A meeting of the South East Coast Ambulance Service (SECAmb) NHS Foundation Trust – Regional HOSCs Sub-Group held at SECAmb Headquarters, Crawley on Tuesday 17 October 2017

Present: Mr Bryan Turner (Chairman, West Sussex HASC); Cllr Ken Norman (Chairman, Brighton & Hove HOSC); Cllr Ann Norman (Member, Brighton & Hove HOSC); Cllr Mike Angell (Vice-Chair, Kent HOSC); Cllr David Mansfield (Member, Surrey Wellbeing and Health Scrutiny Board)

In Attendance: Daren Mochrie (Chief Executive, SECAmb); Jon Amos (Acting Executive Director of Strategy and Business Development, SECAmb); Mark Whitbread (Consultant Paramedic, SECAmb); Claire Lee (Officer, East Sussex HOSC); Andrew Baird (Officer, Surrey WHSB); Nuala Friedman (Officer, Brighton & Hove); Lizzy Adam (Officer, Kent HOSC) and Helena Cox (Officer, West Sussex HASC)

Apologies: Cllr Colin Belsey (Chair, East Sussex HOSC); Cllr Ruth O'Keefe (Vice-Chair, East Sussex HOSC); Cllr Sue Chandler (Chair, Kent HOSC); Cllr Wendy Purdy (Chair, Medway HOSC); Cllr David Royle (Chair, Medway Children's OSC); Dr James Walsh (Vice-Chairman, West Sussex HASC); Giles Rossington (Officer, Brighton & Hove HOSC) and Jon Pitt (Officer, Medway HOSC)

CQC re-inspection report key findings and Trust response

1. Daren Mochrie, highlighted to members the key themes from the recent Care Quality Commission (CQC) re-inspection report and feedback from the Quality Summit, which was held on 5 October. The Trust was disappointed with the overall rating but was pleased with the pockets of good and outstanding practise, particularly in relation to 111.

2. Two 'Notice of Proposal' had been issued to the Trust in relation to Medicines Management and 999 call recording, which had since been withdrawn due to significant improvements since the notice had been issued. In relation to 999 recording, there were issues with the telephony platform and this was on the Trusts risk register. Improvements had been made and the issues were now a small number. A paper would be presented to the Trust Board to seek approval to replace the telephony platform to resolve issues of technically finding calls and the static on the line. The Trust had brought in a member of staff to help with the issues and Mr Mochrie was confident that the Trust would have a grip on this. The replacement platform would be funded from money received as the Trust was in special measures. BT was also recording the line to trace any fall out calls. It was asked what the target would be in relation to numbers of calls recorded/completed. This would be between 95-100%.

3. The Trust had 17 'must-do's' set by the CQC. Eleven task and finish group (these built on the success of the medicines management task and finish group chaired by Mr Mochrie) had been set up and were chaired by a member of the executive leadership team, to monitor a comprehensive action plan and ensure rigour and grip in terms of improvement. Mr Mochrie's presentation focused on an example of some of the 'must-do's', which included:

- **Incident Reporting** – There was a need to improve incident reporting and reduce the current backlog. It was asked how many serious incidents the Trust reported each month, to which members were told that there was

about 400 incidents a month which were reported but around one a week was then considered to be a serious incident, so approximately 50 per year. Members were told of the good relationship which the Trust had with other blue light colleagues, although a vitally important relationship for the Trust was with other health colleagues in relation to serious incidents. Mr Mochrie expressed his wish to make the organisation more of a 'learning organisation', minimising mistakes and learning from those that did occur.

- **Safeguarding** – Members were informed that the Trust had not necessarily had the right resource in the key areas but there were some improvements and plans in place for all staff to complete level 3 safeguarding training.
- **Staffing in EOC** – Staffing in the control centre on 999 call handling was a challenge since we had moved to the new EOC. There is a robust plan in place to recruit new staff and plans to recruit a more multidisciplinary clinical workforce. Since the move to the new EOC we have implemented seamlessly a new command and control system. On 22 November, the national Emergency Response Programme (ERP) would be implemented at the Trust.
- **Improved ACQI – Heart Attack** – A strategy would be implemented across the Trust in relation to improving clinical outcomes for, in this example, heart attack patients. A new health informatics system would be in place by March 2018 which would provide more meaningful data and audit. Members were informed that the Trust had 70 Critical Care Consultant Paramedics who were targeted to patients who were really sick, with a critical care hub within the control centre. Members were informed that Mark Whitbread, a consultant paramedic, had been employed by the Trust to drive the strategy, embed it within the organisation and engage with staff.
- **Staff Engagement** – The Trust planned to design solutions from the bottom up and had held a number of local staff engagement sessions across the Trust. It was early days but there were signs of improvement, with a 200% increase in the response rate for the staff Friends and Family test. Feedback from the unions was also improving. Work would continue and the importance of the leadership team leading by example was emphasised.

