South East Coast Ambulance Service NHS Foundation Trust

Trust Board Meeting to be held in public.

26 January 2017

10:00-13:00

Tangmere Make Ready Centre
City Fields Way, Tangmere, PO20 2FT

Agenda

Item No.	Time	Item	Encl.	Purpose	Lead
159/16	10.00	Chairman's introduction	-	-	PD
160/16	10.01	Apologies for absence	-	-	PD
161/16	10.02	Declarations of interest	-	-	PD
162/16	10.03	Minutes of the previous meeting: 24 November 2016	Y	Decision	PD
163/16	10.05	Matters arising (Action log)	Y	Discussion	PD
Organisational culture					
164/16	10.10	Patient story	-	Set the tone	
165/16	10.15	Chief Executive's report	Y	Information	GD
Trust strategy					
166/16	10.30	HQ Update	Y	Assurance	SG
167/16	10.40	Board Assurance Framework	Y	Decision	PL
168/16	10.55	Risk Management Strategy & Policy	Y	Decision	EW
Allocating resources to achieve plans					
169/16	11.05	Financial Recovery Plan	Y	Assurance	DH
170/16	11.20	HART Business Case	Y	Decision	DH
Ten minute Break					
Monitoring performance					
171/16	11.25	CQC Action Plan Update	Y	Assurance	EW
172/16	11.45	Integrated performance report	Y	Assurance	DH
173/16	11.55	Risk Register [deferred]	Y	Review	EW
Holding to account					
174/16	12.00	Escalation report; Quality & Patient Safety Committee	Y	Information	LB
175/16	12.10	Medicines Management	Y	Assurance	AC
176/16	12.20	Escalation report; Audit Committee	Y	Information	TW
177/16	12.30	Escalation report; Workforce & Wellbeing Committee	Y	Information	TH
178/16	12.40	Escalation report; Finance & Investment Committee	Y	Information	GC
179/16	12.50	Any other business	-	Discussion	PD
180/16	-	Review of meeting effectiveness	-	Discussion	ALL

			-		
Close of meeting					

Date of next Board meeting: 23 February 2017 – Ashford 111 Centre, Moat Way, Willesborough, Ashford, Kent, TN24 0TL

After the close of the meeting, questions will be invited from members of the public.

South East Coast Ambulance Service NHS Foundation Trust

Trust Board Meeting, Thursday 24 November 2016,

Holiday Inn, Guildford
Minutes of the meeting, which was held in public.

Present:

Graham Colbert	(GC)	Independent Non-Executive Director & Deputy Chair (Chair)
Geraint Davies	(GD)	Acting Chief Executive
Alan Rymer	(AR)	Independent Non-Executive Director
Andy Newton	(AN)	Executive Paramedic Director
David Hammond	(DH)	Executive Director of Finance & Corporate Services
Emma Wadey	(EW)	Acting Executive Director of Quality and Patient Safety
Ian Ferguson	(IF)	Interim Executive Director of Operations
Jon Amos	(JA)	Acting Executive Director of Strategy & Business Development
Katrina Herren	(KH)	Independent Non-Executive Director
Lucy Bloem	(LB)	Independent Non-Executive Director
Rory McCrea	(RM)	Executive Medical Director
Terry Parkin	(TP)	Independent Non-Executive Director
Tim Howe	(TH)	Independent Non-Executive Director
Trevor Willington	(TW)	Independent Non-Executive Director

In attendance:

Steve Graham	(SG)	Interim Director of Human Resources
Janine Compton	(JC)	Head of Communications
Peter Lee	(AC)	Trust Secretary
Richard Quirke	(RQ)	Improvement Director

138/16 Chairman's introductions

Deputising for the Chairman, GC welcomed to the meeting board members, those in attendance, and the staff, governors and members of the public observing, including Joe Garcia who joined the Trust on Monday 21 November and Richard Quirk for whom this was their first board meeting.

139/16 Apologies for absence

Sir Peter Dixon	(PD)	Chairman

140/16 Declarations of conflicts of interest

The Trust maintains a register of directors' interests. No additional declarations were made in relation to agenda items.

141/16 Minutes of the meeting held in public on 27 October 16

Item 128/16: add *simply* to the sentence "…rather than (*simply)* looking back"
Item 135/16: add *wide-spread* to the sentence "Signals (*widespread*) issues of internal control"

Subject to these two amendments, the minutes were approved as a true and accurate record.

142/16 Matters arising (action log)

The progress made with outstanding actions was noted as confirmed in the Action Log and completed actions will now be removed.

143/16 Patient story

A video was played in which a relative of a patient described her experience when she phoned 999 for her mother in law who had fallen. She contacted the Trust's complaints department as she was made to feel like a 'time-waster' by the 999 call-taker, although she was very happy with the crew when they did turn up.

She has had to subsequently call 999 again for her mother in law and was very happy on that occasion with the service received; she is also very happy with how her concerns were looked into with support of the complaints team, and that she has had an opportunity through the film to share her experiences.

The Board discussed the issues raised by this experience. IF explained that call takers receive training and although felt confident that on the whole we get it right, confirmed that we do always need to listen carefully to feedback such as this to ensure we learn.

144/16 Chief Executive's report.

GD started by thanking IF for his good work since his time with the Trust. Joe Garcia will be taking over as our new director of operations and IF and Joe are in process of handover.

GC asked GD to respond to a question from member of public regarding the pressures on paramedic and other front line staff, in particular relating to shift overruns. GD explained that we need to ensure through our staff health and wellbeing strategy that we ensure staff are always supported, and that in our negotiations with commissioners we are enabled to resource as fully as possible to meet the demands on our services.

GC asked that through the Workforce and Wellbeing Committee, the board is sighted on the impact of the issue highlighted. IF explained that he is very concerned with end of shift overruns and the related policy is currently under review as is the number of disturbed meal breaks.

RM added that it is important to recognise the work of staff during these times of significant pressure and as a Board thank them for this. The Board agreed.

GD confirmed that there was a constructive meeting yesterday with stakeholders about handover delays at hospital A&E departments. We are working on a concordat over 120 days to resolve this very important issue in order to help reduce delays and improve patient care. Over the next three months the aim is to agree and sign the concordat; review how we use A&E delivery boards to monitor and hold to account; and agree KPIs to track the impact on handover delays to test whether the interventions are working.

Action:
Update on the progress with Handover delays to the Board in February

KH noted that 120 days takes us over the Christmas period when pressure is greatest. This was acknowledged and GD felt it was still positive that we have engaged all 17 trusts with NHSI to ensure a true system meeting, where we recognise that we each have issues that impact on each other.

GD touched on the other issues set out in his report. On i-pads, he highlighted the positive impact this will have in terms of patient care and improved communication.

Contract negotiations have highlighted the funding gap of circa £40m. So GD suggested that if real steps to address this aren't taken then we cannot in good faith sign the contract by December, resulting is us needing to go to into arbitration. GD asked the Board to support this should the need arise. We have already informed NHSI about this risk. We aren't expecting CCGs to fund the full £40m, but we do need to work through the choices in terms of what can be afforded and, therefore, what we can reasonably provide. And then what is the clinical impact on patients.

TP confirmed his support in this approach to contract negotiations explaining that we are quite good at costing the services we provide and so should not agree a contract we can't reasonably deliver.

KH also supportive of this and asked more broadly about clinical outcomes; there are key dispositions that are time dependent and so in our negotiations we need to focus in the right areas for these patients.

GD agreed that we need to challenge CCGs what they are funding. STPs are all about avoiding hospital so for us we need to have the resources and skills to help achieve this system-wide aim otherwise we will need to revisit our clinical model. This will be key challenge when we talk about our strategy (later on agenda).

In terms of not signing the contract TH asked whether there are others in the same position. GD has spoken to a number of CEOs and every ambulance Trust is facing the same problems, although the gaps they are reporting are typically between £8-12m. Ours is a much wider gap, but we recognise the wider issue and difficult for commissioners as a result of many acute Trusts also having big gaps.

GC confirmed that the Finance Committee considered this in great detail at its last meeting and agreed that notwithstanding what GD has rightly highlighted, there are things we need to do internally to close the gap; it doesn't all rest with commissioners. The Board acknowledged this.

GD set out the issues with the 111 service in East Kent, which was meant to transfer to the new provider on 30 September despite our concerns expressed at the time about the likelihood of the new provider being able to mobilise by then. They weren't able to mobilise and so commissioners asked us to maintain the service. This has had a detrimental impact on performance and patient care. Commissioners are aware of this and they need to be held to account for their commissioning decisions.

Finally, in giving a summary overview of the organization, GD confirmed that he was pleased we are delivering performance against the revised trajectories agreed with commissioners. In terms of clinical performance, there is underperformance (on agenda). In terms of workforce, we understand vacancy figures with better data. However, we are still not consistently delivering appraisals.

145/16 Patient Harm Review Recommendations

RM confirmed that the recommendations have already been taken forward, as per the paper, via the URP.

The Board noted this and was assured that we are taking forward the recommendations.

146/16 Recovery Plan

GD took the Board through the slides.

The URP was signed off by Board last time. We have appointed a new head of PMO from PWC who starts soon and their immediate objective will be to review the project management support to the URP to ensure we have the right capacity and capability. The purpose of gateways is to ensure clarity on the remit of the objective, the outcome, impact and delivery.

GC noted that we need to see the outcomes are having a positive effect, but confirmed from the Board committees we are starting to see some improvements in how things are coming together. Although still much to do.

AR spent time with the PMO and felt there are clear tools coming together to track progress, although expressed disappointment that we aren't today discussing actual progress.

Action:
The Board to receive a detailed overview of the progress against the URP

TW reminded the Board that there are quarterly reviews undertaken by Internal Audit testing the progress against the URP. A report is due to the next meeting. The concern is that we do not set realistic milestones and so there is a need to set the priorities, despite all the actions needed being a must do. The PMO is key to ensuring this happens.

GC asked JA about the view of PMO in the realism of the plans. JA explained all the projects need to go through Gateway 2 which is the process of scrutiny and sense-checking about how achievable the plans are, including the resource required.

KH expressed concern that clinical issues are being missed; how does the process cope with things that change that aren't part of the URP? EW reinforced the importance of not mixing recovery with business as usual, the latter not requiring a project through the URP. In response KH asked how the Board can get assurance that business as usual is happening. RM outlined the various working group meetings which pick up business as usual.

GC asked whether QPS Committee picks all this up. LB confirmed that it is starting to ensure that it does, and in December for example we are receiving the first draft of the new quality and patient safety report, which effectively sets out the business as usual. This will be a quarterly report and so issues arising will form part of escalation report to the Board.

AR suggested too that the PMO tracker process will enable the Board to see what progress is being made and where we might be falling short.

147/16 Improving Clinical Governance

EW explained that due to the gaps in clinical governance highlighted by the CQC inspection, we asked NHSI to undertake a deep dive to get a good understanding of the underlying causes. The report from NHSI was received this week and a number of actions have already been taken as set out in the paper. EW confirmed that all the actions identified by NHSI are within URP/CQC action plan.

The fundamental issues include gaps in policies and oversight of committees/groups, but also resource. A cultural shift is therefore needed, especially regarding incident reporting and learning; moving from a blame organisation to learning. This will be cost neutral and is extremely important given positive impact on patient experience and safety.

EW updated on the work with Datix (risk management database) and the recent recruitment to help address the resource gaps.

KH noted the two SIs relating to sepsis and asked where are we with this and implementing NICE. And noted the number of outstanding actions which is a concern. EW confirmed that we have been over reporting SIs which links to outstanding actions, as some of them are not our incidents and so we have no control over

the actions. We have started to resolve this problem and will start to track actions via the SI Review Group to ensure they happen and learning is implemented. On sepsis AN explained that through the Drug and Therapeutics Group we will aim to get support from a microbiologist to help with these issues.

148/16 EPRR

AN explained that this comes to the Board to provide more detail on how the issues are being taken forward. AN took members through the action log at the back of paper, confirming that some of the actions due in October have been completed in the last couple of weeks.

TW asked about item 12, HART estate and the date of 31 March 2016. AN confirmed that this relates to two business cases which aren't yet complete. Both relate to Ashford MRC. The areas of non-compliance were explained by AN. The business cases will be produced and taken to commissioners to establish the extent to which they need to be given priority given the financial constraints. The issue is a similar one with HART fleet.

149/16 Trust Strategy Review

JA explained that this paper is to update the Board on the proposal by the Executive to take forward a review of the Trust's strategy.

AR expressed delight that we are reviewing this and it is really important NEDs are engaged early in the process. JA acknowledged this.

TW added that we need to achieve a strategy that works for Trust while aligning with the four STPs and the commissioning intentions. JA explained that the aim is to align against both and the clinical pathways we are already aligned with. GD confirmed that while we are engaged with STPs this is by no means without difficulty.

Action:
Overview of STPs to the Board in January

150/16 111 Winter Capacity Plan

IF outlined what is in the paper, which includes the lessons from last year and what the escalation process is, as well as being realistic about what we can reasonably achieve.

AR clarified whether we have a shortfall in number of call handling staff. IF confirmed that we do. Much is covered by agency. Regarding East Kent over Christmas we will retain 20% of the activity. The first set of volume transfer occurred earlier in the week, successfully. The second transfer is scheduled for 6 December.

151/16 Agency Self-Certification Check List

SG explained this is a one-off return introduced by NHSI to help Boards hold executives to account on agency spend. It is for the Board to complete to confirm its assurance that the Trust is taking all appropriate actions on agency spending. SG confirmed that the draft is completed in a way which recognises the work needed to get a proper grip.

AR asked whether private ambulance providers are defined as agency and DH confirmed they are not. The biggest agency issue is with 111.

Resolution:
The Board approved the return subject to any comments received prior to the deadline (30.11.16)

Action:
Board members to provide comments on the draft check list to SG or PL

Comfort break at 11.53am

152/16 CQC Action Plan

EW explained the process of how we are updating the action plan, which is supported by the PMO and sent monthly to CQC, NHSE and NHSI.

The monthly meetings with CQC typically incorporates a site visit. The meeting in January will be with the executive team.

GC asked whether the CQC are content with what we have done to-date. EW confirmed that they are content with the actions we have taken. The monthly meetings are used to interrogate the evidence which support the stated action taken. Also, the outcomes we are aiming for are tested with front line staff. The plan going forward is to provide dashboard to the Board and report by exception.

TP reinforced the need to meet the targets we set. The Board agreed.

153/16 Ambulance Response Programme

IF confirmed that we joined the pilot on 18 October and it was well implemented with no serious incidents. The programme is in two parts. Firstly, to identify the sickest patients. But the problem we have is that currently this is only happening in 50% of Red 1 calls. Now we have 4 weeks' experience and we are in touch with national leads who are helping us to review our questioning. Any changes will be made through the clinical directors and relevant national bodies. The second element is dispatch on disposition, where call takers have up to 4 mins to dispatch. They have responded well and we compare well to other trusts. The benefit is that we send the right resource to all patients.

In summary, it has been well implemented, some things have gone well but some improvement needed.

LB asked about point 12 of paper and what is the right governance given our history. IF explained that we will go through our internal clinical governance processes and then through the national team should we wish to make any changes to ensure they agreed. SCAS changed questions in this way and improved to 85% the identification of Red 1 calls.

Action:
JG to give an update to the Board in January, in particular on the identification of Red 1 calls

154/16 IPR

IF confirmed that the commissioners are now content that the new trajectories for 999 are sufficiently challenging. We are meeting these as set out in the paper.

On finance DH confirmed the outturn is as per the revised plan, with the usual caveats. We held executive challenge sessions to ensure clarity of the position and areas of delivery. We are well sighted on the cash position and will be applying to NHSI for a working capital facility in Q4, as agreed at FIC this week. This is effectively an overdraft; one we need to have in place but might not need to use it.

Tim asked about the likelihood of us being placed in financial special measures. DH explained that we have already triggered this as per the Single Oversight Framework, due to the distance from plan and our use of agency. However, NHSI confirmed that we won't be placed in special measures so long as we have robust and sufficient plans to ensure we meet the revised plan of £7.1 deficit. The executive is really committed to ensuring this happens.

KH asked about quality and outcomes, and what is happening regarding stroke services. JA explained there will be a public consultation on the configuration of services, but will likely result in longer conveyance times and so we are engaging in discussions about journey and treatment time targets. JA is using the same methodologies we used in East Sussex when it reconfigured services.

155/16 Workforce & Wellbeing Committee Escalation report

TH highlighted bullying and harassment, explaining that we need at Board to set the right tone. In terms of training, the Committee is not assured by the controls as currently being applied but action is being taken.

The Committee was satisfied with the quality of the risk register, in so far as it related to workforce.

156/16 Finance & Investment Committee Escalation report

GC reinforced the cash position and need in short term to apply for loan facility. Commissioning round really key.

RM asked if we explored a commercial facility. DG confirmed we did and we get much better value for money with NHSI.

157/16 Any other business

None

158/16 Review of meeting effectiveness

Questions from observers

GC asked if there were any questions from anyone observing the meeting; there were none. However, a question was received in advance of the meeting from a member of staff asking how the CCP programme could better demonstrate or improve its worth to the Trust.

AN who helped develop the CCP programme was asked to respond. He began by reinforcing the importance of recognising all staff and the work they do. Specifically to CCPs he said that, in times of such financial pressures, there is a need to revisit the Trust's clinical model. CCPs are extremely valuable with good

evidence demonstrating the benefit they provide. That is not in doubt. However, the Trust needs to demonstrate value and improvement in experience and outcomes, and this is why the decision was taken to review the CCP operating model, specifically in relation to how these practitioners were being deployed.

RM added that there are a number of things we do that are excellent, including our CCP programme, but as a matter of fact some of these have not always been funded by commissioners. So we need to show the value to commissioners as they are responsible for commissioning the right services to the majority of the people we serve.

GC agreed and on behalf of the Board acknowledged the value of CCPs. He explained that we need to demonstrate across all our services how we ensure good use of resources to best ensure the most positive patient experience and outcomes.

The member of staff who asked the question was in the audience and fed back that he feels CCPs are under-resourced. They are behind the Trust and feel proud to be part of SECamb. He agreed that we need a business plan so that commissioners can make an informed decision about whether the fund this service.

GD offered to keep the dialogue open.

There being no further business, the meeting closed at 12.50pm

Signed as a true and accurate record by the Chair: _____

Date _____

South East Coast Ambulance Service NHS FT action log

Meeting Date	Agenda item	Action Point	Owner	Target Completion Date	Report to:	Status: (C, IP, R)	Comments / Update
26.7.16	076/16	The Executive to clarify the arrangements for sighting the Board in real time on serious incidents and as fast as reasonably practical on the learning and change in practice arising from incident investigation (September, RM).	Emma Wadey	September	Board	**C**	**Update from 24.11.**16: EW explained SIs are now shared in real time with the executive and senior clinicians. And as part of the new Quality and Patient Safety Report overseen by the QPS Committee, summaries of Sis are included.
27.10.2016	122/16	The Chair requested that the executive ensure we proactively seek feedback from the patient to confirm whether she is satisfied with the current service	Emma Wadey	December	N/A	**C**	Patient Experience Lead contacted the patient. She was very happy with the outcome of her complaint and is happy with the PTS service she has received since.
27.10.2016	127/16	to report back to the January Board on plans to resolve call taker audits.	Joe Garcia	January	Board	IP	**Verbal Update to be provided 26.01.2017**
27.10.2016	131/16	Future IPRs to include a clear statement about whether we are within the national control limit	Andy Newton	November	Board	**C**	**Update from 24.11.16**: AN we are within national limits but in some in lower quartile as per IPR. We will make clear when outside
27.10.2016	132/16	The output from the M&M Group to be monitored via the quality and patient safety committee	Rory McCrae	Q4	Board	IP	Under review as part of review of board and management governance structure
27.10.2016	133/16	Future SI reports will include more narrative / interpretation, including benchmarking and comparative data	Emma Wadey	Q4	Board	IP	Whole SI process including reports is under review and training has been arranged in Human factors and RCA for Feb. We are piloting a new apaproach supported by NHSE
27.10.2016	134/16	Paper on 111 to come to the Board after consideration by the Executive	David Hammond	Q4	Board	IP	
24.11.2016	144/16	Update on the progress with Handover delays to the Board in February	Geraint Davies	23.02.17	Board	IP	On agenda orward plan
24.11.2016	146/16	The Board to receive a detailed overview of the progress against the URP	Geraint Davies	23.02.17	Board	IP	
24.11.2016	149/16	Overview of STPs to the Board in January	Jon Amos	26.01.17	Board	**C**	On agenda (part 2)
24.11.2016	151/16	Board members to provide comments on the draft agency self certification check list to SG or PL prior to 30.11.16	Board Members	30.11.16	Board	**C**	No comments were received and the return was submitted
24.11.2016	153/16	JG to give an update on the ARP to the Board in January, in particular on the identification of Red 1 calls	JG	26.01.17	Board	IP	**Update to be provided 26.01.17**

South East Coast Ambulance Service NHS
NHS Foundation Trust

Item No	165/16

Name of meeting	Trust Board
Date	26 January 2017
Name of paper	Chief Executive's Report
Executive sponsor	Acting Chief Executive
Author name and role	David Hammond, Director of Finance & Corporate Services
Synopsis (up to 120 words)	The Chief Executive's Report provides an overview of the key local, regional and national issues involving and impacting on the Trust and the wider ambulance sector.
Recommendations, decisions or actions sought	The Board is asked to note the content of the Report.
Why must **this** meeting deal with **this** item? (max 15 words)	To receive a briefing on key issues, as noted above.
Which strategic objective does this paper link to?	2. Culture

Does this paper, or the subject of this paper, require an equality analysis ('EA')? (EAs are required for all strategies, policies, procedures, guidelines, plans and business cases).	Yes / **No**

SOUTH EAST COAST AMBULANCE SERVICE NHS FOUNDATION TRUST

CHIEF EXECUTIVE'S REPORT TO THE TRUST BOARD

January 2017

1. Introduction

1.1 This report seeks to provide a summary of the key activities undertaken by the Chief Executive and the local, regional and national issues of note in relation to the Trust.

2. Local issues

2.1 Recruitment to the substantive Chief Executive role

2.1.1 On 4th January 2017, the Trust announced the appointment of Daren Mochrie as the new Chief Executive, following a robust recruitment and selection process.

2.1.2 Daren, a paramedic, is currently Director of Service Delivery for the Scottish Ambulance Service and has worked in the NHS in Scotland since 1988. He has extensive experience of managing ambulance services in both rural and urban settings and was the lead for ambulance provision to the 2014 Commonwealth Games in Glasgow. We have now confirmed that he will start with the Trust on 3rd April 2017.

2.2.3 Geraint Davies will continue as Acting Chief Executive until Daren joins the Trust in April.

2.2 Changes at Director/Senior Management level

2.2.1 On 6th January 2017, it was announced that Dr Rory McCrea had decided to step down from his role as Medical Director, with immediate effect, for personal reasons.

2.2.2 Dr Andy Carson has now joined the Trust as Interim Medical Director. Dr Carson is a practising GP and his substantive position is as Medical Director with West Midlands Ambulance Service.

2.2.3. On 6th January 2017, it was also announced that Professor Andy Newton would be stepping down from his role as Executive Paramedic Director but would remain with the Trust as a Consultant Paramedic.

2.2.4 In early January 2016, Dr Katrina Herren resigned as a Non-Executive director of the Trust. The recruitment process for a new Non-Executive Director is currently underway.

2.2.5 I also wanted to provide you with an up-date on the recruitment process for a substantive Chairman for the Trust, as Sir Peter Dixon's term of office is due to end shortly. The recruitment and selection process is currently underway, with interviews due to take place at the end of February. We will be able to provide more information in due course.

2.2.6 With regard to further senior management appointments, I am pleased to announce that the Trust has appointed Sarah Songhurst into the new position of Deputy Chief Nurse. Sarah, who started with the Trust on 4th January 2017, is an extremely experienced nurse who will provide valuable support to Emma Wadey.

2.3 Computer Aided Dispatch (CAD) system procurement

2.3.1 On 13th January 2017, it was announced that, following a final presentation day with the short-listed potential suppliers, that involved feedback from 50 members of staff, Cleric Computer Services have been selected to provide the new Computer Aided Dispatch (CAD) system for the Trust.

2.3.2 Cleric are already a major provider of CAD systems to UK ambulance services for 999 and 111.

2.3.3 The project to implement the new CAD system within the Trust is now underway and will run in parallel with the development of the new EOC at Crawley.

2.4 Operational Unit (OU) leadership re-structure

2.4.1 The second period of consultation regarding the OU restructure ended on 12th January 2017.

2.4.2 After considering all possible options and listening to the feedback we have received from staff and their representatives through the consultation process, the Trust has decided to re-phase the transformation of the Make Ready Centre Managers and Scheduling Managers accountability and responsibilities. This part of the project will now be implemented in the second quarter of 2017, to coincide with the HQ move to Crawley.

2.4.3 The rest of re-structure programme is continuing and recruitment is now underway for both the Operations Manager and Operational Team Leader positions, which will close on 30th January 2017.

2.5 Winter period

2.5.1 The Trust experienced a difficult Christmas and New Year period operationally, compounded by higher than expected demand, failures in Out of Hours (OOH) services and pressures in the acute sector, resulting in extremely high levels of hospital handover delays.

2.5.2 In the early hours of 1st January 2017, London Ambulance Service (LAS) experienced a CAD failure, which saw them revert to working on paper and significant numbers of calls being transferred to SECAmb, along with other neighbouring Trusts.

2.5.3 Following resolution of the LAS CAD issue, we continued to experience extremely high levels of demand during 1st January 2017, resulting in the

Trust declaring a Business Continuity Incident (BCI) in order to prioritise our response to the most serious patients.

2.5.4 I would like to thank staff across the Trust for their hard work and commitment during what was a very challenging period operationally.

3. Regional Issues

3.1 Contract negotiations

3.1.1 After a considerable and challenging negotiation phase, the two-year contract for 999 services with each of the three counties was signed on 23rd December 2016, in line with the nationally-set timescales.

3.1.2 The Trust agreed with its Commissioners on growth and price for the contract which covers the two-year period between 2017 and 2019.

3.1.3 As part of the process, it has also been agreed that a joint piece of work will be undertaken between January and March 2017 to establish the correct levels of funding which SECAmb require from Commissioners in order to run an effective service, taking into consideration the issues that we face on day to day basis such as handover delays, lack of alternative pathways to Emergency Departments and continuing increased demand.

3.2 Financial position

3.2.1 The Trust continues to report a forecast outturn at 31st March 2017 of a £7.1m deficit. This deficit was declared at month 3 following the CQC inspection and the Trust being placed into Special Measures.

3.2.2 The immediate financial measures being put in place by the Trust, including steps being taken to prioritise overtime and reduce the payments made to staff for interrupted meal-breaks, has resulted in some local and national media attention this month.

3.3 Sustainable Transformation Plans (STPs)

3.3.1 We continue to work actively with the four STPs in our region. We have individual meetings booked with each of the STP leads in the near future to ensure that we remain engaged in the most effective way .

4. National Issues

4.1 National Audit Office (NAO) report on ambulance services

4.1.1 The National Audit Office (NAO) report into NHS ambulance services is due to be published in late January 2017.

4.1.2 A summary of the key findings of the report and the potential implications for the broader sector and for SECAmb will be reported to a future Trust Board meeting.

4.2 NHS England report ‘Allied Health Professions into Action’

4.2.1 On 17th January 2017 NHS England published its report 'Allied Health Professions into Action', designed to inform and inspire the system about how AHPs, including paramedics, can be best utilised to support future health, care and wellbeing service delivery. It offers examples of innovative AHP practice and a framework to develop a plan of delivery.

4.2.2 In discussion with our Commissioners, we will be considering the implications of the report on our future clinical model and associated workforce planning.

5. Recommendation

5.1 The Board is asked to note the contents of this Report.

South East Coast Ambulance Service NHS
NHS Foundation Trust

Item No	166/16

Name of meeting	Board
Date	26th January 2017
Name of paper	Moving to Crawley – People and Culture Change
Executive sponsor	Steve Graham – Interim Director of HR
Author name and role	Steve Graham – Interim Director of HR Ibrahim Razak – Project Manager
Synopsis, including any notable gaps/issues in the system(s) you describe (up to 150 words)	Update on the HQ & EOC Move to Crawley including brief progress update and a high level summary of what will be delivered within the EOC and HQ areas. Discussion around the HR elements and cultural change.
Why must **this** meeting deal with **this** item? (max 15 words)	Strategic direction of the Trust
Which strategic objective does this paper link to?	Strategic Direction with regards to: Governance, Culture, Financial Sustainability

Moving to Crawley – People and Culture Change

1.0 Introduction

1.1 The purpose of this paper is to advise the Trust Board of the current status of the New HQ and EOC Project.

2.0 Background

2.1 The building phase of the New HQ and EOC site in Crawley is nearing completion. The IM&T infrastructure necessary for running the EOC and HQ is being developed and installed in parallel. The EOC is expected to be ready in April 2017, with the HQ following in May-June 2017.

2.2 To date, the Project's focus has been on the building and physical aspects of the move, which are running to plan. Focus has now shifted to the People impact.

2.3 With the merger of Lewes and Banstead EOCs, and support staff from the three regional offices, it is necessary to identify and embed new ways of working. The move to Crawley is an opportunity to depart from existing regional cultures and implement common working practices.

3.0 Emergency Operations Centre

3.1 Situated on the ground floor of the Surrey County Council building, the new EOC features:

- 81 desks for call taking, dispatch and clinical functions
- The EOC training facility (2 x 13 desks) will be dual purpose and will transform into a fall back EOC.
- Gold Command Suite which will be used by Clinical Audit during normal operations
- Enhanced resilience through diverse routing and avoidance of a 'single point of failure'.
- Two standby generators capable of running the EOC should there be a loss of power to the site.

3.2 Specialist ergonomic consultants have been engaged to work with EOC staff and managers to deliver the EOC design required to support delivery of the 999 service.

3.3 The Trust has been successful has secured building enhancements including:

- A higher floor to ceiling height to improve ergonomics
- Good natural light and ventilation
- A flexible open plan design which provides flexibility to meet future demand. The Mechanical & Electrical installation has been designed to support this.
- Appropriate localised welfare facilities
- 600mm voids below the floors and above the ceilings to facilitate the high levels of cabling required at present, and for future adaptability.

4.0 New Trust Headquarters

4.1 Predominantly situated on the first floor, with Board Room (which can be subdivided into 3 meeting rooms), Staff Welfare Facilities and IT server room on

the ground floor. Designed to accommodate all support staff from the Banstead HQ and two regional offices, features:

- 175 desks in an open plan configuration
- 18 Meeting Rooms (in addition to the Board room)
- New fit for purpose data centre for all 999 and Corporate Systems
- Staff welfare facilities for all staff
- 175 car parking spaces including disabled and electric charging points
- Bicycle racks
- Fire Protected lifts

5.0 Meeting and Training Facilities

5.1 The New HQ has a number of training and meeting facilities including:

- 18 meeting rooms of varying sizes throughout the building, suitable for 121 meetings, PADRs, confidential conversations and for groups of up to 12 people.
- Board Room including public hearing loop.
- Board Room suitable for Public Trust Boards and other large meetings when not sub-divided.
- EOC Training will take place in the two training rooms provided

6.0 Benefits Realisation

- £2.040k financial benefit package, which includes;
    - Saving on rent of £1,440k
    - Landlords reverse premium incentive of £600k

- £200k p.a. estimated saving on Staff Travel
- £250k p.a. estimated saving by removal of duplicate costs (circa 12 WTE)
- £250k p.a. planned savings associated with staff time efficiencies
- £240k p.a. saving on EOC Management Costs
- £240k p.a. estimated saving on High Cost Allowance (Banstead Staff)

7.0 A building staff are proud to work in

- A modern newly constructed office building in Manor Royal, Crawley.
- Design consultants have engaged with EOC and HQ staff to ensure the new space meets our needs.
- A good standard fit-out of EOC and office spaces.
- Purpose built IT Server Room.
- Standardised and matching furniture.
- Improved teamwork and interaction amongst colleagues.

8.0 People and Culture

8.1 The HR team has conducted one round of 1 to 1 meetings with all affected staff. This yielded valuable information on the intentions of staff and the outstanding issues.

8.2 A second round of 1 to 1 meetings is about to commence led again by the HR team.

8.3 This round will focus on feeding back the responses to the first round of questions and obtaining confirmation from employees on their intention to relocate or not.

8.4 In addition, an external consultancy specialising in the relocation of multiple teams to a single site has been identified to provide support on the engagement of transferring staff and development of culture within the new building.

8.5 This consultancy (called Ignite) has identified in their proposal that

8.5.1 Around two thirds of the posts which will be relocated are EOC staff. The key issue in transferring these posts is to maintain safe services by maximising retention of trained staff.

8.5.2 For the remaining posts (support staff) there will be a greater emphasis on using the transfer to explore new ways of working across the various functions to improve performance and deliver efficiencies.

8.5.3 For all staff (and managers) transferring to the new location support will be required to ensure that a shared culture and common set of working practices are adopted.

8.6 To deliver the move and achieve the outcomes mentioned above the key areas of focus for Ignite will be:

- Staff Engagement
- Developing and embedding new ways of working
- HR Support

8.7 Procurement processes are underway to secure the services of Ignite in the delivery of these outcomes.

South East Coast Ambulance Service NHS
NHS Foundation Trust

	Item No	167/16

Name of meeting	Trust Board
Date	26 January 2017
Name of paper	Board assurance framework
Executive sponsor	Executive Team
Author name and role	Peter Lee, Company Secretary
Synopsis, including any notable gaps/issues in the system(s) you describe (up to 150 words)	The Board Assurance Framework (Appendix 1) sets out the strategic risks facing the Trust, the mitigation, and actions to be taken. It also confirms the current risk rating, and the target risk rating post treatment.
Why must **this** meeting deal with **this** item? (max 15 words)	The Board needs to confirm its tolerance of the target risk scores as set out and form a view as to the adequacy of arrangements the Executive has put in place to establish and maintain a sound system of internal control.
Which strategic objective does this paper link to?	All 16-17 objectives.

1. Background

This Board Assurance Framework (Appendix 1) sets out the principle strategic risks currently facing the Trust and describes the mitigating controls and assurances. This current version takes account of the absence of any clearly defined strategic objectives, something that is being rectified with the substantive strategy refresh which is due to be completed in March 2017. The BAF is therefore not specifically aligned to the Trust objectives but instead reflects the broad strategic risks structured against the following objectives;

- Financial Sustainability
- Fundamental Standards
- Strategy
- Unified Recovery Plan
- Workforce

The Executive acknowledges that the policy, system and controls over operational risk management are not currently designed nor operating as well as the Trust requires. A revision of the risk management strategy and policy has been completed by the Director of Quality and Patient Safety. The need for a functioning risk register is still key to supporting the change in the culture of risk management; the new Datix risk module is due to go live from April 2017. In the interim, risk management remains variable across the Trust.

2. The Assurance Framework

The Board Assurance Framework provides a structure which enables the Executive and Board of Directors to focus on the Trust's principal risks and seek assurance that adequate controls are in place to manage the risks appropriately.

The risks are rated in accordance with the risk score matrix below.

Risk Score Matrix					
	Likelihood:				
Consequence:	Rare (1)	Unlikely (2)	Possible (3)	Likely (4)	Almost Certain (5)
Insignificant (1)	1	2	3	4	5
Minor (2)	2	4	6	8	10
Moderate (3)	3	6	9	12	15
Major (4)	4	8	12	16	20
Catastrophic (5)	5	10	15	20	25

The Board Assurance Framework has been reviewed by the lead Executive Directors and updated accordingly. The newly established Executive Risk Management & Assurance Group will consider and update it at regular intervals, focussing specifically on the impact of the controls and implementation of the actions.

3. Recommendation

It is recommended that the Board confirms the extent to which is believes that;

i. The risks described represent the main strategic risks facing the Trust
ii. The current risk rating adequately reflects the risk with the controls in place
iii. The risk treatment is appropriate
iv. The stated actions are sufficient
v. The target risk score is tolerable and stretching

Objective:	Unified Recovery Plan		
Principle Risk	Weakness in the governance structure which supports the oversight and delivery of the URP	**Executive Lead**	Chief Executive
		Initial Risk	C4 x L4 = 16
Potential Impact	➢ Insufficient grip and accountability ➢ Lack of understanding as to how the recovery programme is functioning ➢ False assurance being provided about the progress being made ➢ Losing sight via actions	**Current rating**	C4 x L3 = 12
		Risk Treatment (avoid, reduce, transfer, accept)	**REDUCE**
		Target risk score	C4 x L2 = 8

Controls in place (what are we doing currently to manage the risk)

- From 1 January 2017 a new assurance structure has been established to help ensure programme leads are held to account for delivery of the URP and to collate the evidence which demonstrates the same.
- Focus on the CQC must do actions (dashboard gives overview)
- EY has been commissioned to develop greater capacity and capability within the PMO

Gaps in Control

- URP Tracker not being used properly and is not giving a clear enough overview of delivery
- Dashboard to give at a glance where we are with each project

Assurance: Positive (+) or Negative (-)	Gaps in assurance
(-) and (+) CQC dashboard shows a number of completed actions, but some which are at risk (+) Performance Review Meetings with NHSI (-) Steering Group highlighting that structure is still embedding	▪ The pace of recruitment of substantive staff ▪ Clearly defined metric(s) to measure the benefit realisation ▪ Programme Risk Register ▪ Quality Assurance Reviews ▪ Interdependencies map between projects (to ensure nothing falls through the gaps between individual pieces of work)

Mitigating actions planned / underway	Progress against actions (including dates, notes on slippage or controls/ assurance failing.
1. Develop greater capacity and capability within the PMO 2. Quality Assurance Reviews 3. PMO working through each action plan and project to re-test outcomes / benefits	1. EY conducted a maturity assessment to be considered by the Executive 25.01.17 2. Paper setting out the plan for quality assurance reviews considered by the Executive 23.01.17 and schedule of reviews to begin in February. NSHI-led review will be undertaken in March.

