the Trust a written report setting out in a clear, succinct and logical manner the overall conclusion, findings, recommendations, and supporting evidence gathered. The report will include an executive summary containing the

overall conclusion, key findings and recommendations for the Trust and the wider system. The review is expected to take approximately six months from commencement of the work at the end of November 2015.

As indicated above, the review's overall aim is to answer the question of whether, in examining the wider question of patient delay and interruptions to care in the process from call to A&E handover, on balance and in the opinion of the expert reviewer, there was benefit or harm for patients calling the 999 or 111 services overseen by the Trust during the period of this project. This question is to be answered bearing in mind the points made in sections (A) and (B) above.

Any report and underlying material produced shall be provided to NHS Improvement and the Trust. NHS Improvement reserves the right to use and share this material in fulfilling its statutory functions; this includes sharing it with third parties for the purpose of carrying out follow-on reviews.

Regular updates on emerging findings and hours spent on the review will be provided to NHS Improvement. The independent expert will need to provide a draft and a final report, with no more than three iterations in total.

APPENDIX 3: CALL DATA

TABLE 1: CALLS INITIALLY CATEGORISED AS RED 2

Period	NHS111 Call Priority	SECAmb - Final Call Priority								
	R2 (R3)	R1	R2	G2 30	G4 60	G4 HCP 60	G4 HCP 120	G4 HCP 240	H&T	Routine
20 - 31 Dec 2014	1958	2	1320	242	31	11	8	3	341	0
01 - 31 Jan 2015	4528	6	3043	677	71	20	8	1	702	0
01t - 24 Feb 2015	3130	1	2133	495	45	7	4	2	443	0
Total for Period	**9616**	**9**	**6496**	**1414**	**147**	**38**	**20**	**6**	**1486**	**0**
Change in Priority %	100.0%	0.1%	67.6%	14.7%	1.5%	0.4%	0.2%	0.1%	15.5%	0.0%

Table 1:   The table shows that for calls originally classified by the NHS 111 call handler as R2, 15.5% were managed by the specialist paramedics by telephone advice (hear and treat) without the need for ambulance dispatch; 67.6% remained as R2, while 0.1% were upgraded to R1 and 16.9% were downgraded to a lower priority.

TABLE 2: CALLS INITIALLY CATEGORISED AS GREEN 2

Period	Green Call Priority Green Calls (G5)	SECAmb - Final Call Priority								
		R1	R2	G2 30	G4 60	G4 HCP 60	G4 HCP 120	G4 HCP 240	H&T	Routine
20 - 31 Dec 2014	1882	0	10	1305	87	14	19	2	445	0
01 - 31 Jan 2015	5229	0	38	3477	233	53	46	6	1376	0
01t - 24 Feb 2015	3878	0	32	2658	168	31	14	2	972	1
Total for Period	**10989**	**0**	**80**	**7440**	**488**	**98**	**79**	**10**	**2793**	**1**
Change in Priority %	100.0%	0.0%	0.7%	67.7%	4.4%	0.9%	0.7%	0.1%	25.4%	0.0%

Table 2: The table shows that for calls originally classified by the NHS 111 call handler as G2, 25.4% were managed by "hear and treat", avoiding the need for ambulance dispatch.

TABLE 3: RED1 - FINAL CATEGORISATION OF CALLS DURING THE PROJECT

	NHS111 R1 Calls (R1)	R1	R2	G2 30	G4 60	G4 HCP 60	G4 HCP 120	G4 HCP 240	H&T	Routine
20 - 31 Dec 2014	51	40	7	1	1	0	0	0	2	0
01 - 31 Jan 2015	94	73	7	7	4	0	0	0	3	0
01 - 24 Feb 2015	72	54	9	6	0	0	0	0	3	0
Total for Period	217	167	23	14	5	0	0	0	8	0
Total NHS111 calls	**20822**	**176**	**6599**	**8868**	**640**	**136**	**99**	**16**	**4287**	**1**
Change in Priority %	100.0%	77.0%	10.6%	6.5%	2.3%	0.0%	0.0%	0.0%	3.7%	0.0%

Table 3:   **These calls came from the NHS 111 into the 999 emergency operations centre as Red1, were not part of the project but did meet the criteria for call back due the delays being experienced. These calls were outside the scope of the project.**

APPENDIX 4: THE WORK STREAMS

A1	Comparison of like-for-like 111 and 999 performance indicators	
A2	Comparison of like-for-like 111 and 999 mortality data	
A3	Comparison of like-for-like 111 and 999 delayed response	
A4	Comparison of like-for-like 111 and 999 SI Reviews	
B1	Random sample Red 3 patient interviews (harm assessment)	Removed
B2	Random sample Green 5 patient interviews (harm assessment)	Removed
B3	Independent review of Datix records	
B4A	Random sample re-prioritised Red 3 patient interviews (harm assessment)	Removed
B4B	Random sample re-prioritised Green 5 patient interviews (harm assessment)	Removed
C1	Collation of letters from 44 MPs (harm/enhanced safety)	
C2	Specialist Paramedic interviews	
C3	Review and triangulation with NHSE and Deloitte Reports	
C4	Collate feedback from call centre staff	
C5	Healthwatch-generated interviews with patients/callers	Removed
C6	Consult patient groups (HOSCs and CQC; harm assessment)	
C7	Consult whistleblower views (via NED, Deloitte, CQC and Monitor)	
C8	Consult CCGs Patient Safety Leads (safety issues)	
C9	Review and triangulate with Operations and Strategic Delivery Group	

APPENDIX 5: THE TRUST'S RE-TRIAGE PROJECT: CLINICAL IMPACT REVIEW - THE DETAILED ANALYSIS

SECTION 1: AIM AND SUMMARY

This appendix summarises the quantitative analysis of routinely collected call-management data provided by South East Coast Ambulance Service NHS Foundation Trust (the Trust) to help assess the 'clinical impact' of the Re-Triage Pilot Project (the 'project') undertaken between 20 December 2014 to 24 February 2015.

When calls arrived at the Trust's 999 emergency operations centres (EOCs), the project introduced a 'pause' of up to 10 or 20 minutes for those originating from NHS 111 that had an initial categorisation indicating an 8-minute or 30-minute response. This pause was to allow additional 're-triaging' by dedicated specialist paramedics deployed within EOCs during the project exclusively for this purpose. Calls made direct to 999 were not subject to re-triage.

For some calls, data were complete and showed:

- initial' and 'final' priority categorisation

- the time the call was received at the EOC, whether direct or after initial triage by NHS 111

- the time at which dispatchers alerted/allocated a response

This made it possible to compare time intervals for calls from NHS 111 with those for calls made direct to 999. It was also possible to compare responses when different numbers of re-triage staff were on duty. This varied by day of the week and hour of the day: there could be one, two or no re-triagers working exclusively on calls originating from NHS 111.

We excluded calls with missing data on arrival times, resource alert times or dispatch times. We also excluded calls where it was unclear whether they came direct to 999 or via NHS 111, or whether their initial and final categorisation had remained equivalent to an 8 or a 30-minute response.