4. Mr Mochrie emphasised that much more pace was needed on what was required to be done and the year would focus efforts on areas within the overall Trust strategy and the various different work streams to take the organisation forward. The Trust's project management office was wrapping around the task and finish groups to ensure evidence of improvement .

5. In terms of the Quality Summit and discussions with partners, Mr Mochrie highlighted the importance of handover delays at emergency departments across the Trust area and that this was something that needed to be addressed as a whole system and would have a significant impact on the performance of the Trust and patients. Members agreed that they would like to receive monthly performance/handover delay statistics to identify hotspot areas, which would allow HOSCs to ask the question of local health partners if required. Regarding the cleaning of vehicles once a patient had been handed to an acute trust, members were informed that it would be for the paramedics to decide whether they would need to visit a make ready system or not to be prepared for the next job.

6. SECAmb had not previously had a surge management plan, unlike the acute trusts and other ambulance trusts such as London, so was working with partners to put a surge plan in place before the winter. To address demand and handover delays system solutions were required in the community as well as emergency

departments as it was not a good use of paramedic time to be spending hours on scene trying to secure additional pathways or looking after patients in emergency departments awaiting handover. In terms of handover delays, it was asked where the area sat nationally. Members were informed that there were hospitals in the patch which were in the top 10 hospitals nationally for delays. Mr Mochrie explained that there was work underway with commissioners in regard to demand and capacity modelling to ascertain whether it had the right baseline funding to meet demand or whether additional investment in SECAmb was required. Mr Mochrie's view is that by investing in the right ambulance model it could take pressure off other parts of the system. For example if SECAmb transported 10% less patients to attending emergency departments this would have a significant benefit to the whole system but this model needed funded. Between now and January, the Trust would work with commissioners and an external company – Operational Research in Health (ORH) to undertake a demand and capacity review and there needed to be a conservation with all stakeholders on any potential models which would be planned for January 2018 onwards.

7. An enquiry was made as to what staff turnover levels were at the Trust. Members were informed that the turnover of advanced paramedics was high as they could receive higher paid rates working at acute trusts or in Primary care. This is why this needs included in the demand capacity modelling. It was also asked what impact there had been on the ambulance service in regard to Friday/Saturday call outs for issues related to the use of alcohol. Members were informed that with better data collection the Trust would be able to understand this more but like most ambulance Trusts alcohol related calls were significant during these times. There were additional issues regarding fallers, in that there were not 24/7 fall prevention team support so an ambulance was called to lift patients, so more work was needed with local authorities and Careline and nursing homes to try and address the problem. Members agreed that receipt of SECAmb on data regarding call outs to care homes/falls/alcohol/mental health would be incredibly useful and give councillors the opportunity to take issues forward. Mr Amos highlighted that the data was available at a high level and could be shared in order for the importance to be highlighted.

Professor Lewis report - key findings and Trust response

8. Mr Mochrie informed members that the Professor Lewis had identified issues of a culture of bullying and harassment at the Trust, which was disappointing but the Trust was taking appropriate action including individual investigations to address this. The Trust Board had agreed that the report should be made publically available as they did not wish to hide the findings contained in the report and want to encourage and open and honest culture. The Board would receive a further report at the end of the month regarding the strategy moving forward and continued efforts to strengthen staff engagement. An additional member of staff with an OD/cultural background had been employed to drive this work forward.

Quality Improvement Plan (QIP)

9. Mr Amos informed members that a revised QIP was to be presented to the Trust Board next week, with measures which could be tracked on a weekly/monthly basis and was much more focused on key performance indicators. There were challenges of balancing finances, quality and performance and the focus on a

demand and capacity review would assist this. It was agreed that the revised QIP would be presented to members at the next meeting of the sub group.

10. Members were informed that the Trust had not formally been notified whether NHSI would keep the Trust in special measures but believed this would not be reviewed until the Trusts re-inspection next year.

Performance and Clinical Outcomes

11. Members noted that a paper regarding performance and clinical outcomes was not attached so would be circulated separately. Challenges of staff turnover in the control room were discussed, these was due to multifactorial factors and were typical of overall system pressures regarding workforce. The impact of control room relocation to Crawley was starting be seen regarding control room turnover although all call centres tended to have a high turnover of staff. A lot was being done regarding recruitment processes. All control centre staff were being trained on the national ambulance response programme. The impact of the temporary relocation of services from Kent & Canterbury Hospital was raised. Mr Amos informed Members that the Trust was working with East Kent CCGs who had agreed short-term funding to resource additional journeys; as a result, there had been no real impact on the Trust's performance. Focused work with NHS Improvement was being undertaken to reduce handover delays particularly at the Ashford site.

