East of England Ambulance Service NHS Trust

Governance Review

April 2013

Undertaken by

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Background

East of England Ambulance Service NHS Trust (the Trust) is suffering with sub-standard, Operational Performance, significant Negative Media and Stakeholder interest and an increasingly adverse risk profile. The Trust reached a Monitor Board to Board in December 2012 but a deferral for up to 12 months was decided due to a lack of robust planning for recovery of A19 targets, and CQC were unable to provide confirmation that the Trust meets the Quality Performance threshold. All of this is against a backdrop of significant NHS reform and a variety of changes within the Executive Management Team of the Trust.

The four main objectives (set out in the Terms of Reference in Appendix A) of the Review are:

1. To undertake a swift review of Governance at the East of England Ambulance Service with a focus on stakeholder engagement, workforce relations, performance reporting and data integrity
2. To review the relationship between governance processes and practice on the ground at the Trust
3. To Review the actions underway and planned by the Trust Board and to propose any further actions
4. The review report should be practical and forward looking in terms of clear and timed recommendations.

This report includes a summary of my findings, methods used to gather the evidence and my proposed actions and recommendations on how the Trust could make improvements to assist in performance recovery and long term sustainability.

The Review has taken place during March and April 2013. Where a face to face meeting was not possible due to either diary commitments or geographic limitations a conference call has taken place (Appendix B).

In July 2011 Peter Bradley CBE the former National Ambulance Director visited EEAST as response times were deteriorating. Mr Bradley subsequently wrote to the former CEO Hayden Newton QAM, outlining areas of concern and offering ideas and support to restore performance. However not all actions and recommendations have been put in place and performance has not risen as would be expected.

Acknowledgments

During the course of the Review all participants have been very helpful, professional, open and honest, which has greatly assisted given the short amount of time available I would like to express my sincere thanks to all those who contributed for their cooperation.

Introduction

The Trust was created on July 1, 2006 and covers the six counties which make up the East of England - Bedfordshire, Cambridgeshire, Essex, Hertfordshire, Norfolk and Suffolk.

Spread over about 7,500 square miles and containing a mix of rural, coastal and urban areas, serving a population of more than 5.83million people.

The Trust website states "The Trust employs nearly double the number of frontline staff now than in 2007 at more than 1,800 against less than 1,000. Out of these 1,492 are paramedics and 333 are emergency care assistants (ECAs)"

As stated, the above paragraph is taken from the Website of the Trust, and once the figures were cross checked with data provided by the Trust (set out below) there was a significant difference.

Skill level	Budget WTE	Actual WTE
Paramedics, including Supervisors and Emergency Care Practitioners	1514	1012
Technicians	371	348
Student Paramedics	0	341
Emergency Care Assistants	291	320
Total	**2176**	**2021**

EEAST attends more than half a million emergency calls a year and transports nearly twice that many patients to and from routine hospital appointments through the Patient Transport Services.

The Trust has almost 1000 vehicles and 110 ambulance stations and response posts. Total income for 2011/12 was more than £227million. Budgeted income for 2013 / 14 is £228 million (Trust Board presentation March 2013).

The Trust Board is made up as follows:

Chair (V)	Vacant (27/03/13)	**Interim Chief Executive (V)**	Andrew Morgan
Non-executive Director/Vice Chair (V)	Paul Remington	**Medical Director (V)**	Dr. Pamela Chrispin
Non-executive Director (V)	Caroline Bailes	**Interim Director of Clinical Quality (V)**	John Martin (Interim)
Non-executive Director (V)	Phil Barlow	**Director of Emergency Operations (V)**	Neil Storey
Non-executive Director (V)	Anne Osborn	**Director of Finance (V)**	Paul Scott (leaving 2nd June 13)
Non-executive Director (V)	Margaret Stockham	**Interim Director of HR and OD (NV)**	Christina Youell (Interim)
		Director of Strategy & Business Development (NV)	Adrian Matthews

Operational Performance – Regional

Standard	Target %	Year End 2010 - 2011	Year end 2011-2012	QTD Q4 12-13	Year End 2012 -13	Trajectory 2013 /14
Red1	75%	76.67	74.63	73.65	74.30	76.30
Red 2	75%	74.46	75.44	70.23	73.14	75.00
A 8	75%	74.56	75.41	70.39	73.19	
A 19	95%	95.61	94.90	92.24	93.53	94.10
Green 1	*95%	94.64	87.86	76.18	78.49	-
Green 2&3	*95%	98.56	95.39	78.34	80.53	-
Green 4	*95%	84.55	77.54	74.18	74.04	-
Referrals Card 35 only	*95%	-	-	-	67.5%	-
Call Answer <5secs	95%	70.49	86.19	94.24	94.39	-

*Provided by the Trust in Terms of Reference for ORH Ltd Clinical Capacity Review (taking place in 2013)

Clinical Performance

	Target	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13
STEMI Pats to Hosp <150min	95%	95.0 %	90.2 %	86.4 %	92.7 %	86.9 %	94.2 &	91.9 %	94.8 %	83.3 %	88.0 %
STEMI Care Bundle	80%	81.6 %	86.9 %	79.3 %	85.5 %	77.5 %	86.2 %	81.4 %	87.9 %	83.2 %	88.7 %
Stroke Pats to Hosp <60 min	62%	47.8 %	50.2 %	46.6 %	55.3 %	54.3 %	38.3 %	44.9 %	47.3 %	44.8 %	47.6 %
Stroke Care Bundle	95%	94.3 %	94.3 %	93.4 %	95.6 %	94.9 %	97.2 %	96.3 %	97.4 %	97.8 %	97.9 %
ROSC - overall	21.5%	21.5 %	22.9 %	20.5 %	21.7 %	24.5 %	18.6 %	20.5 %	23.5 %	21.0 %	23.2 %
ROSC - Utstein	45.0%	60.0 %	65.0 %	50.0 %	55.0 %	54.8 %	43.2 %	50.0 %	48.5 %	44.7 %	38.3 %
Cardiac Arrest to Discharge - Overall	6.0%	4.5%	3.8%	5.9%	5.7%	6.9%	9.7%	6.3%	6.4%	4.4%	7.5%
Cardiac Arrest to Discharge - Utstein	25%	19.4 %	19.4 %	22.6 %	27.3 %	25.8 %	32.4 %	26.5 %	32.3 %	13.9 %	21.9 %

Reference Costs

	2009 - 2010	2010 - 2011	2011 - 2012
EEAST	111	107	112

This indicates the Trust is funded above the national average for Ambulance Trusts by possibly several million pounds.