Update	23.01.17	Date discussed at Board	

Objective:	Workforce		
Principle Risk	Insufficient capacity and capability within key departments across the Trust	**Executive Lead**	Director of HR
		Initial Risk	C4 x L4 = 16
Potential Impact	➢ Lack of consistent leadership ➢ Insufficient ownership and pace re improvement ➢ Stop / start nature of interims ➢ Poor staff morale: ▪ sickness ▪ turnover ▪ patient care	**Current rating**	C4 x L3 = 12
		Risk Treatment (avoid, reduce, transfer, accept)	**REDUCE**
		Target risk score	C4 x L2 = 8

Controls in place (to manage the risk)

- Resourcing to the current funded establishment (vacancy rate currently below 10% target)
- Substantive Chief Executive appointed (starts 03.04.17)
- Independent Non-Executive Director appointed (starts 01.02.17)
- £0.5m to fund workforce-related initiatives provided by Health Education Kent Surrey & Sussex
- Two posts created with HR Directorate to focus on staff engagement

Gaps in Control

- Board succession plan
- Department/Directorate workforce plans
- Leadership development programme
- Board development programme

Actual Assurances: Positive (+) or Negative (-)	Gaps in assurance
(-) Integrated Performance Report (-) Workforce and Wellbeing Committee (-) Appointment & Remuneration Committee (ARC) (-) PMO (EY initial review)	2016/17 Staff Survey (due late Q4)

Mitigating actions planned / underway	Progress against actions (including dates, notes on slippage or controls/ assurance failing.
1. HR Business Partners to develop workforce plans for each department/directorate 2. Chair recruitment underway 3. Initiatives being developed re culture, e.g. leadership development programme; bullying and harassment plan. 4. Pilot of an on-line appraisal system (HR team; Executive). 5. Executive restructure	1. Plans being developed; target end of March 17 2. Interviews 21 February 3. Met with Kings Fund and a leadership development business case scheduled to be considered by the executive in Q4. Engaged an external Professor on bullying & harassment diagnostic. 4. Evaluations early February for roll out to whole Trust in April 5. Consultation runs to end of January. ARC scheduled in February will agree succession plans for Executive

Update	23.01.17	Date discussed at Board	

Objective:	Financial Sustainability		
Principle Risk	Capability & Capacity of staff to own and manage budgets effectively and deliver required saving plans. Uncertainty within commissioning (identified structural gap)	**Executive Lead**	Director of Finance
		Initial Risk	C4 x L4 = 16
Potential Impact	➢ Not achieving financial plans and control total ➢ Inadequate cash reserves leading to borrowing ➢ Adverse impact on improvement plans and future investment strategy ➢ Going concern	**Current rating**	C4 x L3 = 12
		Risk Treatment (avoid, reduce, transfer, accept)	**REDUCE**
		Target risk score	C4 x L2 = 8

Controls in place (to manage the risk)

- Finance team restructure
- Financial Sustainability Steering Group
- Executive challenge sessions
- Reinforcement of monthly budget (challenge) meetings
- Financial business partner model established
- Contract negotiations provided £3-4m improvement on initial offers
- Support from NHSI
- Overdraft facility secured from NHSI

Gaps in Control

- Finance team restructure (starting February, implementation April)

Actual Assurances: Positive (+) or Negative (-)	Gaps in Assurance
(-) (+) Internal Audit (-) (+) FIC (-) NHSI	Cost Improvement Plans for 2017/18

Mitigating actions planned / underway	Progress against actions (including dates, notes on slippage or controls/ assurance failing.
1. Following mediation work to address structural gap jointly commissioned by with the 22 CCGS 2. Finance team restructure 3. CIP planning	1. PID to be agreed by 31.01.17 and agreement by 31 March 2017 2. Planning started and aim to put in place by April 17 3. 40% plans agreed. All plans by end of March with QIAs overseen by QPS Committee

Update	23.01.17	Date discussed at Board	

Objective:	Trust Strategy		
Principle Risk	No up-to-date strategy	**Executive Lead**	Chief Executive
		Initial Risk	C4 x L5 = 20
Potential Impact	➢ Lack of strategic direction which takes account of the internal and external changes since last strategy was developed ➢ Inappropriate decision-making and allocation of resources	**Current rating**	C4 x L2 = 8
		Risk Treatment (avoid, reduce, transfer, accept)	**REDUCE**
		Target risk score	C4 x L1 = 4

Controls in place (to manage the risk)

- Recruitment of a deputy director of strategy to lead the substantial refresh of the Trust's strategy, which is to run from November 2016-March 2017.
- Engagement of internal and external stakeholders to ensure their views are considered and fed-back to decision-makers in real time
- Sessions held with the Board, Council of Governors, Executive and Senior Management Team
- Some decisions with strategic consequences paused until the outcome of the strategy refresh
- Sessions held with each directorate to ensure the work to date is discussed, debated and cascaded.

Gaps in Control

- Although some work has started, there are a number of enabling strategies to review and / or develop. Such as; staff health and wellbeing; Fleet etc.
- Agreement of the clinical model

Assurances: Positive (+) or Negative (-)	Gaps in assurance
(+) Progress updates provided to the Board of Directors and Council of Governors (-) Recent review by the executive identified some weaknesses in the development of the clinical model	None

Mitigating actions planned / underway	Progress against actions (including dates, notes on slippage or controls/ assurance failing.
1. Clinical Directors in the process of developing the new clinical model 2. The write up of the context and framework of the strategy to ensure readiness for implementation from April 2017 3. Executive Strategy Group established to ensure delivery scheduled on 08.02.17; 01.03.17; 29.03.17 and 12.04.17 to ensure delivery.	3. Strategy Group scheduled on 08.02.17; 01.03.17; 29.03.17 and 12.04.17

Update	23.01.17	Date discussed at Board	October 2016

Objective:	Fundamental Standards		
Principle Risk	Non-compliance with the Fundamental Standards (section 2 of the Heath & Social Care Act 2008 (Regulated Activities) Regulations 2014)	**Executive Lead**	Director of Quality & Patient Safety
		Initial Risk	C5 x L4 = 20
Potential Impact	➢ Inappropriate and unsafe provision of care and treatment ➢ Suspension or cancellation of our CQC registration to provide services ➢ Breach of contract with commissioners ➢ Regulatory, criminal and / or civil sanctions ➢ Poor use of resources	**Current rating**	C5 x L3 = 15
		Risk Treatment (avoid, reduce, transfer, accept)	**REDUCE**
		Target risk score	C5 x L2 = 10

Controls in place (to manage the risk)

- A quality and compliance work plan and strategy is being implemented to concentrate on the quality and compliance with the CQC Fundamental Standards (launched from February 2017).
- Publication on 03.02.2017 of the CQC Fundamental Standards staff handbook, developed in consultation with a wide range on internal stakeholders
- Quality Steering Group established to ensure improvement in standards
- Recruitment to key governance roles
- Staff training
- Upgrade to risk management database

Gaps in Control

- Quality & Compliance Strategy
- Implementing new working group governance structure
- Vacancies within the risk and clinical audit teams
- Interim staff in key roles

Assurances: Positive (+) or Negative (-)	Gaps in assurance
(-) CQC comprehensive inspection and related s.29a Warning Notices (+) & (-) Board Assurance Committees (-) NHSI diagnostic (safeguarding, incident and risk management)	▪ Quality Assurance Reviews ▪ CQC re-inspection ▪ External well-led review

Mitigating actions planned / underway	Progress against actions (including dates, notes on slippage or controls/ assurance failing.
1. Quality Assurance Reviews 2. Staff training workshops (safeguarding, SI and risk management) 3. Self-Assessment tool kit 4. Quality & Compliance Strategy in development	1. Reviews to start on 08.02.2017 2. Due to start February 2017 3. Due to start February 2017 4. Scheduled to be considered by the Executive in April 2017

Update	23.01.17	Date discussed at Board	

South East Coast Ambulance Service NHS
NHS Foundation Trust

Item No	168/16

Name of meeting	Board
Date	26 January 2017
Name of paper	Risk Management Strategy
Executive sponsor	Emma Wadey
Author name and role	Dan Hale - Interim Associate Director Governance
Synopsis (up to 120 words)	The Risk Management Strategy (Appendix 1) outlines how the Trust will identify, assess, manage and report risk, whilst defining the risk appetite for the Trust.
Recommendations, decisions or actions sought	The Board is asked to approve/ratify the Risk Management Policy for implementation across the Trust.
Why must **this** meeting deal with **this** item? (max 15 words)	Board level ownership for Risk Management, and as part of meeting CQC Fundamental Standard Good Governance (Regulation 17)
Which strategic objective does this paper link to?	

Does this paper, or the subject of this paper, require an equality analysis ('EA')? (EAs are required for all strategies, policies, procedures, guidelines, plans and business cases).	**No**

South East Coast Ambulance Service NHS
NHS Foundation Trust

Risk Management Strategy & Policy

Document Number	[To be inserted by CRA if this is a new document]
Version:	
Name of originator/ author:	Interim Associate Director Governance

Policy:	
Approved by:	[Trust Board or name of Committee]
Date approved:	

Procedure:	
Approved by:	[Name of Working Group]
Date approved:	

Date issued:	[To be inserted by CRA]
Date next review due:	
Target audience:	
Replaces:	

Equality Analysis (EA) Record

Approved EA submitted	Dated:	

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1 Governance of Risk Management

1.1 Introduction

1.1.1. South East Coast Ambulance Service (The Trust) is committed to establishing and implementing a Risk Management Strategy, which minimises risk to its stakeholders' through a comprehensive system of internal controls. The Risk Management Strategy provides a framework, which encompasses strategic, financial, quality, reputational, compliance and health & safety risks. Its aim is to ensure the safety of patients, staff and the public and to deliver quality, patient centered services that achieve excellent results, promoting the best possible use of public resources, through an integrated approach to managing risks.

1.1.2. From a strategic perspective, The Trust aims to fully understand the current and potential risks to the organisation and to ensure that risk reduction/mitigation strategies are developed to address risks. This in turn will provide public and board assurance that the controls in place to reduce risks are working effectively. As such the system of internal control should;

- Be embedded in the operation of the organisation and form part of its culture;
- Be capable of responding quickly to evolving risks; and
- Include procedures for reporting and escalating any significant control failings immediately to appropriate levels of management.

1.1.3. The Trust expects all staff to subscribe to its vision, values and strategic goals to which this strategy relates. This strategy is therefore integral to the work of all the Trust's Directorates and supports the delivery of strategic goals over the next five years. Failure to successfully implement an effective risk management process could severely impact on the Trust's ability to deliver safe, high quality care and reputation.

1.1.4. The strategy is supported by the Risk Identification, Assessment and Risk Register Procedure (as outlined in Section 2.0) which includes the process to identify and manage local risks and the systemic means by which these local risks are escalated to Board level attention through the Board Assurance Framework (BAF). This demonstrates how the Trust's policies, systems and processes provide an effective and robust governance structure enabling the identification of emerging issues and their control, monitoring, and escalation at appropriate levels in a timely way.

1.1.5. The Trust has identified 3 Strategic Goals for 2015-2019 as outlined in the Trust Recovery Plan;

- Improve operational performance
- Meet our financial commitments
- Improve quality of patient care and experience

1.1.6. As reflected in the Board Assurance Framework the three key thematic risks to the achievement of its strategic objectives over the next year are;

- Ineffective controls and mitigation in place to enable improvements to operational performance, governance and clinical quality
- Failure of, or ineffective outcome delivery of projects and plans delivering operational re-structure, relocation of Emergency Operation Centres to the new Headquarters and implementation of ePCR
- Insufficient control or unplanned required investment affecting financial sustainability.

1.1.7. The following document therefore sets the aims and objectives for risk management and the assurance mechanisms for measuring performance and progress.

1.2. Legislative, Regulatory and Guidance Framework for Risk Management

Legislation

1.2.1. The Trust has statutory responsibilities for risk assessing and reducing risks under

- Health and Safety at Work Act 1973; and
- Management of Health and Safety at Work Regulations 1992 (amended 1999);

1.2.2. In addition, the Trust has a number of responsibilities as outlined in the Health and Safety Policy.

Care Quality Commission

1.2.3. The CQC use a risk based approach to make decisions on compliance with the Fundamental Standards; as such it is essential the Trust make a connection between quality and risk.

1.2.4. Regulation 16 - Assessing and Monitoring the Quality of Service Provision requires that healthcare providers “have an up to date description of the systems and methods the continuous quality improvement system uses to identify, assess, manage, monitor and record risk”.

NHS Improvement

1.2.5. As a Foundation Trust that it is essential the Trust develops a strategy and culture which will enable compliance with the following Frameworks/guidance;

- NHS Foundation Trust Code of Governance, Section C2. Risk Management and Internal Control; and
- Compliance Framework, Section 3 Risk Assessment.

International Standard ISO31000

1.2.6. It is the policy of the Trust to align to the International Standard for Risk Management (Principles and Guidelines) ISO31000 as a good practice framework

1.3. Purpose and Objectives

1.3.1. The purpose of the Risk Management Strategy is to deliver a pragmatic and effective multidisciplinary approach to risk management, which is underpinned by a clear accountability structure from Board to Practitioner level. It recognises the need for robust systems and processes to support continuous programmes of risk management enabling staff to integrate risk management into their daily activities and support better decision making through a good understanding of risks and their likely impact.

1.3.2. The strategy enables the identification and management of risks which may prevent the achievement of the Trust's Strategic Goals or the delivery of safe, high quality care; therefore the key objectives of the Risk Management Strategy are to;

- Develop a culture where risk management is integrated into all Trust business;
- Ensure appropriate structures are in place to manage risks with clear escalation levels and processes;
- Create a system which is user friendly and allows the prompt assessment and mitigation of risk;
- Clearly describe the risk appetite of the organisation;
- Reduce risks to patients, carers, staff, sub-contractors, members of the public, visitors etc to an acceptable level;
- Develop an 'open culture' which encourages staff, patients and members of the public to report adverse events in a just and fair environment, so that potential trends and lessons may be identified and support offered to those reporting.
- Maximise resources available for patient services and care;
- Minimise financial liability;
- Prioritise risk management action plans;
- Embed risk management throughout the Trust, in support of integrated governance; and
- Provide a system, which integrates into the planning and performance management frameworks to minimise duplication whilst adding value.

1.4. Risk Management Policy Statement

1.4.1. The management of risks is a key factor in achieving the provision of the highest quality care to patients. Of equal importance is the legal duty of the Trust to control any potential risk to staff and the general public, as well as safeguarding assets of the Trust. It is the responsibility of all staff to be involved in the identification and reduction of risks.

1.4.2. All staff are responsible for their own health and safety, and the health and safety of other staff, patients, visitors and others who attend our premises and

this is the main component of much health and safety legislation, as identified within the Health and Safety Policy.

2 Definitions

Board Assurance Framework	The Board level log of Strategic Risks. The BAF also includes any Operational Risks, which may affect the achievement of the Five Year Strategic Plan escalated to the Board by the Executive Leardership Team.
Consequence	A measure of the impact that the predicted harm, loss or damage would have on the people, property or objectives affected.
Control	Immediate actions put in place to control the risk - these may be short term controls.
Directorate Risks	Those risks that if realised could threaten the way in which the organisation operates at a local or departmental/directorate level, affecting the delivery of services, but unlikely to directly impact the Strategic Goals outlined in the Five Year Strategic Plan.
Existing Controls	The controls and mitigating actions already in place through standard business as usual operations/practise.
Hazard	Anything that has the potential to cause injury, loss, damage or harm.
Issues Log	A log of the Operational Issues requiring business as usual management and monitoring.
Lessons Log	A log of all the lessons captured during incident investigation, to reduce the likelihood of incidents re-occurring.
Likelihood	A measure of the probability that the predicted harm, loss or damage will occur
Mitigating Action	Actions which cannot be implemented immediately to control the risk, but which are required to control the risk in the longer term.
Operational Risks	Those risks that if realised could threaten the way in which the organisation operates across the Trust or a number of divisions/departments and may have an indirect impact to the achievement of the Strategic Goals outlined in the Five Year Strategic Plan. Generally Operational Risks will require controls or mitigating actions outside/above business as usual management.
Operational Issue	An operational problem, not so severe/serious enough for it to be considered an Operational Risk and requires business as usual management.
Residual Risk	The risk remaining following mitigation.
Risk	The combined likelihood and consequence of harm, injury, damage or loss occurring or impacting the achievement of the Trusts objectives or strategic goals.
Risk Appetite	The Trust's cultural, attitude/approach toward the management of risk, including setting the level of organisational risk that the Trust is willing to accept after mitigating actions have been applied.
Risk Assessment	The process by which hazards are identified and the risk rated using tools implanted by the Trusts for use by all employees. Assessments can be either general or specific, but will be undertaken by competent persons who have received the appropriate degree of information,

	instruction and training.
Risk Management	The systematic application of management policies, procedures and practices to identifying, analysing, assessment, treating and monitoring risk.
Risk Matrix	The tool used to 'score' each risk and determine its place on the Risk Register.
Risk Mitigation	The systemic reduction in the extent of exposure to a risk and/or the likelihood of its occurrence.
Risk Register	A log (captured in Datix) of all the risks that may threaten the success of the Trust in achieving its declared aims and objectives.
Strategic Risks	Those risks that if realised could threaten the way in which the organisation exists or operates. These risks will have a direct detrimental effect on the achievement of the Strategic Goals outlined in the Five Year Strategic Plan and are captured in the Board Assurance Framework.
Tolerable Risk	The risk that has been identified, assessed and evaluated and does not require any further mitigating actions because the risk has a score of less than 6 (low), the Trust's ability to mitigate the risk is constrained or taking action would be disproportionately costly.

3 Responsibilities

The organisational management of risk forms part of the Trust's overall approach to governance, with individual and committee responsibilities as outlined below;

3.1. Individual Responsibilities

3.1.1. The **Chief Executive**, as Accountable Officer has overall responsibility for risk management and for ensuring the Trust has a Risk Management Strategy and infrastructure in place to provide a comprehensive system of internal control and systemic and consistent management of risk. S/He will delegate specific roles and responsibilities to the appointed Executive Director/Senior Managers to ensure risk management is co-ordinated and implemented equitably to meet the Trusts objectives.

3.1.2. The **Director Quality and Safety / Chief Nurse** has the delegated board level responsibility for ensuring that all risk and assurance processes are devised, implemented and embedded, reporting to the Chief Executive and Executive Team any significant issues arising from the implementation of this strategy including evidence of non-compliance or lack of effectiveness arising from the monitoring process so that remedial action can be taken.

3.1.2.1. In addition the **Director Quality and Safety / Chief Nurse** has the delegated board level responsibility for quality, health and safety and patient experience in relation to risk management processes and holds the responsibility for the Trust risk of non-compliance with CQC fundamental standards, and is the director with responsibility for decontamination and infection prevention and control.

3.1.3. The **Director of Finance, Facilities and IM&T** has the delegated board level responsibility for financial constraints and balances competing financial

demands and for coordinating the audit programme within the Trust. S/He is also the Senior Information Risk Owner (SIRO) with responsibility for information governance risk management.

3.1.4. The **Operations Director** is responsible for the operational delivery of the Trusts services, and as such holds the executive level ownership for risks relating to the delivery of operational services.

3.1.5. The **Director of Strategy** has the board level responsibility for implementing an effective Programme Management Office and for Change Control Processes. S/He is responsible for ensuring that risks relating to delivering service transformation and re-design are identified, mitigated and managed through robust business case and change control processes.

3.1.6. The **Director of Human Resources** has the board level responsibility for implementing effective workforce planning, staff welfare, recruitment and retention and organisational development strategies. S/He is responsible for ensuring that risks relating to human resources and organisational development are identified, mitigated and managed.

3.1.7. **All Executive Directors** are accountable for the delivery of quality services in the areas within their remit (whether clinical or operational) and lead on the delivery of the Trust's Strategy with responsibility for ensuring that risks are appropriately identified and controlled. They will ensure the quality agenda is effectively co-ordinated, resourced and implemented across the Trust in an integrated way, ensuring actions to improve the quality of service delivery are completed, measured and shared to identify lessons and areas for improvement and of best practice. Executive Directors are accountable for ensuring that the potential effect on the quality of service delivery is risk assessed prior to approval of any new business proposal. They will ensure that the infrastructure to enable staff to deliver high quality care within their areas of responsibility is in place.

3.1.7.1. Through directorate Senior Management Teams, Executive directorate are responsible for:

- Ensuring the division is compliant with risk management strategies, policies and processes;
- Managing divisional and service risks;
- Escalating risks, issues or requests for assistance to the Trust Senior Mangement team.
- Managing, implementing and tracking mitigating actions, plans and lessons identified.

3.1.8. All **Senior Managers** are responsible for ensuring systems are in place to implement and monitor programmes of quality improvement within their areas of responsibility in line with the Trust's priorities. Senior Managers are responsible for managing the strategic development and implementation of integrated risk and governance within their directorate vision and service lines. This includes ensuring:

- Systems are in place to identify, assess and manage risks through implementation and review of the Directorate/Service Line Risk Register; and
- Effective systems are employed for reporting, recording and investigating of all adverse events, such as serious incidents, incidents, near misses, complaints and claims.

3.1.8.1. They will identify risks within the service line, ensuring appropriate actions are taken, documented and completed to mitigate risks, complying with reporting and governance arrangements to ensure lessons identified and best practice are shared across the organisation. They will monitor their staff and service compliance against identified standards and safe systems of work whether set nationally or locally and will facilitate and act upon regular user feedback.

3.1.9. The **Company Secretary** is responsible for overseeing the management and maintenance of the Board Assurance Framework and ensuring the Board follows due process.

3.1.10. The **Head of Risk Management** is responsible for ensuring:

- The development of the Risk Management Strategy and Board Assurance Framework. Ensuring they are effectively coordinated, implemented and monitored across the Trust;
- Maintain the Risk Register as an active document and monitor mitigation and action plans.
- Monitor the risk and safety requirements of external agencies, including, but not limited to:
  - NHS Improvement Patient Safety Division (Formally National Patient Safety Agency)
  - Medicines and Healthcare Products Regulation Authority;
  - Health and Safety Executive; and
  - Care Quality Commission.
- Develop and implement suitable and sufficient risk management training provision across the Trust, ensuring role specific training is provided; and
- Responsible for the governance process relating to risks and monitoring compliance with the policy framework and reporting to the Trust Board.

3.1.11. The **Information Governance Manager** is responsible for;

- Ensuring the Trust meets statutory obligations in relation to information governance and freedom of information and that risks are identified and managed;
- Ensuring that risks and incidents are escalated to the attention of the Senior Information Risk Owner (SIRO) as necessary/required;
- Analysing and identifying trends in information governance from incidents, complaints and claims data; and

- Providing training, information and support in information governance to staff.

3.1.12. The **Head of Procurement** is responsible for;

- Providing advice and guidance on purchasing strategies, to enable the minimisation of risk; and
- Working with the **Medicines Management Lead / Medical Director** to maintain an effective response to Medicines and Healthcare Products Regulatory Agency guidance.

3.1.13. The **Health and Safety Manager** is responsible for;

- Acting as a specialist advisor (competent person) to the Trust on compliance with health and safety legislation, standards, policies and procedures;
- Ensuring adequate investigation and follow up to health and safety incidents, providing reports, analysis and identifying trends;
- Identifying specific health and safety risks and ensuring that they are adequately assessed, recorded and mitigated;
- Responding to health and safety issues identified through complaints, legal claims and medical device alerts; and
- Providing a comprehensive training programme for health and safety to staff.

3.1.14. **All staff** are accountable for the quality of the services they deliver and complying with, and participating in risk assessment processes as required. They will comply with identified standards and safe systems of work specific to their roles, whether identified in national, professional or Trust policy, procedures and guidelines. They will report quality issues, however caused, through identified channels to ensure prompt action can be taken using existing reporting systems within the Trust.

3.1.15. **All Managers and staff** have responsibility for managing risks within the services within which they work and for ensuring that they have attended the appropriate Risk Management Training commensurate to their role.

3.2. Committee Responsibilities within the Organisation

The Committee structure set out below is designed to ensure that risks are being effectively identified, assessed and mitigated.

3.2.1. The **Trust Board** is responsible for establishing the principal Strategic Goals and for driving the organisation forward to achieve these. It is also responsible for ensuring that there are effective systems in place to identify and manage the strategic risks associated with the achievement of these objectives through the Board Assurance Framework. The Board Assurance Framework also includes

the Operational Risks, which may affect the achievement of the Strategic Goals, escalated to the Board by the Executive Management Team.

3.2.2. The **Audit Committee** has delegated responsibility on behalf of the Board to seek satisfactory assurance that the Trust is meeting statutory internal and external requirements to remain a safe and effective business through embedded and effective risk management systems and processes with appropriate support from internal/external audit.

3.2.3. The **Quality and Safety Committee** has delegated responsibility on behalf of the Board to seek satisfactory assurance that there are adequate controls in place to ensure The Trust provides high quality services and care to its patients and is capable of meeting the CQC outcomes in relation to risk.

3.2.4. The **Finance and Investment Committee** has delegated responsibility on behalf of the Board to seek satisfactory assurance that there are suitable financial arrangements in place for the management of performance, providing scrutiny of major business cases and proposed investment decisions, whilst regularly reviewing contracts with key partners to ensure suitable and sufficient risk management.

3.2.5. The **Executive Management Team** is responsible for monitoring and managing the strategic risks, providing assurance to the Trust Board that they are being monitored and managed through the Board Assurance Framework. The Executive is also responsible for reviewing and monitoring the Operational Risk Register escalating any operational risks, which may affect the achievement of the Strategic Goals to the Trust Board as necessary/required through the Board Assurance Framework.

3.2.5.1. The Executive Performance and Governance committee is also responsible for receiving and assessing risks escalated by Quality Working Group for inclusion on the Board Assurance Framework and for de-escalating risks from the Board Assurance Framework to the Senior Management Team.

3.2.6. The **Director Quality and Safety / Chief Nurse** chairs the monthly Quality Working Group. The Group is responsible for ensuring the delivery of the Trust's Quality Governance, including risk management procedures and practices.

3.2.6.1. The Quality Working Group is supported by a number of subject-specific sub groups, which are responsible for risks within a defined area as identified within the Quality Governance Structure and the group terms of reference.

3.2.7. The **Senior Management Team** will receive escalated risks from Directorate Risk Registers and de-escalated risks from the Executive Management Team Performance, Governance and Quality Meeting. Specifically in relation to risk the group will;

- Regularly review the Operational Risk Register, escalating risks as required to the Executive Management Team;
- Ensure systems are in place to support delivery and compliance with legislation, mandatory NHS standards and relevant bodies;

- Monitor the delivery of action plans to ensure gaps in controls are closed and to identify robust assurance mechanisms;
- Undertake critical review of services; and
- Encourage and foster greater awareness of risk management throughout the Trust.

Principles and method of risk management

The following section outlines the Principles and Method by which Sussex Community NHS Trust will implement its Risk Management Strategy.

Principles and method of risk management

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4 Principles and Methods of Risk Management

The following section outlines the Principles and Method by which the Trust will implement its Risk Management Strategy.

4.1. Key Principles

4.1.1. Healthcare provision and the activities associated with caring for patients, employing staff, providing premises and managing finances will always involve an inherent degree of risk.

4.1.2. In broad terms, groups or areas that may be affected are;

- Patients and visitors;
- Staff (including contractors and volunteers);
- Finances;
- The business of the Trust;
- Compliance with statutory duties; and
- The Trust's reputation.

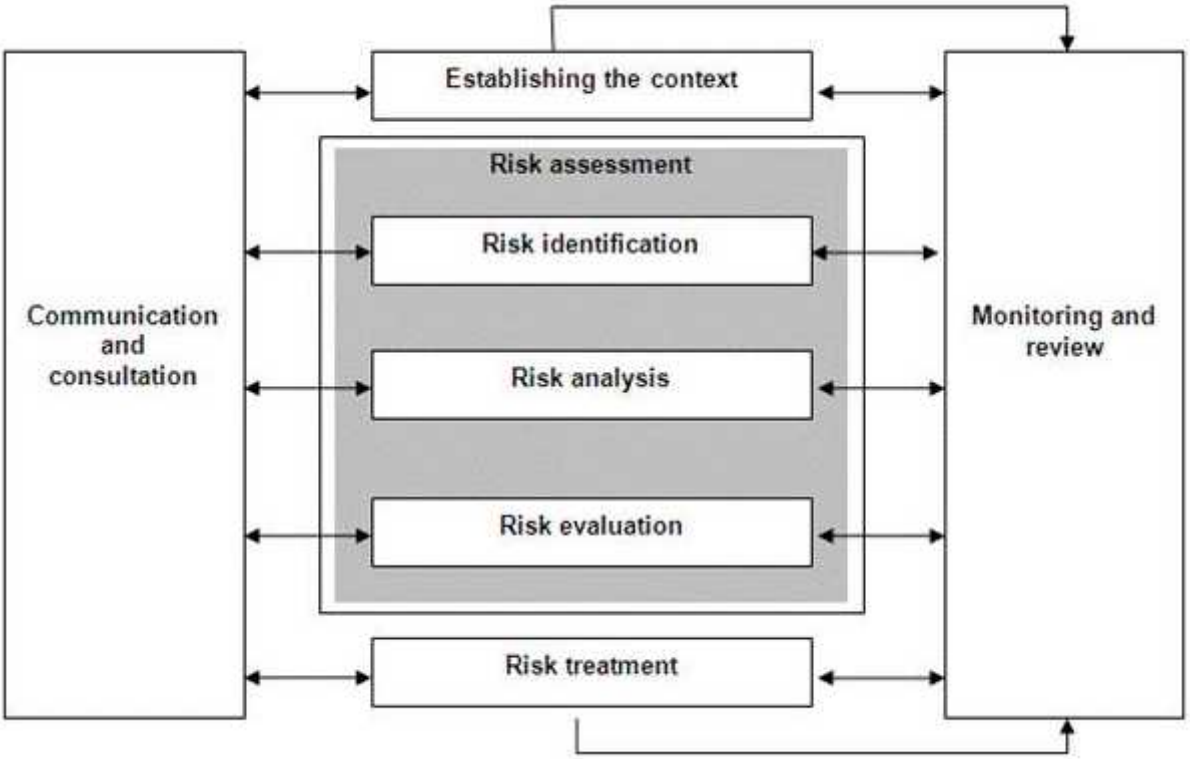
4.1.3. The key sources of risks to those groups are:

- Acts or omissions by staff and contractors;
- Information systems and the reports they generate (information governance);
- Trust estates and environmental impact;
- Work force planning;
- Business Continuity i.e. the unexpected failure of systems, which may have a wide impact on the continued delivery of services;
- Internal change control; and

- Changes to the commissioning environment.

4.2. Risk Management Process

4.2.1 The Trust will use the risk management process as outlined by ISO31000 in implementing its risk management strategy:



Risk Identification

4.2.1. Risks may be identified via a number of mechanisms and may be both proactive and reactive from a number of sources, including but not limited to;

- Analysis of key performance indicators;
- Capital and service development projects;
- Change control processes.
- Claims, incidents, serious incidents and complaints;
- Clinical Risk Assessments;
- Contingency/Disaster recovery planning and exercising;
- Coroners reports;
- Environmental and workplace risk assessments;
- Equipment and system malfunction or failure;
- Equipment purchase/modification;
- Information Governance Toolkit;
- Internal and External reviews, visits, inspections, audits and accreditation;

- National recommendations;
- New legislation and guidance;
- Preventative maintenance issues;
- Risk assessment of everyday operational activities, especially when there is a change in working practice or environment;
- Safety alerts (e.g. Central Alerting System and NHS protect)
- Staff and patient surveys; and
- Raising Concerns Policy;

4.2.2. Each risk identified should be clearly defined using simple and unambiguous language. Ideally risks should be defined in no more than one or two sentences and should not be emotive.

Risk Analysis and Evaluation

4.2.3. Risk analysis and evaluation involves developing a further understanding of the risk to enable an evaluation of how the risk should be treated. As such risk analysis involves the consideration of the causes and sources of the risk, their positive and negative consequences and the likelihood that those consequences may occur.

4.2.4. Ideally, risk analysis should be an objective process and wherever possible should draw on independent evidence and valid quantitative data. However it is recognised that such evidence and data may not be available to the assessor(s), who will be required to make a subjective judgement. When facing uncertainty, the assessor(s) should take a precautionary approach.

4.2.5. In order to ensure consistency of risk quantification across the Trust a standardised set of descriptors and scoring matrices (based upon the Australian/New Zealand Standard AS/NZS 4360:2004) will be used for risk analysis.

Risk Scoring

4.2.6. The risk score will be based upon the consequence of a risk and the likelihood of it being realised;

Consequence x Likelihood = Risk Score

4.2.7. The Trust uses three risk scores during the management of risks;

- **Initial Risk Score** - Score when the risk was first identified and is assessed with existing controls in place. This score will remain unchanged for the lifetime of the risk and is used as a benchmark against which the effect of risk mitigation can be measured

- **Current Risk Score** - Score at the time the risk was last reviewed in line with the set review dates. It is expected that the current risk score will reduce and move toward the Target Risk Score as action plans and mitigating actions are developed and implemented.

- **Target Risk Score** - Score that is expected to be reached after the action plan and mitigating actions have been fully implemented to enable the risk to be reduced to a level which is tolerable.

Scoring the Consequence

4.2.8. Consequence must be scored using the Table of Consequences, with existing controls in place. The Trust provides a number of domains for consideration, where there are multiple domains to be considered the highest consequence should be used.

Table of Consequences					
	Consequence Score and Descriptor				
	1	2	3	4	5
Domain:	Insignificant	Minor	Moderate	Major	Catastrophic
Injury or harm Physical or Psychological	No/ minimal injury requiring no / minimal intervention or treatment No Time off work required	Minor injury or illness requiring intervention Requiring time off work < 4 days Increase in length of care by 1-3	Moderate injury requiring intervention Requiring time off work of 4-14 days Increase in length of care by 4-14 days RIDDOR / agency reportable incident	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days	Incident leading to fatality Multiple permanent injuries or irreversible health effects
Quality of Patient Experience / Outcome	Unsatisfactory patient experience not directly related to the delivery of clinical care	Readily resolvable unsatisfactory patient experience directly related to clinical care.	Mismanagement of patient care with short term affects <7 days	Mismanagement of care with long term affects >7 days	Totally unsatisfactory patient outcome or experience including never events.
Statutory	Coroners verdict of natural causes, accidental death or open No or minimal impact of statutory guidance	Coroners verdict of misadventure Breech of statutory legislation	Police investigation Prosecution resulting in fine >£50K Issue of statutory notice	Coroners verdict of neglect/system neglect Prosecution resulting in a fine >£500K	Coroners verdict of unlawful killing Criminal prosecution or imprisonment of a Director/Executive (Inc. Corporate Manslaughter)
Business / Finance & Service Continuity	Minor loss of non-critical service Financial loss of <£10K	Service loss in a number of non-critical areas <6 hours Financial loss £10-50K	Service loss of any critical area Service loss of non-critical areas >6 hours Financial loss £50-500K	Extended loss of essential service in more than one critical area Financial loss of £500k to £1m	Loss of multiple essential services in critical areas Financial loss of >£1m
Potential for patient complaint or Litigation / Claim	Unlikely to cause complaint, litigation or claim	Complaint possible Litigation unlikely Claim(s) <£10k	Complaint expected Litigation possible but not certain Claim(s) £10-100k	Multiple complaints / Ombudsmen inquiry Litigation expected Claim(s) £100-£1m	High profile complaint(s) with national interest Multiple claims or high value single claim .£1m
Staffing and Competence	Short-term low staffing level that temporarily reduces patient care/service quality <1day Concerns about skill mix / competency	On-going low staffing level that reduces patient care/service quality Minor error(s) due to levels of competency (individual or team)	On-going problems with levels of staffing that result in late delivery of key objective/service Moderate error(s) due to levels of competency (individual or team)	Uncertain delivery of key objectives / service due to lack of staff Major error(s) due to levels of competency (individual or team)	Non-delivery of key objectives / service due to lack/loss of staff Critical error(s) due to levels of competency (individual or team)
Reputation or Adverse publicity	Rumours/loss of moral within the Trust Local media 1 day e.g. inside pages or limited report	Local media <7 days coverage e.g. front page, headline Regulator concern	National Media <3 days coverage Regulator action	National media >3 days coverage Local MP concern Questions in the House	Full public enquiry Public investigation by regulator
Compliance Inspection / Audit	Non-significant / temporary lapses in compliance / targets	Minor non-compliance with standards / targets Minor recommendations from report	Significant non-compliance with standards/targets Challenging report	Low rating Enforcement action Critical report	Loss of accreditation / registration Prosecution Severely critical report

Scoring the Likelihood

4.2.9. Likelihood must be scored using the Table of Likelihood, with existing controls in place.

Table of Likelihood			
Descriptor	Score	Frequency	Probability
Rare	1	This will probably never happen / recur	> 1 in 100,000
Unlikely	2	Do not expect it to happen / recur but it may	> 1 in 10,000
Possible	3	Might happen / recur occasionally	> 1 in 1,000
Likely	4	Will probably happen / recur but it is not a persistent issue	> 1 in 100
Almost Certain	5	Will undoubtedly happen / recur, possibly frequently	> 1 in 10

Risk Score

4.2.10. Once the Consequence and Likelihood have been determined, the over-all risk score can be measured using the Risk Score Matrix:

Risk Score Matrix					
	Likelihood:				
Consequence:	Rare (1)	Unlikely (2)	Possible (3)	Likely (4)	Almost Certain (5)
Insignificant (1)	1	2	3	4	5
Minor (2)	2	4	6	8	10
Moderate (3)	3	6	9	12	15
Major (4)	4	8	12	16	20
Catastrophic (5)	5	10	15	20	25

4.2.11. Risk rating makes evaluation of the risk easier with reference to the directorate and/or Trust wide risk profile; providing a systemic framework by which to identify the level at which risks will be managed, prioritising remedial action and availability of resources to address risks.