Our analysis of the data then provided evidence that the 'pause' introduced for calls from NHS 111 is likely to have been responsible for longer 'arrival-alert/allocation' times for these calls.

Analysis of the data for calls whose 'initial' and 'final' priority remained an eight or 30 minute response (or equivalent) – after excluding calls with missing data on call arrival and/or resource alert/allocation times; and where other fields called into question either the origin of the call (i.e. whether direct to 999 EOCs or via NHS111) or whether its initial and final categorisation had remained equivalent to an eight or a 30 minute response – provided evidence that the 'pause' introduced for calls originating from NHS111 is likely to have been responsible for longer call 'arrival-alert/allocation' times for calls originating from NHS111.

Call origin:	NHS111		999 EOCs	
Call response categorisation:	8 minutes	30 minutes	8 minutes	30 minutes
Number (n)	7,047	8,404	32,149	35,400
Mean (00:00:00)	00:06:08	00:14:26	00:01:14	00:03:08
Median(00:00:00)	00:06:09	00:13:31	00:00:55	00:01:10
Lower IQR (00:00:00)	00:01:47	00:03:45	00:00:32	00:00:38
Upper IQR (00:00:00)	00:09:52	00:21:24	00:01:28	00:02:30
Maximum (00:00:00)	00:44:28	02:42:03	00:33:35	02:46:24
Minimum (00:00:00)	00:00:01	00:00:01	00:00:00	00:00:00

Table 4: 'Arrival-Alert' time intervals for calls whose 'initial' and 'final' priority

classification remained either eight or 30 minutes, originating from NHS 111 and 999 EOCs during the project

Table 4 shows that the distribution of all the call 'Arrival-Alert' time-interval data was distorted. It was more commonly situated towards the lower end of the distribution, with fewer prolonged periods at the upper end of the distribution. For these reasons the median value provided a better representation of the average 'Arrival-Alert' time than the mean value.

From the median values it is clear that during the project, and irrespective of how many staff were on duty to re-triage calls, 'Arrival-Alert' time intervals for:

(i)   calls prioritised for an 8-minute response took about 5 minutes longer (00:05:14) if they originated from NHS 111 rather than from 999

(ii)   calls prioritised for a 30-minute response took about 12 minutes longer (00:12:21) if they originated from NHS 111 rather than from 999.

Call origin:	NHS111			999 EOCs		
Specialist Paramedics on duty	**0**	**1**	**2**	**0**	**1**	**2**
Number (n)	2,805	1,922	2,320	17,104	5,462	9,583
Mean (00:00:00)	00:05:26	00:06:28	00:06:44	00:01:08	00:01:22	00:01:21
Median(00:00:00)	00:04:43	00:06:54	00:07:23	00:00:52	00:00:57	00:00:59
Lower IQR (00:00:00)	00:01:25	00:01:52	00:02:31	00:00:30	00:00:33	00:00:34
Upper IQR (00:00:00)	00:09:06	00:10:07	00:10:05	00:01:23	00:01:36	00:01:35
Maximum (00:00:00)	00:44:28	00:29:30	00:30:01	00:33:35	00:24:22	00:27:51

Minimum (00:00:00)	00:00:03	00:00:06	00:00:01	00:00:00	00:00:00	00:00:00

Table 5: 'Arrival-Alert' time intervals for calls with 'initial' and 'final' priority classifications of 8 minutes, originating from NHS111 and 999 EOCs, disaggregated by the numbers of re-triage staff on duty

Table 5 shows that for calls prioritised for an 8-minute response, 'Arrival-Alert' time intervals tended to be longer when more re-triage staff were on duty, regardless of whether the calls originated from NHS 111 or 999. This is likely to reflect the fact that more staff were on duty to re-triage calls originating from NHS 111 during periods with higher call volumes per hour.

Table 5 also shows that when no re-triage staff were on duty, 4:43 minutes of the approximate 7-minute interval (00:06:54 and 00:07:23) – observed when one or two staff re-triaged NHS 111 calls – appeared unrelated to these employees' activities. This indicates an 'excess' interval associated with re-triage of approximately 2 minutes for these NHS 111 calls, compared to about 1 minute for calls from 999, on which no project-related re-triage took place.

Call origin:	NHS111			999 EOCs		
Specialist Paramedics on duty	0	1	2	0	1	2
Number (n)	3,408	2,288	2,708	18,698	5,924	10,778
Mean (00:00:00)	00:12:57	00:15:04	00:15:46	00:02:44	00:03:51	00:03:26
Median(00:00:00)	00:11:02	00:15:32	00:15:48	00:01:04	00:01:18	00:01:17
Lower IQR (00:00:00)	00:03:12	00:03:15	00:05:20	00:00:35	00:00:40	00:00:42
Upper IQR (00:00:00)	00:20:33	00:22:13	00:22:13	00:02:09	00:03:01	00:02:56
Maximum (00:00:00)	02:42:03	02:17:17	02:20:27	01:49:07	02:46:24	02:02:36

Minimum (00:00:00)	00:00:03	00:00:01	00:00:02	00:00:01	00:00:02	00:00:00

Table 6: 'Arrival-Alert' time intervals for calls with 'initial' and 'final' priority classifications of 30 minutes, originating from NHS111 and 999 EOCs during the project, disaggregated by the number of specialist paramedics on duty

Table 6 shows that for calls prioritised for a 30-minute response, 'Arrival-Alert' time intervals tended to be longer when more re-triage staff were on duty, regardless of whether the calls originated from NHS 111 or 999. Again, this is likely to reflect the higher call volumes per hour during the periods in which more staff were on duty to re-triage calls originating from NHS 111.

Table 6 also shows that when no staff were on duty, 11:02 minutes of the approximate 16-minute interval (00:15:32 and 00:15:48) – observed when one or two staff were re-triaging calls from NHS 111 – appeared unrelated to the activities of these staff. This indicates an 'excess' interval associated with re-triage of approximately 5 minutes for these NHS 111 calls compared to about 1 minute for calls from 999, on which no project-related re-triage activity took place.

SECTION 2: INTRODUCTION

2.1 Scope of the quantitative data-derived analysis

The scope of the analysis for this component of the review draws on the "Scope of Service – Impact Review" document approved by NHS Improvement on 3 February 2016, which detailed 18 separate strands of work to be undertaken (see Appendix 2). Nine of these strands relate to or depend on quantitative analysis of routinely collected call-management data:

A1	Comparison of like-for-like 111 and 999 performance indicators
A2	Comparison of like-for-like 111 and 999 mortality data
A3	Comparison of like-for-like 111 and 999 delayed response
A4	Comparison of like-for-like 111 and 999 Serious Incident Reviews
B1	Random sample Red 3 patient interviews (harm assessment)
B2	Random sample Green 5 patient interviews (harm assessment)
B3	Independent review of Datix records
B4A	Random sample re-prioritised Red 3 patient interviews (harm assessment)
B4B	Random sample re-prioritised Green 5 patient interviews (harm assessment)

This report will not address the three strands (A1, A2 and A4) for which the data required comprises dedicated assessments (of performance, mortality and Serious Incidents) separate from the routinely collected call-management datasets examined here.