Sickness Absence

	Target	Actual
2011-2012	6.2%	6.9%
YTD 2012-2013	5.5%	8.8% End Feb 13

This represents nearly double the national average for Ambulance Trusts in England.

Risk Profile – Care Quality Commission

	Feb 12	Mar 12	Apr 12	May 12	Jun 12	Jul 12	Aug 12	Sep 12	Oct 12	Nov 12	Dec 12	Jan 13	Feb 13
HIGH RED													
LOW RED													
HIGH AMBER									1				
LOW AMBER													
HIGH NEUTRAL	2	1	1	No report				No report	2	4	4	No report	5
LOW NEUTRAL	5	6	4	No report	3	4	5	No report	5	7	7	No report	7
HIGH GREEN		1	1	No report	1	1	2	No report	2	1	1	No report	
LOW GREEN		1	1	No report	3	4	3	No report	3	2	2	No report	2

Training days – completion

	Day 1	Day 2
2011-2012	100%	87%
2012-2013	85%	59%

Appraisals / Personal Development Review Completion

	Target	Actual
2011-2012	75%	82%
2012-2013	90%	45%

Cost Improvement plans 2013 / 14

Risk level	Value of schemes £'s
Low Risk	2.4m
Medium Risk	4.1m
High Risk	950k
Total	7.45m

Of the CIP schemes identified for the 2013 / 14 financial year, at present only 1/3rd is secured leaving the remaining £5m still either medium or high risk. This appears to be a significant risk to the organisation during this period of poor performance and transformation.

This Review has revealed some interesting and useful observations but none clearer than that which has been mentioned by almost everyone spoken to – the Trust needs to change and do things better, otherwise the situation will not improve. What differs though is how this is communicated around the organisation and its stakeholders and the extent to which the Trust is prepared to make difficult and challenging decisions to achieve the necessary outcome. In an email issued jointly by the CEO and Chair (Appendix C) to all staff at EEAST on 22nd March reference is made to the long road ahead (there needs to be some quick actions as well) and that there was acceptance at Board level that things will have to be done differently, but it was left cold i.e. no tangible examples of what actions will be taken to improve the current position and certainly no timelines for improvements to take place. The Chair has subsequently resigned.

There appears to be a lack of accountability throughout the organisation, partly due to a complicated organisational structure and confused Managers within the Trust. This has led to a lack of clarity on both accountability and responsibility, individually and collectively, therefore critical decision making has ceased in some areas. The Trust has lost focus of the strategic objectives, which may partly be due to the board not fully understanding the purpose of the business.

Managers and staff are feeling frustrated and unsupported which is leading to silo working across the organisation where duplication is also occurring. The management structure is overly layered, and appears heavy. Reducing managers will free up finance for front line resource to respond to patients. However the Trust seems to demonstrate limited urgency and pace in moving forward.

There is a feeling across the organisation that the Trust Board does not listen, and that Leadership does not come from Board level, this can be evidenced in the fact that the Board have only recently accepted that there is a shortage of front line ambulance crews within the Trust yet managers state they have been raising this for some time. Despite this recognition, there are still plans to recruit c£350k worth of non-operational staff to the Trust (appendix D). This funding would be far better utilised recruiting further Front line Paramedics, providing patient care and meeting response times. Furthermore, there is a risk that recruiting to some of the advertised additional management posts will come from internal front line operational and clinical staff, thus reducing even further the available front line ambulance crew workforce. In addition there are c400 front line vacancies and considerable spend on Voluntary and Private Ambulance providers assisting the Trust. This is one example of conflict between Operations, Finance and the Clinical departments.

Findings

One notable point to mention is that although the Trust was established in 2006, it still feels like three Trusts. There are plans afoot to undertake a restructure of operations and my concern is that this stays with a three HEOC and three area operational model which will continue to divide the region into three operating areas. This makes it very difficult to adequately 'share' resources and in the absence of an adequate Regional Operational Coordination cell there will continue to be duplication within each of the HEOC's and an overall cohesive, integrated approach to managing issues such as Hospital Turnaround delays.

There is a view / opinion that EEAST should be split into the three previous constituent Trusts i.e. Essex, Bedfordshire and Hertfordshire, Norfolk Suffolk and Cambridgeshire. There is another view that one of the counties could merge with the Fire Service of that County. I do not believe that either of these options would solve the challenges confronted by EEAST. That said, I do recognise that there is frustration amongst staff, manager and Stakeholders i.e. Politicians, Volunteers and other Emergency Services about the way in which the service is being delivered in different geographical parts of the organisation. It is recognised that one size does not fit all and there must be local arrangements to meet the needs of the local population and health community i.e. Rural versus Urban. Furthermore, the Ambulance Trust must work more closely with other emergency services.

The use of dashboards and data is somewhat sporadic in nature. There is, as expected, good data and plenty of it, but it isn't always displayed or interpreted effectively and consistently. During the course of the Review data integrity appears good, and I have found no evidence of any misreporting of standards. The A8 Target is still being reported based upon the previous arrangements i.e. not Red 1 and Red 2. This doesn't show that the Trust is committed to keeping up with the changing National picture and performance management arrangements are inadequate in the Trust. Furthermore all response time performance targets should be reported by County.

The table below shows how the Trust performed in A8 and A19 against their planned trajectory for the six week period 3rd February 2013 to 31st March 2013:

Week Ending	A8 Trajectory	Actual	A19 Trajectory	Actual
03/02/2013	71.00%	67.9%	92.0%	90.2%
10/02/2013	72.30%	70.2%	92.7%	93.3%
17/02/2013	73.60%	70.2%	93.3%	93.1%
24/02/2013	75.00%	71.1%	93.5%	91.7%
03/03/2013	76.50%	67.9%	95.0%	90.3%
10/03/2013	76.50%	67.4%	95.0%	90.4%
17/03/2013	76.50%	69.0%	95.0%	91.0%
24/03/2013	76.50%	71.1%	95.0%	93.0%
31/03/2013	76.50%	71.9%	95.0%	92.7%

Tabled below are A8 and A19 performance trajectories for 2013 /14. It appears ambitious given that during the review process there has not been a single cohesive improvement action plan to underpin the achievement of this level of performance. Furthermore, the current recruitment and training programme does not align to be able to achieve this performance.