12. In terms of headlines, the capacity to answer calls in the control room was a core focus and the impact on Red 1/Red 2 response times, as was patient safety and wait times. The Trust was looking at those patients in the 'tail end' who wait longer than 8 or 9 minutes. From 22 November the national ambulance response programme would be adopted by the Trust and Red 1 and Red 2 calls would disappear and be replaced by new clinically led targets.

13. There was a new online system for appraisals and e-learning for staff across the Trust which allowed staff to access these when they are out and about. It was early days but there had been uplift in the numbers of staff completing training and feedback had been positive. Regarding quality, historical backlogs were being cleared with extra staff being brought in to help. Financially the Trust was to achieve £15m of efficiencies this year which was on track but there were pressures in other areas.

Ambulance Response Programme (ARP)

14. Mr Amos presented members with details of the new national Ambulance Response Programme (ARP). Currently the Trust had 60 seconds to answer a call and deploy a resource at which time the clock starts for an 8 minute response. There are a large number of patients within that cohort and doesn't differentiate well, with multiple resources being sent to one patient in order to hit targets. There approximately 750,000 duplicate calls a year. The ARP wad developed working with patients groups and changes the order in which questions are asked, using technology to identify the location of the caller. The time allowed prior to resource despatch has been extended to 4 minutes for calls other than cardiac arrest to ensure the right resource goes to the right patient. The national review saw no patient harm as a result of the changes and positive feedback had been received from staff, patients and stakeholders.

15. The four new categories were detailed as follows, with a response by an ambulance in the first instance, expected for the first two:

Category	Target Time	Example	Target
Category 1	7 minutes	Cardiac, life threatening	50% within target time
Category 2	18 minutes	Stroke, critical burns	50% within target time
Category 3	120 minutes	Late stages of labour, non-severe burns, diabetes	90% within target time
Category 4	180 minutes	D&V, infections	90% within target time

16. The longer terms challenges emerging from the ARP were that there would need to be a change to the mix of vehicles needed, as SECAmb had a large number of cars at the moment. Ambulance Trusts would be monitored and the first set of data which would show the impact on SECAmb would be available in January. Local issues in East Sussex regarding maternity provision were raised due to the target time of 120 minutes to reach women in the later stages of labour and that work would be needed to communicate rationale to the public. Uninjured falls were cited as a hidden group as patients could wait 3-5 hours for assistance. Staff in the control room will continually monitor and re-prioritise if necessary. It was asked how categories related to the out of hours service, the benefit of a new platform would make it easier to refer category 4 calls to the out of hours service with an automated referral system. It was agreed that the presentation slides would be shared with members after the meeting.

Surge Management Plan

17. Mr Amos informed members that discussions were currently ongoing with partners regarding a surge management plan for the Trust to ensure that there could be prioritisation and balance of risk. It was planned to share details with the sub group at the next meeting.

Cardiac survival to discharge data

18. Mark Whitbread, Consultant Paramedic, informed members that he had been employed by the Trust to ascertain how outcomes for those patients treated for cardiac arrest can be improved and shared data regarding analysis of cardiac arrest data over April – June 2017. Mr Whitbread explained the use of 'utstein' figures when considering cardiac arrest data so that figures across the country could be compared like for like. The higher survival rate figures relating to the Isle of Wight needed the caveat of the small numbers the data was based on. Data was being reviewed by the Trust Board on a monthly basis. However, the Trust was struggling to receive outcome data from some acute trusts across SECAmb's area, especially St Peters, Chertsey, although there was no mandate for trusts to share this data. Six to twelve months of data was needed to breakdown to understand the geography and be under constant review.

19. The current cardiac arrest data for SECAmb in 2016/17 was 22.2%, the Trust wished to raise this to between 30-40%, going above 40% would be extremely challenging. A rise of 1 or 2% was also quite hard.

20. Mr Whitbread had presented the Trust Board with a number of recommendations based on his work so far. One of these was related to public education and promote resuscitation and access to defibrillators. Calls are to be triaged correctly so that a response is despatched quickly and can reach a specialist centre when required. Members noted that there was only one specialist centre in Kent, with other options based at Brighton and St Georges, London. The recommendations were short, medium and long term. Members were informed that the Fire Brigade Union had called on their members to reject a proposal to be able to co-respond with the ambulance service.

21. Members discussed the location of defibrillators and agreed to speak to their local communities to ensure that defibrillator cabinets are not locked and available to be used quickly when needed.

Date of Next Meeting

22. It was agreed that the next meeting of the sub group would be held in late January/early February 2018. Claire Lee would liaise with the Trust on possible dates.

Members of the sub group were given a tour of the control room followed the conclusion of the meeting.