4.2.12. Risk rating also allows the Trust to set its risk appetite, with the 'Risk Rating - Actions Table' used to define the guidance on the documentation/registration of the risk, the urgency of action to mitigate the risk and clarifies ownership, reporting and oversight.

Risk Rating - Action Table						
Score	Level	Action	Risk Owner *	Governance/Monitoring**	Register	Escalation Route
1-6	Low	Entered on to Datix	Head of service / Manager	Directorate SMT Meeting	Directorate Risk Register	Trust Senior Management Team
8-12	Moderate	Entered on to Datix	Senior Manager	Trust Senior Management Team Meeting	Operational Risk Register	Executive Management Team
15-25	High	Entered on to Datix	Executive Director	Executive Management Team	Strategic Risk Register	Trust Board via Board Assurance Framework
Issues Log	None	Entered onto the Issues Log	Head of service / Manager	Directorate SMT Meeting	Operational Issues Log	Trust SMT via the Senior Manager

* The Risk Owner has the over-arching organisational responsibility for the risk; however they may delegate the management of the risk through the implementation of controls and production of action plans as appropriate.
** The committee, group or meeting responsible for Governance and Monitoring will validate scoring and undertake the monitoring / review of action plans and any tolerated risks. They are also responsible for escalating risks as appropriate.

Risk Treatment

4.2.13. Having identified, assessed, scored and rated the risk, it is important to identify and document what action needs to be taken to enable the Target Risk Score to be achieved. In general there are four potential responses to address a risk once it has been identified and assessed;

Tolerate

4.2.13.1. The risk may be considered tolerable without the need for further mitigating actions, for example the risk is rated low or the Trusts ability to mitigate the risk is constrained or if taking action is disproportionately costly.

4.2.13.2. In general the Trust will tolerate all risks scored 6 or less, which do not require further mitigating actions; however they must be regularly assessed and monitored, (at least annually) to identify any change in circumstances or scoring.

4.2.13.3. Where the decision to tolerate a risk is taken, consideration should be given to developing contingency arrangements for managing the consequences if the risk is realised.

Treat

4.2.13.4. This is the most common response to managing risks. It allows the Trust to continue with the activity whilst ensuring that mitigating actions are implemented to reduce the risk to a tolerable level e.g. as low as reasonably practicable. In general action plans will reduce the risk over time, but are unlikely to eliminate it.

4.2.13.5. It is important to ensure that mitigating actions are proportionate to the identified risk and give reasonable assurance that the risk will be reduced to a tolerable level. Once a tolerable level of risk has been reached, it should continue to be reviewed a minimum of annually to ensure that there has not been a change in circumstances or scoring.

4.2.13.6. It is the responsibility of the Governance/Monitoring Group to ensure that action plans are suitable to reduce the risk with regular monitoring.

Transfer

4.2.13.7. In some circumstances the risk may be transferred, for example through conventional insurance policies or by sub-contracting a third party to take the risk. This option is particularly suited to mitigating financial risks or risks to assets.

4.2.13.8. It is important to note that risks to the Trusts reputation cannot be transferred.

Terminate

4.2.13.9. In some circumstances, the only way to reasonably prevent the risk is to terminate the activity, which gives rise to the risk or by changing the way in which the activity is undertaken.

4.2.13.10. Within the NHS this option is limited as there are many activities which have associated risks that are deemed necessary for the delivery of effective health care services.

Risk Review

4.2.14. The process and timescales for reviewing risks is outlined as below, and should be undertaken on the Datix risk management system as a formal record.

4.2.14.1. Minimum periods for formal review have been set for all risks aligned to the risk score. All risks must be formally reviewed and documented on Datix in line with these timeframes. More frequent review may be undertaken as necessary/required. Where a risk may require less frequent review this may be approved (an included within minutes) at the governance/monitoring meeting.

Score	Level	Review Period
15-25	High	Monthly Review
8-12	Moderate	Two Monthly Review
1-6	Low	Six Monthly Review
Tolerable	Closed	Annual Review
Issues Log	None	Monthly

Process for Review

4.2.14.2. When undertaking the risk review the following should be considered;

Consideration	Description/Question	Impact/Outcome
Risk Description	Is the risk still the same or has it changed?	Risk updated to reflect the new nature of the risk or a new risk raised
Realisation of the risk	Has the risk occurred? To what extent?	Move to Issues Log and consider any new risks as a result of the risk occurring
Incidents, Complaints or Claims	Have there been related incidents, complaints or claims? or has the number of incidents, complaints or claims increased/decreased?	May change the likelihood Score or Consequence
Control Effectiveness	Are the controls put in place effective in reducing the risk?	Change of consequence or likelihood score
Completed Actions &	Have mitigating actions	Change to consequence

Effectiveness	been completed? If so how effective are they in reducing the risk?	or likelihood score
Consequence Score	Has the likelihood or consequence changed?	Change to consequence or likelihood score
Tolerable Score	Is the tolerable score still achievable or has it been reached?	Change to tolerable score or closure of risk.

Risk Documentation

4.2.15. All risks are entered into Datix to ensure that there are suitable documented records in place, and to ensure regular monitoring and review.

Issues Log

4.2.15.1. Issues logs are held locally by directorate teams to document the operational issues, which require management through business as usual process. They are monitored and managed through the Directorate Senior Management Team Meetings and will be escalated to the Trust Senior Management Team as required. A template issues log can be found within the Risk Management Pages of the intranet.

Operational Risk Register

4.2.15.2. The operational risk register will identify and monitor the risks to the achievement of Trust wide business/service objective and higher rated divisional risks, with risks generally scored between 8 and 25. The Operational Risk Register will be reviewed by the Senior Management Team and Quality Committee.

Strategic Risk Register

4.2.15.3. The Strategic Risk Register accompanies the Board Assurance Framework to highlight all high (scoring 15-25) rated operational risks to the Board. As such the Strategic Risk register contains details regarding the controls and mitigating actions in place and any actions outstanding for completion.

Board Assurance Framework

4.2.15.4. The Board Assurance Framework is the Board level register and will identify and monitor the strategic risks and any operational risks which may affect the achievement of the strategic goals. The Board Assurance Framework will be managed, monitored and reviewed by the Executive Management Team Performance and Governance Meeting, who are responsible for escalating operational risks to the Trust Board as appropriate/necessary. A quarterly Board Assurance Framework update report will be presented to the board, with the full risk register presented at least annually.

Health and Safety Risks

4.2.15.5. Due to their specific nature, health and safety related risks must be recorded on the appropriate health and safety risk assessment form. Health and safety related risk assessments forms will be retained locally and only health and safety risks scoring 8 or more will be added to the Operational Risk Register via Datix.

Patient Clinical / Individual Risks

4.2.15.6. Clinical Patient risks and those relating to individuals will be held locally using the appropriate clinical assessment form/documentation, such as the Patient Care Record, and will not be entered into Datix.

4.2.15.7. Where there is a systemic clinical risk to patients as a result of operational risks scoring 8 or more will be added to the Operational Risk Register via Datix.

Project / Programme Risks

4.2.15.8. Project / Programme risks will be recorded using the projects own internal documentation, typically a risk log. Any project/programme risks which impact outside the project itself and scoring 8 or more will be added to the Operational Risk Register via Safeguard.

Risk Ownership, Escalation and Assurance

4.2.16. The Risk Owner identified in the 'Risk Rating - Action Table' holds the overarching responsibility for the risk, ensuring it is appropriately scored, that suitable and effective controls are implemented and action plans produced; however where suitable and appropriate the management of the risk may be delegated to a competent individual within their division.

4.2.17. The quality governance structure enables risks to be managed at the appropriate level within the Trust, ensuring there is a committee/group or meeting with responsibility for providing assurance that risks have been suitably and effectively identified, assessed and documented. They are also responsible for ensuring that action plans and mitigating actions are proportionate and are implemented effectively.

4.2.18. It is the responsibility of the committee/group or meeting with responsibility for governance and monitoring to ensure that risks are escalated appropriately, including escalating themes where they are observed by a number of similar low level risks.

5 Training

5.1. The Trust is committed to equipping staff with the necessary skills required to undertake their roles competently and confidently. In turn, staff must take responsibility for developing these skills and participating in the lifelong learning process.

5.2. As such a Training Needs Analysis (TNA) has been developed to identify the training requirements of each group of staff.

5.3. The Risk Management Team will deliver a programme of risk management training, including risk assessment and root cause analysis.

5.4. The delivery of training will form a key indicator for the Risk Management Team Annual Performance Report.

6 Risk Management Work Programme

6.1. The Risk Management Work Programme is produced and owned by the Head of Risk Management and outlines the programme of work to be delivered by the Risk Management Team to ensure that the Trust continues to deliver, develop and implement its Risk Management Strategies.

6.2. The Quality Working Group, is responsible for approving the Risk Management Work Programme and for monitoring its development and delivery.

6.2.1. The top priorities for delivery in 2016/17 are;

- Delivery of an updated Risk Management Data system (e.g. Datix);
- Enhanced reporting to enable Directorate Management Teams and the Trust Wide Quality Governance Groups to monitor the completion of action plans with the set timeframes.

6.2.2. The top priorities for delivery in 2017/18 are;

- Delivery of internal Risk Management Training for staff undertaking risk management and assessment;
- 95% of all Trust Operational Risks to be consistently reviewed within the required timeframes.

7 COMPTENCE

7.1. The Trust will ensure they employ a competent Head of Risk Management in line with the approved Job Description.

7.2. Competence of individual staff, varies dependent on the role carried out and is outlined within the TNA.

8 MONITORING

8.1. Monitoring of this policy will be undertaken through the Quality Working Group, reporting to the Quality Committee.

9 AUDIT & REVIEW

9.1. The Head of Risk Management will review this policy and procedure every three years or sooner if new legislation, codes of practice or national standards are introduced.

9.2. The Head of Risk Management will monitor compliance with these procedures through reviewing progress with direct line reports and line management and reported to the Quality Working Group.

9.3. Non-compliance with strategies, policies and procedural documents can affect patient safety, SCT's compliance with the Care Quality Commission (CQC) regulations and audits or inspections carried out by internal and external auditors.

9.4. Compliance with Trust strategies, policies and other procedural documents is a contractual condition of employment (including permanent/temporary staff, students, volunteers and contractors) and will be managed through The Trusts Staff Performance Management Procedure.

10 ASSOCIATED DOCUEMENTATION

10.1. Incident Reporting and Management

11 REFERENECES

11.1. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
11.2. NHS Foundation Trust Code of Governance, Section C2. Risk Management and Internal Control
11.3. Compliance Framework, Section 3 Risk Assessment.
11.4. Health and Safety at Work Act 197
11.5. Management of Health and Safety at Work Regulations 1992 (amended 1999
11.6. CQC Fundamental Standards.

Document Control

Manager Responsible

Name:	(optional, if included, will be placed in the public domain)
Job Title:	
Directorate:	

Committee/Working Group to approve		
Version No.	Final/Draft	Date:

Draft/Evaluation/Approval (Insert stage of process)

Person/Committee	Comments	Version	Date
List stakeholders/working groups consulted and the dates/ comments			

Circulation

Records Management Database	Date:
Internal Stakeholders	
External Stakeholders	

Review Due

Manager		
Period	Annually	Date:

Record Information

Security Access/Sensitivity	[eg: Official (Public Domain) or Official – Sensitive]
Publication Scheme	Yes / No
Where Held	Records Management database
Disposal Method and date:	

Supports Standard(s)/KLOE

	Care Quality Commission (CQC)	**IG Toolkit**	**Other**
Criteria/KLOE:	Good Governance (Reg 17)		

South East Coast Ambulance Service NHS
NHS Foundation Trust

Item No	169/16
Name of meeting	Trust Board
Date of meeting	26 January 2017
Name of paper	Forecast Outturn 2016/17 and Recovery Plan
Executive sponsor	David Hammond, Executive Director of Finance & Corporate Services
Author name and role	Kevin Hervey, Interim Associate Director of Finance
Synopsis (up to 120 words)	This paper sets out the Forecast Outturn for 2016/17, together with the Recovery Plan
Recommendations, decisions or actions sought	The paper is presented for information.
Why must **this** meeting deal with **this** item? (max 15 words)	For Board awareness of the current financial and reporting issues.
Which strategic objective does this paper link to?	Financial Sustainability
Does this paper, or the subject of this paper, require an equality analysis ('EA')? (EAs are required for all strategies, policies, procedures, guidelines, plans and business cases).	**No**

South East Coast Ambulance NHSFT

Financial Recovery Plan and Forecast Outturn for the period to 31st March 2017

1. Executive Summary

1.1. The paper outlines the Trust's likely forecast out turn (FOT) position for 2016/17, a £7.1m deficit, and advises the worst case scenario - a £14M deficit**.** The FOT to be reported to NHSI therefore remains at £7.1M deficit, as disclosed at Month 8.

1.2. It presents the immediate actions already taking place to support the delivery of the FOT and refers to the future actions to be undertaken within Q4 which have previously been shared as part of the URP.

1.3. The paper also highlights the impact and risk on the 2017/18 position.

2. Introduction

2.1. The Trust submitted a plan for 16/17 reflecting a small surplus of £0.7m. This was before CQC visits, special measures and the well-rehearsed issues which saw the removal of the CEO and Chairman. As the severity of the issues came to light, a reforecast exercise was undertaken which was shared with NHSI and moved the forecast financial position to a deficit of £7.1M.

2.2. The reasons for the deficit are again well rehearsed and can be summarised into two areas; operational efficiency and loss of grip and control (£5M); costs of recovery (£2M). (The detailed movements from the plan to the M8 FOT deficit of £7.1M were provided in detail to NHSI colleagues in December).

3. Current position

3.1. In considering the year end position, the Trust will submit its final FOT for 16/17 on the 17th January 2017 as requested.

3.2. The Trust has considered the range of possible outcomes and following the finalisation of M9, the FOT will remain unchanged at a deficit position of £7.1M.

3.3. This FOT contains various non-recurrent items including: the costs associated with concluding outstanding staffing issues at the Executive level; additional PMO support, and the final settlement of CQUIN which reduces income by £0.3m. Each of these items, whilst non-recurrent, has a risk associated with the values assigned to them as the details are still being worked through. A mitigation of £0.3m is included as the Trust has

commenced a revaluation exercise of its estate, which it is hoped will deliver a reduction in PDC for the year ending 31 March 2017.

3.4. The worst case FOT of £14m considers the issues below. A judgement has been made in assigning a worst case FOT value of an additional £7M over the likely case. The key issues are:

3.4.1. Should the Trust continue to be unable to agree a CQUIN position, this creates a total exposure of an additional £2.5M to the likely case.

3.4.2. Should the CCGs impose fines on the Trust for missed performance as the contract allows, this has a maximum value of £2.5M. There have been no fines YTD and no indication that this will occur.

3.4.3. Should an additional withholding via the contract of £1.4M per month or 2.0% of contract value be applied for non-delivery of the recovery plan, this will impact on the cash position. Again there has been no indication of any intention to impose these on to the Trust or how any reinvestment would be made, should a penalty be imposed.

3.5. It is essential that the Trust has sustainable cash resources now and in the long term. Current estimates point to very low cash resources during quarter 4 of the current financial year and into quarter 1 of 17/18 before recovering to a healthier position. The Trust has sought a working capital loan facility from NHSI. It is envisaged that cash drawdowns against the working capital facility amounting to £3M - £5M will be required during quarter 4 of 2016/17 and quarter 1 2017/18 based on current cash flow projections. It is anticipated that, with the continued operational improvements from the recovery plan generating a £1M deficit in 17/18, deferral of certain estates capital projects and utilisation of leasing options, the Trust will start generating cash to recover the position.

4. Immediate Actions

4.1. A detailed review of the 16/17 position has been undertaken to ensure that there is: Trust wide focus; full management ownership of the issues; a change in the emphasis within the organisation towards a balanced and sustainable approach to quality, performance and finances.

4.2. A new governance structure has been implemented from the beginning of January with three strands as follows:

4.3. The Financial Sustainability Steering Group is chaired by the DoF and initially meets twice a week. Its function is as follows:

4.3.1. Delivery of the financial agenda
4.3.2. Fulfilling delivery against NHSI regulatory requirements
4.3.3. Management of CIP and Cost Pressures
4.3.4. Escalation of issues
4.3.5. Assurance against delivery of the programme
4.3.6. Management of Financial risk

4.4. For Q4, it will focus primarily on the delivery of the 24 core spend lines which have been identified as areas of opportunity and focus for cost reduction following an in depth review of the cost base. These areas of spend have been specifically called out as there is a clear lack of grip or a potential quick win to mitigate the financial run rates seen YTD. Each area has an assigned Executive lead responsible for delivery and a lead senior manager. Progress against each of these schemes will be monitored via the twice weekly steering group meetings and escalation will be to the Turnaround Board.

4.5. The responsible Executive directors for each of these areas have been set an aggressive maximum stretch target of saving for each line. The actual expectation against which performance will be judged is lower and is included within the projected savings column in the table below. This is included within the likely FOT delivery of £7.1M.

Top Financial Immediate Corrective Actions Dashboard

No	Top 20 ish Initiative	Proposed Executive Lead	Project Lead	Target Saving £k	Projected Q4 Savings £k	RAG Rating	Narrative	Next Action	Due By
1a	Overtime Preapproval	Joe Garcia	Sue Skelton	400	100	Red	Tighter controls on overtime payments and preauthorisation of all spend	Check Target, Scope and assure delivery	10.1.17
1b	Overtime Preapproval	Steve Graham	Carol Lenz	50	25	Red	Tighter controls on overtime payments and preauthorisation of all spend	Check Target, Scope and assure delivery	10.1.17
2	Meal Break Payments	Joe Garcia	James Pavey	400	250	Red	Grip on procedures and allocation of interruptions	Check Target, Scope and assure delivery	10.1.17
3	Shift overruns	Joe Garcia	Lyande Kaikai / Chris Stamp	100	50	Red	Tighter controls and understanding of the impact of shift overruns on Trust's finances	Check Target, Scope and assure delivery	10.1.17
4	PO Controls	David Hammond	Paul Ranson	250	100	Red	Grip on Trust's commitment to spend	Check Target, Scope and assure delivery	10.1.17
5	PO and SFI levels	David Hammond	Paul Ranson	250	100	Red	Ensure adequate governance & management controls in place	Check Target, Scope and assure delivery	10.1.17
6	Meeting expense/Room Hire	David Hammond	Ed Grimshaw	50	50	Red	Stop non essential room hire and all associated costs. No further away days in hotels	Check Target, Scope and assure delivery	10.1.17
7	Agency costs and controls	Steve Graham	Clare Irving	500	300	Red	Reduce agency overspends to address breaches on Agency cap Conversion of temps to perm and tighter controls on recruitment.	Check Target, Scope and assure delivery	10.1.17
8	Training Costs & Course Fees	Steve Graham	Sally James / Ed Grimshaw	200	100	Red	Tighter controls on training related spend such as hotels etc. Stop on discretionary training	Check Target, Scope and assure delivery	10.1.17
9	Fleet Maintenance and Fuel	Joe Garcia	John Griffins	400	150	Red	Tighter controls around use of fuel and review of maintenance cycle time	Check Target, Scope and assure delivery	10.1.17
10	IT Costs	David Hammond	Mark Chivers	150	100	Red	Efficient utilisation of resources to minimise waste. Cut out non essential spend	Check Target, Scope and assure delivery	10.1.17
11	CQUIN payments assurance	Jon Amos	Andy Collen	1,000	500	Red	Reassure full delivery - no reduction assumed in original forecast	Check Target, Scope and assure delivery	10.1.17
12	Stock and issue Uniforms	David Hammond	Paul Ranson	100	50	Red	Tighter controls on replacement and changes in policy. Training staff....no uniform.	Check Target, Scope and assure delivery	10.1.17
13	Tea Coffee	Jon Amos	Paul Ranson	15	-	Red	No free supply and shift back to Maxwell House	Check Target, Scope and assure delivery	10.1.17
14	Legal costs	Peter Lee	Lyande Kaikai	50	30	Red	Value for money - clearly define what can be done in house and external	Check Target, Scope and assure delivery	10.1.17
15	Medicine Management	Fiona Wray	Ed Grimshaw / P Cloves	500	150	Red	Efficient utilisation of resources to avoid wastage including overordering	Check Target, Scope and assure delivery	10.1.17
16	External Contractors	Steve Graham	Clare Irving	200	80	Red	Grip on spend to justify value for money. Risk assess non coverage	Check Target, Scope and assure delivery	10.1.17
17	Taxi and Vehicle Hire	Joe Garcia	Sue Skelton	50	40	Red	Clearer directive and assessment of utlisation	Check Target, Scope and assure delivery	10.1.17
18	Furniture & Fittings	Jon Amos	Paul Ranson	30	30	Red	Tighter control and process	Check Target, Scope and assure delivery	10.1.17
19	Company credit cards	David Hammond	Ed Grimshaw / P Ransom	30	30	Red	Review to ensure still required and appropriate controls in place	Check Target, Scope and assure delivery	10.1.17
20	Phones and calls	David Hammond	Mark Chivers	100	45	Red	Tighter controls - value for money	Check Target, Scope and assure delivery	10.1.17
21	Corporate Recruitment	Steve Graham	Clare Irving	12	-	Red	Tighter controls - value for money	Check Target, Scope and assure delivery	10.1.17
22	Public Relations Expenses	Peter Lee	Janine Crompton	20	20	Red	Review to ensure value for money	Check Target, Scope and assure delivery	10.1.17
23	Books Journals & Subscriptions	Peter Lee	Sally James / Lyande Kaikai	30	30	Red	Review to ensure value for money	Check Target, Scope and assure delivery	10.1.17
24	Travel & Subsistence	Steve Graham / Joe Garcia	Carol Lenz/ Sue Skelton	100	100	Red	Grip on spend - potential policy changes	Check Target, Scope and assure delivery	10.1.17

4.6. In addition a series of communications have been shared with the whole organisation from the DoF and CEO, as well as specific messages to the relevant groups of staff explaining the severity of the financial situation and the measures being taken. A weekly update from the DoF is also being included within the staff bulletin which goes out each Friday. The update will discuss the work being undertaken and progress against the targets set.

5. Impact on 17/18

5.1. The Trust's two-year plan submitted in December accepted the control totals set. The plan sets an ambitious cost improvement programme target. This obviously comes with risks of non-delivery and work will continue on building more robust delivery plans during Q4 as the Trust starts work on its LTFM and long term sustainability. This timetable and approach was set out in the URP presented to NHSI in November.

5.2. Of more immediate concern is the unknown position between the Trust and its commissioners. The outcome of the joint work agreed to as part of the mediation process presents a nil to £26M gap to the Trust's current plan or is offset by accepting significantly lower operational performance.

5.3. The issues highlighted previously as risks and included within our recently submitted Operating Plan Narrative (30 December 2016) are also at this stage unresolved.

5.4. The final issue to consider for 17/18 is capacity to deliver this agenda and the ongoing costs to support this. The Trust has engaged external support to provide a level of expertise whilst in-house capacity is developed. This support may need to continue into next year and will come at an additional cost.

6. Risk, Conclusion and next steps

6.1. The severity of the financial position is clearly understood by the Executive team and there are a series of work streams underway with Executive owners and accountability.

6.2. SECAmb faces some inherent risks to delivery, including the current temporary and interim status of a number of staff in senior positions, including at board-level. Whilst this is being rectified, there is a risk around ownership and long term buy-in.

6.3. The uncertainty around the commissioning arrangements and the health economy financial deficit, which is either borne by SECAmb or its Commissioners, also causes significant uncertainty on the long term financial sustainability of the Trust. More immediately in closing the 2016/17 position,

the Commissioners' intentions with regard to CQUIN, penalties and reinvestment and other issues add further complexity and potential variation in to the FOT.

South East Coast Ambulance Service NHS
NHS Foundation Trust

Item No	170/16

Name of meeting	Board
Date	26 January 2017
Name of paper	HART Business Case
Executive sponsor	David Hammond
Author name and role	Kirsty Booth – Paramedic Business Support Manager
Synopsis (up to 120 words)	This paper covers the business case (Appendix 1) for the replacement of HART vehicles. The recommendation is that the Trust purchases a new fleet of Vehicles via the NARU procurement frame work. This framework has been implemented to ensure that the specifications for all the vehicles in the fleet will match that required by NARU to ensure that HART Teams nationally can meet the Service Specifications and provide a reliable commissioned service.
Recommendations, decisions or actions sought	This paper has been approved by the Executive Management Team. The Board is asked to approve the Business Case.
Why must **this** meeting deal with **this** item? (max 15 words)	Mandatory requirement from NARU to replace HART vehicles
Which strategic objective does this paper link to?	Governance and Clinical Outcomes

Does this paper, or the subject of this paper, require an equality analysis ('EA')? (EAs are required for all strategies, policies, procedures, guidelines, plans and business cases).	**No**

South East Coast Ambulance Service NHS
NHS Foundation Trust

Investment Management

Business Case

Replacement HART Vehicle Fleet

Author(s): Neil Harrison
Executive Lead: Andy Newton
Date: October 2016
Doc Name: Replacement HART Vehicle Fleet
Version: 0.08
Final Decision:

Date	By	Decision
{Date Decision Made}	Management team, Trust Board}	{Approve/Reject}

Document Control

Change Control

Version	Date	Author(s)	Summary of Changes
V0.01	26/03/2016	Neil Harrison	Draft
V0.02	11/11/2016	Neil Harrison	Final
V0.03	13/12/2016	Kirsty Booth	EMB comments incorporated and appendices included
V0.04	29/12/2016	Kirsty Booth	NARU information updated
V0.05	29/12/2016	Kirsty Booth	Further info updated (Build Slots)
V0.06	06/01/2017	Kirsty Booth	AD Finance (Business Services & Investment)
V0.07	12/01/2017	Kirsty Booth	EMB comments incorporated
V0.08	18/01/2017	Kirsty Booth	

Approval Authorities (For Approval Versions Only)

Name	Position	Signature	Date	Version

Distribution

Name	Position	Date	Version
IAWG			V0.02
EMB			V0.03
EMB	All members of EMB		V0.04
EMB	All members of EMB		V0.05
EMB	All members of EMB, AD Finance(Business), Head of Fleet		V0.06
EMB	All members of EMB	12/01/2017	V0.07
FIC & Trust Board	All members of FIC & Trust Board	18/01/2017	V0.08

CONTENTS

EXECUTIVE SUMMARY

The Trusts Hazardous Area Response Team (HART) provides pre-hospital care to patients in environmentally challenging situations. It also provides a nationally interoperable capability in serious or large scale disasters that can be deployed with the other ten NHS Ambulance Trusts that also operate HART Teams. As part of the nationally defined interoperability the vehicles used by HART are designed to a national specification and have been purchased by the National Ambulance Resilience Unit (NARU) on behalf of NHS England. This supports intra-operability between both the Trusts HART and all other HART across England and Wales.

Ashford HART was the first team to be established in the Trust and the vehicles were originally provided on the basis the costs would be written down over the pre-defined life (either five or seven years) and in-line with all services. As part of the national replacement programme a new specification has been issued along with the pipeline for build slots. The HART vehicles at Ashford are due to be replaced as they are now seven years old. This will enable the Trust HART to maintain interoperability with other national assets along with complying with the NARU Service Specifications 2016/17. Following the Trusts Care Quality Commission (CQC) Inspection concerns were raised about the ability of the Trust to provide a safe and compliant HART capability. The Emergency Preparedness Resilience and Response (EPRR) Core Standards assessment rated HART non-compliant against the National Specification. The replacement of the existing fleet against the new specification is one of the key elements of the resultant action plan agreed with commissioners to move the service to a compliant rating. Failure to deliver the new fleet will therefore impact on the Trusts recovery plan.

This business case has been presented for separate agreement as there is currently no approved fleet replacement strategy, when one is developed it is anticipated that HART vehicle replacement will be incorporated.

As part of the process of developing this case, all HART Managers across England and Wales have indicated that they had or will be ordering their replacement HART vehicles as per the NARU schedule.

A separate case is being developed to consider options for replacement of the Trusts three Incident Command Vehicles (ICVs).

1. INTRODUCTION AND PURPOSE

1.1 The current HART fleet was designed in 2008 at the initial stages of HART development. The current fleet was created to ensure all HART teams could operate both independently and as a nationally interoperable unit should a major incident occur requiring multiple resources. All HART fleets were built to a national specification and built using a number of preferred suppliers to ensure uniformity.

1.2 The life expectancy of the fleet of vehicles was laid out in the NARU HART Implementation document 2008.This document advises that the smaller vehicles such as the two Volvo XC70‘s and the Landrover Discoveries should be replaced after five years and the larger Iveco Daily vehicles be replaced after seven years. The current fleet was delivered in 2010 making the small vehicles overdue for replacement by one year and the larger vehicles due at the end of 2016.

1.3 The new specification is not a like for like replacement in that the vehicles are moving away from a traditional car/ ambulance model to one where the emphasis is on movement of personnel and equipment.

1.4 Having checked with NARU and HART Managers Nationally of the seven Trusts who responded no Trust has challenged the replacement cycle (operational life span) of the vehicles given this was known at the outset and the replacement programme has commenced.

2. CONTEXT

2.1 CONTEXT

The HART has been within SECAmb since July 2010, when the Ashford Team went operational. The project to implement HART was in line with the HART implementation document, Implementing HART (2008) which outlined the vehicle HART fleet requirements which are detailed below for both bases, Ashford and Gatwick:

Vehicle Type	Registration Number	Current NBV, £	Replacement Year	Initial Cost, £
Ashford Base				
First Response Vehicle	BX09VPE	0	2015-16	39,503
First Response Vehicle	BX09VPD	0	2015-16	39,503
Heavy Equipment Carrier	WX59GVK	0	2015-16	129,530
Light Recon	WX63VFP	0	2015-16	134,913
Forward Command	WX59GVY	0	2015-16	1,114,874
Personnel Carrier	WX10AVB	0	2015-16	58,273
4*4 Team Leader	CN10DTZ	0	2015-16	40,278
4*4 Water Unit	CN10DUE	0	2015-16	40,278
6*6 Vehicle (Polaris)	SF10AVB	7,455	2017-18	24,087
Prime Mover	WX60CCE	30,759	2017-18	99,374
Grand Total		**38,214**		**1,720,613**

Vehicle Type	Registration Number	Current NPV, £	Replacement Year	Initial Cost, £
Gatwick Base				
First Response Vehicle	WX61HPC	13,404	2019-20	47,307
First Response Vehicle	WX61HPE	13,404	2019-20	47,307
Heavy Equipment Carrier	WX61KRO	68,848	2019-20	141,055
Light Recon	WX61KRN	65,956	2019-20	145,002
Forward Command	WX61MVC	687,255	2019-20	1,408,036
Personnel Carrier	WX10AVB	31,916	2019-20	70,553
4*4 Team Leader	CN61ETX	13,528	2019-20	47,747
4*4 Water Unit	CN61ETY	13,528	2019-20	47,747
6*6 Vehicle (Polaris)	SF61JKX	12,597	2019-20	25,810
Prime Mover	WX61KVU	51,973	2019-20	106,483
Grand Total		**972,408**		**2,087,047**

The total cost of these vehicles was £3.8 million; this was funded by the Department of Health and the vehicles were acquired by the Trust on the understanding that the assets would be depreciated year on year. The HART Implementation document (2008) states that the vehicles should be replaced at five years for the RRV cars and the Landrovers, and seven years for the larger Iveco vehicles with the funding coming from Trust funds as the Trust will have depreciated these assets. *NARU Service Specifications (2012) section C4.7*

As the Forward Command Vehicle (FCV) will need replacing, NARU have specified a replacement technology package which will be supplied by Excelerate, which will enable mobile communications and streaming of data and video images, along with a secure 4G hub. This equipment will enable HART teams to manage and operate with each other on a local and national basis.

NARU have issued a replacement schedule so that all the HART fleets in NHS England are replaced according to their commissioned dates.

Set No.	Trust / location	Commissioned Date	Replacement Due Date	Lead time for delivery, from the receipt of Trust purchase order		
				WAS 22 Week	Wilker 18 Weeks	Excelerate 12 Weeks
1	WMAS	Mar-09	Mar-16	Sept	Oct-15	Dec-15
2	NWAS - Manchester	Mar-09	Mar-16	Sep-15	Oct-15	Dec-15
3	LAS - East	Apr-09	Apr-16	Sep-15	Oct-15	Jan-15
4	EMAS	Apr-09	Apr-16	Sep-15	Oct-15	Jan-15
5	YAS	Jun-09	Jun-16	Nov-15	Dec-15	Aug-15
6	EoEamb - Melbourne	Aug-09	Aug-16	Feb-16	Mar-16	May-16
7	NEAS	Jan-10	Jan-17	Jun-16	Jul-16	Oct-16
8	SECAMB - Ashford	May-10	May-17	Nov-16	Dec-16	Feb-17
9	NWAS - Liverpool	Jun-10	Jun-17	Dec-16	Jan-17	Feb-17
10	LAS - West	Aug-10	Aug-17	Mar-17	Apr-17	Jun-17
11	SWAST - Bristol	Jul-10	Jul-17	Jan-17	Feb-17	Apr-17
12	SCAS	Sep-10	Sep-17	Mar-17	Apr-17	Jun-17
13	WMAS - Spare	Dec-10	Dec-17	May-17	Jun-17	Feb-17
14	EoEamb - G Notley	Apr-11	Apr-18	Oct-17	Nov-17	Jan-18
15	LAS - Spare	Jun-11	Jun-18	Nov-17	Dec-17	Mar-17
16	SWAST - Exeter	Feb-12	Feb-19	Sep-18	Oct-18	Nov-18
17	SECAMB - Gatwick	Jun-12	Jun-19	Dec-18	Jan-19	Mar-19
18	EMAS - Spare	Jul-12	Jul-19	Jan-19	Feb-19	Apr-19

2.2 STRATEGIC CONTEXT

How does the project link to the Trust's 6 Strategic Objectives and / or 4 pillars or other key strategies or policies?