Month	Predicted Red 1 performance	Predicted Red 2 performance	Predicted A19 performance
April	74.1%	72.1%	92.3%
May	74.1%	72.1%	92.3%
June	74.9%	72.9%	92.9%
July	75.0%	73.0%	94.1%
August	76.1%	75.1%	94.7%
September	76.9%	75.9%	94.9%
October	78.0%	77.3%	95.1%
November	77.5%	76.8%	94.6%
December	76.3%	75.8%	93.9%
January	76.0%	75.0%	93.1%
February	76.9%	75.8%	94.6%
March	78.9%	77.8%	95.8%
Year End	**76.3%**	**75.00%**	**94.1%**

I also cannot understand how a Performance Improvements Action Plan can have a trajectory that fails A19 for the entire year when the plan and trajectory is being put in place in April i.e. at the start of the year.

Predicted Red 1 Red 2 and A 19 performance by quarter

Quarter	Red 1	Red 2	A19
1	74.3%	72.4%	92.5%
2	76.1%	74.6%	94.6%
3	77.2%	76.5%	94.5%
4	77.2%	76.2%	94.5%
Year end	**76.3%**	**75.0%**	**94.1%**

Green and GP Urgent Referral Performance

There is clearly a situation which requires immediate attention in terms of reporting and monitoring of Green and Urgent cases. There appears to be no reporting on Green and Urgent Referral targets, to the point where some very senior people in the Trust do not know what the targets are, let alone how the Trust performs against them. The fact there is a clinician in the Health Emergency Operations Centre (HEOC) calling back Urgent referral cases to say that an ambulance isn't coming or

it will be significantly delayed demonstrates that these patients, who have often previously been seen by a Healthcare Professional, are not being attended and transported in a timely fashion. Urgent referral performance for 12/13 was 67% against a target of 95% within the given time frame. There needs to be a whole system approach to service delivery and performance achievement.

During the review, many different people have used different figures when referring to the operational performance targets, where they are even known, however there appears to be no clarity in what is being monitored and reported. Furthermore, once all the data had been collected for the purpose of this Review, it was still difficult to understand what, and how Green and Urgent Referral performance is being considered and reported.

Below is a table provided by the Trust within the Terms of Reference for the Clinical Capacity Review which is being undertaken by ORH Ltd. However there are senior managers of the trust who believe the urgent target was actually 90% for 12-13.

Green Category response times Green 1 (20 minutes) Green 2 (30 minutes) Green 3 (60 minutes) Green 4 (60 minutes)	 95 % 95 % 95 % 95 %
Calls from a General practitioner for transport to a treatment facility The agreed time set at time of request to be in attendance with the patient	95 %
For all 999 calls irrespective of their categorisation to be attended to and closed within 60 minutes from the call (NB: this excludes GP transport as above)	95 %

The proposed indicators for response times in 2013/14 are detailed below. However the 60% target for Urgent referral cases with a 4 hour response time appears to be long in terms of acceptable time for a patient to wait for transport, therefore the Trust and Commissioners may wish to review further. The new commissioning arrangements are an opportunity for the health care system to both support and challenge one another and commission services appropriately. The previous commissioning arrangements of the Trust have been criticised by stakeholders.

Response Code	Standard	% to be achieved	99th centile by:
R1	8 mins	75%	25 mins
R2	8 mins	75%	25 mins
R1/2	8 mins	75%	25 mins
G1	20 minutes	75%	30 mins
G2	30 minutes	75%	60 mins
G3 telephone	20 minutes	75%	60 mins
G3 face-to-face	50 minutes	75%	120 mins
G4 telephone	60 minutes	75%	120 mins
G4 face-to-face	90 minutes	75%	150 mins
Urgent referrals	1 hour	75%	90 mins
	2 hours	75%	180 mins
	4 hours	60%	360 mins

Organisational Development

The Trust has been developing an Organisational Strategy to coincide with a transformation strategy; however the Trust doesn't appear to be clear on how many staff it requires (different figures have been provided through this review process), how they will reach their target skill mix profile (currently 50% Paramedics) and more importantly when this will be reached.

The Trust may want to consider the Volunteers within the Region as part of this workforce planning, as there is an obvious disconnect between the amount of volunteers wanting to help, and the level of engagement and usage of Volunteers by the Control rooms. Volunteers can support achievement of performance if there is some investment in time for them to engage and develop.

Staff Survey 2012

Results from the 2012 staff survey were highlighted on 27th February 2013 in a Managers Briefing paper. The key points to note were:

No of key findings that have improved – 1
No of key findings that have stayed the same – 11
No of key findings that have got worse – 9

What this means in real terms against the other Ambulance Trusts in the country is that EEAST had the worst staff survey results of all Ambulance Trusts in England with 13 Red (lowest) scores. The next nearest was 5 red scores. One point of note is the overall staff engagement score is only 2.96, where the highest is 3.48 and the average is 3.29. This is also echoed amongst staff and has come through clearly during the compilation of this Review. In addition EEAST scored 2.64 on staff recommendation of the Trust as a place of work or receive treatment. The average score in this category was 3.12 and the highest was 3.39. Staff portraying a positive attitude towards the organisation would greatly assist in raising the reputation of the Trust moving forwards.

Resourcing

There is significant utilisation of Private and Voluntary Ambulance Service staff and vehicles, currently approximately 30 – 35 crews per day, which will be costing significant amounts of money. It would be prudent to develop plans including a timeline to reduce this usage which would fall in line with the updated workforce and recruitment plans. Currently these extra resources are deployed from the three HEOCS to all cases that they are able to deal with dependent upon their skill level, this includes Emergency calls. It would be better to focus these resources to move patients that are waiting for transport to hospital that have been seen by a GP or other Healthcare Professional, or backing up RRV's on appropriate low priority cases who are waiting for an ambulance. This would make Trust emergency ambulances available to respond to patients or back up RRV's waiting for an ambulance as there is further work required to address backup delays being experienced on occasions.