The Trust provided three datasets relating to the period of the project and two comparison periods. One dataset covered the same period during the year preceding the project: 20 December 2013 to 24 February 2014; the second covered the same number of days immediately preceding the project: 15 October 2014 to 19 December 2014).

A summary of the data provided in each of these three datasets is provided below:

Dataset 1 (Project):

n=184,140 calls originating from NHS 111 and 999

n=37,903 999 calls with 'initial' and 'final' priority = R2

n=9,488 111 calls with 'initial' and 'final' priority = R2 or Red 3

Initial priority call categorisation: was available for 999 calls only

Final priority' call categorisation: was available for both 111 and 999 calls

Dataset 2 (Project-1year):

n=164,336 calls originating from NHS 111 and 999

n=35,054 999 calls with 'initial' and 'final' priority = R2

n=8,884 111 calls with 'final' priority = R2

Initial priority call categorisation: was available for 999 calls only

Final priority' call categorisation: was available for both 111 and 999 calls

Dataset 3 (Period B4 Project):

n=176,129 calls originating from NHS 111 and 999

n=35,322 999 calls with 'initial' and 'final' priority = R2

n=8,894 111 calls with 'final' priority = R2

Initial priority call categorisation: was available for 999 calls only

Final priority' call categorisation: was available for both 111 and 999 calls

Note: given the lack of data on how the 'initial priority' of NHS 111 calls in Datasets 2 and 3 were categorised, it is not possible to analyse them on a like-for-like basis with those calls initially prioritised for an 8 or 30-minute response during the project, and whose final priority classification remained at 8 and 30 minutes.

For the period of the project (Dataset 1), the data contains information on the 'initial' and 'final' priority classification of calls from both NHS 111 and 999, from which it is possible to identify calls that remained classified as 'Red 2' or 'Green 5'.

Unfortunately, as noted above, for the comparison periods before the project, 'initial' priority classifications are only available for calls originating from 999.

All three datasets contain the time recorded when the calls arrived (so-called 'T_0') at the EOCs (either from NHS 111 or direct to 999), and the time recorded when dispatchers alerted a response. The interval between these two times provides a measure of how long dispatchers took to alert/allocate a response after the calls arrived at the EOC (calls originating from NHS 111 arrived with an 'initial' priority classification following triage by NHS 111; calls originating from 999 required triage by call handlers in the EOC).

Finally, the project involved specialist paramedics across all three EOCs working a roster to ensure staff were available to re-triage calls from NHS 111 when call volumes were likely to be higher.

- On Saturdays and Sundays, this involved placing one specialist paramedic on duty between 8am and 4pm; two specialist paramedics on duty between 4pm and 8pm; and one specialist paramedic on duty between 8pm and midnight.

- On weekdays this involved two specialist paramedics on duty between 4pm and midnight.

- At all other times (midnight to 8am at weekends; and midnight to 4pm on weekdays), no specialist paramedics were scheduled to be on duty.

These duty shift patterns permitted a comparison of 'T_0 -T_{Alert}' intervals during periods where zero, one and two specialist paramedics were on duty.

WEEK	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY	HOURS
1	RD	RD	16:00 - 00:00	16:00 - 00:00	16:00 - 00:00	RD	RD	22.5
2	16:00 - 00:00	16:00 - 00:00	RD	RD	RD	12:00 - 00:00	12:00 - 00:00	38
3	RD	RD	16:00 - 00:00	16:00 - 00:00	16:00 - 00:00	RD	RD	22.5
4	16:00 - 00:00	16:00 - 00:00	RD	Governance	RD	08:00 - 20:00	08:00 - 20:00	43.5

SECTION 3: DATA PREPARATION

3.1 Calls during the project

The data provided for the period of the project comprised a spreadsheet containing 184,140 calls and 14 separate variables, together with descriptions of each of these variables.

Variables	Definition
IncidentID	Identification of the incident (primary key)
Incident No	CAD Incident No
Dateofincident	Date of the incident
Problem	Variable to differentiate 999 and 111 calls. If it's a 111 call, says "NHS 111", otherwise 999
Initial_priority	Initial code. First priority of incident. For 111 call is the code assigned during the 111 call.
Priority	Final code. Priority of incident when the first vehicle arrives on the scene.
time_enteredqueue_R3	Time the call entered the stack as R3/G5
time_changed_from_R3	Time "Priority" is set: i.e. time when it changed to final priority
Time_First_Unit_Alerted	First vehicle assigned
R3 Clockstart of incident	minimum of (Time entered queue+10 minutes, time_changed + 1min,time_first_unit_alerted)
G5 Clockstart of incident	minimum of (Time entered queue+30 minutes, time_changed + 1min,time_first_unit_alerted)
OriginalCallConnect (T0)	Time when call hits the switch
Original Clockstart of incident	For R2, G2 clockstart will be minimum of callconnect+60, Time_first_unit_alerted, Firstdxtimein(not available).
	For R1 and other priorities clockstart will be the callconnect time.
time_first_unit_on_scene	First resource at the scene
Call Source	Source of the incident

3.1.1 Calls originating from NHS 111

Of the 184,140 calls included in the spreadsheet, 42,093 were identifiable as originating from NHS 111.

This total was arrived at from a number of the variables/fields:

- 31,593 from a 'Problem' coding of 'NHS111'

- 6,249 from a 'Problem' coding of 'NHS111 (Manual Entry)'

- 183 from an 'initial_priority (From Cad)' coding of '111 RED 3'

- 293 from an 'initial_priority (From Cad)' coding of '111 GREEN 5'

- 3,602 from a 'call_source' coding of 'NHS 111'

- 56 from a 'Cancel_Reason' coding of '23 - 111 CB/Downgrade to Green'

- 49 from a 'Cancel_Reason' coding of '24 - 111 CB/Downgrade to H&T'

- 6 from a 'Cancel_Reason' coding of '25 - 111 CB/UPGRADE TO RED'

- 60 from a 'Cancel_Reason' coding of '26 - 111 CB/no change'

- 2 from a 'FinalPriority' coding of 'R3 111'.

3.1.1.1 NHS 111 Calls with a Red 2 (or equivalent) initial priority

Of the 42,093 calls identified as originating from NHS 111, 10,855 were identified as having an initial categorisation of R2 (or equivalent).

This total was arrived at from a number of the variables/fields:

- 920 from an 'initial_priority (From Cad)' coding of '03 CAT A RED 2'

- 9,935 from an 'initial_priority (From Cad)' coding of '111 RED 3'.

3.1.1.2 NHS 111 Calls with a Red 2 (or equivalent) initial and final priority

Of the 10,855 calls identified as originating from NHS 111 with an R2 (or equivalent) initial priority, 7,370 were identified as having a final categorisation of R2 (or equivalent).