Strategic objective	Contributes? (Y/N)	Comment (state how the project contributes)
Improve on the Trust's performance standards and reduce variation	Y	Any deployment to patients in hazardous areas will be enhanced by the provision of a suitable HART fleet. The fleet will provide a quicker more flexible and reliable resource.
Deliver excellence in leadership and development	Y	The new fleet of vehicles will deliver a more flexible platform to the HART team along with improved Incident command technology which is interoperable with other HART assets on a national basis.
Improve access and outcomes to match international best practice	Y	The new fleet will provide better communications to the Trust and others that require live streaming of information needed to manage a scene along with a more reliable response to incidents and one that is interoperable with other stakeholders
Improve satisfaction and experience for all stakeholders	Y	The new HART fleet will have the latest technology and will form part of a national infrastructure that will be high profile.
Be an organisation that people seek to join and are proud to be a part of	Y	The new HART fleet has been designed to be a more adaptable set of vehicles than the previous fleet. The vehicles are comparatively smaller, more fuel efficient and above all more reliable.
Convert all available pounds / resources to maximise patient benefit	Y	Any deployment to patients in hazardous areas will be enhanced by the provision of a suitable HART fleet. The fleet will provide a quicker more flexible and reliable resource.
Pillar:	Y	The new fleet will be based on the VW and Mercedes vans which have proved much more reliable than the previous fleet. SECAmb Fleet Department already runs a fleet of Mercedes Ambulances and has the diagnostic capability of repairing and maintaining these vehicle types. Thus

		reducing expensive diagnostic machinery for other makes of vehicles.
Response time reliability	Y	Provide support to clinicians and directly improve the patient experience due to timely intelligence and communication and reliable response
Clinical effectiveness	Y	As above
Customer satisfaction	Y	As a smaller more efficient use of the vehicles it will reduce maintenance, fuel costs and will increase the HART team's resilience.
Economic efficiency	Y	The new fleet will be based on the VW and Mercedes vans which have proved much more reliable than the previous fleet. SECAmb Fleet Department already runs a fleet of Mercedes Ambulances and has the diagnostic capability of repairing and maintaining these vehicle types. Thus reducing expensive diagnostic machinery for other makes of vehicles.
Key Trust outcomes:		
Improve clinical outcomes	Y	The new fleet will provide a more reliable response to patients in need of HART capabilities.
Less patients transported to hospital	Y	Although the HART fleet is not capable of transporting patients it will provide the technology to enable clinicians to communicate with other stakeholders and assist in the triage of patients.
More patients to other places	Y	As above
Increased patients seen by specialists	Y	As above
Reduced costs to the health economy /NHS	Y	As above

3. OPTIONS

3.1. A number of options have been identified:

- Option 1 – Do nothing
- Option 2 - Purchase new fleet from Cash Funds (This will result in the Trust falling below the £10m cash threshold)
  - As per NARU schedule, capital expenditure would fall into 2016-17
  - With a delay to the NARU schedule capital expenditure will fall into 2017-18
- Option 3 - Purchase new fleet via Lombard Facility
  - As per NARU schedule, capital expenditure would fall into 2016-17

- With a delay to the NARU schedule to ensure capital expenditure falls into 2017-18

Options	Description	Investment	Benefits	Main risks
Option 1	Do nothing	£0		As the fleet becomes older the reliability will become less which will lead to risks to staff and the inability of SECAmb HART to respond to patients. Noncompliance with the NARU Service Specifications and the inability of HART to provide its commissioned service.
Option 2A	Purchase the new fleet from cash funds as per the NARU procurement framework	Capital - £2,019,669	Compliance with National Ambulance Resilience Service Specifications 2016 Increase in fleet reliability SECAmb's own Fleet Department will have equipment to aid repair and servicing. Greater flexibility around deployment of the vehicles Greater resilience Greater interoperability with other HART units nationally and other services locally	Non Compliance could result in conflict with local Commissioning groups. Poor fleet reliability Injury to staff from out-dated equipment. Poor local and national reputation for the Trust if NARU requirements are not followed

Option 2B	Purchase the new fleet from cash funds with a delay in ordering	Capital - £2,019,669	Delay allows Trust to raise sufficient funds The vehicle change specification may change and a delay may allow changes to the new fleet to be made	HART unit will be non-compliant with the Service specification. As we have been recently reviewed by the Commissioners and NARU one of the main concerns was the compliance of the fleet The Trust HART Team is under considerable scrutiny and the replacement HART fleet is part of the recovery plan. SECAmb HART will eventually become non – interoperable with other HART units which again is mandated in the Service Specifications If SECAmb HART delays ordering the new fleet the Trust will miss the manufacturing slot and will be pushed back further down the list compounding the issue of non-compliance. Poor reputation for the Trust having still a non-compliant HART team. There may be a risk of consequences by the Commissioners. All 7 of the HART managers who replied when contacted, confirmed that they have and are planning on ordering their replacement vehicles as per the NARU schedule.
Option 3A	Purchase the new fleet via the Lombard facility as per the NARU procurement framework	Annual Revenue Expenditure - £476,567	Same as Option 2a	Same as option 2a
Option 3B	Purchase the new fleet via the Lombard facility with a delay in ordering	Annual Revenue Expenditure - £476,567	Same as Option 2b	Same as option 2b

4. FINANCIAL CASE

4.1 The Department of Health through NARU initially funded the purchase of the FCV and a service contract with Excelerate for a period of three years. Within the NHS Service Specification for HART (2015/16) section 5.5 “Providers have the autonomy to assign and manage capital and revenue allocations for HART servicing providing the interoperable equipment referenced in the National HART Standard Operating Procedure is effectively maintained.”

4.2 The two Volvo Fast Response Vehicles (FRV) and two Landrover Discoveries are due for replacement at Ashford HART Base as they are now over five years old. The two Volvos’ condition has deteriorated considerably, as an example there is a need to replace brake pads every 12 weeks and service 10,000 miles. The Landrovers are in a similar condition. The mileage on the 2 x RRV‘s is now 245,207 and 230,277 and the Landrovers 124,683 and 100,545 respectively.

4.3 The vehicles were designed prior to 2008 and after five years of operational use they are often proving to be inappropriate for current HART operations.

4.4 The new fleet can be purchased via the NARU procurement contract which outlines the vehicles required in the fleet, its specifications and costs.

4.5 The current communications systems are contained in the Forward Command Vehicle (FCV). The new specification does not replace this vehicle, rather it provides for Incident Ground Technology (IGT). The IGT is an integral part of the fleet, housed in portable containers allowing interoperability with HART teams both locally and nationally. In addition, it will allow data and information to be sent to other Trust locations.

4.6 The capital investment and revenue recurring costs for each option are summarised below. In option 2a the vehicles would be paid for on delivery which would occur in 2016-17. In option 2b the Trust would delay the ordering of the vehicles to ensure that delivery and hence payment fell into 2017-18.

	Option 1	**Option 2**	**Option 3**
Capital Spend			
Ashford HART Vehicles	£0.00	£1,009,835.00	£0.00
Gatwick HART Vehicles	£0.00	£1,009,835.00	£0.00
Total Capital Spend	**£0.00**	**£2,019,670.00**	**£0.00**

	Option 1	**Option 2**	**Option 3**
Capital Spend			
Ashford HART Vehicles	£0.00	£0.00	£238,283.00
Gatwick HART Vehicles	£0.00	£0.00	£238,283.00
Total Capital Spend	**£0.00**	**£0.00**	**£476,566.00**

4.7 The capital investment cost is detailed below by vehicle; each base will require a full set of the vehicles listed.

Vehicle Type & Extras	Number	Cost	Total
PRIMARY RESPONSE	3	£56,190.80	£168,572.40
Full Respray	3	£3,788.00	£11,364.00
Datapoint Telematics	3	£2,768.68	£8,306.04
		£62,747.48	**£188,242.44**
SECONDARY RESPONSE	3	£82,552.00	£247,656.00
Night Owl	3	£7,245.90	£21,737.70
Datapoint Telematics	3	£2,768.68	£8,306.04
		£92,566.58	**£277,699.74**
PERSONNEL CARRIER	2	£73,173.61	£146,347.22
Night scan mast	2	£4,383.96	£8,767.92
Awning	2	£1,188.60	£2,377.20
Fit of free issue Tetra kit (provided by Trust)	2	£338.25	£676.50
		£79,084.42	**£158,168.84**
STAFF WELFARE	1	£96,607.00	£96,607.00
Night Owl	1	£7,245.90	£7,245.90
Datapoint Telematics	1	£2,768.68	£2,768.68
		£106,621.58	**£106,621.58**
INCIDENT GROUND TECHNOLOGY	1	£240,190.00	£240,190.00
Back Office Options - Provision of Back Office Hardware		£30,000.00	£30,000
Support and Maintenance and all additional Licensing for above option (cost per annum)		£6,000.00	£6,000
Provision of a virtual back office and full automatic download capability and access to Secure Cloud* pricing excludes initial set up as per email cover, indicative pricing.		£1,600.00	£1,600
Additional Option for Physiological Monitoring Data		£3,250.00	£3,250
Briefing screen stand		£250.00	£250
Tablet docking station (quantity 2)		£1,500.00	£1,500
STATIC DEPLOY CAMERA (12v)	2	£14,200.00	£28,400.00
BODYWORN CAMERA	14	£4,995.00	£69,930.00
PORTABLE SATELLITE	1	£44,000	£44,000.00
PORTABLE BRIEFING SCREEN	1	£3,000	£3,000.00

PORTABLE MONITORING DEVICES	14	£5,250.00	£73,500.00
PORTABLE PRINTER	2	£600.00	£1,200.00
UAV - Price based on UAV with 2 x Handheld Controllers and 2 x Tablets	2	£5,559	£11,118.00
Cost per Data Network Equipment for the provision of 1	1	£63,000	£63,000.00
PHYSIOLOGICAL MONITORING - Price based on 1 Sensor	14	£1,105	£15,470.00
SPARE HOLDERS	14	£204	£2,856.00
PORTABLE GENERATOR	2	£1,550	£3,100.00
Software Licenses - Revenue Cost - Per Year	1	£19,000.00	£19,000.00
3G/4G Data Charges - Revenue Cost	1	£2,400.00	£2,400.00
Satellite Backhaul Data Charge Package - Revenue cost	1	£3,420.00	£3,420.00
Fully Inclusive Service & Maintenance - Per Year	1	£67,850.00	£67,850.00
Training for up to 10 persons	9	£13,500.00	£121,500.00
			£812,534.00
Total Cost excluding VAT			**£1,543,266.60**

4.8 As well as the capital cost listed above the IGT will cost £67,850 per annum for service and maintenance and £13,500 training costs for up to 10 staff.

4.9 The new specification has been developed to fall within the old vehicles write down costs and as such there is no additional costs being placed on Trusts to absorb, i.e. the costs of the fleet per HART unit will fall into the £1.9 million envelope.

4.10 This BC does not cover the replacement of the Polaris or Prime Mover vehicles as NARU have not yet released the specification for these vehicles. NARU are currently out to tender, a business case will be submitted when the specification is available.

4.11 The preferred option based on the available information would be option 3a. This would ensure that funding was available to purchase the fleet within the NARU build schedule.

5. MANAGEMENT CASE

5.1 The replacement of the HART fleet will ensure the Trust meets the nationally defined HART specification and supports national resilience through the provision of interoperable vehicles.

5.2 The transition from the old fleet to the newly specified vehicles will be overseen by the HART Manager and NARU Procurement Lead with support from the Trusts Finance and Fleet Departments.

6. PREFERRED OPTION

6.1 Preferred option would be Option 3A. To purchase the new fleet of Vehicles via the NARU procurement frame work. This frame work has been implemented to ensure that the specifications for all the vehicles in the fleet will match that required by NARU to ensure that HART Teams nationally can meet the Service Specifications and provide a reliable commissioned service.

7. IMPACT ANALYSES

7.1 A full Quality Impact Analysis has been completed and can be found in **Appendix 4.** *(Will be sent later pending agreement of Clinical executives)*

7.2 The funding for the HART replacement will not affect the replacement of our frontline vehicles, there is a Capital fund of £8.3 Million to replace frontline vehicles.

8. CONCLUSION

8.1 The funding for this replacement will be delivered from the depreciation of the existing fleet which will be equivalent to £1.9m.

8.2 The existing fleet will be decommissioned, any monies received from this will belong to the Trust.

9. APPENDIX 1 FLEET SPECIFICATION COMPARISON

Vehicle Type	Current Fleet	New Fleet
Light Recon **1 per team**	This vehicle has including the gvw of 7,500kg carrying capacity and is designed to carry the majority of PPE for 6 operatives. The vehicle also carries lighting equipment and communications equipment to link in with the other vehicles in the fleet. It has a crew cab that is useable due to weight constraints. This vehicle also carries a mass Oxygen delivery system	Long wheel base Sprinter van x3. This will carry similar levels of equipment but split between 2 lighter more agile vehicles with one van acting as a reserve. The equipment will be split between the 3x VW Transporters and the long wheel base Sprinter vans. This will not only give a more flexible load capacity but also greater resilience in the case of break down etc.
Heavy Equipment Carrier **1 per team**	This vehicle is a 7,500kg large equipment carrier. The vehicle is equipped with a generator, communications and lighting and mass casualty equipment including mass oxygen delivery system plus additional cylinders.	As above this vehicle will be replaced by the smaller Long wheel base Sprinter van with the equipment being split between 2 vehicles 1 being used as a reserve. It is anticipated that the mass Oxygen delivery system will only now be carried on the Major Incident vehicles held by CP&R
Forward Command Vehicle **FCV**	Is a large communication vehicle that carries a secure satellite system, satellite phone network, IT that enable access to the internet, briefing facilities, and a rest and welfare facility. The FCV's technology has proved difficult to use during set up and operation. Also because it takes up at least 2 operatives to deploy the asset this reduces the ability of the HART team to concentrate on setting up safe systems of work which are more of a priority. Other issues with the FCV include its size being the biggest vehicle in the current fleet which often restricts its access. Also if one element of the technology break down the entire vehicle is then unusable.	This vehicle will be replaced by the new IGT system which rather than being fixed into 1 vehicle will be a boxed system and will be split between the other vehicles. This will greater flexibility and resilience should individual parts fail the system. The technology in the current fleet is 10 years old and now is out performed by current technology. The welfare element will be replaced using another long wheel based Sprinter vehicle which will be equipped with rest, food preparation and shower facilities for protracted incidents. The IGT system will be much more portable enabling HART team to set up a secure 4G network to enable them to

		communicate with other HART teams and the Trust Command Structure along with the ability to stream images to Tactical/ Strategic Command Cells or EOC
Forward Recon Vehicle **FCV** **2 per team**	4x4 estate cars which carry individual PPE along with minimal Paramedic Clinical equipment along with a Breathing Apparatus set. Primarily used for first response to incidents to act as recon. This vehicle can also be used to respond to other incidents to support normal operations. This vehicle is limited by its weight carrying capacity and only has the ability to carry 1 Operative.	These vehicles will be replaced by 3x Primary response vehicles, i.e. 3x VW short wheel base Transporter vans which will be capable of carrying more equipment including a more enhanced paramedic kit including a 12 lead Monitor Defibrillator. These vehicles will also have a 4x4 capability and be able if required to carry 2 operatives.
4x4 **2 Per team**	These vehicles are based on a standard Land Rover Discovery 3 & 4. Used as the HART Team Leader's Response vehicle and the Inland Water Operations (IWO) Support Vehicle. The Team Leaders vehicle carries the Team Leaders and Drivers PPE limited basic Paramedic kit and AED. The IWO vehicle carries water Sled PPE lines and ropes and limited paramedic kit with AED. These vehicles are limited because of the load capacity and then need to secure heavy PPE items.	These 2 vehicles will be replaced by the 3x Primary Response Vehicles. These vehicles have a 4x4 capability and a greater load carrying capacity.
Personnel Carrier Vehicle **1 per team**	Personnel Carrying Vehicle is used to transport a team of 6 Operatives to training venues, or to replace teams on protracted incidents. These vehicles are used also to deploy to Public Disorder Incidents. The vehicle is racked out to ensure all PPE is secured whilst on the move.	NARU is recommending the purchase of 2 PCV'S per team to allow a more flexible response to incidents using one PCV for incident support and one for training use. These vehicles again will be Sprinter based and will be similar in specification to the current fleet.
6x6 vehicle and Transporter	This vehicle currently is based on the Polaris 6x6 vehicle with an Iveco modular transporter	The specification of these vehicles have yet to be confirmed so do not form part of this b/case.

It should be noted currently NARU hold a number of spare vehicles which are the same specifications the original fleet. This was to provide support to Trusts when their own vehicles were damaged or broken down. This spare fleet is to be decommissioned and no replacements will be purchased, so HART units will need to ensure they have their own spare vehicles to ensure compliance.

Since the original fleet was designed ten years ago HART Teams have developed and the role has changed with new capabilities being brought in such as, extended water operations, tactical medicine and public disorder. A greater use of the FRV vehicles for supporting Operations was not envisaged at the implementation of HART and as a result the FRV‘s have proved inadequate.

A report in 2013 by NARU “HART Vehicle User Requirement

Concluded that

Although the current fleet was suitable on the implementation of HART it now presents a number of challenges;

- The size and dimensions of the large vehicles impair the current HART response.
- Reliability across the fleet has been below expectations (especially among the bigger vehicles.
- The specialist bespoke design of each of the larger vehicles reduces operational flexibility
- The Complexity of the FCV reduces the opportunity to utilise it effectively, consumes too much of the operational paramedic’s time and the reliability of the technology has been below expectations.
- The ability of the core HART staffing levels of six to effectively mobilise the current fleet of 8 bespoke vehicles each of which may be required at an incident may is impaired.

The report further concluded that the new fleet should;

- Maintain the current national core capabilities in line with the service specifications whilst improving the efficiency of day to day deployments.
- Maintain national interoperability and commonality of the HART fleet
- A smaller and more rapidly deployable fleet
- Improved reliability
- Simplified Technology
- More flexible load spaces
- Vehicles designed around a primary, secondary, and resupply concept of operations
- Increased commonality in vehicle design and type for each local fleet
- Must be accommodated in the existing HART estate.
- There is no longer a requirement to carry mass casualty supplies and mass oxygen delivery systems as these aspects are duplicated on the wider EPRR mass casualty provisions.

10. APPENDIX 2 CURRENT FLEET MILEAGES

The current mileages for the HART Fleet are below:

Ashford HART			Vehicle type
Flt No and veh type		Speedo	
4002	Volvo	276246	SE107
4003	Volvo	254883	SE106
4004	Heavy	25251	SE103
4016	Light	83910	SE102
4006	FCV	19170	SE101
4007	PCV	96004	SE104
4010	Disco	129961	SE108
4009	Disco	159182	SE109
4012	Pod	26675	SE105
4008	Polaris	798	
4001	Unit 1	5943	MCV Not HART
4051	Mass Casualty	2320	MCV Not HART
5012	Logistics	74985	SE110
Gatwick HART			**Vehicle type**
4002	NMCEV		MCV not HART
4022	Volvo	154954	
4023	Volvo	147924	
4024	Heavy	27830	
4025	Light	104008	
4026	FCV	9166	
4027	Personnel Carrier	66011	
4032	Pod	40234	
4029	Disco	120528	
4030	Disco	101053	
4028	Polaris		
926	ic24	99949 km	

11. APPENDIX 3 IAWG SUPPLEMENTARY INFORMATION

Please see below an email trail which was requested by Kevin Hervey (AD Finance) with regards to the other UK Ambulance Trusts planned HART vehicle replacement.

Kevin

Re the request to contact other HART Teams in England around the procurement of the new HART fleet, I have so far received 7 replies from other Trusts.
NWAS
SWAST
LAS
EAS of England
WMAS
NEAS
Yorkshire

All have either placed or are just about to place orders via the national procurement process apart from West Mids who have already taken delivery of their fleet.

Regards Neil

From: Kevin Hervey
Sent: 19 October 2016 14:20
To: Rachel Murphy <Rachel.Murphy@secamb.nhs.uk>
Cc: Neil Harrison <Neil.Harrison@secamb.nhs.uk>; Andy Cashman <Andy.Cashman@secamb.nhs.uk>
Subject: RE: Re HART B/case

Neil,

I had understood that one of the outstanding actions from the discussions at IAWG was that those ambulances trusts in England who were scheduled to replace their HART vehicles in 16/17 would be contacted to ascertain if they were going for the replacements before 31 March or were deferring until 17/18. Please advise. Can we get their response in writing please?

Regards,

Kevin Hervey
Associate Director of Finance (Interim)
South East Coast Ambulance Service NHS FT

Mobile: 07768 421 014
kevin.hervey@secamb.nhs.uk

From: Rachel Murphy
Sent: 19 October 2016 13:36
To: Kevin Hervey <kevin.hervey@secamb.nhs.uk>
Cc: Neil Harrison <Neil.Harrison@secamb.nhs.uk>; Andy Cashman

<Andy.Cashman@secamb.nhs.uk>
Subject: FW: Re HART B/case
Importance: High

Kevin,

See below email and attached additional information regarding the queries from the IAWG meeting.

Can this now go to exec for a decision.

Rachel.

Rachel Murphy
Financial Manager – Projects, Business and Investments
Landline – 01273 484 778
Mobile – 07775 863 156

From: Neil Harrison
Sent: 19 October 2016 09:12
To: Rachel Murphy
Cc: Andy Cashman
Subject: Re HART B/case
Importance: High

Hi Rachel

Please see amended HART fleet business case with supporting documents.

1. First document is the amended business case
2. Is the review report from NARU which they undertook with the Commissioners. Section 7 refers to the non-compliance of the fleet. Section 7 as highlighted that if we have not placed the order for the new fleet by the 12 Oct 2016 we will be deemed as non-compliant as far as the EPRR standards require.
3. This document outlines the EPRR assessment criteria which we as a Trust are measured against.
4. Document 4 Veh costs spread sheet out lines costs that the Trust is currently paying to maintain the current fleet. This is to support the comment in the document around unreliability. Obviously as the fleet ages the costs generally increase. These figures do not take into account any defects repairs or damage to the technology or other equipment which the vehicles currently carry.

If you need to clarify or feel you need anything else please give me a bell

Thanks Neil

12. APPENDIX 4 QUALITY IMPACT APPRAISAL

South East Coast Ambulance Service NHS
NHS Foundation Trust

Agenda No	171/16

Name of meeting	Board Meeting
Date	26/01/2017
Name of paper	CQC 'Must Do' Action Plan update
Responsible Executive	Emma Wadey Interim Chief Nurse/ Director of Quality & Safety
Author	Emma Wadey Interim Chief Nurse/ Director of Quality and Safety
Synopsis	This paper provides an overview of current progress made to deliver the 'Must Do' actions as identified during the recent full CQC inspection in May 2016.
Recommendations, decisions or actions sought	The Board are asked to review current progress and note the exception reports for those actions currently identified as at risk of completion by March 2017

Does this paper, or the subject of this paper, require an equality impact analysis ('EIA')? (EIAs are required for all strategies, policies, procedures, guidelines, plans and business cases).	**No**

CQC 'Must Do' Action Plan Update

1. Introduction

1.1. The purpose of this report is to provide the Board with an overview of the current status of delivery against the 16 'Must Do' Actions which were identified following a full wave CQC inspection in May 2016. The trust has a set a target to have addressed these areas by the end of the financial year by when it is known that the CQC will be returning to re-inspect.

1.2. A Quality Steering group to provide additional internal scrutiny of the CQC action plan was introduced in late December. This weekly meeting supported by the PMO and chaired by the Interim Chief Nurse oversees the progress of actions and ensures the evidence of completion is sufficient to meet all areas of the CQC requirements.

1.3. The increased capacity and capability of key areas in addition to more robust governance processes of self-regulation has highlighted further areas of improvement which require attention to ensure full regulatory compliance.

1.4. As a result, the CQC action plan has evolved to be a more comprehensive document providing greater assurance that its completion will demonstrate, safe, effective, responsive, caring and well led services.

2. Progress Dashboard January 2017

CQC Must Do	Executive Lead	RAG	Complete	On target	At Risk
1.Safeguarding Action Plan	EW		21	38	3
2. Security Improvement Plan	JG		3	1	2
3. CAD Improvement Plan	DH		1	1	1
4. HART Improvement Plan	RW		6	0	0
5. PTS Improvement Plan	JG		5	0	1
6. Governance & Clinical Governance Improvement Plan	EW		2	7	5
7. Incident and SI Reporting Improvement Plan	EW		2	14	2
8. 999 Take Action to ensure that national targets are met	JG		2	7	7
9. Outcomes Improvement Plan - Take action to improve outcomes for patients who receive care and treatment	RW		5	8	0

10. Infection Prevention and Control Improvement Plan	**EW**		**4**	**4**	**0**
11. Staff and Resourcing Improvement Plan	**JG**		**1**	**6**	**2**
12. HART Staffing Improvement Plan	**RW**		**1**	**2**	**0**
13. Intelligent Dispatch Improvement Plan	**JG**		**0**	**4**	**0**
14. Medicines Management Improvement Plan	**AC**		**12**	**52**	**3**
15. Patient Records Improvement Plan	**AC**		**7**	**8**	**2**
16. NHS 111 Improvement Plan	**JG**		**28**	**11**	**0**
Total			**100**	**163**	**28**

2.1. During the last month we have built on the progress made during the last 3 months, with a reduction in actions rated at risk, down from 28 in November to 18 and an increase in actions completed to 45 compared with 37 at the end of November.

2.2. A total of 291 actions across all 16 'must do's have now been identified, of these 100 have been completed and 163 are on target for completion by March 2017.

2.3. The comprehensive action plan has now identified 30 actions across 10 of the 'must do' themes which are now at risk of missing the March deadline. Exception reports for each action detailing the remedial actions being taken are included in Appendix 1.

3. Special Measures Template

3.1. In addition to the completion and submission of the Must Do action to the CQC each month, our inspectors have requested completion of a Special Measures Template Appendix 2). This requires us to share actions completed to improve patient safety, demonstrate being well led and staff engagement.

3.2. All actions completed must articulate the impact to patients and detail the evidence to support their completion. These submissions will be used by the CQC in conjunction with our action plan to provide assurance on our progress and compliance with the fundamental standards.

3.3. Our CQC inspector have not yet shared their response to our submission this is to be provided during an executive scrutiny session on 30/01/2017

4. Summary

4.1. Following the CQC inspection in May 16 'Must do' actions were identified which required urgent attention.

4.2. It has been noted that steady improvement and progress has been made across the areas, however increased self-regulation and knowledge had identified gaps in the robustness of the previous plans specifically for medicines management, patient records, 111improvement, safeguarding improvement plan and clinical audit.

4.3. To date only one ‘Must do’ action has been fully completed, 5 are rated Amber with reasonable progress made and actions currently on target whilst a further 10 are rated as at risk of not being delivered by April 2017.

4.4. Those areas currently identified as at most risk of delivery are medicines management and 999 delivery of national targets.

5. Recommendations

5.1. The Board is asked to note the increased scrutiny and quality assurance process to test progress made to date to ensure we have implemented all required actions by end March 2017.

5.2. The Board is also asked to note the increased areas of action identified as at risk of completion and to note the mitigation taken to address these within the escalation reports.

CQC Improvement Plan

(Issued 16 December 2016)

Exception Report

'Must Do' Action Reference	***CQC Must Do 16***	**Current RAG Status**	**RED**
Action	***Workforce structure to be signed off (SECAmb), implemented and operational.***	**Action Completion Date** (as per CQC Improvement Plan)	*On going*
Action Owner	*John O'Sullivan*	**Reporting Officer**	*Joe Garcia – Director of Operations*
CQC Domain	*Safe / Responsive*	**CQC Fundamental Standard(s)**	
Date of Exception	*20.01.17*		
Reason(s) this action is at risk	*Not yet fully implemented*		
Explanation of the reasons for the action being at risk (detail)			
What steps are currently being taken to mitigate the risk of non-completion?	*Changes to the workforce structure have been implemented with a significant shift to employed staff over agency staff. The recent changes with the East Kent transfer of 111 activity has allowed for further reduction in Agency surge resources.*		

What is the likely impact of this mitigation?	*Reduction in costs* *More stable workforce*
Support required (E.g. Exec, Management, Admin, Financial, IT)	*HR support to progress recruitment of substantive posts*

Executive actions to be completed in support of CQC Improvement Plan Exception Report
'Must Do' action reference: … Safeguarding (SG18)……

To be completed during Executive Team Meeting and shared back with the Action Owner and Responsible Manager named in the Exception Report

Action	Exec Lead	By When?

Name:……Signed: ……. Date: ……..
(Lead Executive Director)

CQC Improvement Plan

(Issued 16 December 2016)

Exception Report

'Must Do' Action Reference	***CQC Must Do 16***	**Current RAG Status**	**RED**
Action	*Revised ways of working to be discussed and then agreed at Provider Contract Meetings.*	**Action Completion Date** (as per CQC Improvement Plan)	*On-going as part of BAU activities*
Action Owner	*John O'Sullivan -HO 111 service*	**Reporting Officer**	*Joe Garcia – Director of Operations*
CQC Domain	*Safe / Responsive*	**CQC Fundamental Standard(s)**	
Date of Exception	*20.01.17*		
Reason(s) this action is at risk	*No clear agreement on revised ways of working*		
Explanation of the reasons for the action being at risk (detail)			
What steps are currently being taken to mitigate the risk of non-completion?	*Regular monthly provider Contract meetings are held between the 111 Team and the SECAmb Director of Operations, any scope for revised working is discussed in this forum.*		

What is the likely impact of this mitigation?	*New ways of working will be agreed*
Support required (E.g. Exec, Management, Admin, Financial, IT)	*Executive support to continue to drive progress. Board decision regarding the future of the 111 contract.*

Executive actions to be completed in support of CQC Improvement Plan Exception Report
'Must Do' action reference: … Safeguarding (SG18)……

To be completed during Executive Team Meeting and shared back with the Action Owner and Responsible Manager named in the Exception Report

Action	Exec Lead	By When?

Name:……Signed: ……. Date: ……..
(Lead Executive Director)

CQC Improvement Plan

(Issued 16 December 2016)

Exception Report

'Must Do' Action Reference	***CQC Must Do 16***	**Current RAG Status**	**RED**
Action	***Develop opportunity to utilise apprenticeship programme in Ashford***	**Action Completion Date** (as per CQC Improvement Plan)	*On going*
Action Owner	*John O'Sullivan*	**Reporting Officer**	*Joe Garcia – Director of Operations*
CQC Domain	*Safe / Responsive*	**CQC Fundamental Standard(s)**	
Date of Exception	*20.01.17*		
Reason(s) this action is at risk	*Non approval from HR to proceed with local development of the programme*		
Explanation of the reasons for the action being at risk (detail)	*111 services are keen to develop an apprenticeship programme by combining a Nationally accredited programme for call centres with NHS Pathways trainings both of which are currently available. However SECAmb strategy is to develop a programme in house.*		
What steps are currently being taken to mitigate the risk of non-completion?	*Discussions continue in relation to a range of apprentice roles within SECAmb. A specific discussion between Sally Wentworth James & Joe Garcia related to the soon to be introduced apprenticeship levy and the SECAmb approach need to be followed up with the DR Director*		

What is the likely impact of this mitigation?	*Approval to proceed with the development of the proposed approach to an apprenticeship programme* *Achievement of this action would:* ✓ *Ensure the Trust is able to retain staff within the service* ✓ *Provide assurance to patients that our workforce is suitably trained to manage their calls efficiently and appropriately*
Support required (E.g. Exec, Management, Admin, Financial, IT)	*Executive HR decision to proceed with the proposal put forward by 111 services.*

Executive actions to be completed in support of CQC Improvement Plan Exception Report
'Must Do' action reference: … Safeguarding (SG18)……

To be completed during Executive Team Meeting and shared back with the Action Owner and Responsible Manager named in the Exception Report

Action	Exec Lead	By When?

Name:……Signed: ……. Date: ……..
(Lead Executive Director)

CQC Improvement Plan

(Issued 16 December 2016)

Exception Report

'Must Do' Action Reference	***CQC Must Do 16***	**Current RAG Status**	**RED**
Action	**SECAmb/CareUK to formally agree ONE revised harmonised rota to be used across both sites and then implement following staff consultation.**	**Action Completion Date** (as per CQC Improvement Plan)	*On going*
Action Owner	*John O'Sullivan*	**Reporting Officer**	*Joe Garcia – Director of Operations*
CQC Domain	*Safe / Responsive*	**CQC Fundamental Standard(s)**	
Date of Exception	*20.01.17*		
Reason(s) this action is at risk	*Harmonised rota not yet agreed*		
Explanation of the reasons for the action being at risk (detail)	*Care UK and SECAmb unable to agree a unified way to populate the rota despite regular meetings outside of the conventional contract meetings*		
What steps are currently being taken to mitigate the risk of non-completion?	*Discussions continue with Care UK & John O'Sullivan, however challenges over the contract arrangements between SECAmb & Care UK remain a significant challenge to agreement. Progress is still being pursued.* *SECAmb continue to over populate the rota in order to maintain safety.*		

What is the likely impact of this mitigation?	*Safe rotas are maintained* *Achievement of this action would:* ✓ *Ensure patients can access timely care and treatment when first contacting the service*
Support required (E.g. Exec, Management, Admin, Financial, IT)	

Executive actions to be completed in support of CQC Improvement Plan Exception Report
'Must Do' action reference: … Safeguarding (SG18)……

To be completed during Executive Team Meeting and shared back with the Action Owner and Responsible Manager named in the Exception Report

Action	Exec Lead	By When?

Name:……Signed: ……. Date: ……..
(Lead Executive Director)

CQC Improvement Plan
(Issued 16 December 2016)

Exception Report
PTS Improvement Plan

'Must Do' Action Reference	**CQC must do 05 PTS**	**Current RAG Status**	**RED**
Action	Consider the wider implications of losing PTS in Surrey and undertake a risk assessment and contingency plan development to mitigate this	**Action Completion Date** (as per CQC Improvement Plan)	February 17
Action Owner	Sue Skelton	**Reporting Officer**	**Joe Garcia** Interim Director of Operations
CQC Domain	Effective	**CQC Fundamental Standard(s)**	
Date of Exception	*24 January 2017*		
Reason(s) this action is at risk	Will not be completed by deadline.		
Explanation of the reasons for the action being at risk (detail)	Due to the complexity of the process and detailing how a total loss of services for PTS within the Dorking site would impact on the trust, patient care and other stakeholders such as appointment centres it is not possible to complete a robust plan that would and explore all areas of concern within the current timeframe.		
What steps are currently being taken to mitigate the risk of non-completion?	PTS recently completed and updated business continuity plan that could adapt to support a loss of the site, however it is acknowledged that at this time it is not specific enough to effectively deal with a total loss. Process is to be completed by the end of February.		

What is the likely impact of this mitigation?	Extend deadline 4 weeks from 1st February to 28th February Achievement of this plan would allow PTS to design an effective plan, that would if required allow the service to run in a continuous and appropriate manner with limited impact on patients and other stakeholders.
Support required (E.g. Exec, Management, Admin, Financial, IT)	PTS management capacity to complete this work. EPP support to ensure plans are effective and meet the required legislations. Finance department to approve funding for temporary site.

Executive actions to be completed in support of CQC Improvement Plan Exception Report
'Must Do' action reference: … Safeguarding (SG18)……

To be completed during Executive Team Meeting and shared back with the Action Owner and Responsible Manager named in the Exception Report

Action	Exec Lead	By When?

Name:……Signed: ……. Date: ……..
(Lead Executive Director)

CQC Improvement Plan

(Issued 16 December 2016)

Exception Report

'Must Do' Action Reference	***999 Performance (CQC MD 8)***	**Current RAG Status**	**RED**
Action	*Take action to ensure that national targets are met*	**Action Completion Date** (as per CQC Improvement Plan)	*31 March 18*
Action Owner	*Sue Skelton Associate Director Operations*	**Reporting Officer**	*Joe Garcia Director of Operations*
CQC Domain	*Effective*	**CQC Fundamental Standard(s)**	
Date of Exception	*19 January 2017*		
Reason(s) this action is at risk	*The following schemes within the 999 Performance Improvement portfolio are currently showing at Risk within the CQC tracker. The reasons are as follows:*		

Scheme	*Reason for At Risk Status*
a) Supply and effectiveness of Private Ambulance Providers	*Anticipated performance improvement is below trajectory for December (Planned 2.5%, Actual 2.2%)*
b) Improved Scheduling and Forecasting	*The Scheduling team restructure has been deferred to June 2017.*
c) Improved EOC retention	*Updates to the current CAD have not been implemented.*
d) Reduce Response Ratio	*Auto response plans have not been implemented.*
e) Improved Operational interface between 999 and 111 services	*This project plan has not yet gone through Gateway 2*
f) Reduced Hospital Turnaround	*Revised Hospital Handover Policy has not been implemented.*

Explanation of the reasons for the action being at risk (detail)	Scheme	Reason for At Risk Status
	a) *Supply and effectiveness of Private Ambulance Providers*	*Delivery of the PAP project plan activities is currently at 70% completion with the remaining activities supporting the transition into Business as Usual processes. However the anticipated performance improvement is below trajectory for December (Planned 2.5%, Actual 2.2%) hence this has been RAG rated at risk. In addition a number of operational issues are impacting on the use of PAP's including a reduction in PAP hours being made available and an increase in demand over the December period.*
	b) *Improved Scheduling and Forecasting*	*There are activities within the project plan associated to the restructuring of the Scheduling Team which is directly aligned to the Operating Unit restructure Project. A recent decision has been made to defer the Scheduling team restructure to June 2017 in line with the EOC move. Therefore the planned activities are at risk.*
	c) *Improved EOC retention*	*This project has now been merged with the "Improved call Answer Service" Project. There are a number of activities within the plan that relate to implementing improvements to the current CAD system. These updates were put on hold whilst the Trust made a decision on a replacement CAD therefore the project status is "At Risk".*
	d) *Reduce Response Ratio*	*This project has a number of actions within the plan that relate to the implementation of "automated response plans". This has not been possible to implement with the current CAD and therefore the project status is "At Risk"*
	e) *Improved Operational interface between 999 and 111 services*	*This project plan has not yet gone through Gateway 2 as it was felt the original items on the URP tracker did not address the potential benefits to be made from an improved interface between the two services.*
	f) *Reduced Hospital Turnaround*	*The activities on the current plan relate to the implementation of a new Hospital Handover Policy which has not gained the support of the local commissioners and Acute Trusts.*

What steps are currently being taken to mitigate the risk of non-completion?	a) *Supply and effectiveness of Private Ambulance Providers*	1. *Mitigation plan has been drafted and presented to the Operational Recovery Steering Group (18.01.17).* 2. *Focus to be on contract management and performance.* 3. *Long term strategy to be developed which has less reliance on the use of PAP's and is aimed at re-introducing the role of technicians.*
	b) *Improved Scheduling and Forecasting*	1. *Replan the timeline for the scheduling team restructure activities. Note: this project does not give a direct contribution to the performance trajectory.*
	c) *Improved EOC retention*	1. *The EOC retention activities that have been merged with the "Improved Call Answer" project will need the timelines for an improved CAD aligned to the replacement CAD project.* 2. *Request that this line is removed from the CQC tracker in line with the changes made to the Improvement Tracker*
	d) *Reduce Response Ratio*	1. *Mitigation plan has been drafted and presented to the Operational Recovery Steering Group (18.01.17).* 2. *Delivery of auto response plans will need to be realigned to the replacement CAD project.*
	e) *Improved Operational interface between 999 and 111 services*	1. *Ownership for this has been delegated to the KMSS NHS 111 – Head of Service* 2. *Mandate to be worked up to Gateway 2 status*
	f) *Reduced Hospital Turnaround*	1. *Mitigation plan has been drafted and presented to the Operational Recovery Steering Group (18.01.17). This includes actions to ensure a better grip on the management and escalation processes to implement the current handover policy. Two Incident command hubs to be established.* 2. *Additional work with commissioners is required to get sign off of the new policy*

What is the likely impact of this mitigation?		
	a)Supply and effectiveness of Private Ambulance Providers	*Additional tasks will need to be added to the plan. Long term strategic intention will require dates to extend to March 2018 (tbc)*
	b)Improved Scheduling and Forecasting	*Deadline will need to be extended to October 2017*
	c)Improved EOC retention	*This line on the tracker to be removed. The actions relating to EOC retention are visible within the "Improved call answer" project plan. Activities in relation to an improved CAD will need t be aligned with the CAD project (dates tbc)*
	d)Reduce Response Ratio	*Deadline for delivery of auto response plans will ne to be extended in line with the CAD implementation plan (dates tbc)*
	e)Improved Operational interface between 999 and 111 services	*Deadline for delivery will need to be extended. Date will not be known until the Project mandate has bee completed. Due to be completed the week ending 27.01.17*
	f)Reduced Hospital Turnaround	*Activities for the introduction of two Incident Comma hubs to be added to the current plan. No change to current delivery date of March 18 required.*
Support required (E.g. Exec, Management, Admin, Financial, IT)	*Long term strategic plan to reduce the dependency on PAP's will be subject to business case approval* *IT – CAD Implementation Project Lead – requirement to have sight of the replacement CAD Implementation plan in order to align dates for projects c and d above* *Exec support is required to get buy in/ support from local commissioners with regard to the enforcement of the Immediate Handover policy at the Acute Trusts*	

Executive actions to be completed in support of CQC Improvement Plan Exception Report
'Must Do' action reference: … Safeguarding (SG18)……

To be completed during Executive Team Meeting and shared back with the Action Owner and Responsible Manager named in the Exception Report

Action	Exec Lead	By When?