Below is a table outlining the backup times for each level of case, at the three HEOC's for calendar year 2012-13 and the first 3 months of 2013. One piece of data that is not included here are the longest back up times, these are averages only.

Control Centre	Backup Type	Average Back up time (minutes) 1st Jan 12 – 31st Dec 12	Average Backup time (minutes) 1st Jan 13 – 4th Apr 13
Bedford	HOT1	18	17
Bedford	HOT2	26	25
Bedford	COLD3	36	32
Bedford	REPRI4	1hr 57mins	52
Chelmsford	HOT1	20	19
Chelmsford	HOT2	33	32
Chelmsford	COLD3	47	44
Chelmsford	REPRI4	2hrs	2hrs 23mins
Norwich	HOT1	23	24
Norwich	HOT2	29	35
Norwich	COLD3	37	45
Norwich	REPRI4	1hr 21mins	1hr 2mins

A redesign of the rotas for staff has recently been undertaken, however the implementation of this has been strongly criticised by staff during the Review for being handled badly, further eroding morale and potentially increasing sickness absence as a consequence. The Trust Board need to accept the responsibility for this and collectively re-engage local managers and staff to realise the benefits of these rota changes.

There are currently enough RRV's in the system to respond to calls, at times there are too many, however reducing this number on occasions and providing an increased number of double crewed ambulances would assist performance, as there are currently insufficient numbers on the streets. All RRV's should be staffed by Paramedics, ECP's or Advanced Paramedics, which will assist in reducing multiple resourced incidents and also increase the non-conveyance rates, both of which will provide greater hours of staff availability.

Community First Responders

Volunteer Community First responders are a valuable resource to patient care and performance. Clinical volunteers do however, need to feel and be engaged in the Trust. The former Chief Executive had begun work with this group of First Responders and a paper was produced outlining the direction of travel he thought the Trust should take First Responders. However the meetings which took place appear to have become too detailed and have not resolved the issues highlighted, leaving First Responders despondent.

In addition there is a paper entitled 'Best Practice in the use of First Responders' by a community first responder, Dr Timothy Thirst MBE, which was also brought to the attention of the Trust, and contains valuable information which could help the Trust engage volunteers in a meaningful way and increase patient care and rural response times. Dr Thirst shared his report with me which is most informative. I also spoke with him during my Review.

With Rural performance particularly in Norfolk as poor as it is, often below targets for Red Calls it would really help to have some further good Community First Responder schemes in these areas as well as being a good way to engage community spirit. It is true that it can be time consuming to have so many volunteers but in my view the benefits to patients are worth the effort.

Organisational Risk

The Trust's risk profile has been worsening over recent months despite being reported to the Trust Board on a regular basis through the Corporate Dashboard. It would have been expected that as this continual reporting has been occurring that an early action plan would have been drawn together by the Board, as leaders of the Organisation, to drive change and grip the Trust to make the required improvements; this does not appear to have been the case.

In February 2013 the Care Quality Commission (CQC) undertook an unannounced visit to the Trust which highlighted some areas of good work, but also some areas that require improvement. Most importantly the CQC identified that EEAST were not meeting the standard of 'Care and Welfare of people who use the services'. It is believed this is the first time an Ambulance Service has failed this standard. This was predominantly focussed on the failure to meet response times but also the delays experienced by responders awaiting backup by an ambulance crew.

There was also a concern raised in the report around a previously identified shortfall in the Ambulance Clinical Quality Indicators (ACQI's), the extract is below.

> 'A comparative analysis of the trust's performance in November 2011 compared to this November's 2012 performance showed significant improvement in all but one of the ACQI's – its ability to convey people who had suffered a stroke to a specialist centre within 60 minutes of the call being received. This was an area of concern we highlighted at our previous inspection in March 2012 and no significant improvement by this inspection'.

It was also reported at the March 2013 Board meeting (Agenda Item 10) that the ACQI's have declined since September 12 and at that point six of the eight indicators had declined below standards. Further comment was made around the Quality Risk Profile (QRP) with the following being presented:

'The QRP has been published which shows that Outcome 4 (care and welfare of people who use the services) has moved from a low yellow to a high yellow risk estimate, Outcome 11 (safety, availability and suitability of equipment) has moved from a high green to a low yellow risk estimate and Outcome 14 (supporting Staff) has moved from low yellow to a high yellow risk estimate.'

The Board should be taking leadership decisions and actions on these Outcomes and holding others to account, yet this doesn't appear to be happening. The Trust has drawn together an action plan (Appendix E) but this appears inadequate to sufficiently address the situation and provide assurance to the CQC that the improvements are achievable and meaningful.

Findings

Strategic issues

Trust Board Responsibilities
Reduce Hospital Handovers
Reduce Sickness Absence
Reputation Management
Stakeholder Engagement – MP's / HOSC's / Police / Fire

Trust Board Responsibilities

It is the responsibility of the Board of all organisations to ensure the Governance arrangements and the plans for the Trust are appropriate and robust enough to keep risk as low as practicably possible and ensure all patients receive the best treatment in a timely fashion. However the current Trust Board and Senior Management Team appear to have developed a sense of 'helplessness' i.e. it is what it is. It is therefore appropriate that the Board be accountable for the actions and in some cases the wrong doings of the staff operating within the organisation and those individuals are held accountable for their own actions.

It is my opinion that the Board have not been taking both the responsibility collectively as well as they could or should have and that Board members have not been held to account as robustly as I believe is required when an organisation is in a position such as this.

Whilst some members of the Executive Team have already departed the organisation, which in itself is an issue that needs to be resolved carefully and quickly, there is a recognised shortage of experts available to fulfil these roles with the appropriate professional knowledge, expertise, experience and gravitas. It is essential that Board members have a deep understanding of the business, including how the Trust delivers performance.

Hospital Handovers

It is without doubt that this is a real problem in some parts of the East of England as it is across some other parts of the country. However it is something that can and does need to be tackled robustly and consistently at all sites that experience delays. There is an existing National Standard for handover of patients at hospital within 15 minutes and an absolute maximum of 30 minutes but the application of this process is not sufficiently robust. The current hospital arrival screen displays the time elapsed since the ambulance left scene, when it would be better to shoe the hospital; the estimated time of arrival instead. Further work in this area will ensure all ambulances are turned around within 30 minutes at all Acute Hospital Sites. Achieving this requires engagement from the ambulance trust, hospitals and commissioners.