This total was arrived at from a number of the variables/fields:

- 7,367 from a 'FinalPriority' coding of 'Cat A 8 RED 2'

- 1 from a 'FinalPriority' coding of 'PreAlert' where the 'CancelReason' was coded as '19 - CALL BACK-RED-NO CHANGE'

- 2 from a 'FinalPriority' coding of 'PreAlert' where the 'CancelReason' was coded as '26 - 111 CB/no change'.

3.1.1.3 NHS 111 Calls with a Red 2 (or equivalent) initial and final priority and no missing or contradictory data

Of the 7,370 calls identified as originating from NHS 111 with an R2 (or equivalent) initial priority, and a final categorisation of R2 (or equivalent), 7,067 remained after excluding calls with contradictory 'CancelReason' classifications, and only 7,047 after excluding 18 calls with missing or contradictory data (17 with missing data on one of the two key analytical fields/variables, T_{Alert}; 1 where T_0 was later than T_{Alert}).

This total was arrived at from a number of the variables/fields by removing:

- 8 with a 'CancelReason' coding of '02 - CANCEL BEFORE ARRIVAL'

- 7 with a 'CancelReason' coding of '05 - CANCELLED BY CALLER'

- 125 with a 'CancelReason' coding of '06 – DUPLICATE CALL'

- 9 with a 'CancelReason' coding of '08 – INFORMATION ONLY'

- 14 with a 'CancelReason' coding of '09 – PASSED TO OTHER AMB/SERV' (presumed to therefore lack an appropriate T_{Alert} value)

- 6 with a 'CancelReason' coding of '10 – TEST/TRAINING CALL'

- 39 with a 'CancelReason' coding of '16 - HEAR and TREAT'

- 11 with a 'CancelReason' coding of '18 - CALL BACK-RED-DOWNGRADE'

- 43 with a 'CancelReason' coding of '23 - 111 CB/Downgrade to Green'

- 37 with a 'CancelReason' coding of '24 - 111 CB/Downgrade to H&T'

- 2 with a 'CancelReason' coding of '25 - 111 CB/UPGRADE TO RED' (presumed to indicate upgrade to Red 1).

3.1.1.4 NHS 111 Calls with a Green 5 (or equivalent) initial priority

Of the 42,093 calls identified as originating from NHS 111, 13,472 were identified as having an initial categorisation of G2 (or equivalent).

This total was arrived at from a number of the variables/fields:

- 11,949 from an 'initial_priority (From Cad)' coding of '111 GREEN 5'

- 1,361 from an 'initial_priority (From Cad)' coding of '06 CAT C 30 Emrg Treat/Transp'

- 4 from an 'initial_priority (From Cad)' coding of '07 CAT C 30 Priority Trans'

- 158 from an 'initial_priority (From Cad)' coding of '08 CAT C 30 HCP'.

3.1.1.5 NHS 111 Calls with a Green 5 (or equivalent) initial and final priority

Of the 13,472 calls identified as originating from NHS 111 with a G2 (or equivalent) initial priority, 9,048 were identified as having a final categorisation of G2 (or equivalent).

This total was arrived at from a number of the variables/fields:

- 8,824 from a 'FinalPriority' coding of 'CAT C 30 Emrg Treat/Transp'

- 106 from a 'FinalPriority' coding of 'CAT C 30 HCP'

- 116 from a 'FinalPriority' coding of 'CAT C 30 Priority Trans'

- 2 from a 'FinalPriority' coding of 'G5 111'.

3.1.1.6 NHS111 Calls with a Green 5 (or equivalent) initial and final priority and no missing or contradictory data

Of the 9,048 calls identified as originating from NHS 111 with a G2 (or equivalent) initial priority, and a final categorisation of G2 (or equivalent), 8,459 remained after excluding calls with contradictory 'CancelReason' classifications, and only 8,404 after excluding 55 calls with missing data on T_{Alert}.

This total was arrived at from a number of the variables/fields by removing:

- 9 with a 'CancelReason' coding of '02 - CANCEL BEFORE ARRIVAL'

- 19 with a 'CancelReason' coding of '05 - CANCELLED BY CALLER'

- 322 with a 'CancelReason' coding of '06 – DUPLICATE CALL'

- 17 with a 'CancelReason' coding of '08 – INFORMATION ONLY'

- 18 with a 'CancelReason' coding of '09 – PASSED TO OTHER AMB/SERV' (presumed to therefore lack an appropriate T_{Alert} value)

- 2 with a 'CancelReason' coding of '10 – TEST/TRAINING CALL'

- 106 with a 'CancelReason' coding of '16 - HEAR and TREAT'

- 1 with a 'CancelReason' coding of '18 - CALL BACK-RED-DOWNGRADE'

- 1 with a 'CancelReason' coding of '19 - CALL BACK-RED-NO CHANGE'

- 20 with a 'CancelReason' coding of '20 – CALL BACK-GREEN-UPGRADE' (presumably from Green 5 to a <30 minute response)

- 3 with a 'CancelReason' coding of '22 - CALL BACK-GREEN -TO H&T'

- 48 with a 'CancelReason' coding of '24 - 111 CB/Downgrade to H&T'

- 18 with a 'CancelReason' coding of '25 - 111 CB/UPGRADE TO RED'

- 3 with a 'CancelReason' coding of 'DUPLICATE INCIDENT'

- 2 with a 'CancelReason' coding that was missing/blank.

3.1.2 Calls originating from 999

Of the 184,140 calls included in the spreadsheet, 142,047 were identifiable as originating from 999 EOCs.

This total was arrived at by subtracting the 42,093 attributable to NHS 111 (see 3.1.1, above) from the total number of calls (184,140).

3.1.2.1 999 calls with an R2 initial priority

Of the 142,047 calls identified as originating from 999, 42,726 were identified as having an initial categorisation of R2.

3.1.2.2 999 calls with an R2 initial and final priority

Of the 42,726 calls identified as originating from 999 with an R2 initial priority, 33,552 were identified as having a final categorisation of R2. This total was arrived at from a 'FinalPriority' coding of 'CAT A RED 2'.

3.1.2.3 999 calls with an R2 initial and final priority and no contradictory or missing data

Of the 33,552 calls identified as originating from 999 with an R2 initial priority, and a final categorisation of R2, 32,171 remained after excluding calls with contradictory 'CancelReason' classifications, and only 32,149 after excluding 12 calls with missing or contradictory data (19 with missing data on the one of the two key analytical fields/variables, T_{Alert}; 3 where T_0 was later than T_{Alert}).

This total was arrived at from a number of the variables/fields by removing:

- 21 with a 'CancelReason' coding of '02 - CANCEL BEFORE ARRIVAL';

- 4 with a 'CancelReason' coding of '04 – ABANDONED/HOAX CALL';

- 12 with a 'CancelReason' coding of '05 - CANCELLED BY CALLER';

- 1,054 with a 'CancelReason' coding of '06 – DUPLICATE CALL';

- 15 with a 'CancelReason' coding of '08 – INFORMATION ONLY';

- 229 with a 'CancelReason' coding of '09 – PASSED TO OTHER AMB/SERV' (presumed to therefore lack an appropriate T_{Alert} value);

- 30 with a 'CancelReason' coding of '10 – TEST/TRAINING CALL';

- 8 with a 'CancelReason' coding of '16 - HEAR and TREAT';

- 4 with a 'CancelReason' coding of '20 - CALL BACK-GREEN-UPGRADE'; and

- 4 with a 'CancelReason' coding of 'DUPLICATE INCIDENT'.