Name:……Signed: ……. Date: ……..
(Lead Executive Director)

CQC Improvement Plan

Exception Report

'Must Do' Action Reference	Governance 6.04	**Current RAG Status**	**RED**
Action	Finalise and implement senior management team (working group) governance structure	**Action Completion Date** (as per CQC Improvement Plan)	December 2016
Action Owner	Peter Lee	**Reporting Officer**	Emma Wadey
CQC Domain	Well-Led	**CQC Fundamental Standard(s)**	17 – Good Governance
Date of Exception	19 January 2017		
Reason(s) this action is at risk	Final stages of confirming the final working group structure to be completed, and associated revision of the groups' terms of reference		
Explanation of the reasons for the action being at risk (detail)	The timeframe agreed was in hindsight probably too optimistic. The review of the groups currently in place took longer than expected and there was greater complexity establishing the functions and reporting lines of the clinical-related groups. The latter was compounded by the movement within the (clinical) executive which delayed the agreement in how the structure should align. The original timeframe also did not consider the period of transition required to allow the deletion of groups and transfer of functions.		

What steps are currently being taken to mitigate the risk of non-completion?	Having sought agreement on the working group structure the executive and senior management team will work together to ensure revision of the groups' terms of reference so that they reflect the new structure. This will be overseen by the executive via the main 'parent groups'.
What is the likely impact of this mitigation?	The review will give clarity and reduce some of the confusion that currently exists relating to the working groups' purpose and authority.
Support required (E.g. Exec, Management, Admin, Financial, IT)	Among the many competing priorities time is needed to carefully review the terms of reference, schedule approval of the same and then organise the groups to fulfil their purpose.

CQC Improvement Plan

(Issued 16 December 2016)

Exception Report

'Must Do' Action Reference	MEDICINE MANAGEMENT ***(MM14)***	**Current RAG Status**	**RED**
Action	Review CQC action plan to ensure it includes all actions required to ensure medicines are stored and administered safely. These actions will have achievable timescales and identified owners	**Action Completion Date** (as per CQC Improvement Plan)	25 January 2017
Action Owner	Paul Cloves, Medicines management lead	**Reporting Officer**	Fiona Wray
CQC Domain	Safe (S3): are there reliable systems, processes and practices in place to keep people safe and safeguarded from abuse?	**CQC Fundamental Standard(s)**	Regulation 12 Safe care and treatment
Date of Exception	19 January 2017		
Reason(s) this action is at risk	The actions included in the previous plan did not accurately reflect all known medicine management issues that are contributing to noncompliance with this regulation.		
Explanation of the reasons for the action being at risk (detail)	The Trust was not fully aware of the wide range of medicine management issues. While the CQC inspection identified some areas of non-compliance, following this inspection additional issues relating to medicine management have been identified through staff raising concerns, audit and review of practice. Taking this into account the action plan has been updated to reflect all known issues, the timescales have been reviewed to include achievable deadlines and have identified owners.		

What steps are currently being taken to mitigate the risk of non-completion?	Paddock Wood business case is currently not approved as alternative storage arrangements are being explored by Estates. Once preferred options have been identified these will be submitted to finance. Security at non omnicell sites remains an issue as controlled drugs are routinely being signed out by a single member of staff. This is outside legal/professional guidance and actions to mitigate the risks associated with this practice are being explored. Collection of waste as medical waste is currently not included in the contract to remove waste from the Trust, therefore there is no budget or contract for the removal of medical waste, this is an area currently being explored to identify the actions to mitigate the known risks. The action plan has been reviewed and prioritised to ensure urgent action is taken to suspend any know practice that is not in line with legal or professional guidance. After several years of the Trust not have a pharmacist, we have used a consultant pharmacist for advice we have recruited a pharmacist.

What is the likely impact of this mitigation?	As actions are reviewed deadlines may be extended it is not possible to give details of these amended timescales as the plan is currently being redrafted. The appointed pharmacist will not commence in post until April 2017, therefore the Trust is seeking additional support during this period to ensure progress in addressing the prioritised actions in the medicine's management action plan is made. Consequences of this are; • The action plan has been updated but not yet shared with CQC and NHSI. • Limited assurance that all medicines are stored and administered in a safe manner • Negative impact on patient safety • Non-compliance with the CQC 'Safe' domain and Fundamental Standard relating to safe care and treatment • Limited assurance that all staff are administering medicines in line with their professional code of practice Achievement of this action would: ✓ Ensure the Trust is able to obtain, store and administer medicines legally and in line with best practice. ✓ Provide assurance to patients, the Trust Board and stakeholders that all staff handling medicines are doing so safely and in line with their professional codes of conduct. ✓ Meet legislative and regulatory compliance requirements
Support required (E.g. Exec, Management, Admin, Financial, IT)	Support from Estates to identify and secure funding for suitable storage facilities at Paddock Wood Pharmacy support until the new Pharmacist comes into post in April 2017. Review of current contracts with CCGs re service of providing a course of antibiotics for patients provided by PPs. To provide these medicines the packs have to be over labelled. The trust is currently over labelling, this must be done under the direct supervising of a pharmacist, as we do not have one in post we are currently acting illegally. Support from logistics to review how medical gases are stored, tracked and audited. Commitment from the Clinical Directors to attend DAT to ensure the group is quorate and decisions can be made in a timely manner.

Executive actions to be completed in support of CQC Improvement Plan Exception Report
'Must Do' action reference: … Safeguarding (SG18)……

To be completed during Executive Team Meeting and shared back with the Action Owner and Responsible Manager named in the Exception Report

Action	Exec Lead	By When?

Name:……Signed: ……. Date: ……..
(Lead Executive Director)

CQC Improvement Plan

(Issued 16 December 2016)

Exception Report

'Must Do' Action Reference	**No. 15 Patient Records Improvement Plan**	**Current RAG Status**	**RED**
Action	QI workshop programme (Ref: 15.15)	**Action Completion Date** (as per CQC Improvement Plan)	*31st March 2017*
Action Owner	*Dr Andy Carson Medical Director*	**Reporting Officer**	*Andy Collen Head of Clinical Development*
CQC Domain	*Safe*	**CQC Fundamental Standard(s)**	
Date of Exception	*19th January 2017*		
Reason(s) this action is at risk	1) Trust Quality Improvement methodology not agreed yet 2) Recruitment to the Clinical Leadership structure (CLIN16002).		
Explanation of the reasons for the action being at risk (detail)	1) At the current time, the Trust has not agreed its Quality Improvement methodology, and so planning cannot take place for the QI workshops focusing on improving outcomes. Review of Audit Methodology is being undertaken by Maggie Oldham ahead of Exec discussion 2) The requirement to recruit to the Clinical Leadership structure (CLIN16002) is delayed due to the consultation relating to the future of the Paramedic Directorate.		
What steps are currently being taken to mitigate the risk of non-completion?	1) Development of the options for agreed QI methodology in progress 2) Preparation for business processes to support completion of work-stream (finance, HR support, Exec paper etc) being undertaken to ensure rapid movement post Directorate consultation is concluded		

What is the likely impact of this mitigation?	1) Not know (Maggie Oldham Leading) 2) Reduction in delays following closure of consultation as work being done in preparation.
Support required (E.g. Exec, Management, Admin, Financial, IT)	*Exec support for Clinical Leadership Structure* *HR Support for SRG papers.*

Executive actions to be completed in support of CQC Improvement Plan Exception Report
'Must Do' action reference: …

To be completed during Executive Team Meeting and shared back with the Action Owner and Responsible Manager named in the Exception Report

Action	Exec Lead	By When?
None		

Name:……Signed: ……. Date: ……..
(Lead Executive Director)

CQC Improvement Plan

(Issued 16 December 2016)

Exception Report

'Must Do' Action Reference	PATIENT RECORDS IMPROVEMENT PLAN ***(PRP15)***	**Current RAG Status**	**RED**
Action	Review the work programme for Supply and installation of PCR collection boxes at stations Improved compliance to PCR completion standards by operational clinicians	**Action Completion Date** (as per CQC Improvement Plan)	25 January 2017
Action Owner	Eva Szwarc-Delves	**Reporting Officer**	Fiona Wray
CQC Domain	Safe (S3): are there reliable systems, processes and practices in place to keep people safe and safeguarded	**CQC Fundamental Standard(s)**	Patient centred care Regulation 09
Date of Exception	19 January 2017		
Reason(s) this action is at risk	The supplier advised the Trust that the collection boxes will be delivered 26/27th January 2017, this is two weeks later than planned. This has delayed installation. The quality improvement workshop programme is being developed but implementation has been delayed due to operational pressures.		
Explanation of the reasons for the action being at risk (detail)	The business case for new collection boxes was delayed due to quotes from three providers being required. This impacted on contracting the preferred provider and ordering the collection boxes.		

What steps are currently being taken to mitigate the risk of non-completion?	All location have confirmed the location for the collection box and an installation schedule is being prepared which will be monitored for completion. Communication with all OUMs and CTLs regarding the box installation location. The contractor responsible for installation is in the process of formulating an installation schedule. Operational Instruction outlining the process for completion, submission and collection of PCR following installation of the new boxes which is awaiting approval. Operation's managers have committed to auditing one PCR per member of staff per month for completion.
What is the likely impact of this mitigation?	There is a two week delay in the installation of the collection boxes Consequences of this are; • The action plan may not be completed within the agreed timescales shared with CQC and NHSI. • Limited assurance that all health records are completed and stored in a manner that protects patient confidentiality • Negative impact on patient confidentiality • Loss of patient data • Non-compliance with the CQC 'Safe' domain and Fundamental Standard relating to patient centred care • Limited assurance that all staff are fully completing records • Patient records may not be readily available if required by other health professionals or the Coroner. • Information may be shared inappropriately. Achievement of this action would: ✓ Ensure the Trust is completing patient in line with best practice. ✓ Provide assurance to patients, the Trust Board and stakeholders that all patient information is stored confidentiality ✓ Meet legislative and regulatory compliance requirements

Support required (E.g. Exec, Management, Admin, Financial, IT)	Support from logistics to ensure there is a clear plan for the collection and return of patient records from the stations to health records. Commitment from Operations staff to audit the quality and completion of health records. Executive support to release staff to attend quality improvement workshops. .

Executive actions to be completed in support of CQC Improvement Plan Exception Report
'Must Do' action reference: … Safeguarding (SG18)……

To be completed during Executive Team Meeting and shared back with the Action Owner and Responsible Manager named in the Exception Report

Action	Exec Lead	By When?

Name:……Signed: ……. Date: ……..
(Lead Executive Director)

CQC Improvement Plan

Exception Report

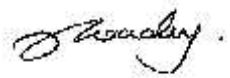
'Must Do' Action Reference	***Safeguarding (SG31)***	**Current RAG Status**	**RED**
Action	Mental Capacity Act e-learning to be identified and promoted to all staff	**Action Completion Date** (as per CQC Improvement Plan)	December 2016
Action Owner	Jane Mitchell, Safeguarding Lead	**Reporting Officer**	Emma Wadey Interim Chief Nurse
CQC Domain	Safe (S3): are there reliable systems, processes and practices in place to keep people safe and safeguarded from abuse?	**CQC Fundamental Standard(s)**	Regulation 13: Safeguarding service users from abuse and improper treatment
Date of Exception	*18 January 2017*		
Reason(s) this action is at risk	Adaptation of existing eLearning module		
Explanation of the reasons for the action being at risk (detail)	Historical workload and delivery		
What steps are currently being taken to mitigate the risk of non-completion?	Individual given additional external and internal support to complete the task		

What is the likely impact of this mitigation?	The deadline will be extended by Deputy Chief Nurse and reset to 31st January 2017 Failure to meet internal training targets for Safeguarding will result in non-compliance for the year 2016/17 and 2018. The consequences of / penalties for this would include: • Limited assurance that all staff have an understanding of current safeguarding policies/ procedures/ process to protect patients from avoidable abuse and harm • Negative impact on patient safety • Non-compliance with the CQC 'Safe' domain and Fundamental Standard to safeguard service users from abuse and improper treatment Achievement of this action would: ✓ Ensure the Trust is able to deploy a safe workforce that has the latest knowledge and understanding of Safeguarding practice, both internally and externally ✓ Provide assurance to patients that our workforce is suitably trained to safeguard them from abuse and improper treatment ✓ Meet legislative and regulatory compliance requirements
Support required (E.g. Exec, Management, Admin, Financial, IT)	SG L2 - The Safeguarding team requires support of the Operations Directorate to identify who, how and when those yet to undertake their training can complete these modules (Children, Adults) online via www.secamblive.nhs.uk. Key roles required for this are Production / Scheduling Managers and OUMs. The eLearning (all modules) can be accessed via SECAmb LiVE using any fixed or mobile device with internet connection therefore a Wi-Fi connection is required. Seek clarification from IT of what facilities are available at local level. There is no additional financial investment / support required.

Executive actions to be completed in support of CQC Improvement Plan Exception Report
'Must Do' action reference: … Safeguarding (SG31)
To be completed during Executive Team Meeting and shared back with the Action Owner and Responsible Manager named in the Exception Report

Action	Exec Lead	By When?

Name: Emma Wadey
(Lead Executive Director)

Signed: 

Date: 19.01.19

CQC Improvement Plan

(Issued 16 December 2016)

Exception Report

Example

'Must Do' Action Reference	***Security (CQC MD 2)***	**Current RAG Status**	**RED**
Action	**Consistency of security arrangements across the Trust**	**Action Completion Date** (as per CQC Improvement Plan)	*31 March 2017*
Action Owner	*Adam Graham*	**Reporting Officer**	*Joe Garcia*
CQC Domain	*Safe*	**CQC Fundamental Standard(s)**	
Date of Exception	*19 January 2017*		
Reason(s) this action is at risk	*Completion of this task is dependent on the appointment of a Security Coordinator role. The role description banding is currently under dispute.*		
Explanation of the reasons for the action being at risk (detail)	*Security is managed centrally and currently with no support for the Security manager. The appointment of a Security Coordinator post is required to manage the administrative tasks associated to the quarterly audits. Without this it is not possible for the Security Manager to provide the trend analysis and recommended remedial actions.*		
What steps are currently being taken to mitigate the risk of non-completion?	*The Security Coordinator Job role is required at a Band 4 and is currently graded as a Band 3. This is being disputed with HR. Sign off for a band 4 is required without further delay to enable recruitment to the post in time to manage the Q4 audits. Responsibility for*		

What is the likely impact of this mitigation?	*Achievement of this action would:* ✓ *Ensure the Trust is able to coordinate and document the Q4 and beyond, site security audits and therefore support the Security manager in providing an analysis and recommendations for operational managers to develop local action plans.* ✓ *Mitigate against a possible investigation from the Health and Safety Executive* ✓ *Meet H&S legislative and regulatory compliance requirements*
Support required (E.g. Exec, Management, Admin, Financial, IT)	*HR – Require support from HR to resolve the dispute on banding as a matter of urgency and once resolved to provide support to expedite the recruitment process.*

Executive actions to be completed in support of CQC Improvement Plan Exception Report
'Must Do' action reference: … Safeguarding (SG18)……

To be completed during Executive Team Meeting and shared back with the Action Owner and Responsible Manager named in the Exception Report

Action	Exec Lead	By When?

Name:……Signed: ……. Date: ……..
(Lead Executive Director)

CQC Improvement Plan

(Issued 16 December 2016)

Exception Report

'Must Do' Action Reference	***Staffing and Resourcing Plan***	**Current RAG Status**	**RED**
Action	**There is a sufficient workforce to deliver the service**	**Action Completion Date** (as per CQC Improvement Plan)	*31 March 2017*
Action Owner	*Sue Skelton and Senior Operational Leadership Team*	**Reporting Officer**	*Joe Garcia Director of Operations*
CQC Domain	*Well Led*	**CQC Fundamental Standard(s)**	
Date of Exception	*19 January 2017*		
Reason(s) this action is at risk	*Will not be complete by the deadline*		
Explanation of the reasons for the action being at risk (detail)	*This action is at risk due to the Trust not being funded to meet national performance targets. There is a current gap of £26M.* *National Performance Targets will not be met whilst this gap exists. The Trust is in negotiation with CCG partners to agree local performance targets.*		
What steps are currently being taken to mitigate the risk of non-completion?	*Mitigation actions are in place to minimise the impact on staff end of shift over runs and meal break interruptions. These will be closely monitored and concerns highlighted to the executive team.* *Other projects within the recovery plan focus on efficiency improvements e.g. Task Cycle Time, Hear and Treat and Hospital Handover in order to achieve locally agreed targets* *Regular meetings with CCG partners are held.*		

What is the likely impact of this mitigation?	*Unlikely to change the current funding gap so this action will remain at risk.* *Progress on project that yield improved efficiency will support the achievement of targets*
Support required (E.g. Exec, Management, Admin, Financial, IT)	*Executive support to the continued CCG negotiations and management of local targets and expectations.*

Executive actions to be completed in support of CQC Improvement Plan Exception Report
'Must Do' action reference: … Safeguarding (SG18)……

To be completed during Executive Team Meeting and shared back with the Action Owner and Responsible Manager named in the Exception Report

Action	Exec Lead	By When?

Name:……Signed: ……. Date: ……..
(Lead Executive Director)

CQC Improvement Plan

(Issued 16 December 2016)

Exception Report

'Must Do' Action Reference	***CAD Maintenance 3.02***	**Current RAG Status**	**RED**
Action	*Take action to ensure the CAD system is properly maintained.*	**Action Completion Date** (as per CQC Improvement Plan)	*Dec 16*
Action Owner	*Mark Chivers, Head of IT*	**Reporting Officer**	*Mark Chivers, Head of IT*
CQC Domain	*Safe: The Trusts CAD system had not been appropriately updated*	**CQC Fundamental Standard(s)**	
Date of Exception	*20 January 2017*		
Reason(s) this action is at risk	*Failure of the CAD Supplier (3tc) to deliver the gazetteer update within the agreed timescales.*		
Explanation of the reasons for the action being at risk (detail)	*The Trust is wholly reliant on the CAD supplier to take the latest data from the Ordnance Survey and create/import a new gazetteer. Assurances were received that this would be completed in December 2016 but the supplier cited technical difficulties and missed the deadline. A new installation date of February 2017 has been given.*		
What steps are currently being taken to mitigate the risk of non-completion?	*Pressure is being applied to the senior levels of the supplier organisation. The situation is compounded by a breakdown in relations between the UK Supplier and the US Manufacturer of the software. The Trust board has taken the decision to replace the CAD system and the procurement has already completed, contract awarded and implementation started in January 2017.* *A separate gazetteer lookup capability has been provided to all Trust 999 call takers.*		

What is the likely impact of this mitigation?	*The Trust will implement a CAD system designed for and implemented in the UK ambulance sector.* *The standalone gazetteer lookup tool allows CAD operators to find the correct coordinates for addresses not on the CAD system itself. Vehicle navigation from the CAD is done by sending coordinates to the vehicle as opposed to an address as per a normal satnav so this tool allows call takers to find the correct coordinates and manually enter them into the CAD record so that the vehicle has the correct location.*
Support required (E.g. Exec, Management, Admin, Financial, IT)	*Further pressure on the supplier may require Exec intervention.* *The implementation of a new CAD is a major project already supported and underway with an established project board and governance structure.*

Executive actions to be completed in support of CQC Improvement Plan Exception Report
'Must Do' action reference: … Safeguarding (SG18)……

To be completed during Executive Team Meeting and shared back with the Action Owner and Responsible Manager named in the Exception Report

Action	Exec Lead	By When?

Name:……Signed: ……. Date: ……..
(Lead Executive Director)

CQC Improvement Plan

(Issued 16 December 2016)

Exception Report

'Must Do' Action Reference	***Staffing and Resourcing Plan***	**Current RAG Status**	**RED**
Action	**Staff receive adequate meal breaks and time off between shift**	**Action Completion Date** (as per CQC Improvement Plan)	*31 January 2017*
Action Owner	*Regional Operations Manager – James Pavey*	**Reporting Officer**	*Joe Garcia Director of Operations*
CQC Domain	*Well Led*	**CQC Fundamental Standard(s)**	
Date of Exception	*19 January 2017*		
Reason(s) this action is at risk	*Will not be complete by the deadline*		
Explanation of the reasons for the action being at risk (detail)	*Work commenced on this action late November 2016 with the initial joint meeting of ops and staff side taking place on the 6th December 2016. Timescales to achieve the deliverable were agreed at this meeting. February 2017 was considered a realistic timeframe by which to have an agreed draft policy ready for review by PPG/JPF/Executive Team.*		
What steps are currently being taken to mitigate the risk of non-completion?	*Revised completion date of 28.02.17 required.*		

What is the likely impact of this mitigation?	*A realistic and joint operations /staff side developed policy will be available for sign off and subsequent implementation.* *Less resistance when policy reviewed by JPF, as the additional time to complete the task will ensure that staff side can engage in the policy development and issues can be resolved prior to the formal review by JPF.*
Support required (E.g. Exec, Management, Admin, Financial, IT)	

Executive actions to be completed in support of CQC Improvement Plan Exception Report
'Must Do' action reference: … Safeguarding (SG18)……

To be completed during Executive Team Meeting and shared back with the Action Owner and Responsible Manager named in the Exception Report

Action	Exec Lead	By When?

Name:……Signed: ……. Date: ……..
(Lead Executive Director)

CQC Improvement Plan

(Issued 19 January 2016)

Exception Report

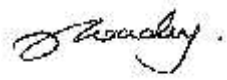
'Must Do' Action Reference	***Safeguarding (SG9 & 10)***	**Current RAG Status**	**RED**
Action	*Development of training plan compliance trajectory Level 1 adult & Children*	**Action Completion Date** (as per CQC Improvement Plan)	*31 March 2017*
Action Owner	*Jane Mitchell, Safeguarding Lead*	**Reporting Officer**	*Dan Hale Interim AD Governance*
CQC Domain	*Safe (S3): are there reliable systems, processes and practices in place to keep people safe and safeguarded from abuse?*	**CQC Fundamental Standard(s)**	*Regulation 13: Safeguarding service users from abuse and improper treatment*
Date of Exception	*09 January 2017*		
Reason(s) this action is at risk	*Training Trajectory not met*		
Explanation of the reasons for the action being at risk (detail)	*Delivery/completion of Level 1 adult and child training not in line with the agreed trajectory.*		

What steps are currently being taken to mitigate the risk of non-completion?	*A full list of names of staff having undertaken the training has been requested from Learning and Development to compare to a list of all current Trust staff. This will be shared with relevant managers and a reminder to complete the training on-line will be sent to each individual member of staff identified as yet to complete their training.* *This will be monitored on a weekly basis and reported to the Director responsible for each staff group.* *Planned training delivery and trajectory for 2016-17 and 2017-18 has been developed. Training will be delivered for 2 days each week, with 25 staff abstracted to attend each session. The planned trajectory outlines a delivery plan for 180 people per month with an actual planned delivery of 200 per month. This has been designed to ensure that any non-attendance/new starters can be accommodated within the year.*
What is the likely impact of this mitigation?	*Failure to meet internal training targets for Safeguarding will result in non-compliance for the year 2016/17. The consequences of / penalties for this would include:* *) Limited assurance that all staff have an understanding of current safeguarding policies/ procedures/ process to protect patients from avoidable abuse and harm* *) Negative impact on patient safety* *) Non-compliance with the CQC 'Safe' domain and Fundamental Standard to safeguard service users from abuse and improper treatment* *Achievement of this action would:* ✓ *Ensure the Trust is able to deploy a safe workforce that has the latest knowledge and understanding of Safeguarding practice, both internally and externally* ✓ *Provide assurance to patients that our workforce is suitably trained to safeguard them from abuse and improper treatment* ✓ *Meet legislative and regulatory compliance requirements*
Support required (E.g. Exec, Management, Admin, Financial, IT)	*SG L1 – This level is aimed at non-clinical staff with no direct patient contact. All Executive Directors with non-operational roles in their structure are asked to contact the people in these roles to ask them to complete their training. Training needs to be undertaken by 31 March 2016, however the recommended deadline is Friday 24 February to allow for data validation prior to submission of year-end figures. Staff lists are available in SharePoint -* *Key Skills Staff List 2016-17 v2 4* *The eLearning (all modules) can be accessed via SECAmb LiVE using any fixed or mobile device with internet connection therefore a Wi-Fi connection is required. Seek clarification from IT of what facilities are available at local level.* *There is no financial investment / support required.*

Executive actions to be completed in support of CQC Improvement Plan Exception Report
'Must Do' action reference: … Safeguarding (SG9 & 10)……

To be completed during Executive Team Meeting and shared back with the Action Owner and Responsible Manager named in the Exception Report

Action	**Exec Lead**	**By When?**
Emma Wadey to escalate this risk to the Executive management Team	Emma Wadey	Complete
All Executive Directors with non-operational roles in their structure are asked to contact the staff to ensure completion of their training	Emma Wadey	Friday 20th Jan
Continued monitoring and escalation of delivery/completion against trajectory	Emma Wadey	On-Going

Name:Emma Wadey Signed:  Date: 19.01.17

(Lead Executive Director)

CQC Improvement Plan

(Issued 16 January 2016)

Exception Report

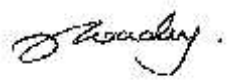
'Must Do' Action Reference	***Incident Management & Reporting (IR11)***	**Current RAG Status**	**RED**
Action	*Procurement and development of the Datix App to enable reporting through Ipads being rolled out as part of ePCR*	**Action Completion Date** (as per CQC Improvement Plan)	*Jan 2017*
Action Owner	*Dan Hale, Interim AD Governance*	**Reporting Officer**	*Jo Habben, Lead Clinician for Quality & Compliance*
CQC Domain	*Safe (S2): Are lessons learned and improvements made when things go wrong?*	**CQC Fundamental Standard(s)**	*Regulation 12: Safe care and treatment*
Date of Exception	*19 January 2017*		
Reason(s) this action is at risk	*The Datix App is being developed externally by Datix.*		
Explanation of the reasons for the action being at risk (detail)	*Datix are developing the App as part of their product offering. We are intending to work with them to be an early adopter. The current app development timeline is not likely to commence until April 2017.*		
What steps are currently being taken to mitigate the risk of non-completion?	*Ipad roll out will enable access to the current web version of the Datix report form, which will improve crew access to incident reporting whilst not on station.*		

What is the likely impact of this mitigation?	*This action will be split into two actions:* *1) Use of current Datix Web report form on the Ipad.* *2) Development of the Datix App*
Support required (E.g. Exec, Management, Admin, Financial, IT)	*It is suggested we trial and test the Datix Web form on the Ipad before roll out to ensure there are no technical/user issues as a result of using the report form in this format, as it is not supported by Datix.*

Executive actions to be completed in support of CQC Improvement Plan Exception Report
'Must Do' action reference: … Incident management & Reporting IR11

To be completed during Executive Team Meeting and shared back with the Action Owner and Responsible Manager named in the Exception Report

Action	**Exec Lead**	**By When?**
CQC Action Plan to be updated to create two subsequent Actions	Emma Wadey	Complete for next version
Testing of Datix Web on the Ipad, for technical/user issues	Emma Wadey	1st April 2017
Communication to front line staff of ability to report using Datix Web on Ipad	Emma Wadey	1st April 2017

Name:Emma Wadey Signed:  Date: 19.01.17

(Lead Executive Director)

South East Coast Ambulance NHS Foundation Trust
CQC Engagement Meeting
Date:
Attendents:

1. Core Issues

		FOR TRUST USE		FOR JOINT AGREEMENT	FOR CQC USE POST MEETING	
Domain	**Area**	**Action**	**Evidence**	**Expected Outcome**	**Quality assessment of evidence**	**Plan for corroboration at Inspection**
SAFE	**Patient Safety**	Chief pharmacist appointed to lead medicines management supported by medical Director and medicines amangement team	JD Contract			
		Independent safegarding review completed	Draft report received and reviewed by Chair, NED safegarding lead and Chief Nurse. Factual accuarcy checks underway			
		Designated Nurse for Child safegarding appoined and started to provide additional oversight and resourse for training for 12 weeks.	JD, contract			
		learning from safegarding review presented to all ROM and OUMs	trainin glog and presentation slides.			
		Medicines management diagnostic commissioned by SECAMB from NHSI Chief Pharmacist	scope and TOR of review			
		Infection control advisor recruited and started in post on 5th january	JD Contract			
WELL LED	**Leadership and Governance**	New NED appointment	JD Contract			
		Quality and safety group Tor agreed first meeting 17th Jan	TOR meeting notes			
		First draft of clinical stategy completed	Clinical strategy document			
		New CAD sytem selected in consultation with 50 staff members	new CAD system attendence list scope of business case. Implementation plan.			
		Development and implementation of a new clinical handover procedure	implementation plan, guidance documents. Enagagement with staff, letetrs to Emergency care boards and CCGs. Documentation and ausits of use.			
	Staff Engagement	Next Steps event held for all ROM and OUMs on role of STPs, startegy, vision perormance and proffesional standards	Attendence log, presentations and agenda			
		Engagment events with CCps and PPs to discuss changes to deployment	Attendence log, minutes			
		Initial Bullying & Harassment diagnostic project agreed	Duncan Lewis from Plymouth University will be brought in starting Feb 17			
		Engagement Lead secondments out to advertise and filled with expectation they will be filled Jan 17	Roles on internal add, buisness case			

2. Other Areas of discussion

3. Areas of developing risk (identified during meeting)

4. CQC Challenge

South East Coast Ambulance Service NHS
NHS Foundation Trust

Item No	172/16

Name of meeting	Board Meeting
Date	26th January 2017
Name of paper	Integrated Performance Dashboard
Executive sponsor	Geraint Davies
Author name and role	Executive Team
Synopsis (up to 120 words)	The monthly Integrated Performance Dashboard gives the board oversight of the key performance indicators for the Trust, together with explanatory commentary to give suitable context and what actions are being taken to address any shortfalls. The dashboard includes score cards for each area (Workforce, Performance, Clinical Effectiveness, Quality & Outcomes and Finance), suitable supporting commentary and charts with historic performance for trending purposes. The Integrated Performance Dashboard is an evolving item and is expected to undergo continuous improvement and change going forward.
Recommendations, decisions or actions sought	For Discussion
Why must this meeting deal with this item? (max 15 words)	Overview of the Trusts key performance indicators including patient outcome KPIs, AQI and associated performance KPIs, finance KPIs, and workforce KPIs.
Which strategic objective does this paper link to?	All

Does this paper, or the subject of this paper, require an equality analysis ('EA')? (EAs are required for all strategies, policies, procedures, guidelines, plans and business cases).	No

Executive Summary

The performance for Red 1, Red 2 and Red 19 were below the national targets; as a reminder, SECAmb has not been commissioned to hit these in 2016/17. However, it was also below the revised recovery plan performance trajectory. The main causes of the under-performance against trajectory were the significant loss of resource hours due to hospital handover delays and the compounding impacts of increased activity. Both activity and performance continues to show a slow but steady improvement from the second week of January onwards.

SECAmb's delivery against the Clinical Outcome Ambulance Quality Indicator (cAQIs) continues to show variable standards in delivering patient outcomes compared to the national average. Overall, two cAQIs continue to be consistently above the national average (Stroke in 60 minutes and STEMI 150 minutes) and two consistently below the national average (STEMI Care Bundle, Stroke Care Bundle).

A new section focusing on Quality and Patient Safety was added to the IPR in Decembers and nearly all the new KPIs now have data present. This includes additional data on Serious Incidents, Complaints and Safeguarding.

The Trust's financial performance for month 9 was a surplus of £0.1m, which is £0.2 behind forecast and £0.8m behind plan. This takes the Year to Date (YTD) deficit to £6.2m compared to the £0.8m surplus position assumed in the plan. The forecast for the year was revised to £7.1m in June 2016 following a review of the quality and governance issues to be resolved. This forecast position has remained constant since Q1.

The Trust continues to be at level 4 using the new NHSI Use of Resources rating (UOR), which can potentially trigger financial special measures. The adverse drivers of the rating are the variance against the original plan and the volume of agency spend, which breaches the Trust's pro-rated agency cap. A series of actions are taking place to drive improvement in the immediate financial position and also to ensure the Trust is sustainable in the long term. These include internal actions; ongoing directorate level financial reviews are being undertaken by the Turnaround and Finance Directors and the Executive Directors and senior staff have been challenged on delivering the year end forecast position; as well as working with Commissioners and other system partners to ensure SECAmb is paid appropriately for the services it provides.

Within our workforce, the vacancy rate for December across the Trust remains below the target rate of 10% with a detailed breakdown shown further in this report. There has been a rise in turnover and vacancy figure, largely as a consequence of 41 leavers in frontline services in December including 22.1 in A&E, 15.2 in EOC and 3.8 in NHS 111 services.

Sickness absence remains constant, with long term absence showing a drop on last year's figures.

Appraisal rates and mandatory training both show negative variance from the plan. It is expected that mandatory training will deliver on target in year but appraisals will be below target for the year (but in line with the CQC action plan).

1. SECAMB Regulation Statistics

ID	KPI	Value
R1(b)	Use of Resources Metric (Financial Risk Rating)	4 (Red)
R2	Governance Risk Rating	Red
R3	CQC Compliance Status	Trust: Inadequate (Special Measures) 111 service: Requires improvement
R5	IG Toolkit Assessment	Level 2 - Satisfactory
R6	REAP Level	3

2. Workforce

2.1. Workforce Summary

2.1.1. The vacancy rate for December across the Trust remains below the target rate of 10%. However, there is significant variation in rates across departments as shown in the table below. The HR Business Partners are working with management teams to develop workforce plans at the individual department/OU level.

2.1.2. We have seen a rise in turnover and vacancy figures as a consequence of 41.0 leavers in frontline service in December (A&E: 22.1, EOC: 15.2, 111: 3.8). Further work will be undertaken to understand the reasons behind these moves.

2.1.3. Sickness absence remains constant, with long term absence showing a drop on last year's figures.

2.1.4. Appraisal rates and mandatory training both show negative variance from the plan. It is expected that mandatory training will deliver on target in year as the activity in the next quarter picks up but appraisals are expected to be below target for in year (but in line with the target committed to in the CQC action plan).