The Operations Cell within the Trust does attempt to deal with these delays, but needs more focussed resource to enable it to be truly effective and most importantly consistent. High level engagement with Acute Hospital Directors and Commissioners will aid the smooth transfer of care as all parties will be better informed and 'signed up' to any actions being taken. The use of Major Incident equipment as seen on Easter Weekend 2013 at Norfolk and Norwich Hospital should always be a very last resort as this could be damaging to the reputation of both the Acute Hospital and the Ambulance Service alike and does not represent best quality of care for patients.

Reduce Sickness Absence

There is a clear understanding that reducing sickness levels from the current 8% and highs of 14% during 2012/13 will have a marked improvement on available resource to respond to patients, but what is not clear is whether there is a concise, robust organisational plan to reduce sickness which everyone is both signed up to, and fully aware of. I am not sure the trajectory to reduce sickness down to 5.5% overall is achievable without this level of full organisational support. I did not get the sense that support services were fully engaged in sickness reduction and that occupational health functions were robust enough to cope with the current situation, reports of 2-3 year long term sickness is hard to believe but was mentioned during meetings.

Reputation Management

This is something that I have referred to several times through this report. The reputation of an organisation is critical in ensuring confidence in the Service. Confidence from both staff and stakeholders maintains motivation and positivity and assists the organisation in gaining support, particularly when making changes to improve services to patients. There has been considerable negative press lately for the Trust, some of which may have been avoidable or at least limited but engagement with stakeholders, staff and unions alike has been poor which has been evidenced from the meetings I have undertaken.
Managing the reputation of an organisation is always difficult and sometimes the small things can have an unforeseen adverse effect e.g. civilian staff wearing Officer Uniform whilst undertaking a Television interview when they are not a career Officer.

As a blue light Emergency Service it is critical to undertake regular meetings and updates with colleagues from local Police and Fire Services, particularly when there are changes occurring that may affect them directly or how they interact with staff. Undertaking this regular engagement would prevent the Trust receiving letters from Police and Fire jointly as has happened in February 13, expressing concern at the lack of engagement and use of Private and Voluntary ambulance resource as well as the delay in response times to incidents. Restoring confidence in the service must be a top priority.

Stakeholder Engagement – MP's / HOSC's / Police / Fire

This is a critical area that requires immediate action to improve the reputation and engagement of the Trust. Stakeholders can be an extremely useful conduit for information both in a positive way but also (as is being seen at EEAST) in a negative way; this continuous negativity has an effect on staff and does not encourage a culture of improvement. Additionally this negative press is having a marked effect on staff and their productivity. I would suggest an Executive lead be appointed to Stakeholder Engagement and a plan of engagement drawn up which spans the next twelve months as a minimum. This should include the offer of visits to the Trust, the Executive and Non-Executive team meeting with stakeholders, open days, and written briefings as appropriate. Gaining support from the MP's, HOSC's etc. is critical to take forward the transformation plans of the organisation and positively promoting the reasoning behind the plans. This will ensure that the Trust is both the provider of choice and employer of choice in a sustainable way into the future, ensuring there is a committed team of staff to deliver the plans of the organisation.

Tactical issues

Improvement Action Plan
Use of Data
Compelling Vision and Re-launch of Strategic Direction
Emergency Preparedness Exercise

Improvement Action Plan

For any organisation who is having difficulties finding a way through problems, and for them to be able to improve in a way that is manageable and sustainable, there needs to be one single improvement action plan defining the route everyone will travel and this needs to be owned and driven forward by the Board. Within EEAST there are at least three different improvement plans available that have been shared during this Review.

There is a three point plan which has a fair level of detail incorporated, but is inadequate to achieve sustained organisational performance improvement. Following the CQC unannounced visit in February 13 there was a further action plan submitted to CQC on 27 March 2013. This plan simply doesn't go far enough, or explain in any detail what the Trust will be doing to improve the current situation. Combine this with a further Performance Improvement plan, that is predominantly owned by Operations and there are now three plans that don't tie together, with no clearly assigned lead to them. The lead for the overall plan should be the Executive Management Team once agreement has been sought at Trust Board. The Executive Management Team should be held accountable for the delivery of the one single cohesive plan drawing all the critical elements from the three current plans together.

Use of Data

Historically, Ambulance Services have a wealth of data through the use of Information Technology, what is important is to use this data and information to inform decisions and create evidence based decision making. EEAST is no different and there is a wide variety of data available, the usage and display is not as good as it should be. A good example as mentioned previously, of this is the Green response and Urgent referral targets as these were not displayed anywhere on my visits to the Trust. These targets whilst not set nationally are still very important and not to be ignored, in terms of patient safety and responding appropriately.

Compelling Vision and re-launch of Strategic Direction

For the Trust to succeed, its vision and values must be both fit for purpose and visible. The Trust made good progress towards becoming a Foundation Trust during 2012 but was unsuccessful due to Operational response times being below standard. Therefore the Trust must have spent time developing the Strategy, Vision and Values going forward. This needs to be far more visible to the

staff, public and stakeholders for them to believe the Trust will make the required changes to improve in a sustainable manner. In the current situation, it is not possible for EEAST to achieve Foundation Trust status in 2013/14.

The vision needs to be brought alive and with passion, drive, energy, focus and grip all of which is meaningful, understood and believable by staff and key stakeholders.

The staff, local managers and some senior managers appear to be looking to the Board for leadership and guidance on where to go next, and whilst this happens the organisation will not recover its position. As there is a lack of confidence and trust that the Board has the expertise, experience or gravitas to respond to the substantial challenges facing the organisation. The Strategic Direction should be reviewed by the Board before being re-launched in the spirit of transformation and improvement so as not to be seen as a necessity to reach Foundation Trust status. There is a real opportunity to get the staff and Stakeholders on board with the transformation and create a positive mind-set going forward.

Emergency Preparedness Exercise

Emergency preparedness and in particular the Hazardous Area Response Team (HART) are very good news stories in the Ambulance Service. This could be a real opportunity to undertake some meaningful stakeholder engagement by arranging an exercise, ideally a joint services demonstration. This would have the effect of promoting the good work of the Trust and its interoperability at large scale incidents, as well as being an opportunity to invite guests along to meet staff and Managers of the organisation.