3.1.2.4 999 calls with a 30-minute initial priority equivalent to Green 5

Of the 142,047 calls identified as originating from 999, 48,319 were identified as having a 30 minute initial categorisation equivalent to G2.

This total was arrived at from a number of the variables/fields:

- 42,101 from an 'initial_priority (From Cad)' coding of '06 CAT C 30 Emrg Treat/Transp' ;

- 12 from an 'initial_priority (From Cad)' coding of '07 CAT C 30 Priority Trans';

- 6,165 from an 'initial_priority (From Cad)' coding of '08 CAT C 30 HCP'; and

- 41 from an 'initial_priority (From Cad)' coding of '31 Clinician 30'.

3.1.2.5 999 calls with a 30-minute initial and final priority equivalent to Green 5

Of the 48,319 calls identified as originating from 999 with a 30-minute initial categorisation equivalent to G2, 38,570 were identified as also having a 30-minute final categorisation equivalent to G2.

This total was arrived at from a number of the variables/fields:

- 38,356 from a 'FinalPriority' coding of 'CAT C 30 Emrg Treat/Transp';

- 193 from a 'FinalPriority' coding of 'CAT C 30 HCP'; and

- 17 from a 'FinalPriority' coding of 'CAT C 30 Priority Trans'; and

- 4 from a 'FinalPriority' coding of 'Clinician 30'.

3.1.2.6 999 calls with a 30-minute initial and final priority equivalent to Green 5, and no contradictory or missing data

Of the 38,570 calls identified as originating from 999 with a 30-minute initial categorisation equivalent to G2 and a 30-minute final categorisation equivalent to G2, 35,418 remained after excluding calls with contradictory 'CancelReason' classifications, and only 35,400 after excluding 18 calls with missing or contradictory data (12 with missing data on the one of the two key analytical fields/variables, T_{Alert}; 6 where T_0 was later than T_{Alert}).

This total was arrived at from a number of the variables/fields by removing:

- 164 with a 'CancelReason' coding of '02 - CANCEL BEFORE ARRIVAL'

- 106 with a 'CancelReason' coding of '04 – ABANDONED/HOAX CALL'

- 141 with a 'CancelReason' coding of '05 - CANCELLED BY CALLER'

- 2,218 with a 'CancelReason' coding of '06 – DUPLICATE CALL'

- 2 with a 'CancelReason' coding of 'NEARER RESPONSE'

- 41 with a 'CancelReason' coding of '08 – INFORMATION ONLY'

- 374 with a 'CancelReason' coding of '09 – PASSED TO OTHER AMB/SERV' (presumed to therefore lack an appropriate T_{Alert} value)

- 32 with a 'CancelReason' coding of '10 – TEST/TRAINING CALL'

- 43 with a 'CancelReason' coding of '16 - HEAR and TREAT'

- 6 with a 'CancelReason' coding of '18 - CALL BACK-RED-DOWNGRADE'

- 1 with a 'CancelReason' coding of '19 - CALL BACK-RED-NO CHANGE'

- 6 with a 'CancelReason' coding of '20 - CALL BACK-GREEN-UPGRADE'

- 3 with a 'CancelReason' coding of '22 – CALL BACK-GREEN-TO H&T'

- 13 with a 'CancelReason' coding of 'DUPLICATE INCIDENT'

- 2 with a 'CancelReason' coding that was missing/blank.

SECTION 4: ANALYSES

4.1 Data quality

It is clear from the preceding section that substantial data is missing for each of the variables required for the analyses that follow. For some calls this includes data missing on 'initial' and 'final' priority classification, and on the time calls arrived at 999 EOCs ('T_0') and/or the time a response was alerted/allocated by dispatchers ('T_{Alert}').

The datasets include additional fields/variables that may contain contradictory information on the status, priority and response allocated to a substantial number of calls with 'initial' and 'final' priority classifications suggesting an 8-minute (i.e. R2/R3) or 30-minute (i.e. G2) response. This includes 'duplicate' and 'cancelled' calls, and calls where the 'Cancel Reason' field indicated that non-ambulance responses (such as 'hear-and-treat') had been allocated.

The analyses that follow have sought to eliminate these potential sources of error. They exclude calls where missing data on the time the call arrived at an EOC (i.e. 'T_0') and/or the time dispatchers alerted/allocated a response (i.e. 'T_{Alert}') meant it was not possible to calculate the interval between these.

4.2 Results

4.2.1   A3 - Comparison of like-for-like 111 and 999 delayed response

We compare below the time difference between 'T_0' and 'T_{Alert}', which enables us to assess the time taken for calls from NHS 111 and 999 to be allocated a response. It is only possible to do this with data from the period of the project, as that was the only period in which both initial and final categorisation of calls from both NHS 111 and 999 were available.

Analysis of this data for calls whose 'initial' and 'final' priority remained R2 or G2 (or equivalent) – after excluding calls with missing data – provided evidence that the 'pause' introduced for calls from NHS 111 is likely to have been responsible for longer call 'arrival-alert' time intervals for these calls.

Call origin:	NHS 111		999 EOCs	
Call response categorisation:	8 minutes	30 minutes	8 minutes	30 minutes
Number (n)	7,047	8,404	32,149	35,400
Mean (00:00:00)	00:06:08	00:14:26	00:01:14	00:03:08
Median(00:00:00)	00:06:09	00:13:31	00:00:55	00:01:10
Lower IQR (00:00:00)	00:01:47	00:03:45	00:00:32	00:00:38
Upper IQR (00:00:00)	00:09:52	00:21:24	00:01:28	00:02:30
Maximum (00:00:00)	00:44:28	02:42:03	00:33:35	02:46:24
Minimum (00:00:00)	00:00:01	00:00:01	00:00:00	00:00:00

Table 7: 'Arrival-Alert' time intervals for calls originating from NHS111 and 999 during the project

Table 7 shows the distribution of the 'Arrival-Alert' time-interval data was highly distorted (that is, more commonly situated towards the lower end of the distribution, with fewer prolonged periods at the upper end). For this reasons the median value provides a better representation of the average 'Arrival-Alert' time than the mean value.