2.2. Workforce Balanced Scorecard

ID	KPI	Current Month (Plan)	Current Month (Actual)	Current Month (Prev. Yr.)	YTD (Plan)	YTD (Actual)	YTD (Prev. Yr.)
Wf-1A	Short Term Sickness - Rate		**2.5%**	2.4%		**2.5%**	
Wf-1B	Long Term Sickness - Rate		**2.6%**	3.3%		**2.6%**	
Wf-2	Staff Appraisals	68%	**46.7%**	57.7%			
Wf-3	Mandatory Training Compliance (All Courses)	91%	**77.3%**	87.6%			
Wf-4	Total injuries		**54**	72		**550**	559
Wf-5	Total physical assaults		**20**	15		**166**	145
Wf-6	Vacancies (Total WTE)		**324.7**			**324.7**	
Wf-7	Annual Rolling Staff Turnover		**16.9%**	14.1%			
Wf-8	Reported Bullying & Harassment Cases		**0**			**13**	
Wf-9	Cases of Whistle Blowing		**0**			**2**	

2.3. Workforce Commentary

2.3.1. The table below shows the current staffing levels across the Trust by department/directorate. Several months of accurate data is giving us a robust picture and greater understanding of movement through the services, as staff progress through grades and between roles.

2.3.2. Human Resources (HR) Business Partners (BPs) are using this information to work with managers to develop robust workforce plans for 17/18 which will provide key information for future recruiting strategies and plans.

2.3.3. An audit into sickness absence reporting will start next month to give assurance that the stability in the figures is real.

2.3.4. The appraisal rate is expected to remain below target through the year. There is a recognition that the current system is not delivering the quantity or quality of appraisals required. A pilot is currently underway in selected areas of the Trust which looks at the use of an online system. Initial feedback is that this is seen as a positive development, which increases staff engagement and clarity of purpose and objectives.

2.3.5. A procurement exercise will be undertaken with the intention of rolling a system out to the Trust in April 2017, with an expectation that the appraisal rate for 2017/18 will be on target for 90% by the end of the year. This is in line with the CQC action plan.

Table 1: Detailed breakdown of Vacancy Rates for December 2016

Directorate	Function	Budget (FTE)	Staff in Post Actuals (FTE)	Vacancies	Vacancy Rate
278 EP3 Chief Executive Officer		31.75	30.05	1.70	5.34%
278 EP3 Director of Finance & Corporate Services		70.40	50.29	20.11	28.56%
278 EP3 Director of Human Resources		49.72	40.42	9.30	18.70%
278 EP3 Director of Quality & Safety		23.82	20.65	3.17	13.29%
278 EP3 Director of Strategy & Business Development		13.43	10.85	2.58	19.19%
278 EP3 Medical Director		34.00	25.60	8.40	24.71%
278 EP3 Paramedic Director		160.94	144.85	16.09	10.00%
278 EP3 Director of Operations	278 EP4 Operations - A&E	2195.30	2012.57	182.72	8.32%
	278 EP4 Operations - EOC	451.80	434.51	17.29	3.83%
	278 EP4 Operations - Fleet & Logistics	107.91	95.69	12.22	11.33%
	278 EP4 Operations - Management	18.00	10.67	7.33	40.74%
	278 EP4 Operations - PTS	132.79	117.10	15.69	11.82%
	278 EP4 Operations - Scheduling	33.60	29.80	3.80	11.31%
	278 EP4 Operations - Urgent Care	145.00	119.66	25.34	17.48%
	278 EP4 Operations - Voluntary Services	6.50	7.50	0.00	0.00%
278 EP3 Director of Operations Total		**3090.90**	**2827.49**	**263.41**	**8.52%**
Grand Total		**3474.96**	**3150.22**	**324.74**	**9.35%**

2.4. Workforce Charts

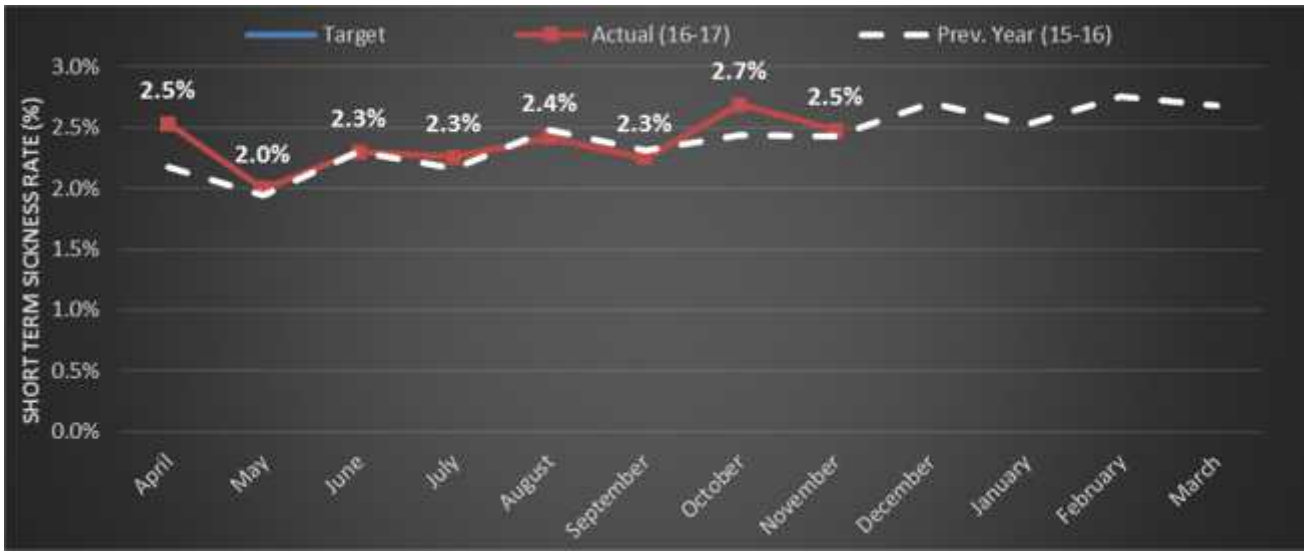


Figure Wf-1A - Short Term Sickness Rate

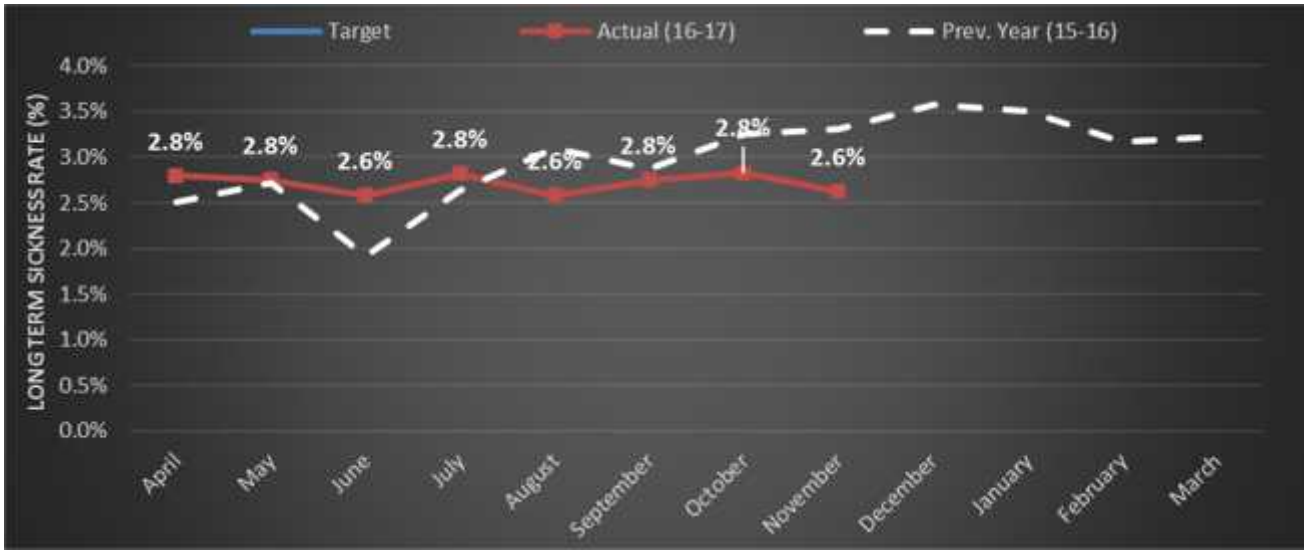


Figure Wf-1B - Long Term Sickness – Rate

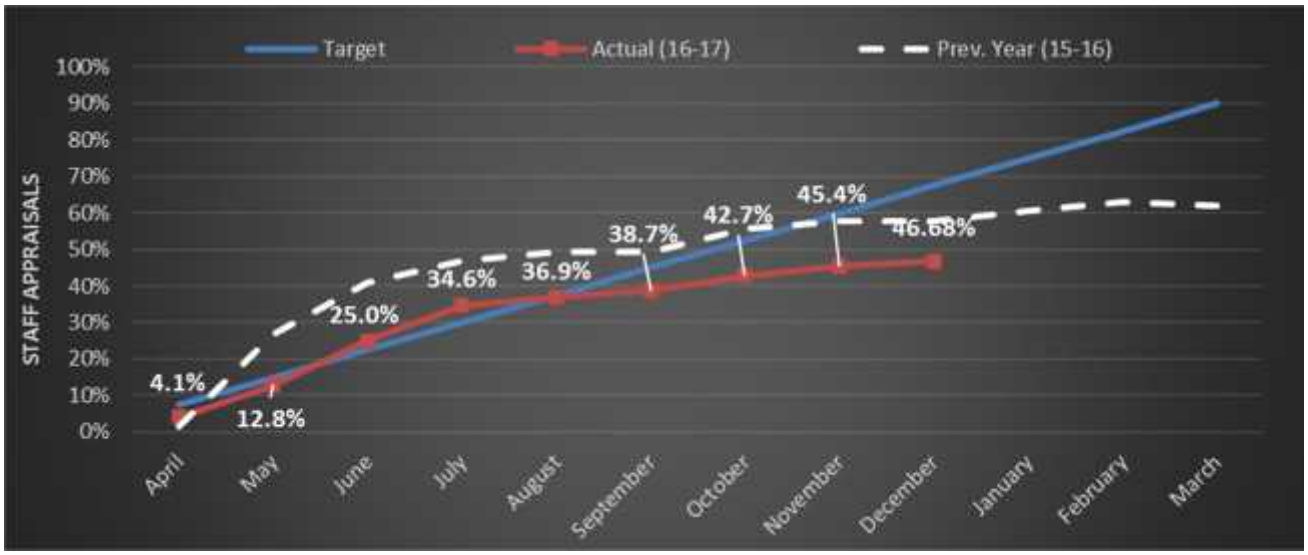


Figure Wf-2 - Staff Appraisals

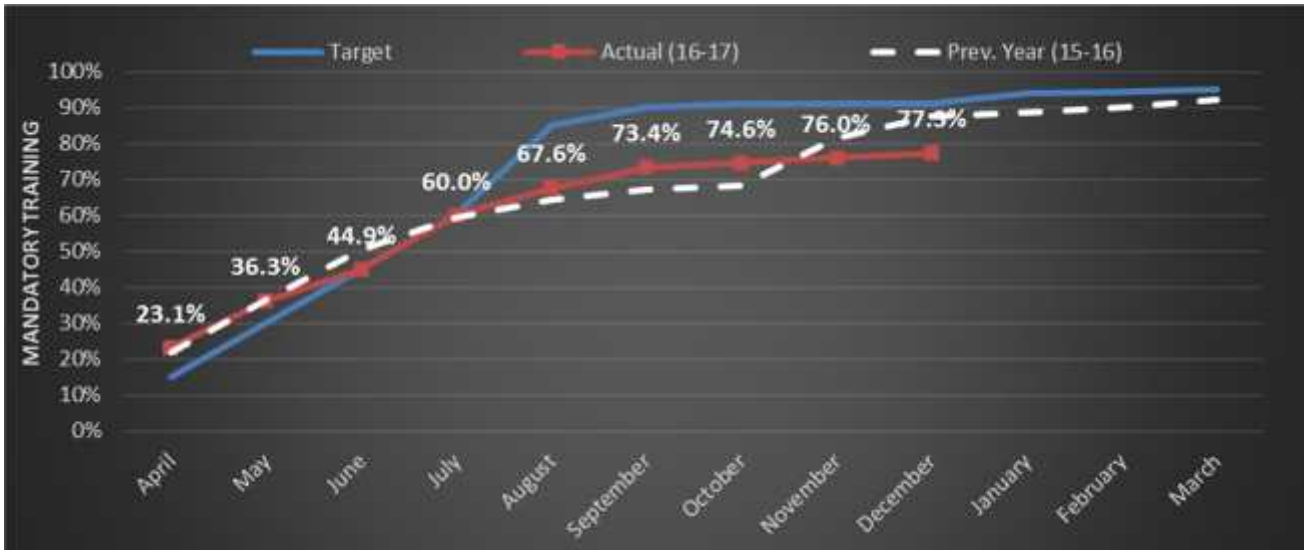


Figure Wf-3 - Mandatory Training Compliance (All Courses)

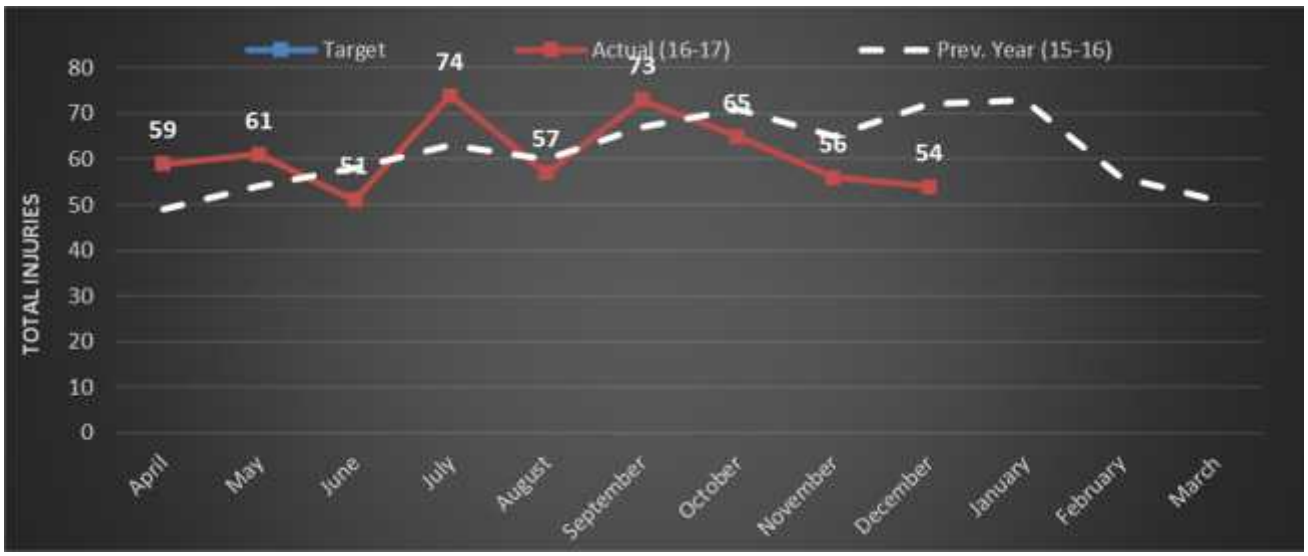


Figure Wf-4 - Total injuries

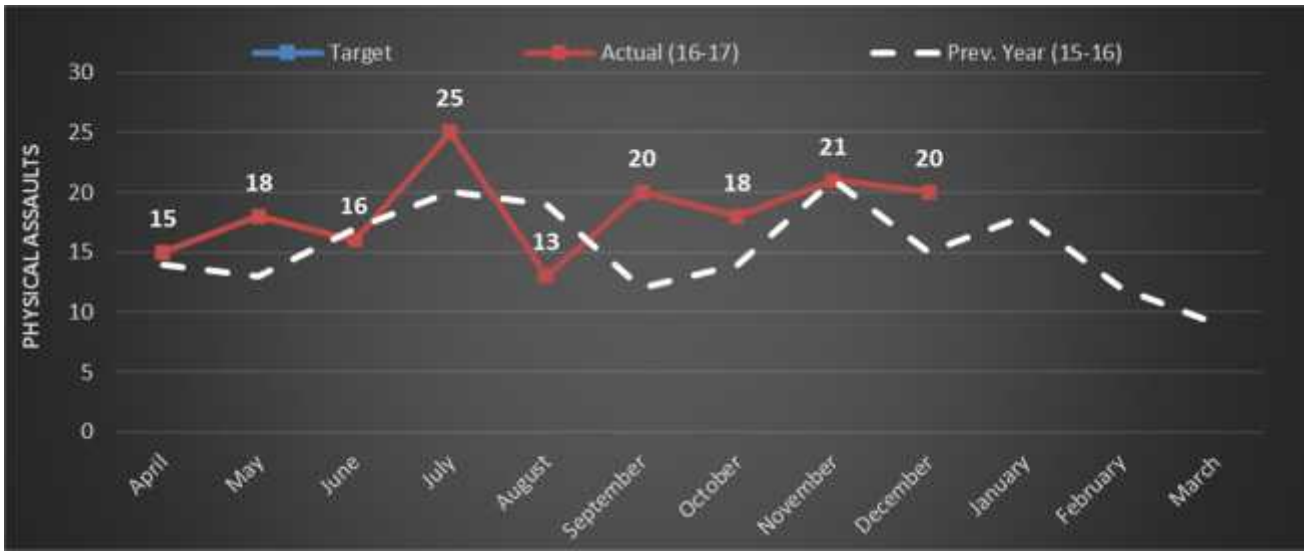


Figure Wf-5 - Total physical assaults.

Figure Wf-6 - Vacancies (Total WTE)

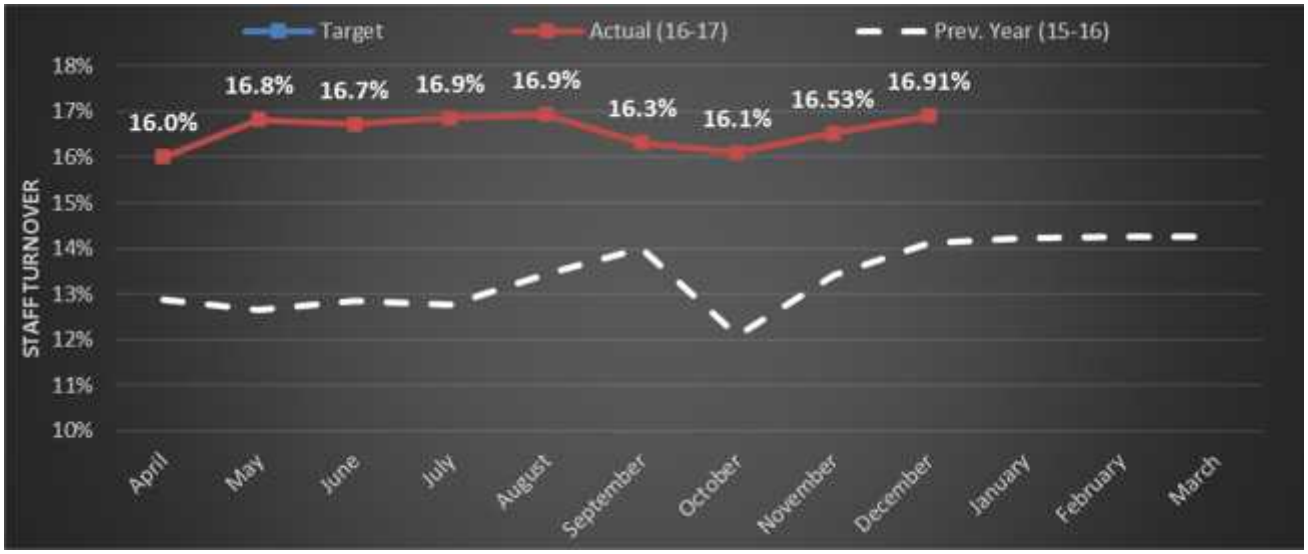


Figure Wf-7 - Annual Rolling Staff Turnover

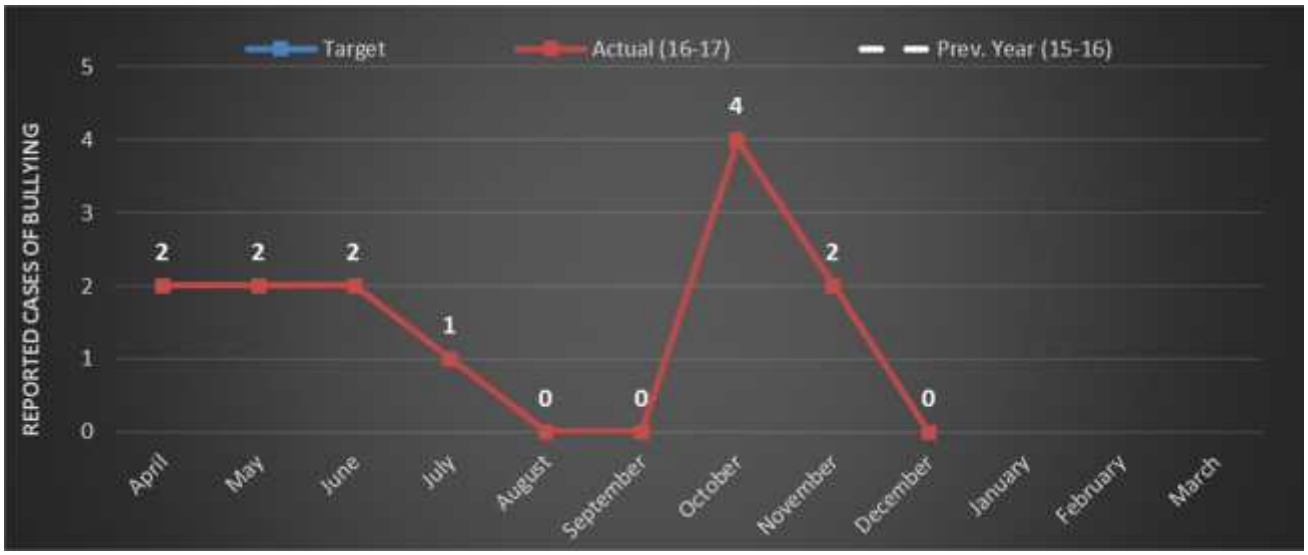


Figure Wf-8 - Reported Bullying & Harassment Cases

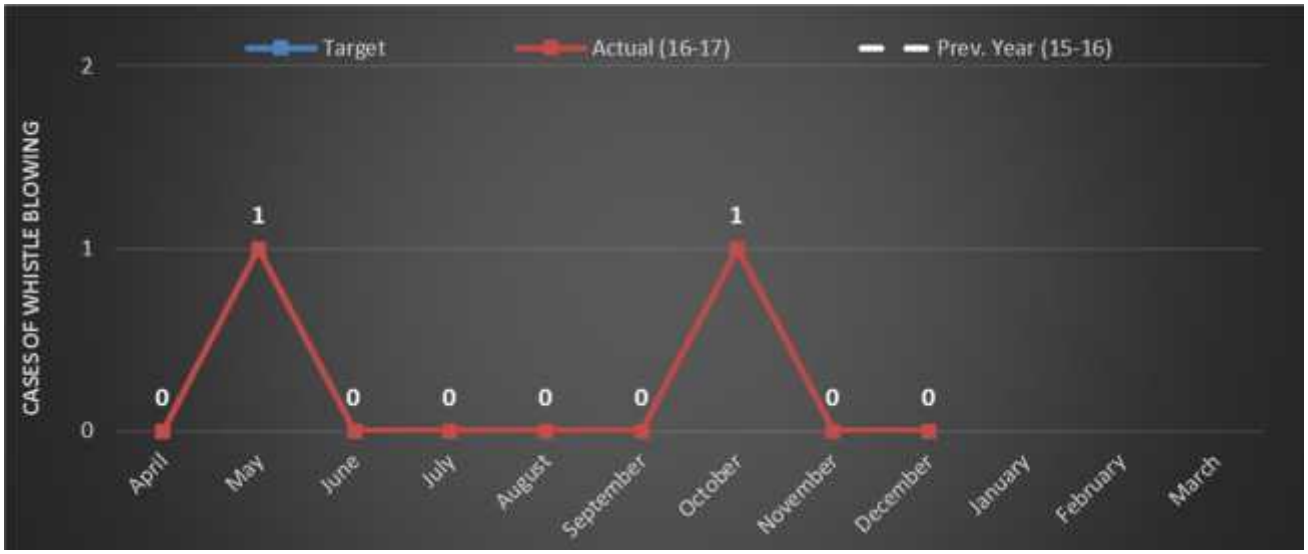


Figure Wf-9 - Cases of Whistle Blowing

3. Operational Performance

3.1. Operational Performance Summary

3.1.1. Performance for Red 1, Red 2 and Red 19 was below the revised trajectory and below the national targets as expected.

3.1.2. On 18th October 2016, SECAmb implemented Nature of Call (NoC) and Dispatch on Disposition (DoD) which aims to improve the ability to respond quickly to the most seriously ill patients. No serious incidents have been reported since go live.

3.2. Operational Performance Commentary

3.2.1. SECAmb's response time performance was well short of the national targets and the Trust did not achieve the new trajectories for Red 1, Red 2 and Red 19 for December. This was primarily due to a significant loss of resource hours through hospital turnaround delays and the compounding impacts of increased activity. Both activity and performance continues to show a slow but steady improvement from the second week of January onwards.

3.2.2. SECAmb has successfully implemented Nature of Call and Dispatch on Disposition as planned on 18th October as part of the national pilot for the Ambulance Response Programme. No serious clinical incidents have been reported since go live.

3.2.3. The 999 Improvement Plan, with the exception of hospital turnaround performance, remains on track. SECAmb has implemented plans to increase contribution from Community First Responders (CFRs). This entails improving technical links with CFRs, new processes in EOC to mobilise CFRs and an extensive engagement campaign with the CFRs themselves. Benefits are being realised in December broadly in line with our plans.

3.2.4. SECAmb has increased its Hear and Treat performance for December.. There is already an encouraging improvement in the Hear and Treat ratios and further recruitment of clinicians continues (we have 31 WTE in post and are aiming for a total of 45 WTE).

3.2.5. SECAmb has been working with both commissioners and acute hospitals to strengthen its hospital handover procedures and reduce delays at hospital. These improvements are built into the improvement trajectories. Hospital delays in December were significantly worse, compared with 5,828 hours in November and compared to a maximum level agreed with commissioners of 3,450. December saw 7,726 lost hours, which was the single biggest impact on our performance trajectory. Hospital turnaround delay is the single factor with the greatest impact on SECAmb performance and one over which we have the least control. A recent instruction from NHSI to increase the prompts to Acute Hospital Directors On-Call for every patient delay over one hour is being developed into a robust Operational Plan to ensure consistency across the region.

3.2.6. Demand was circa 5.4% above the plan agreed with commissioners and 9.7% above last year. However, the recovery plan trajectories are based on an assumed 6% increase, so this now exceeds trajectory assumptions.

3.2.7. Call answer performance deteriorated as a result of the December activity. SECAmb achieved 83.4% in 5 seconds, compared to a trajectory plan of 85%; this was adverse to last year's performance for the same period.

3.2.8. SECAmb's NHS111 service achieved an "Answered in 60" second performance of 80.8%, based on a call volume of 104,000 calls. This easily exceeded the Recovery Plan monthly target of 72%.

3.2.9. In December there was an increased call volume (up 11% year-on-year during the Christmas period). Although the call volume appears lower than the 114,000 calls in December 2015, the NHS111 service for the East Kent area has been fully transferred to the new contractor during December.

3.2.10. Clinical performance, at 72.5%, remained above the national average.

3.2.11. NHS111 successfully supported the wider health system, as evidenced by the lower ambulance referral rates and A&E referral rates, compared to the national benchmark.

3.2.12. NHS111 performance for "Abandoned Calls" was 3.9%, significantly below the Recovery Plan monthly target of 7%.

3.3. Operational Performance Scorecard

ID	KPI	Current Month (Plan*)	Current Month (Actual)	Current Month (Prev. Yr.)	YTD (Plan*)	YTD (Actual)	YTD (Prev. Yr.)
999-1	Red 1 response <8 min	65%	62.9%	74.5%		64.3%	73.6%
999-2	Red 2 response <8 min	54%	51.6%	71.0%		53.8%	71.4%
999-3	Red 19 Transport <19 min	90%	87.8%	95.4%		89.7%	95.0%
999-4	Activity: Actual vs Commissioned	72563	76641	69268	591018	619732	582751
999-5	Hospital Turn-around Delays (Hrs lost >30 min.)	2799	7726	3864	21168	49564.1	31648.9
999-6	Call Pick up within 5 Seconds	85%	83.4%	92.9%		73.9%	87.2%
999-7	CFR Red 1 Unique Performance Contribution	1.3%	1.9%				
999-8	CFR Red 2 Unique Performance Contribution	1.0%	1.5%				
111-1	Total Number of calls offered		104132	114006		865816	864538
111-2	% answered calls within 60 seconds	75%	80.8%	77.9%	75%	77.2%	85.4%
111-3	% of Abandoned call within 30s of the end of intro message excluding phantom calls (NQR 8)	2.0%	1.4%	1.4%	2.0%	1.3%	1.1%
111-4	Abandoned calls as % of offered after 30 secs	6.0%	3.9%	6.1%	6.0%	4.7%	2.4%
111-5	Combined Clinical KPI (% of Call Back >10mins & % of all 111 calls warm referred to a Clinician)	75%	72.5%	88.4%		74.0%	88.3%
PTS-1	PTS Activity (Surrey)	11337	9511	12063	107563	95874	137428
PTS-2	Arrival - % patients to arrive <= 15 min after appt. time.	95%	87.7%	86.3%	95%	86.4%	83.7%
PTS-3	Departure - % patients collected <= 60 min of planned collection time (Surrey)	95%	86.5%	86.0%	95%	86.2%	84.0%
PTS-4	Discharge - % patients collected <= 120 min of booked time to travel (Surrey)	95%	80.8%	77.3%	95%	79.9%	75.8%

3.4. Operational Performance Charts

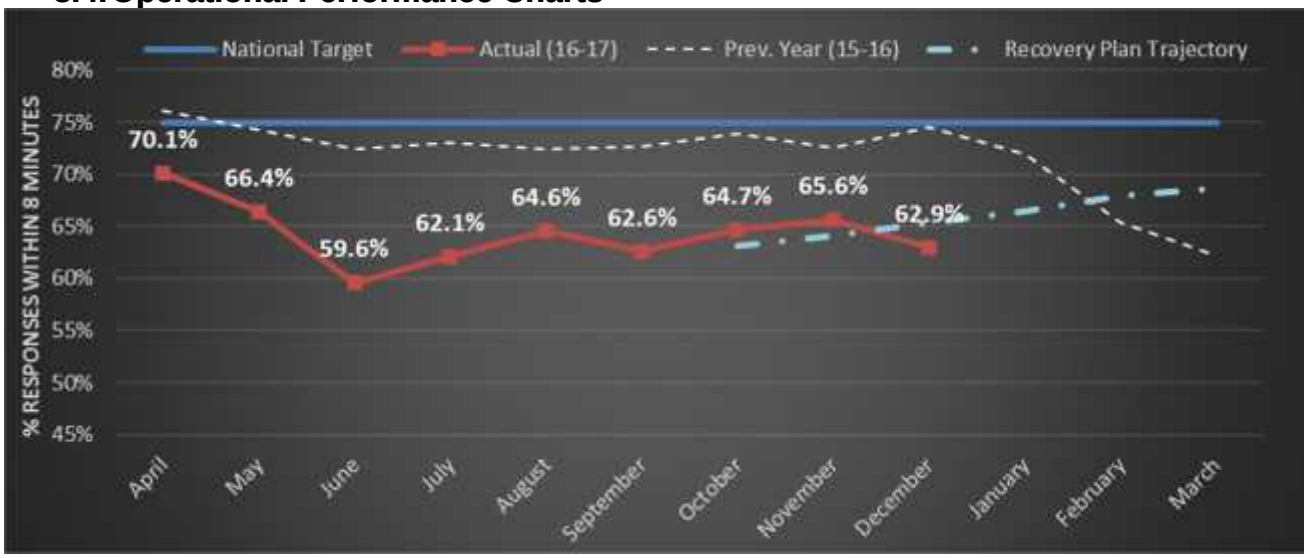


Figure.999-1 - Red 1 response <8 min

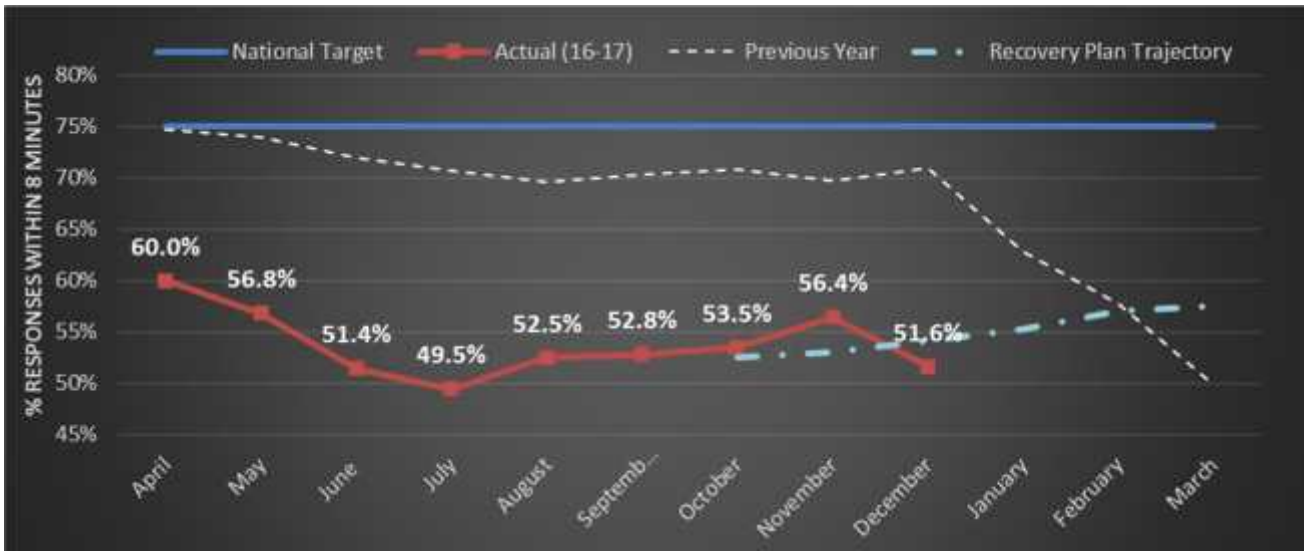


Figure.999-2 - Red 2 response <8 min

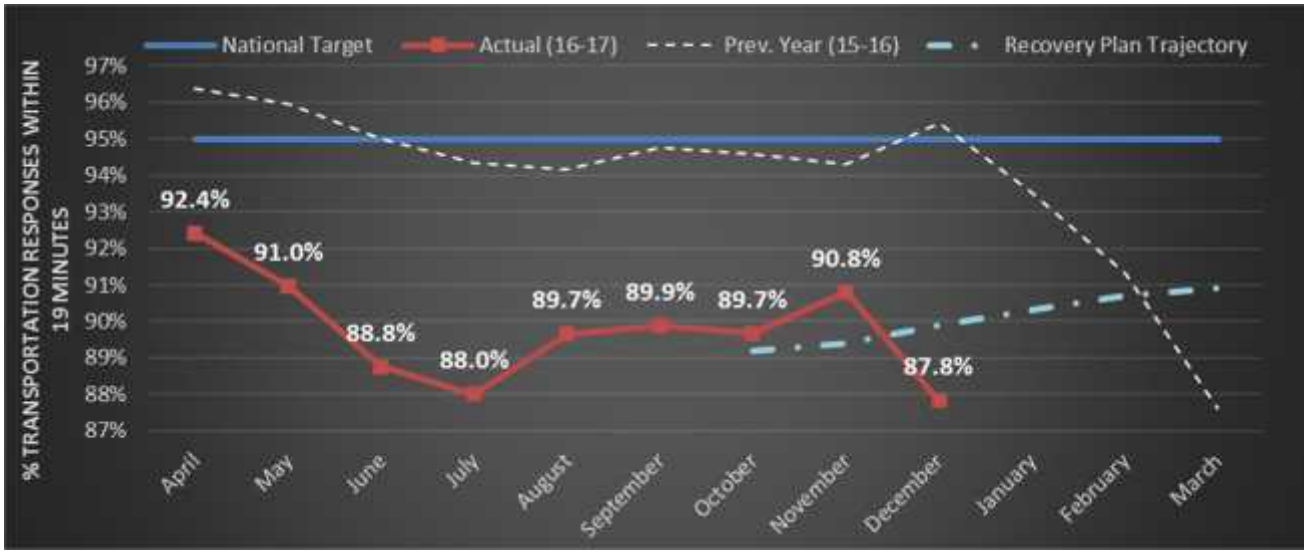


Figure.999-3 - Red 19 Transport <19 min

Figure.999-5 - Hospital Turn-around Delays (Hrs lost >30 min.)