There is willingness from staff and Stakeholders alike to see the good work of the Trust and to promote the good news stories of the organisation. This is an opportunity to invite the Media, as much as anything and promotes positivity and community spirit. There are areas within the organisation that are successful but they can often be overshadowed by others who are failing. The organisation needs to recognise and reward the areas of good practice, and share them amongst the wider community and involve the patients, public and stakeholders more.

Operational issues

Delayer / Reduce Management Structure
Control room deployments
Recruitment Plan
Skill mix – University Placements

Four key drivers:

1. Whole system approach to performance achievement i.e. not just Key National targets of Red 1, Red 2 and A 19 but to include Green calls and urgent referrals as well.
2. Trust Board need to take responsibility and be held to account.
3. Commissioners should take responsibility.
4. Transformational turnaround team required with the experience, expertise, credibility and gravitas to lead the Trust.

De-layer / Reduce Management Structure

It is clear that transformation of the management structure in the operational side of the Trust is underway (example of the new structure in Appendix F) which in my view is a good step in the right direction; however I am not entirely sure it goes far enough. The organisational structures are not sufficiently clear or focused on providing an integrated patient centred service. The idea is that the layering needs reduction, to allow managers to be held accountable more directly, and to avoid overcomplicated decision making. This will mean that some managers are displaced allowing the Trust to reduce its management overhead and can therefore re deploy this finance into more emergency ambulance crews to treat patients in a timely manner.

Control Room Deployments

There are three HEOC's within the EEAST and whilst the teams within are all doing their best with the resource available, some of the deployment practices and protocols do not lend themselves to being able to send the right resource at the right time to the right patient as the arrangements are overly complicated resulting in too much variability and inefficiency. This leaves dispatchers frustrated and is placing even greater and unnecessary pressure upon control room and operational staff. Not all assets deployed by the Trust are electronically tracked, making it even more difficult to choose the correct resource. These problems are leading to delays in assignment and in some cases the most appropriate resource is not sent, there is then a delay reaching patients.

In 2011 a review was undertaken by Daniel Gore Associates for the HEOC's and their deployment protocols / practices. It would be beneficial to review against the action plan what improvements have been made and how this has improved the situation to eliminate any potential clinical risks. Additionally the use of the Inter hospital patient transfer Instruction should be removed as it is unhelpful and potentially represents an unnecessary risk (Appendix G).

Some areas of performance could be addressed quite simply, which would have a marked effect e.g. reducing the number of resources per incident down to an average 1.2 from 1.3, increase RRV contribution closer to 85% within 8 minutes from the current 77%, ensure CFR Schemes are booked on and off appropriately, reduce the conveyance rate further.

It would further assist the staff within the Control Rooms if they were to receive annual refresher training. This should include knowledge and understanding of Major Incident resources and deployment of assets to Major Incidents, as well as providing dispatchers the opportunity to get up to date with current protocols and practices.

Recruitment Plan

Whilst I understand that there are issues arising from being able to fill all of the current vacancies in a short period of time, there appears to be some discrepancy over how the Trust intends to attract and recruit staff, both qualified from other Ambulance Trusts and Graduate Paramedics direct from Universities. This needs to be resolved swiftly for the Trust to have any chance of meaningful recovery. Significantly strengthening the Workforce plan, based on sound assumptions to achieve a Paramedic skill mix of closer to 70% needs to be undertaken as a priority. This needs to dovetail with the Recruitment plan to ensure that the workforce deficit can be closed as soon as possible and the use of external agencies can be removed. This should be communicated across the Trust and to Stakeholders with monitoring by the Board against an agreed timeline with monthly progress reporting.

The current recruitment plan for operational Paramedics, which is summarised overleaf, is not in line with the current vacancy numbers provided by the Trust (below). There is also reference in the plan to recruit further Emergency Care Assistants into the organisation, something I would advise against. The Trust may also want to consider whether it intends to offer the current operational ECA's the opportunity to undertake further training to become Technicians and ultimately Paramedics, therefore further increasing Paramedic numbers and improving skill mix which will in turn improve care for patients.

The Trust has said that "the way the establishment is managed shows staff groups as clinical (yellow) and non-clinical (pink). So although the Trust is showing as being over established on the Paramedics (46) we are funding additional numbers through the band 6 vacancies (116). This doesn't include turnover. Overleaf is what Operations have asked for and how these will be recruited to. These are not shown in the below because these are not mapped against the establishment and it's important the distinction is made."

Current operational vacancies - April 2013

Skill Level	Budgeted Establishment 1 April 2013	February 13 finance adjusted (Staff in Post)	A&E Recruits 01/03/13 to 09/04/13	Total Vacancies by role	Total Vacancies against Establishment
Emergency Care Practitioners and Supervisors	256.92	140.55	0.00	116.37	116.37
Qualified Paramedics (inc Student Ambulance Paramedics)	1185.89	874.41	17.00	294.48	-46.24
Student Paramedics (inc in Paramedic Establishment	0.00	340.72	0.00	-340.72	
Qualified Technicians (inc in ECA Establishment)	0.00	346.11	0.00	-346.11	73.32
ECA's	825.30	319.87	86.00	419.43	
Student Technicians	0.00	0.00		0.00	0.00
Total	**2268.11**	**2021.66**	**103.00**	**143.45**	**143.45**

Planned operational recruitment summary for 2013 / 2014

Skill Level	Total Req'd	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Total
Qualified Paramedics	138	6			15	10	15	25	30	20				121+17 recruited and working
Qualified Technicians	50					10	10	10	10	10				50
Student Paramedics	0													
Student Technicians	0													
Emergency Care Assistants	48		18					18			18			54 (allowing for Induction failure)
Other Front Line Staff (Assumed as Specialist Paramedics – name TBA)	78				13	10	15	15	15	10				78
Total	**314**	**6**	**18**	**0**	**28**	**30**	**25**	**68**	**55**	**40**	**18**	**0**	**0**	**303+17 Recruited**

Furthermore the EEAST Turnaround Plan as Published on 22 April 2013 shows different recruitment figures (listed below) which I believe are unachievable as these staff are just not available.