Call origin:	NHS 111			999 EOCs		
Specialist Paramedics on duty	0	1	2	0	1	2
Number (n)	2,805	1,922	2,320	17,104	5,462	9,583
Mean (00:00:00)	00:05:26	00:06:28	00:06:44	00:01:08	00:01:22	00:01:21
Median(00:00:00)	00:04:43	00:06:54	00:07:23	00:00:52	00:00:57	00:00:59
Lower IQR (00:00:00)	00:01:25	00:01:52	00:02:31	00:00:30	00:00:33	00:00:34
Upper IQR (00:00:00)	00:09:06	00:10:07	00:10:05	00:01:23	00:01:36	00:01:35
Maximum (00:00:00)	00:44:28	00:29:30	00:30:01	00:33:35	00:24:22	00:27:51
Minimum (00:00:00)	00:00:03	00:00:06	00:00:01	00:00:00	00:00:00	00:00:00

Table 8: 'Arrival-Alert' time intervals for calls prioritised for an 8-minute response originating from NHS 111 and 999 during the project, disaggregated by numbers of re-triage staff on duty

Table 8 shows that for calls prioritised for an 8-minute response, 'Arrival-Alert' time intervals when zero, one and two re-triage staff were on duty tended to be longer the more re-triage staff were on duty regardless of whether the calls originated from NHS 111 or 999. This is likely to reflect the fact that more staff were on duty to re-triage calls from NHS 111 during periods with higher call volumes per hour.

Table 8 also shows that when no re-triage staff were on duty, 4:43 minutes of the approximate 7-minute interval (00:06:54 and 00:07:23) – observed when one or two staff were on duty to re-triage calls from NHS 111 – appeared unrelated to the activities of these staff. This indicates an 'excess' interval of approximately 2 minutes for these calls compared to about 1 minute for calls from 999 (on which no project-related re-triage activity took place).

Call origin:	NHS 111			999 EOCs		
Specialist Paramedics on duty	0	1	2	0	1	2
Number (n)	3,408	2,288	2,708	18,698	5,924	10,778
Mean (00:00:00)	00:12:57	00:15:04	00:15:46	00:02:44	00:03:51	00:03:26
Median(00:00:00)	00:11:02	00:15:32	00:15:48	00:01:04	00:01:18	00:01:17
Lower IQR (00:00:00)	00:03:12	00:03:15	00:05:20	00:00:35	00:00:40	00:00:42
Upper IQR (00:00:00)	00:20:33	00:22:13	00:22:13	00:02:09	00:03:01	00:02:56
Maximum (00:00:00)	02:42:03	02:17:17	02:20:27	01:49:07	02:46:24	02:02:36
Minimum (00:00:00)	00:00:03	00:00:01	00:00:02	00:00:01	00:00:02	00:00:00

Table 9: 'Arrival-Alert' time intervals for calls prioritised for a 30-minute response originating from NHS111 and 999 during the project, disaggregated by numbers of re-triage staff on duty

Table 9 shows that for calls prioritised for a 30-minute response, 'Arrival-Alert' time intervals tended to be longer the more re-triage staff were on duty, regardless of whether the calls originated from NHS 111 or 999. This is likely to reflect the fact that more staff were on duty to re-triage calls from NHS 111 during periods with higher call volumes per hour.

Table 9 also shows that when no staff were on duty, 11:02 minutes of the approximate 16-minute interval (00:15:32 and 00:15:48) – observed when one or two staff were on duty to re-triage calls from NHS 111 – appeared unrelated to the activities of these staff. This indicates an 'excess' interval of approximately 5 minutes for these calls compared to about 1 minute for calls from 999 (on which no project-related re-triage activity took place).

APPENDIX 6: SUMMARY OF THE SERIOUS INCIDENTS

Seven Serious Incidents were identified that involved patients whose calls were affected by the project.

Identifying code of the incident	
2015/4127	**Circumstances:** A 111 call was made that was given a categorisation of R2 and transferred to the 999 queue at 0142. It was not re-triaged and an ambulance was allocated at 0152, although it did not respond to the call until 0157, arriving with the patient at 0217. A relative had been providing CPR alone until the ambulance arrived. The patient died. **Conclusion:** NHS England concluded that this patient could have benefited from the project's re-triage offered to other patients, because the call could have been upgraded to R1 (as nine other patients were). Sadly, it is likely that whatever the categorisation, this patient would not have survived.

2015/6145	**Circumstances:** A 111 call was made on behalf of a patient who had unclear symptoms. The call was categorised as R2, sent to the EOC and placed in the queue at 1002. At 1011 it was (re)triaged and categorised as R2 again. An ambulance was allocated and arrived with the patient at 1018. The ambulance crew seems to have failed to identify the severity of the patient's condition (which was sepsis) and left the patient at home. A second call was made, which resulted in advice to contact the patient's GP within three working days. Later, a third 111 call was received, categorised as R2 and transferred to the 999 services at 2011. A clinical supervisor called back at 2020, and was told the patient had died. **Conclusion:** Sepsis is notoriously difficult to identify and on this occasion the crew did not recognise it. However, this outcome was not related in any way to the project.
2015/6674	**Circumstances:** A 111 call was made on the patient's behalf, categorised as R2 and transferred to the 999 service at 0153. At 0156 a clinical member of 111 staff contacted the EOC about the same patient, saying that the patient had breathing difficulties. This call was placed in the queue and not re-triaged. An ambulance was dispatched at 0201. The patient was not taken to hospital at this time. Another 111 call was made later. It was categorised as R2 and transferred to the 999 service at 2159. At 2203 an attempt was made to re-triage the call, which could not be done as the 111 service was still on the phone to the patient. Three minutes later, at 2206 the specialist paramedic did manage to contact the caller and was told the patient had collapsed. CPR advice was given over the phone. An ambulance arrived at 2208. The patient subsequently died. **Conclusion:** This patient was receiving end-of-life care. The project made no difference to the clinical outcome.

2015/7632	**Circumstances:** A 111 call was made on behalf of a 91-year old woman who was a care home resident. Her symptoms were agonal breathing. The call was triaged as R2 and passed to the 999 service at 2347. The call was re-triaged at 2351 and the specialist paramedic stayed on the phone with the care home staff giving advice on CPR until the ambulance crew arrived at 2357. The patient died. **Conclusion:** This was a very elderly patient and the re-triage meant that CPR advice was provided. However, regardless of this, the patient died and the project made no difference to this outcome.
2015/11353	**Circumstances:** A 111 call was received for a patient who had severe breathing difficulties. It was categorised as R3. It was passed to 999 at 1022 and re-triaged at 1028. An R2 categorisation was agreed. A single responder vehicle was sent at 1029. At 1034 the EOC paramedic practitioner contacted the patient, who was struggling to talk. At 1042 they were given coaching for breathing and at 1046 they went into arrest. The call was re-categorised as R1. The crew arrived at 1051 and confirmed that the patient could not be revived. **Conclusions:** In the six-minute delay between 1022 and 1028, while the call was held in the queue allowed by the project, an ambulance that had been available was allocated to another call. Also the paramedic practitioner may have failed to recognise the seriousness of the breathing difficulties over the phone. However, neither of these circumstances will have made a difference to the outcome for this patient.