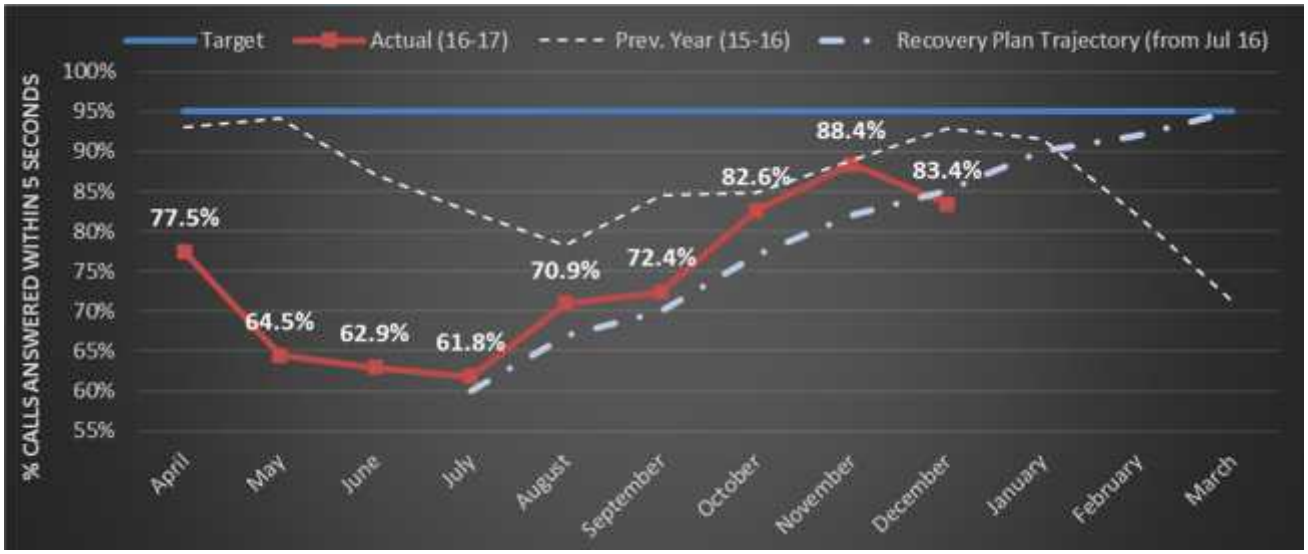


Figure.999-6 - Call Pick up within 5 Seconds

Figure.999-7 - CFR Red 1 Unique Performance Contribution

Figure.999-8 - CFR Red 2 Unique Performance Contribution

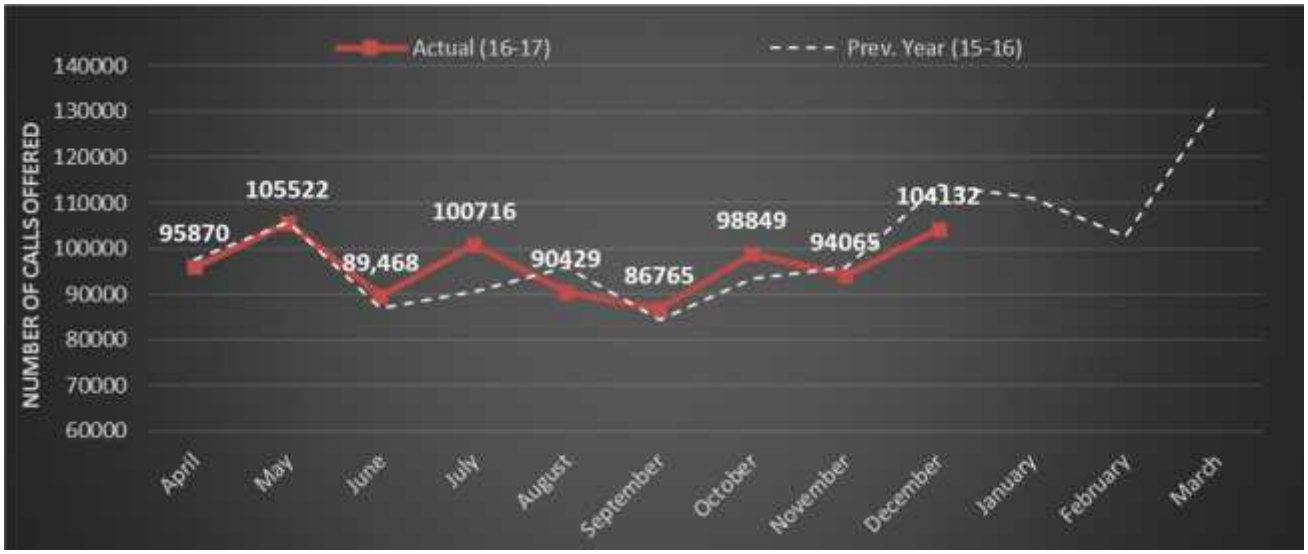


Figure.111-1 - Total Number of calls offered

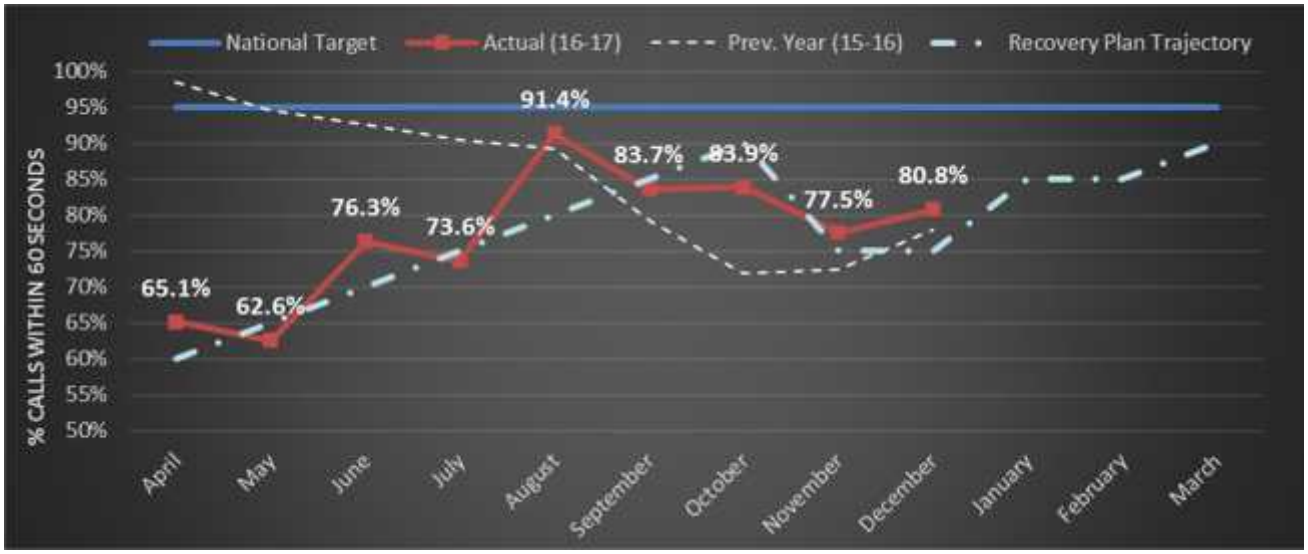


Figure.111-2 - % answered calls within 60 seconds

Figure.111-3 - % of Abandoned call within 30s of the end of intro message excluding phantom calls (NQR 8)

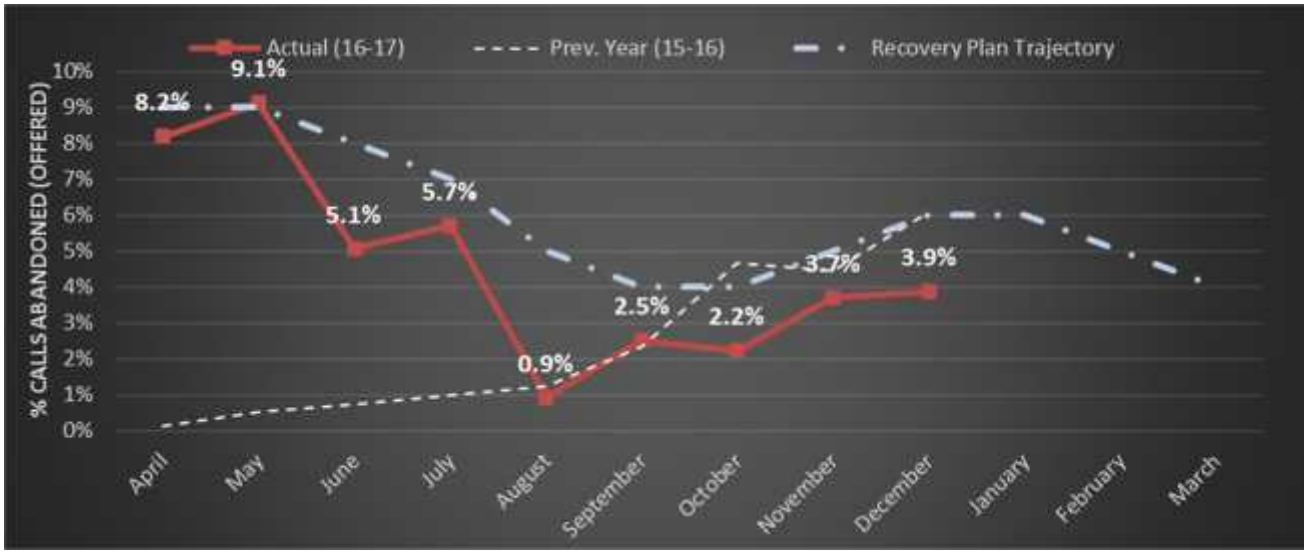


Figure.111-4 - Abandoned calls as % of offered after 30 secs

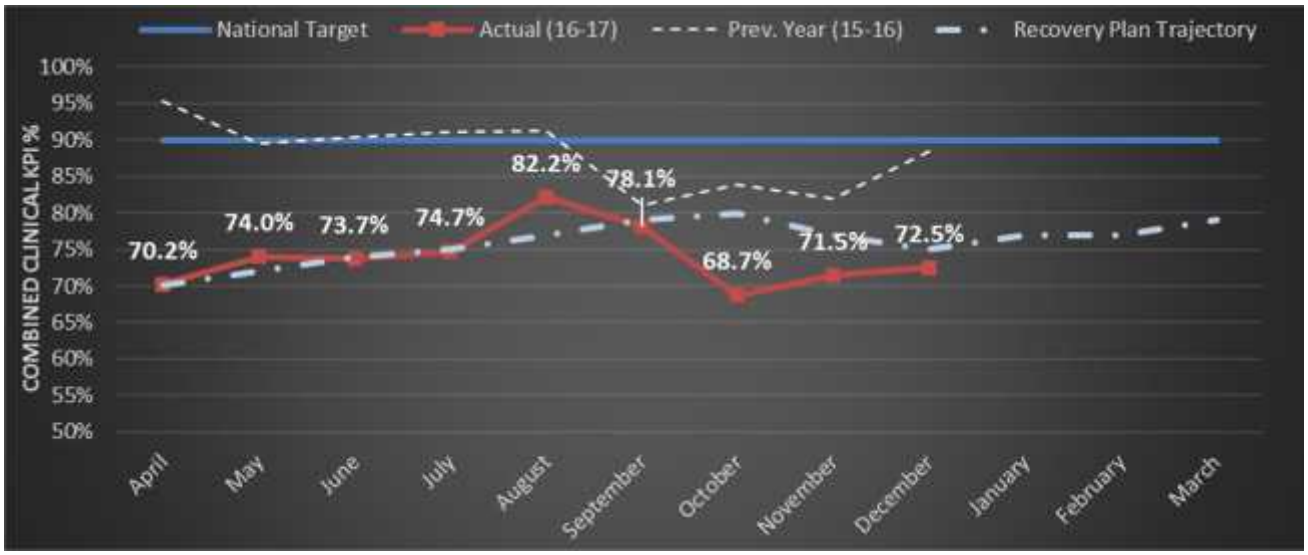


Figure.111-5 - Combined Clinical KPI (% of Call Back >10mins & % of all 111 calls warm referred to a Clinician)

Figure.PTS-1- PTS Activity (Surrey)

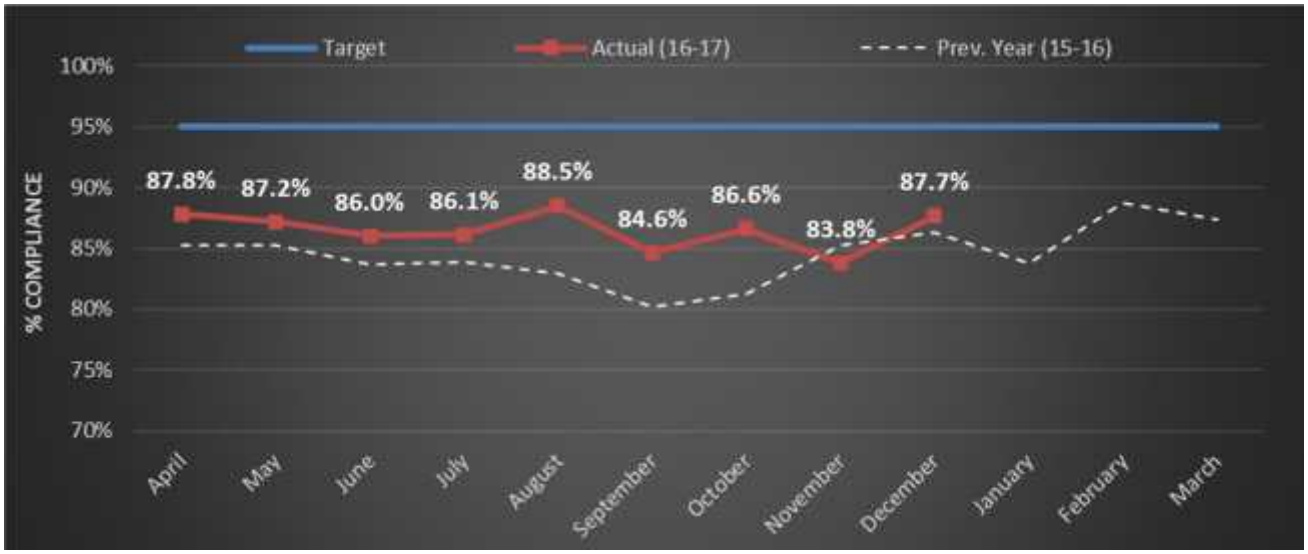


Figure.PTS-2 - Arrival - % patients to arrive <= 15 min after appt. time. (Surrey)

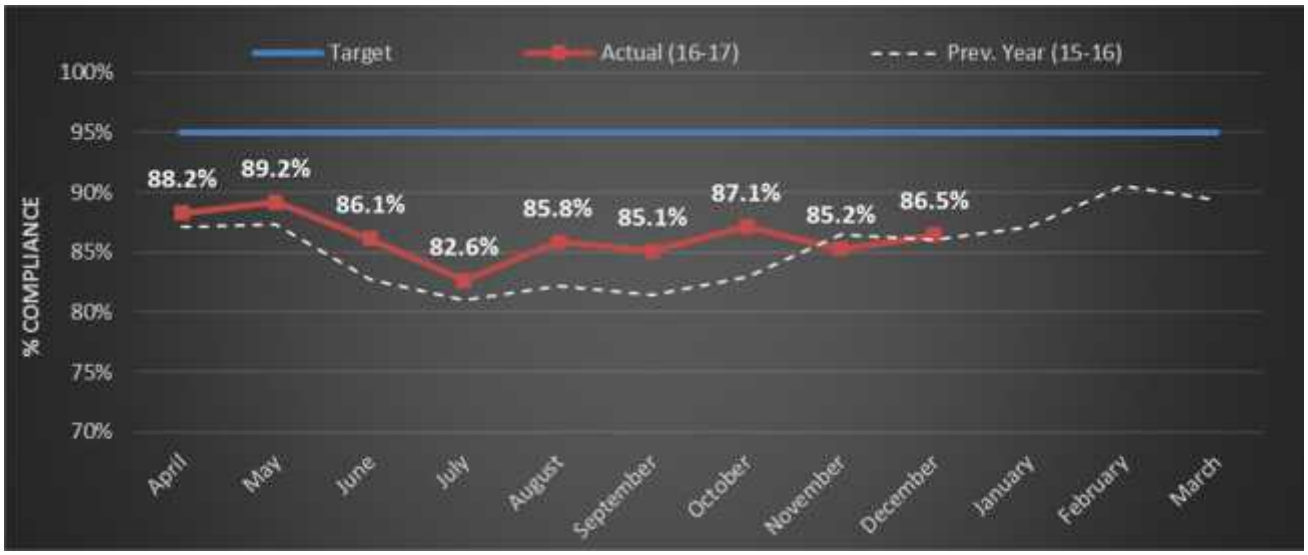


Figure.PTS-3 - Departure - % patients collected <= 60 min of planned collection time (Surrey)

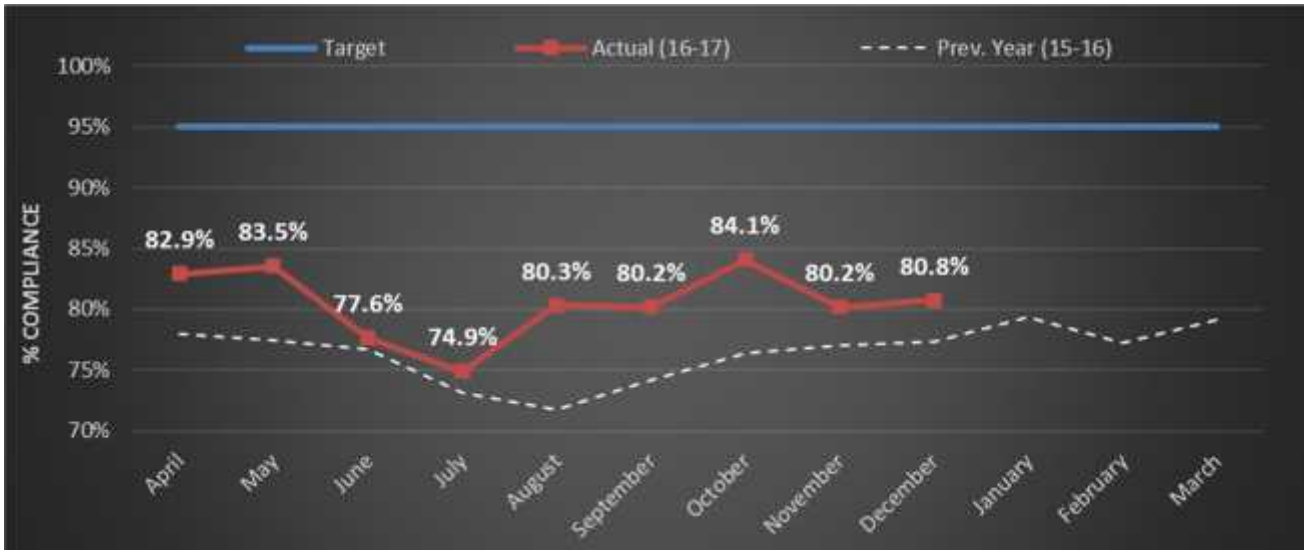


Figure.PTS-4 - Discharge - % patients collected <= 120 min of booked time to travel (Surrey)

4. Clinical Effectiveness

4.1. Clinical Effectiveness Summary

4.1.1. This report describes Trust performance reported against the eight Clinical Outcome Ambulance Quality Indicator (AQIs) to NHS England for Month 5 (August 2016). The data continues to show variable standards in delivering patient outcomes.

4.2. Clinical Effectiveness Commentary

4.2.1. August performance shows some variation in performance against the national averages. Performance trends continue to be relatively consistent.

4.2.2. In August the Trust's performance is better than the national average for three of the eight Clinical Outcome Indicators; Survival to Discharge Utstein (fourth), Stroke 60 (second), STEMI 150 (fifth).

4.2.3. The poorest performance is on Survival to Discharge, Stroke care bundle, STEMI care bundle, ROSC at hospital and ROSC Utstein. Whilst five indicators show a negative variation compared with the national average, compliance with care bundles (STEMI and Stroke) place the Trust in the lower ranked positions across all indicators (ninth, tenth respectively).

4.2.4. ROSC (All) – In August 2016, performance has dipped from the previous two months (June 31.4%; July 31.7%; August 26%), however, August performance is more consistent with performance at the start of the financial year and with the same period last year. Despite this dip the Trust remains in fifth national position as was in July.

4.2.5. ROSC (Utstein) – In August performance took a significant dip from 69% to 48.1% taking the Trust from second to seventh position nationally. However, current performance is more consistent with the same period last year and remains within the national upper and lower control limits (2 standard deviations). It must be noted that performance in the Utstein cohort often experiences great fluctuations; this is due to the small number of incidents that meet the inclusion criteria.

4.2.6. Survival to Discharge (All) – August performance is slightly below the national average at 8.9%, with a 0.5% negative variance. The national standing has dropped from fifth to seventh position.

4.2.7. Survival to Discharge (Utstein) – August figures shows an improvement of 6.2% from the previous month at 34.8%, and is 5.7% above the national average. Performance continues to rise and fall due to the small Utstein cohort size. It should be noted that Trust performance exceeded the national upper control limits (2 standard deviations) in August.

4.2.8. STEMI 150 – Whilst performance has taken a slight dip in August from the previous month (95.2%; 89.9%), the Trust is 4% above the national average and fifth ranked nationally.

4.2.9. STEMI Care Bundle – Performance for this indicator is consistently below the national average, mainly due to poor recording of two pain scores. Whilst performance for August remains below the national average at 72.7% (this is a 6.3% negative variance) it is significantly improved from the previous month's performance.

4.2.10. Stroke 60 – Trust performance is 10.2% above the national average in August, making SECAmb the second best performing Trust.

4.2.11. Stroke Care Bundle - In August, performance has declined further from the previous two months (98.2%; 96.5%; 94.2%). The Trust has a 3.2% negative variance compared to the national performance and significantly below the national lower control limits (2 standard deviations).

4.3. Clinical Effectiveness KPI Scorecard

ID	KPI	Current Month (Nat. Av.*)	Current Month (Actual)	Current Month (Prev. Yr.)	YTD (Nat. Av.*)	YTD (Actual)	YTD (Prev. Yr.)
CE-1	Cardiac arrest - ROSC on arrival at hospital (Utstein)	52.8%	**48.1%**	50.0%	53.0%	**56.6%**	45.7%
CE-2	Cardiac arrest - Return of spontaneous circulation on arrival at hospital (All)	27.2%	**26.0%**	27.6%	29.0%	**28.4%**	27.0%
CE-3	Cardiac arrest -Survival to discharge - Utstein	29.1%	**34.8%**	25.0%	27.4%	**28.6%**	22.5%
CE-4	Cardiac arrest -Survival to discharge - All	9.4%	**8.9%**	8.6%	8.9%	**8.2%**	8.5%
CE-5	Acute ST-elevation myocardial infarction - Outcome from STEMI (Care bundle)	79.0%	**72.7%**	65.6%	79.5%	**67.8%**	66.8%
CE-6	Acute ST-elevation myocardial infarction - Proportion receiving primary angioplasty within 150 minutes	85.9%	**89.9%**	100.0%	86.2%	**91.7%**	94.0%
CE-7	% of FAST positive patients potentially eligible for stroke thrombolysis arriving at a hyperacute stroke unit within 60 minutes	56.6%	**66.8%**	67.1%	55.0%	**68.0%**	65.4%
CE-8	% of suspected stroke patients assessed face to face who received an appropriate care bundle	97.4%	**94.2%**	96.2%	97.7%	**96.1%**	96.3%

4.4. Clinical Effectiveness Charts

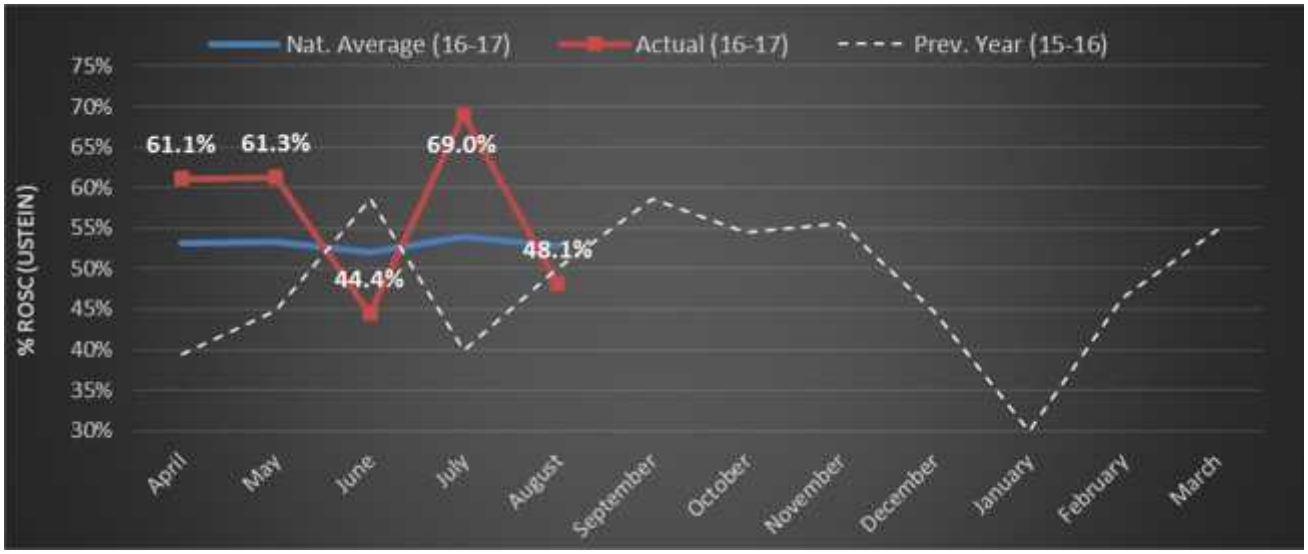


Figure.CE-1 - Cardiac arrest - ROSC on arrival at hospital (Utstein)

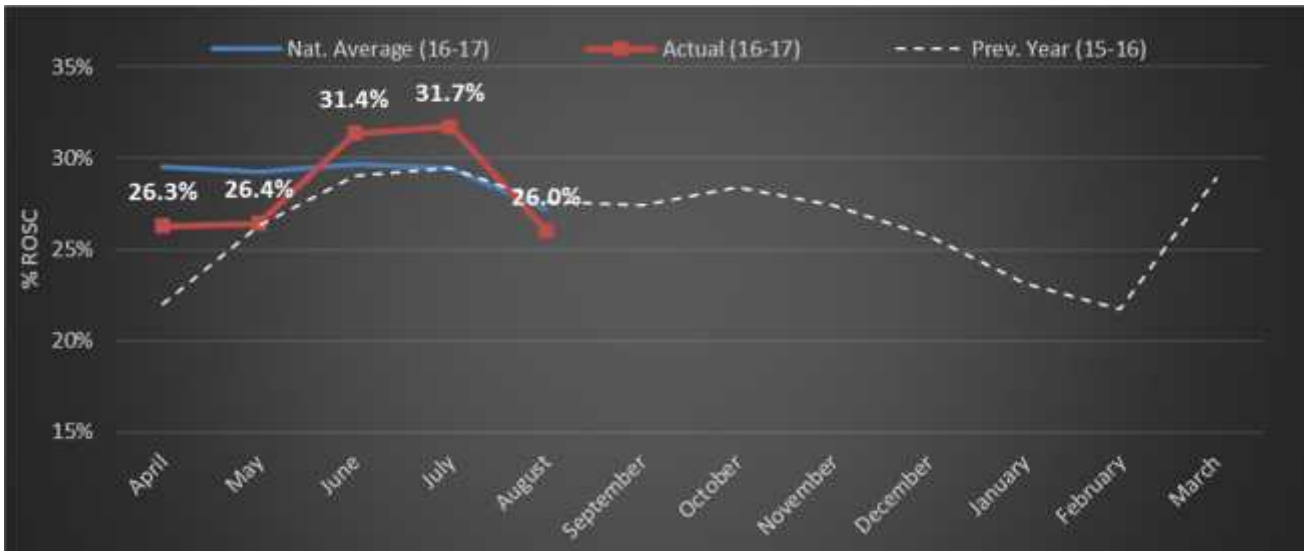


Figure.CE-2 - Cardiac arrest - Return of spontaneous circulation on arrival at hospital (All)

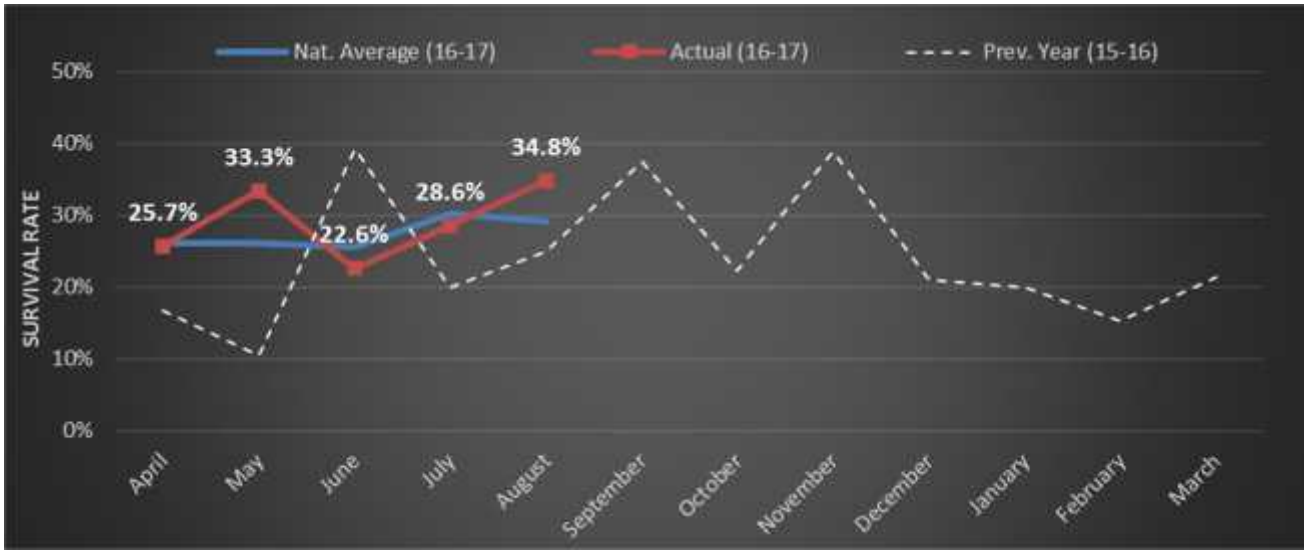


Figure.CE-3 - Cardiac arrest -Survival to discharge - Utstein

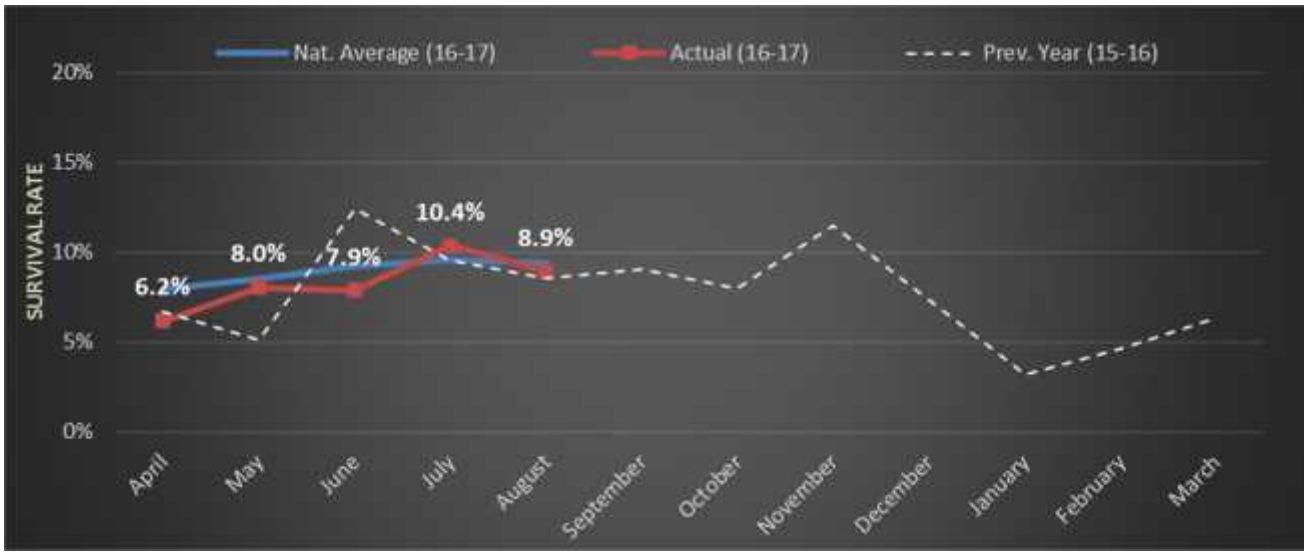


Figure.CE-4 - Cardiac arrest -Survival to discharge – All

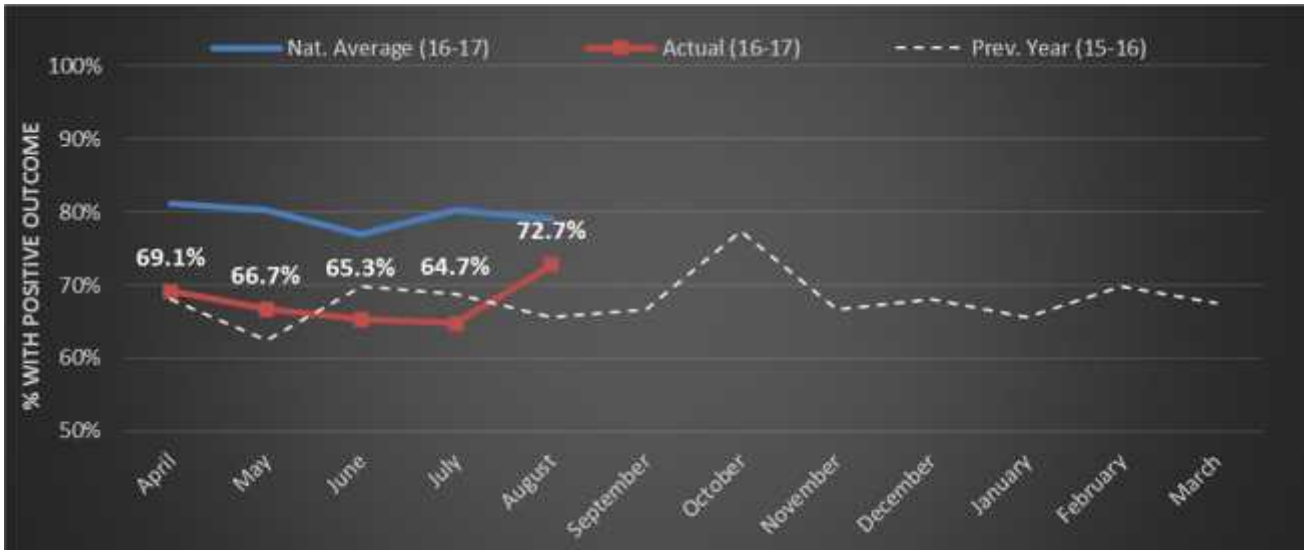


Figure.CE-5 - Acute ST-elevation myocardial infarction - Outcome from STEMI (Care bundle)

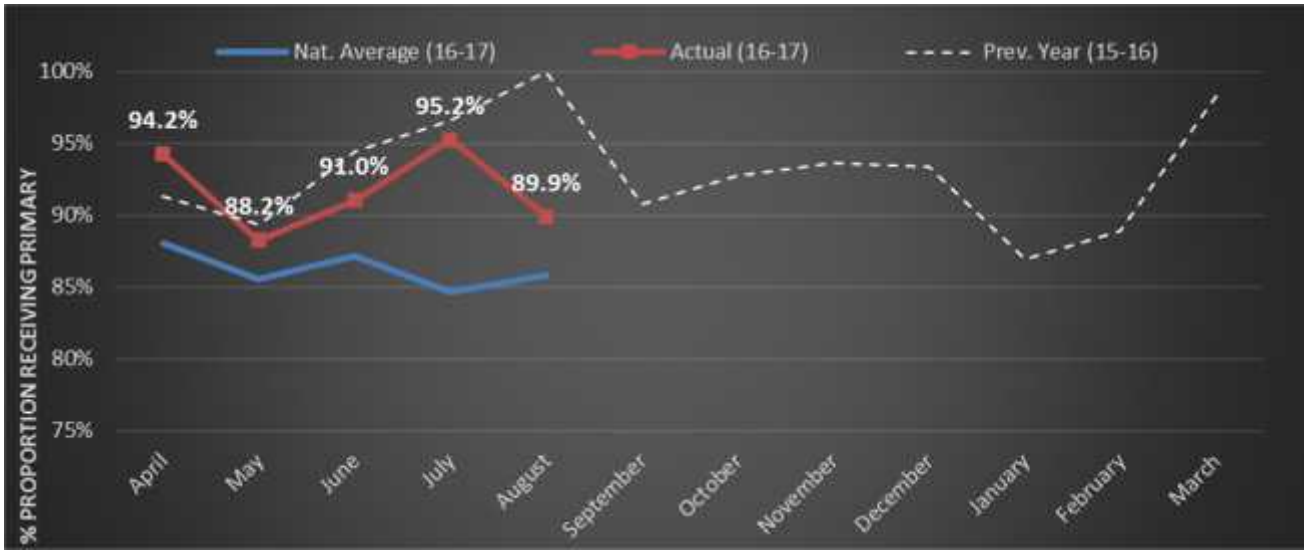


Figure.CE-6 - Acute ST-elevation myocardial infarction - Proportion receiving primary angioplasty within 150 minutes