- 82 Band 6 specialist paramedics
- 149 Band 5 paramedics
- 24 Band 4 technicians
- 96 Band 3 emergency care assistants

Table of New starters and staff who left the Trust between April 2012 and March 2013

Skill Level	Starters	Leavers
Emergency Care Practitioners and Supervisors	0	10.6
Qualified Paramedics (inc Student Ambulance Paramedics)	18.54	48.5
Student Paramedics (inc in Paramedic Establishment	0	13
Qualified Technicians (inc in ECA Establishment)	0	29.23
ECA's	192.61	33.36
Total	**211.15**	**134.69**

Skill Mix – University Placements

There is a clear need for the organisation to both recruit and train more paramedics to increase the skill mix on front line ambulances and RRV's. There is however a shortage of local university places for Paramedic Students and Graduates. Only one university providing placements for student paramedics and Graduates Paramedics is not enough. Increasing this to three universities, which will also help in reducing the back log of 340 - 380 student paramedics, is needed to ensure there are sufficient Paramedics available. Currently this student back log could take up to 3 years to clear, which is too long and needs to be accelerated. The engagement and support of commissioners will help in securing and commissioning these places at universities.

Summary

In this section of my report I have set out the major findings that I consider essential in making sustainable improvements which I am confident will support staff to provide better services for patients.

It has been reported throughout the Review that the Board does not follow through with statements and promises, and there is a feeling that the Trust has made a relatively simple job too difficult. However, commissioners may also wish to consider providing non-recurrent transitional support to the Trust during 2013 / 2014 to accelerate improvements for staff and patients.

There is also clearly a need for a transformational turnaround team of people to be selected and work together to drive forward the plans and implement the changes robustly to ensure performance is delivered as soon as possible. However there also needs to be a realisation from the Board that these experienced experts may not come from within the Trust and that external help may need to be sought.

It would also be prudent to establish a Regional Coordination function ideally situated at one of the HEOCs, to include the following functions:

- Hospital escalation desk – including a Senior Manager to undertake escalation to Executive Directors at the acute hospitals
- Senior Operational Manager with responsibility for Downtime and incident handling
- Incident Command Desk – running larger more complex cases away from the normal dispatch area – working closely with the Critical Care Desk and Air Desk.

The four main objectives (set out in the Terms of Reference in Appendix A) of the Review were:

1. To undertake a swift review of Governance at the East of England Ambulance Service with a focus on stakeholder engagement, workforce relations, performance reporting and data integrity.

There is a definite lack of Stakeholder and staff engagement from the Organisation, and a grass roots approach to rectifying and improving the reputation of the organisation needs to be undertaken as a priority. Performance monitoring and reporting needs simplifying and to be made far more visible throughout the organisation whilst ensuring the integrity of the data will help identify issues early so that action can be taken.

2. To review the relationship between governance processes and practice on the ground at the Trust.

It is fair to say that the overall Governance arrangements cannot have been adequate for the Trust to get into this much difficulty. There are changes happening with the Senior Leadership team of the

Trust which need to be addressed swiftly to ensure the organisation has the experience, expertise, energy and gravitas to drive forward into operational performance.

3. To Review the actions underway and planned by the Trust Board and to propose any further actions.

There are at least three plans currently in circulation within the Trust which have been reviewed. The Trust needs to develop a cohesive, integrated action plan which is achievable and sustainable. The timings of such actions will be a matter for the Trust Board; however responsibility and accountability are key to ensuring there are improvements in performance and patient care.

4. The review report should be practical and forward looking in terms of clear and timed recommendations.

East of England Ambulance Service is fortunate to have highly committed, professional, caring managers and staff who really want to do the best for patients and be part of a successful Organisation; however the current Leadership from the Board just isn't strong enough to take them forward. Furthermore there is a lack of focus and grip from the Board which has contributed towards the deterioration of performance across the Trust.

Patient safety must always remain at the front of our minds when making difficult decisions, it is therefore only right to say that by responding to patients as quickly as we can, and treating them in the most appropriate way we will stand a much greater chance of improving their outcomes and ultimately saving more lives in the community.

Recommendations

- The Trust Board should re-state the purpose, vision, values and strategic objectives of the organisation with energy, ambition, leadership and focus with a compelling vision for improvement in a way that has support of stakeholders, staff and public.

- There needs to be very clear arrangements led by the Executive Management Team which demonstrates integrated working in order to achieve Key Strategic Objectives.

- The Trust Board should consider the capacity and capability of its Directors to demonstrate adequate engagement with Stakeholders and staff and who are committed to continuous improvement for patients.

- Directors need to be very clear what is expected of them at the collective and unitary Board, in order to focus upon what is important and demonstrate grip is being exerted on what matters to protect services and quality for patients.

- Internal and external communications must be improved without delay. Letters and emails sent to Directors and Senior Managers need to be replied and followed up promptly. Visits and meetings need to be offered pro-actively and when requested facilitated promptly.

- Managers at all levels need to form part of an integrated structure with clear objectives set. There should be a review of capacity requirements of all Departments. The Management Structure review that was commenced in 2011 should be concluded.

- There should be regular arrangements scheduled through a Board developed Engagement Plan, for communication and engagement with Key stakeholders, staff, and local managers. In addition regular briefings should be circulated and relationships developed so there is a no surprises culture in place.

- Demonstrable changes need to be promptly and very clearly communicated to front-line staff in order to reduce stress and pressure on staff, and reduce sickness absence.

- CIP needs to be finalised with Quality Impact Assessments completed for the Trust Board to sign off the overall budget and forward plan for 2013 / 14.

- Commissioners may wish to consider providing non-recurrent transitional support to the Trust during 2013 / 14.

- Holistic performance reporting and visibility should be introduced across the Trust at all levels, Stations, HEOC's, Local / Middle Management, Executive Team and Trust Board.

- Directors must develop an integrated Performance Improvement Action Plan that will restore the achievement of key national and local targets as a matter of urgency. The plan will require full Trust Board support and sign off.

- The Board need to set out its expectation in relation to the requirement to reduce sickness absence and local managers need to be provided with clear parameters within which to support staff and take all necessary action to facilitate return to work for staff.

- The Trust must ensure that all announcements / statements that are made can actually be delivered and that promises are followed through with tangible action.

- The Trust Board and Director Team need to ensure they have adequate expertise, experience, grip and gravitas to lead and drive through the necessary changes and improvement programme.