2015/11488	**Circumstances:** A 111 call was received for a patient with symptoms suggesting a stroke, which should have excluded the call from the project. This seems not to have happened because no mention of stroke was made in the "free text" box on the call details screen. It was categorised as R2 and sent to 999 at 0816. It was upgraded back to R2 categorisation at 0827, 11 minutes after the call was received, with no further triage. An ambulance was dispatched at 0827 and arrived on scene at 0843. **Conclusion:** Stroke patients should receive an ambulance response within 8 minutes because some strokes can be treated by thrombolysis, which should be started as soon as possible. But not all stroke patients are eligible for this treatment, and this patient was not. The target for treating all stroke patients in hospital is that the treatment should be started within four hours, which it did for this patient. It is unlikely that the delay contributed to an adverse outcome for this patient.
2015/13062	**Circumstances:** At 2058 a 111 call was made for an 8-day old baby who had vomited. It was categorised as G2, but the caller declined an ambulance. The call was transferred to a clinician within the 111 service, who upgraded it to R2 and transferred it to the 999 service at 2118. The call was put in the queue for the project even though the protocol for the project said that a call that had been re-triaged by a 111 *clinician* should not be held in the queue. The 111 service remained on the phone with the caller and at 2126 told the 999 service that they were still on the phone. An ambulance was dispatched at 2127. Minutes of a CCG Serious Incident meeting on 18 June 2015 state that the child made a full recovery. **Conclusion:** The protocol for the project meant that this patient should not have been held in the queue. By remaining on the line, NHS 111 clinicians also did not follow protocol. There is no evidence of harm for this patient, although it is clear that protocol was not followed.

APPENDIX 7: SUMMERISED INFORMATION FROM THE TRUST'S "DATIX" SYSTEM

The following are records of all incidents that relate, however tenuously, to the project and indicate staff concerns and issues. These 25 incidents may have given rise to newspapers mistakenly have referring to "25 deaths" attributable to the project.

W12112	Patient safety incident: Clinical	20-12-14	Raising concern about leaving R2 calls queuing for up to 10 minutes.
W12114	Staff issues and grievances	20-12-14	Concern that staff were insufficiently prepared for managing the new R3 system. Resulted in a significant period where staff were being trained in the new process, which led to further delays in allocating resources.
W12201	Patient safety incident: Clinical	23-12-14	Concern about information from 111 and delayed callback for paediatric calls.
W12229	Infection control incident	24-12-14	Exposure to flu virus. No warning of incident: incident passed as 111 call generally unwell. So no mask worn to incident. Now have influenza symptoms myself. Aches, Pyrexia/Fever. Cough. Vaccinated against flu, by SECAMB jab. Administered by [identifying details removed], approx. one month ago.
W12238	Patient safety incident: Clinical	25-12-14	When I answered the call and asked for a location the caller was screaming the address, I was not able to understand the address and asked the caller to slow down so that I could understand the address, he continued shouting, I asked him again to stop shouting, he then shouted obscene abuse and I cleared the line.

W12434	Issues concerning use of resources	25-12-14	Concern raised about delayed response to a stroke patient from a number of staff indicated they should have been allocated earlier. There was also concern about trust issues between EOC and 111.
W12250	Delay in service provision (where the delay is primary issue)	26-12-14	Reported confusion around cases where clinicians had duplicated the call and Team Leaders were closing multiple duplicate cases.
W12257	Patient safety incident: Clinical	26-12-14	Concerns about patients who refuse to attend hospital and staff responses when patient calls again.
W12274	Patient safety incident: Clinical	27-12-14	Concerns about delays at times of multiple calls and high demand where relatives are confused and distressed.
W12276	Patient safety incident: Clinical	27-12-14	Concerns about 111 calls, a single responder when the call was closed down and the patient had to call again for a new crew to be assigned.
W12282	Equipment failure or issues (Where patient / treatment unaffected)	28-12-14	Concern about missing equipment and equipment failures.
W12489	Patient safety incident: Clinical	29-12-14	Concern about delay in ambulance assignment to allow for our assessment.
W12477	Issues concerning use of resources	03-01-15	Patient calling 111 for a GP out-of-hours appointment was inappropriately allocated an ambulance. Crew concern: use of resources when no clinical intervention required.

W12478	Issues concerning use of resources	03-01-15	Crew reported that on arrival at scene parents of a child were upset that a 999 ambulance had been dispatched. Further concern that this was a response involving emergency procedures on wet roads when there was considerable pressure on resources.
W12536	Delay in service provision (where the delay is primary issue)	03-01-15	Concern that 111 passed the incident without confirmed location, leading to 35-minute delay once the crew arrived on scene.
W12484	Patient safety incident: Clinical	04-01-15	Concern about confusion between 111 and 999 call operators not following protocols, creating delay in response.
W12499	Delay in service provision (where the delay is primary issue)	05-01-15	Concern about incorrect categorisation of call.
W12635	Staff concerns	08-01-15	Concern about lack of clinical information from 111.
W13707	Delay in service provision (where the delay is primary issue)	10-01-15	Concern about organising appropriate response for a frequent caller.
W12900	Issues concerning use of resources	15-01-15	Concern about delay in arriving at disposition through the 111 system in obtaining information from relatives on the phone.
W13348	Patient safety incident: Clinical	17-01-15	Healthcare assistant in 111 unhappy about the level of clinical support to assist the call.
W13394	Issues concerning use of resources	19-01-15	Crew reported an inappropriate Red call for a patient who was checking whether the out-of-hours service was calling back. This also resulted in significant shift overrun for the crew.

W13108	Patient safety incident: Clinical	22-01-15	Concern about ambulance delays for a stroke patient (reported as a Serious Incident)
W13304	Patient safety incident: Clinical	28-01-15	Concern about protocols followed by 111 service and identification of severity of symptoms.
W13758	Patient safety incident: Clinical	10-02-15	Concern about ambulance delay for re-triage.

APPENDIX 8: CONTACT WITH EXTERNAL STAKEHOLDERS (as at December 2015)

1. Introduction

1.1. After NHS Improvement announced its regulatory action against the Trust and subsequent media coverage, a programme of stakeholder engagement and external communication was implemented. This included a request for any public concerns/queries to be shared with the Trust.

1.2. This Appendix gives details of the programme and feedback received up to December 2015.

2. Trust website

2.1. On 6 November 2015, the notice below was put on the front page of the Trust's website – www.secamb.nhs.uk:

With the recent public attention on our services, if you have any queries or concerns about our 999, 111 or PTS services, please remember that our Patient Advice & Liaison Service (PALS) team is here to help you.

Contact the team on 0300 1239 242, between 11am and 3pm, Monday to Friday, or email pet@secamb.nhs.uk.

Further details can be found on our contact us page.

2.2. It directed queries to the Patient Advocacy Liaison team, and details of responses can be found below.

2.3. The website also contains the generic email address – enquiries@secamb.nhs.uk – as a single contact point for any external queries. This email address is monitored by the Trust's Communications Team and, on average, about a dozen queries are received each day, on a

wide range of issues. No patient concerns relating to R3/G5 have been received at the enquiries email address.

3. Patient Experience Team

3.1.   The Trust's Patient Experience Team is responsible for receiving and responding to all of the informal and formal complaints sent to the Trust, as well as compliments.

3.2.   Following discussions with her team and review of the complaints database, the Trust's Patient Experience Lead confirmed *"that the Trust has received no complaints raised in the last two months that pertain directly to the Red 3 issue itself, nor to any incident at all that took place during the period 20 December 2014 to 24 February 2015"*.