- University Graduate placements need to be increased urgently in order to clear this back-log. Consideration needs to be given to increasing the places at the existing University as well as increasing the number of universities providing this training.

- The Trust needs to review its overheads to ensure it is offering value for money and achieving operational performance targets and clinical effectiveness.

- The use of information, visibility of information, process and systems as well as the supply chain arrangements are too complicated and not fully aligned to the needs of the Organisation.

- There needs to be a robust recruitment plan that gets the staff in to the organisation, trained and operational as soon as possible. However the role of ECA's should not be continued or further posts recruited to. Existing ECA's should be offered training to up skill to Technicians and Paramedics.

- Staff, their representatives and Managers need to be fully supported to achieve their ambition for service improvement.

- There should be a major review of the three HEOC's which should include a review of Enhanced Clinical Triage use of Clinical Support Software, hospital delay desk, care co-ordination, Clinical Support Desk, urgent delay call-back person, use of PAS and VAS, deployment protocols, deployment of RRV's, Critical Care Desk and Air Ambulances and interface of Resource Allocation Desk in each HEOC with Regional Operations Cell. 999 call answering buddying arrangements between the 3 HEOC's needs reviewing and the call lengths during surge transfer should be reduced.

- VAS and PAS crews should only to be used for urgent admission and transfers i.e. no

emergency cases or incidents.

- Local arrangements for supporting volunteers should be reviewed in order to maximise engagement and contribution of volunteer CFR's.

- Back up protocols need to be introduced for RRV's to reduce back up delays which will in turn free up RRV's to respond to other emergency patients.

- Control room staff, in particular Duty Officers should receive refresher training to include:- Action cards, summary of assets and capability

Appendices

(Separate attachment)

A. Terms of Reference for Governance Review

B. List of Participants to the Review

C. Email from Andrew Morgan and Maria Ball

D. Non-Operational Advertised Vacancies List

E. CQC unannounced visit Action Plan – March 2013

F. Proposed Operational Structure for EEAST South Sector

G. HEOC Instruction – Hospital Transfer Procedure (Card 35 & 37)

List of Material reviewed

Title of Document	Author (if Known)	Date of Document
Terms of Reference for Governance Review	NHS TDA / EEAST	Feb 2013
Email from CEO and Chair	Mr Andrew Morgan and Ms Maria Ball	22nd March 2013
Non Operational Vacancies Advertisement – taken from What's new this week	Not known	Received during visit
CQC Unannounced Visit Inspection report and action plan	CQC	February 2013
Operational restructure documentation	Provided by Neil Storey	April 2013
Treatment of Inter Hospital Transfers Document	Not known	Not known – provided during visit
Standard Operational Guidelines – Resource Allocation and Dispatch Guidelines – SOG 4 Ver 11	Not Known	March 2012
March 13 Trust Board Paper – Corporate Dashboard	A Matthews – Director of Strategy and Business Development	27 March 2013
March 13 Trust Board Paper – 2013-14 Draft Annual Budget and Capital Expenditure agenda Item P9	K. Smith – Associate Director of Finance	27th March 2013
April 2012 Corporate Dashboard and Self Certification Report	A Matthews – Director of Strategy and Business Development	25th April 2012
Organisational Development Strategy and Executive Summary	Not known	February 2013
2012/13 Board Development Programme	Not known	Updated 7th June 2012
2011-12 Board Development Timetable	Not known	Updated March 2012
Minutes from Quality and Risk Assurance Committee – 23rd Jan 13	Various EEAST Staff	January 2013

Quality and Risk Committee Paper 14 March 2013 Rule 43 Coroners Report	Marcus Bailey Consultant Paramedic (interim)	14 March 2013
Best Practice in the use of First Responders Paper	Dr Timothy Thirst MBE	Updated 16th January 2013
ORH Clinical Capacity Review – Terms of Reference	A Matthews – Director of Strategy and Business Development	Dec 12
ORH Clinical Capacity Review – Framework	A Matthews – Director of Strategy and Business Development	Dec 12
Care Quality Commission – Unannounced Visit Report March 2013	Care Quality Commission	15th March 2013
CQC Improvement Action Plan 2013 ver1	Not known	January 2013
3 Point Plan Dashboard	Not known	Updated 8th February 2013
HEOC Instruction – Hospital transfer Procedure (Card 35 & 37)	Not known	Received during visit
Letter from Asst. Chief Fire Officer and Asst. Chief Constable to Andrew Morgan	Mr Doug Robinson and Mr John Bouthcer	5th February 2013
Letter form Andrew Morgan to Asst. Chief Fire Officer and Asst. Chief Constable	Mr Andrew Morgan	8th April 2013
Notes of the Executive Group meeting held at County Hall, Hertford on 7th March 2013	Chair of the Committee	7th March 2013
Proposed indicators for Response Times 13/14	Dr Simon Arthurs / Dr Pamela Crispin	Provided on 9th April 2013
Average Back up times Tables	Received from Neil Storey	April 2013
Staff Survey Results for 2012 – Comparison of Ambulance Service Trusts	Not known	Received 2nd April 2013
Managers Brief	Not Known	27th February 2013
EEAST Performance Recovery Paper – version 0.9		30th January 2013
EEAST Operational Review October 2011	Daniel Gore	October 2011
EEAST Performance Trajectory –Draft – version 0.1		28th March 2013
EEAST Back Up Delay action Plan Appendix 1 – Quick Wins	Daniel Gore	15th September 2011
EEAST Discussion Paper – RRV Deployment Model	Daniel Gore	September 2011

EEAST Annual Plan 2013/14 Presentation	Not known	20th March 2013
Setting Standards – Progressing Patient Care	EEAST	Reviewed in April 2013
Letter form Peter Bradley CBE to EEAST	Peter Bradley CBE	11th July 2011
Coroners Letter	William Armstrong – HM Coroner, Norfolk District	31st January 2013
EEAST Performance Summary – W/E 10th March 2013	Gary Morgan – Head of Performance	March 2013
Trust Weekly Operations p[performance Summary – W/E 17th March 2013	Gary Morgan	17th March 2013
Trust Weekly Performance Summary – W/E 31st March 2013	Gary Morgan	31st March 2013
Emergency Operations Presentation – Week Ending 17th March 2013	Not known	17th March 2013