3.3.   In addition, she confirmed that *"the volume of complaints received since the media interest has not increased at all"*.

3.4.   The team received some compliments that refer to the negative media coverage of the Trust.

4. Communication with MPs

4.1.   On 29 October 2015 ahead of the publication of NHS Improvement's regulatory action and on 4 November 2015, ahead of the publication of NHS England's report, the Chief Executive wrote to the 44 MPs representing constituencies across Kent, Surrey and Sussex. In his letter he offered to meet with individual MPs to discuss any concerns that they or their constituents may have had.

4.2.   The Chief Executive and Director of Nursing invited all regional MPs to a face-to-face meeting on 16 November 2015. Around a dozen MPs or their representatives attended.

4.3.   The Chief Executive also met individually and spoke directly with six local MPs on this issue.

4.4.   To date, no specific concerns from patients have been raised by MPs regarding R3 through any of the above mechanisms.

5.   Communications with health overview and scrutiny committees (HOSCs) and Health &and adult social care select committees (HASCs)

5.1.   On 29 October 2015 ahead of the publication of NHS Improvement's regulatory action and on 5 November 2015, ahead of the publication of NHS England's report, the Chief Executive wrote to:

- East Sussex HOSC
- West Sussex HASC
- Brighton & Hove HASC
- Kent HASC
- Surrey HASC
- Medway HASC

5.2.   In the letter the Chief Executive he offered to meet with individual committee members to discuss any concerns they may have.

5.3.   The Chief Executive presented to East Sussex HOSC on 3 December 2015 and to West Sussex HASC on 4 December 2015. In addition, the following presentations were planned:

- Surrey Health Scrutiny Committee – 7 January 2016
- South East Health Scrutiny Network – 18 January 2016
- Dover District Scrutiny Committee – 20 January 2016
- Kent HOSC – 29 January 2016

5.4.   Positive feedback was received from both East Sussex and West Sussex. Both confirmed they do not need to hear further from the Trust until the outcomes of all three on-going reviews are complete.

5.5.   No other queries/concerns have been raised by the HOSCs/HASCs to date.

6.   Communication with Healthwatch

6.1.   On 29 October 2015 ahead of the publication of NHS Improvement's regulatory action and on 5 November 2015, ahead of the publication of NHS England's report, the Chief Executive wrote to:

- Healthwatch Brighton & Hove
- Healthwatch East Sussex
- Healthwatch Kent
- Healthwatch Surrey
- Healthwatch West Sussex
- Healthwatch Medway

6.2.   In the Chief Executive letter he offered to meet with individual Healthwatch members to discuss any concerns they may have

6.3.   After publication of NHS England's report and the media coverage that followed, all regional Healthwatch organisations published appeals on their websites for patients affected to contact them in early November 2015. The example below is from Surrey Healthwatch:

HW Responds to SECamb investigation by its regulator, Monitor

05/11/2015

On 29th October 2015, Healthwatch in the South East were informed by Monitor that it would be taking enforcement action against South East Coast Ambulance Service NHS Foundation Trust (SECAmb), under the Health and Social Care Act 2012. This was due to concerns about how the Trust managed a project to change standard operating procedures for some calls to the NHS 111 service which were transferred to the NHS 999 service.

This notification was followed by a stakeholder briefing from SECAmb, which outlined the Trust's response to Monitor.

SECAmb responds to 999 calls from the public, urgent calls from healthcare professionals, provide NHS 111 services across the region and in Surrey and Sussex provide non-emergency patient transport services.

Kate Scribbins, Chief Executive of Healthwatch Surrey said:

"People who contact the NHS 999 and 111 services have the right to feel confident that the service they are requesting is reliably organised and run properly. This is particularly important for people who are critically ill. They need to be able to trust that their call for help is being prioritised and dealt with immediately.

Healthwatch Surrey is concerned to be informed that this project is likely to have had safety implications for patients, and the fact Monitor has decided to take this formal action, is a further indication of the seriousness of the situation.

Within the enforcement undertakings issued by Monitor, SECAmb has agreed to commission a forensic review of the circumstances surrounding the project. This includes a review of its governance and the impact of the project on patients. As the local health and social care consumer champion for the people of Surrey, we believe that Healthwatch should play a key role in this review, most notably on the impact on patients and their families, to ensure that this doesn't happen again.

If anyone has any concerns about this or any other health or social care issue, please get in touch. We are here to champion the voice of local people".

People can contact Healthwatch Surrey on 0303 303 0023 (local rate) or via the website www.healthwatchsurrey.co.uk

6.4. The Chief Executive presented to a joint meeting of four of the regional Healthwatch organisations on 4 December 2015. Following the meeting, the press release below was issued by Healthwatch:

local healthwatch
working together

On 4th December, four South East Healthwatch organisations met with the Chief Executive of South East Coast Ambulance Service NHS Foundation Trust (SECAmb) in order to seek assurance for patients following recent media interest and claims over problems with their call handling pilot project between December 2014 and February 2015.

In an open and honest meeting, local Healthwatch felt that they have an assurance from the Trust that there will be a platform for the patient voice to be heard from now on.

Fran McCabe, Chair of Healthwatch Brighton & Hove talking on behalf of all the local Healthwatch said,

"We have assurance that going forward, SECAmb will be doing a lot more to ensure the patient experience is at the heart of how services are shaped and delivered, and we look forward to working more closely with the trust in the future.

We would encourage anyone who has concerns about this or any other health and social care issue to get in touch with their local Healthwatch."

6.5.   To date, no specific queries/concerns from patients have been raised by any of the regional Healthwatch organisations*.*

7.   Communication with the Patient Association

7.1.   The Chief Executive wrote to the national Patient Association on 5 November 2015. In his letter he offered to meet with them to discuss any concerns they may have.

7.2.   An extract from the letter can be found below:

7.3.   To date, no contact has been received from the Patient Association.

8.   Staff-side organisations

8.1.   On 2 November 2015 the Chief Executive met representatives of three of the Trust's four recognised trade union organisations:

- Unison

- GMB
- Unite

8.2. Following the meeting, a joint communication was issued to all staff on behalf of the three unions.

8.3. No further queries/concerns have been raised by staff-side regarding this issue, either through the Joint Partnership Forum or directly to the Chief Executive or other members of the Board.

9. Communication with Foundation Trust membership

9.1. As a foundation trust, the Trust has almost 13,000 members.

9.2. On 16 November 2015, the Trust Chairman wrote to the Trust's public and affiliate members. This will be followed by an article in the regular newsletter to members, 'Your Call', which will be delivered to members in January 2016.

9.3. The Membership Office received a number of telephone calls from Foundation Trust public members on 16 November responding to the Chairman's letter. Most sought reassurance that there would be no change to the current service they receive from the Trust, as they generally noted positive experiences.

9.4. A single letter has been received from a Trust member, asking about the governance arrangements around R3. However, no specific queries/concerns were raised by patients via this route.