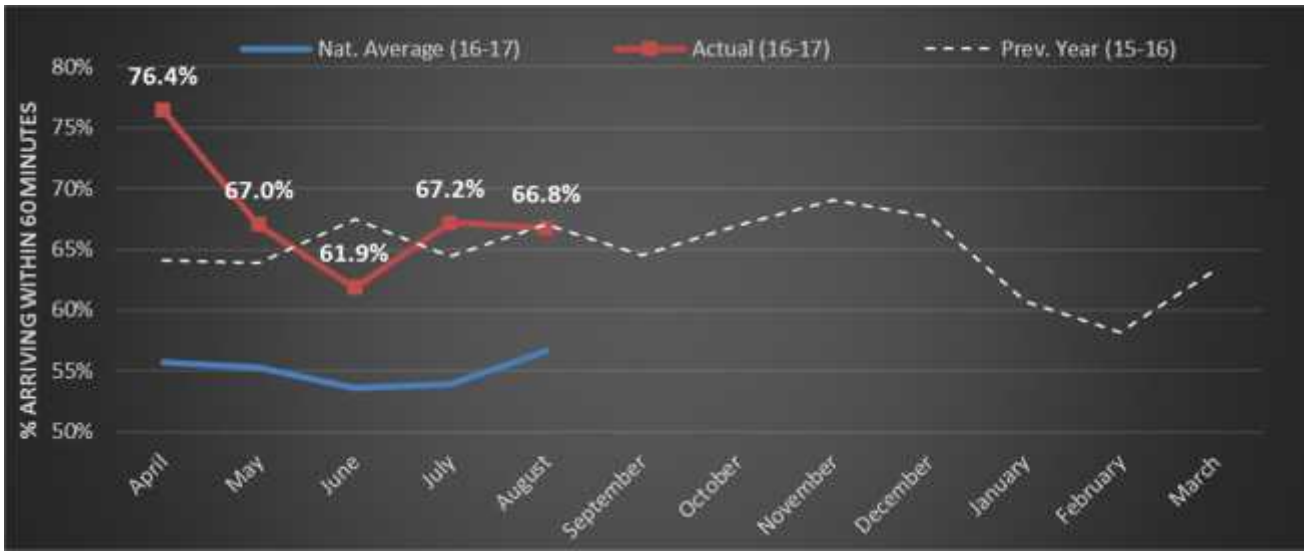


Figure.CE-7 - % of FAST positive patients potentially eligible for stroke thrombolysis arriving at a hyper acute stroke unit within 60 minutes

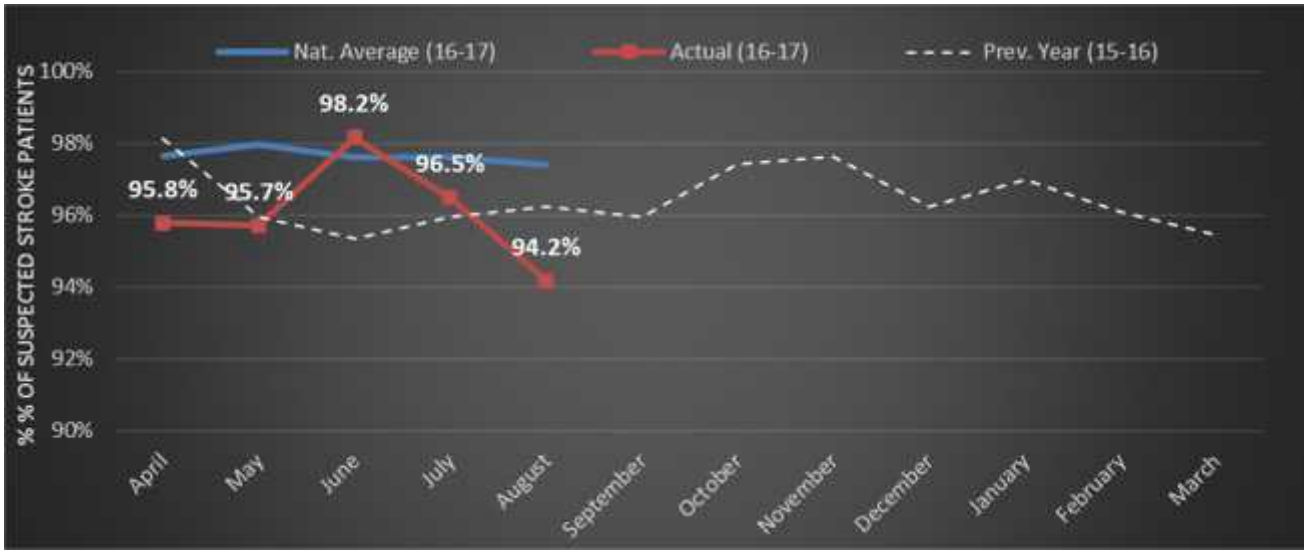


Figure.CE-8 - % of suspected stroke patients assessed face to face who received an appropriate care bundle

5. Quality & Patient Safety

5.1. Quality & Patient Safety Summary

5.1.1. Work is being undertaken with the Datix System to further enhance the ability of the Trust to manage and report against a number of the Quality and Safety KPIs and as such, this section will continue to develop as processes become automated through the system.

5.1.2. Overall the number of incidents reported has increased compared to the previous year, whilst the number of Serious Incidents has reduced. This is likely to reflect recent changes made to the process for declaring Serious Incidents, to ensure those declared fully meet the NHS England Serious Incident Framework.

5.1.3. The Incident Management and Reporting Policy (including Serious Incidents) is out for consultation, and re-aligns the timeframe for Serious Incident Investigation to the NHS England National Timeframes. As such, the number of Serious Incident reports breaching submission to the CCG Closure panel should be reduced.

5.1.4. The Trust continues to make changes to the management of Safeguarding through the Datix System, which will enable more accurate reporting of Safeguarding referrals.

5.1.5. The Trust has now returned to reporting against the national standard of 25 days for complaints responses.

5.2. Quality & Patient Safety Commentary

5.2.1. There were no Serious Incident Reports due for submission to the CCG Closure Panel during December. Of the seven overdue investigations reported within the previous IPR, three have been submitted. An additional five incidents have breached submission to CCG Closure Panel and, as such, there are currently nine reports in this category.

5.2.2. Year to date figures for reporting timeliness (72hrs), remains under development as this is a new KPI.

5.2.3. Duty of Candour reporting remains under development, as this is currently a manual process. As part of the enhancement to the Datix System, the process of managing and reporting, Duty of Candour will be automated through the system.

5.2.4. As part of the Datix System enhancements, the ability to better manage and report safeguarding incidents raised about staff will become more accurate as a consistent approach is implemented. Enhancements will also enable a further quality metric to be implemented, with regard to the number of rejected referrals made, which will provide an overview of the quality/appropriateness of referrals made.

5.2.5. The training figures have been taken from the information shared by Learning and Development, which appears to show that December had four fewer people

trained (overall) in the Trust than in November, however it is not clear what has caused this data anomaly.

5.2.6. The Trust concluded 72% of complaints within timescale, which is a slight deterioration against October and November performance.

5.2.7. Of the 84 complaints due for conclusion, 23 breached the timescale; the reasons for which are as follows:

- 11 x report received late
- 5 x overlooked by the Patient Experience Team (PET)
- 3 x letter unable to be signed in time
- 3 x awaiting information from an internal source
- 1 x complex complaint requiring more time

5.2.8. Of the five complaints overlooked by the PET, three were breached by a temporary member of staff who has now left the Trust. Of the 11 breaches caused by late receipt of investigation reports, eight were informal EOC complaints. These breaches have been caused by a lack of capacity within the EOC Information Team, who are tasked with investigating low-level EOC complaints.

5.2.9. Work is being completed on Datix during January to streamline processes, and work on reviewing and developing the policy and procedure are on-going; once complete, this should reduce the number of breaches.

5.3. Quality & Safety KPI Scorecard

ID	KPI	Current Month (Target)	Current Month (Actual)	Current Month (Prev. Yr.)	YTD (Target)	YTD (Actual)	YTD (Prev. Yr.)
QS1a	SI Reporting timeliness (72hrs)	0%	25.0%				
QS1b	SI Investigation timeliness (60 days)	100%	#N/A	100.0%	100%	**64.3%**	100.0%
QS1c	Number of Incidents reported		**512**	**468**		**4559**	3958
QS1d	Number of Incidents reported that were SI's		**2**	**3**		**19**	21
QS1e	Duty of Candour Compliance	*In Development*					
QS2a	Number of Complaints		**114**	149		**114**	149
QS2b	Complaints reporting timeliness (All Complaints)	95.0%	**72.6%**	50.0%	95.0%	**62.9%**	61.8%
QS3a	Number of Safeguarding Referrals		**886**	906		**7994**	7854
QS3b	Safeguarding Referrals relating to SECAmb staff or services		**0**	0		**3**	2
QS3c	Safeguarding Training Completed (Adult) Level 1		**193**				
QS3d	Safeguarding Training Completed (Children) Level 1		**195**				
QS3e	Safeguarding Training Completed (Adult) Level 2		2629				
QS3f	Safeguarding Training Completed (Children) Level 2		2642				

5.4. Quality & Safety Charts

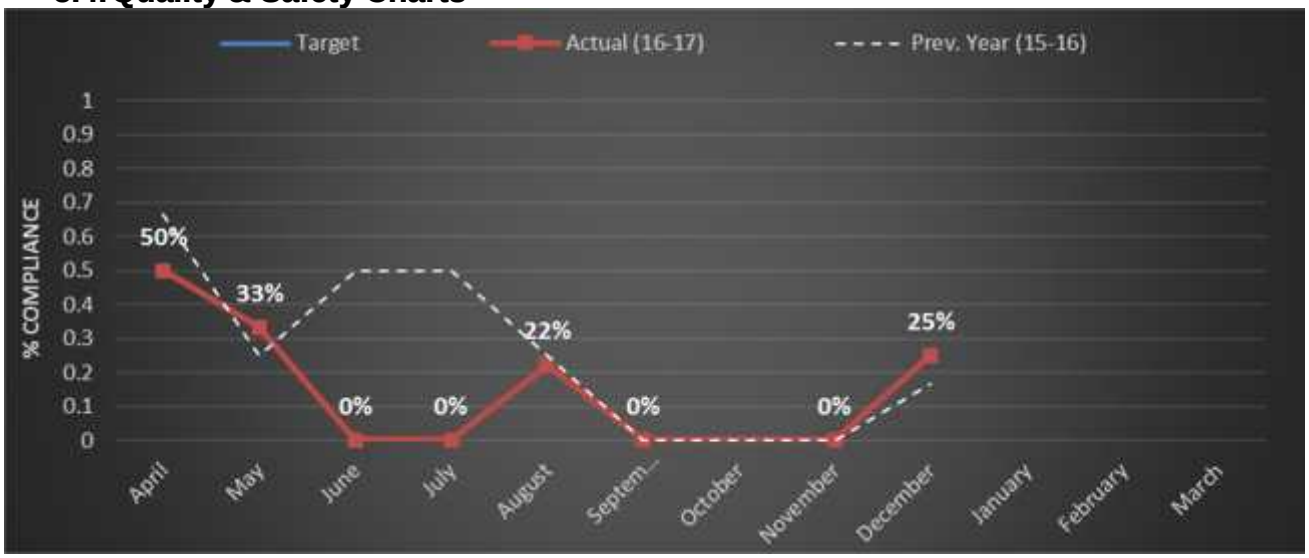


Figure.QS1a - SI Reporting timeliness (72hrs)

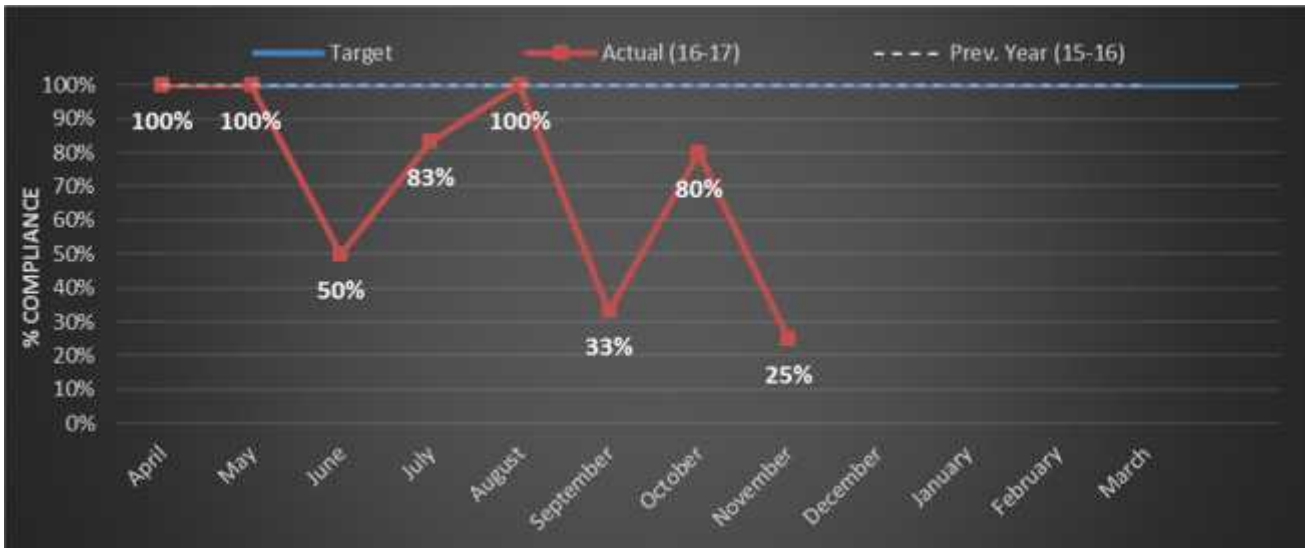


Figure.QS1b - Serious Incident (SI) Investigation timeliness (60 days). Please note that no SI's were due for completion in December 2016 (no data point will be shown)

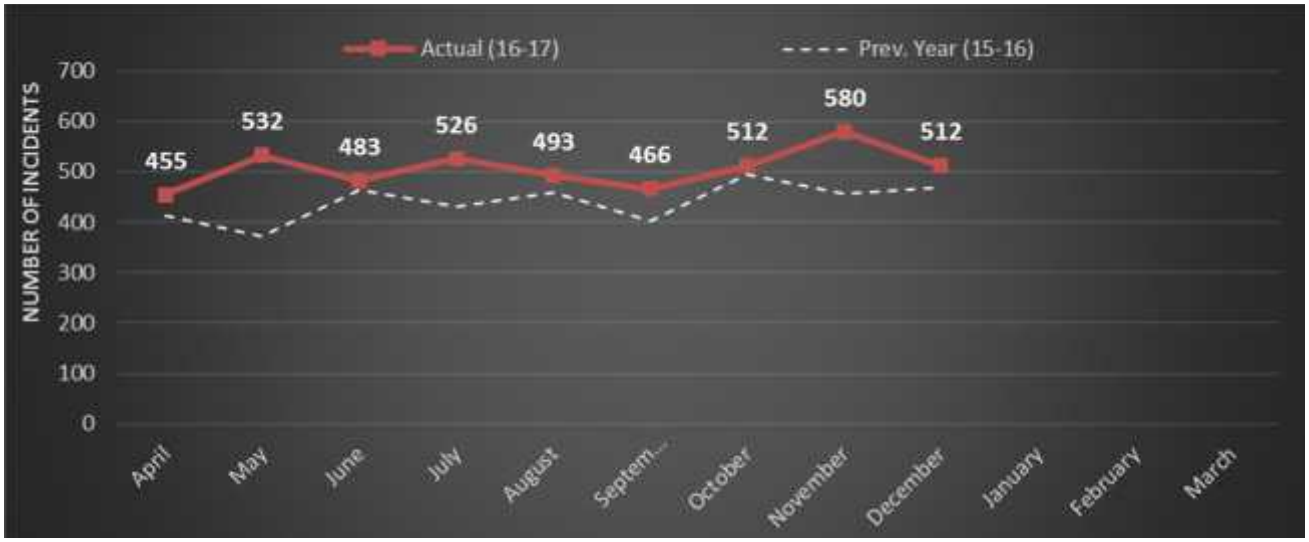


Figure.QS1c - Number of Incidents reported

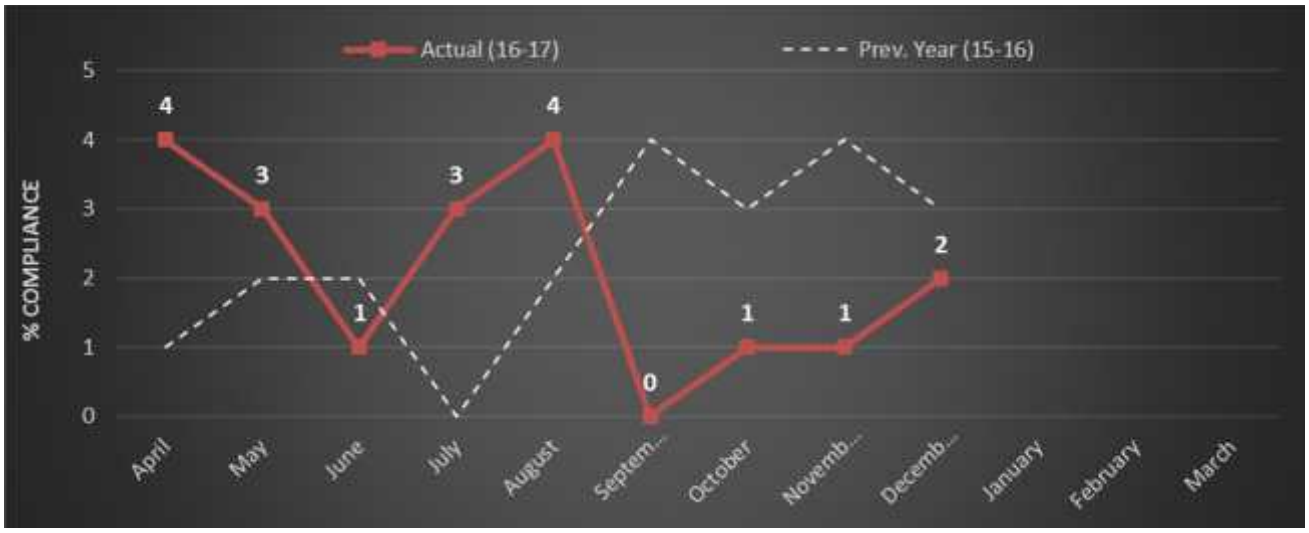


Figure.QS1d - Incidents reported that were SI's

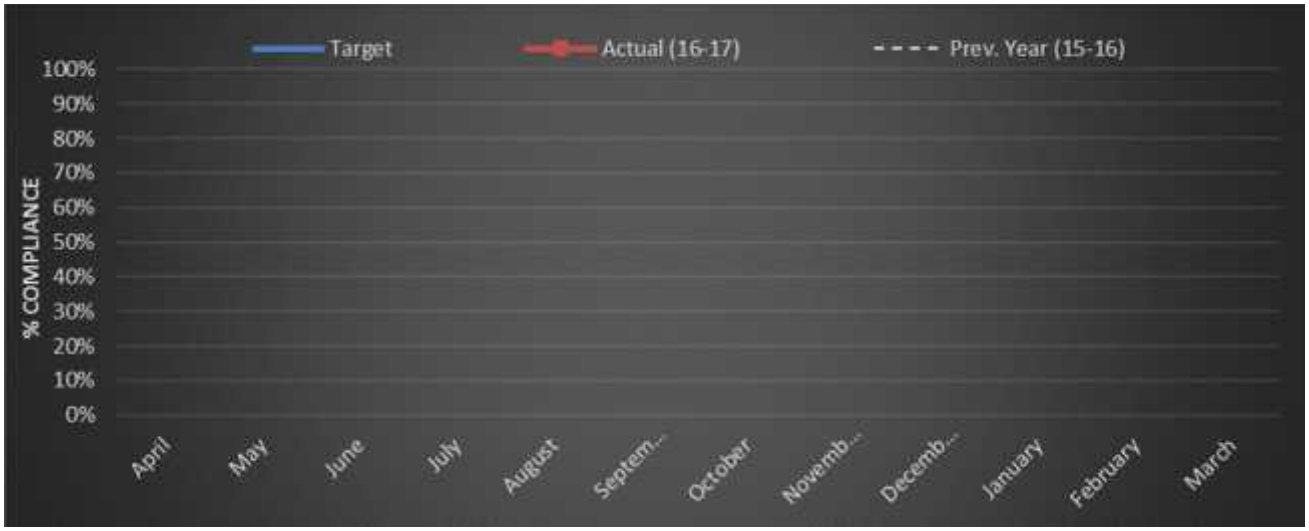


Figure.QS1e - Duty of Candour Compliance – In development

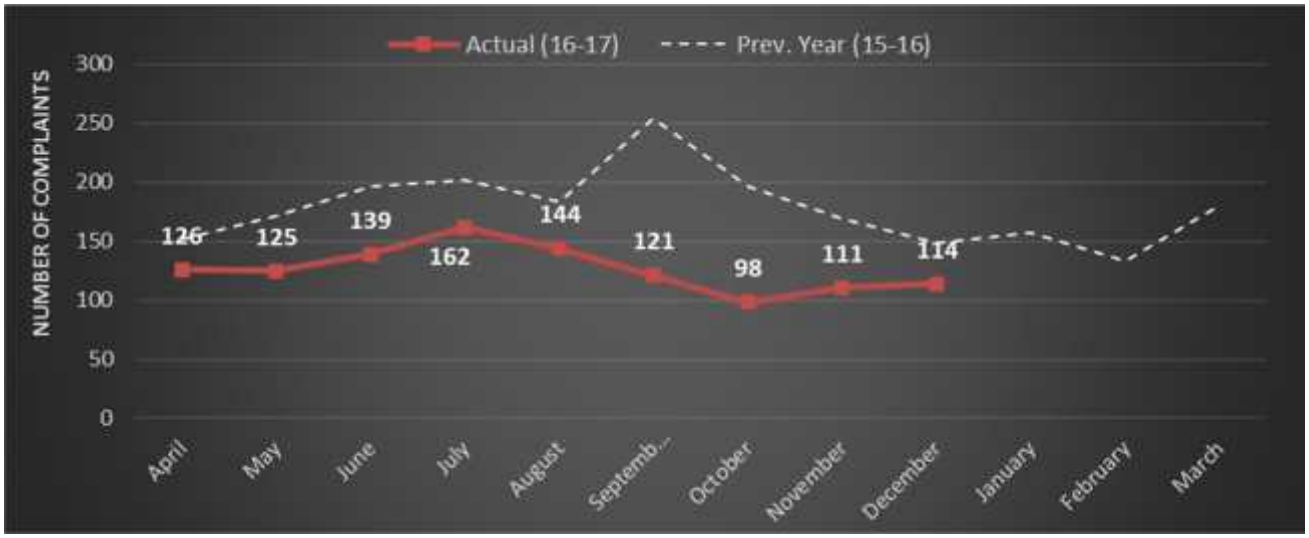


Figure.QS2a - Number of Complaints

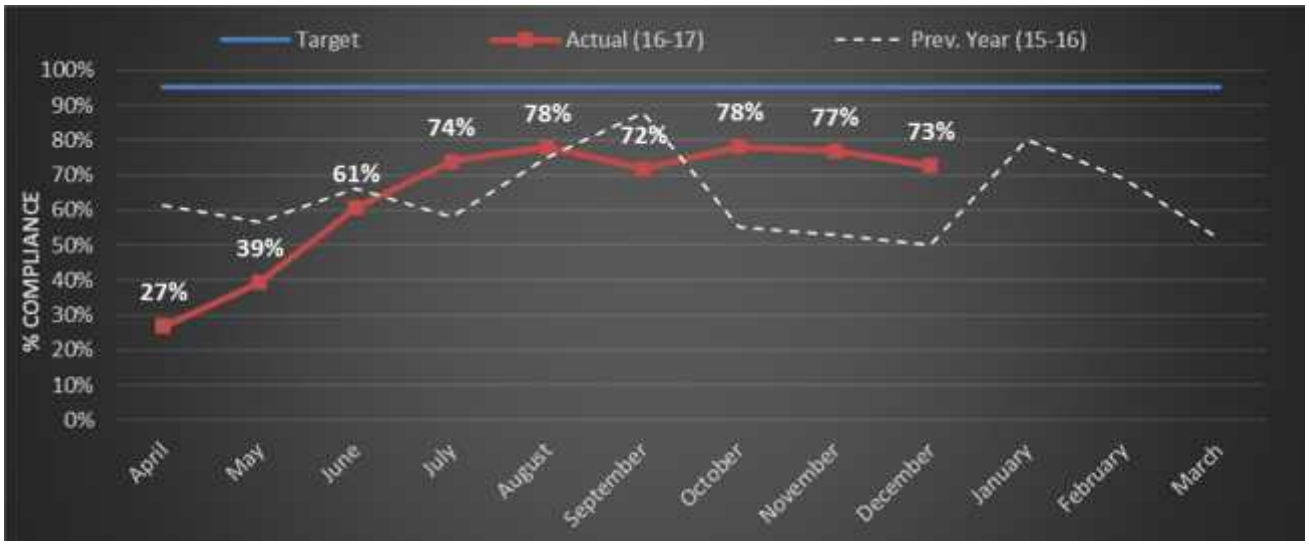


Figure.QS2b - Complaints reporting timeliness (All Complaints)

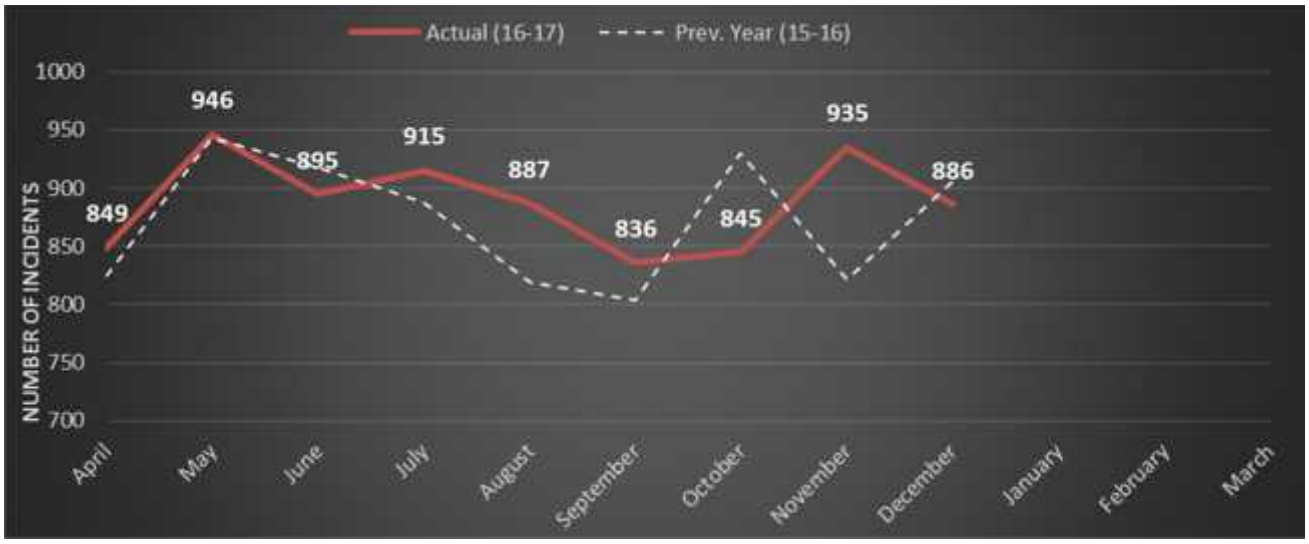


Figure.QS3a - Safeguarding Referrals

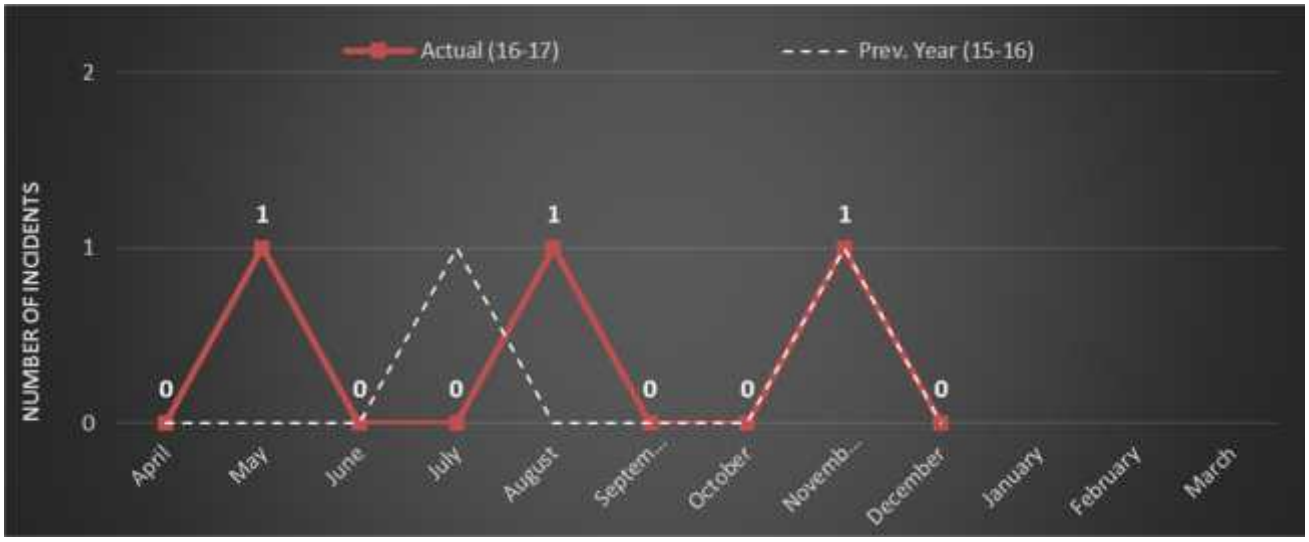


Figure.QS3b - Safeguarding Referrals relating to SECAmb staff or services

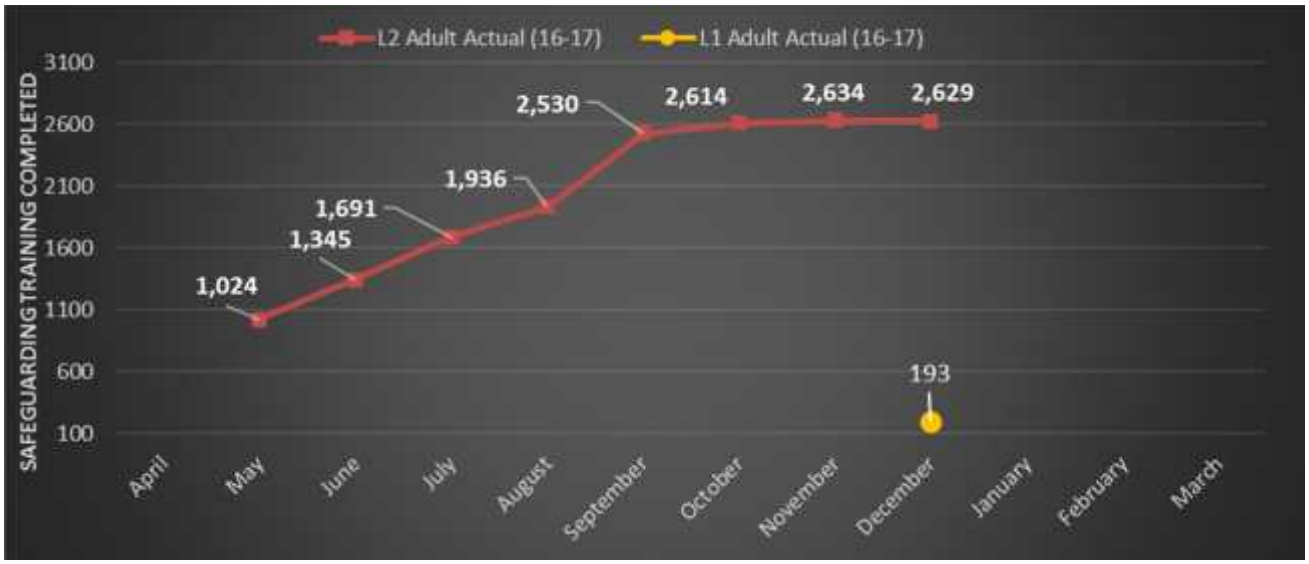


Figure.QS3c and QS3e - Safeguarding Training Completed Adult, Level 1 and 2

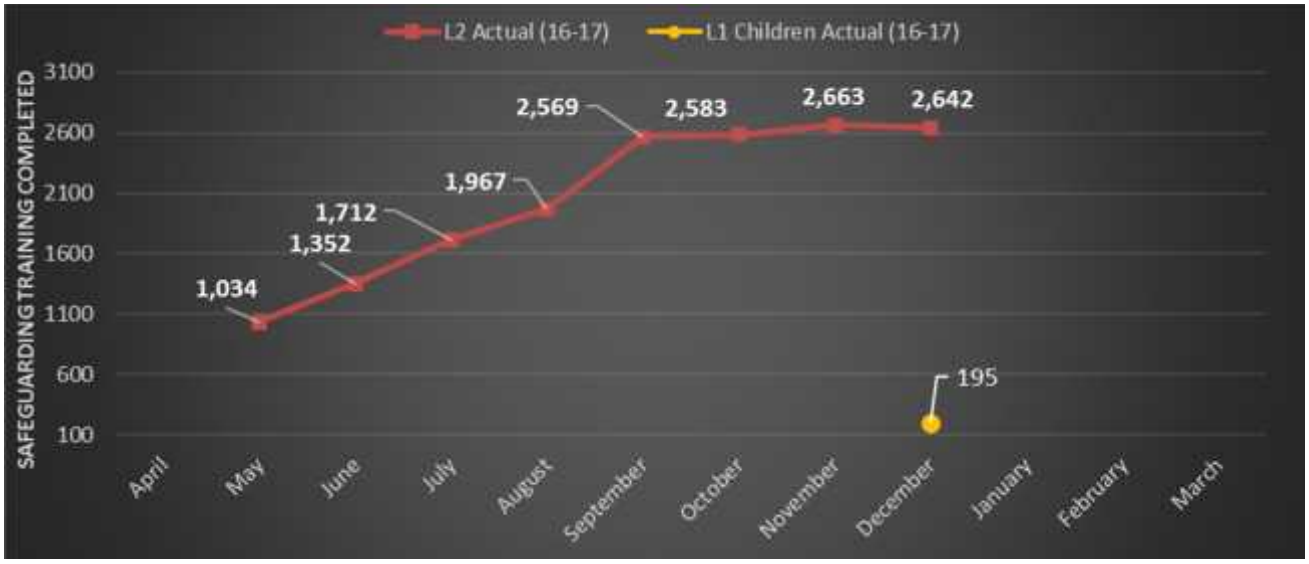


Figure.QS3d and QS3f - Safeguarding Training Completed Children, Level 1 and 2

6. Finance

6.1. Finance Summary

6.1.1. The Trust's financial performance for month 9 was a surplus of £0.1m, which is £0.2 behind forecast and £0.8m behind plan. This takes the Year to Date (YTD) deficit to £6.2m compared to the £0.8m surplus position assumed in the plan. The forecast for the year was revised to £7.1m in Q1, mainly due to unforeseen costs of recovery following governance and CQC failings.

6.1.2. The Trust remains subject to the risks of unfunded paramedic band 6 re-grading ,together with the knock on impacts to other grades, and to possible withholding penalties from CCGs.

6.1.3. The Trust continues to be at level 4 using the new NHSI Use of Resources rating (UOR), which can potentially trigger financial special measures. The adverse drivers of the rating are the variance against the original plan and the volume of agency spend, which breaches the Trust's pro-rated agency cap. The breach in the agency cap is attributable to controls within NHS111 and the additional interim capacity required to support the recovery plan. Both of these areas are being addressed and in particular, NHS111 is looking for a sustainable recruitment approach to reduce reliance on agency workers.

6.1.4. On-going directorate level financial reviews led by the Programme Management Office (PMO) and Finance Director have been held and the Executive Directors and senior staff have been challenged on delivering the year end forecast position. There is clear collective ownership of the issues and required actions.

6.1.5. The demand in A&E activity continues to track above plan. The activity in December is 2.2% (YTD: 2.4%) up on APR and 4.5% (YTD: 4.4%) above the commissioned level.

6.1.6. CIPS of £4.5m have been delivered YTD which is £0.9m behind APR.

6.2. Finance Commentary

6.2.1. The YTD adverse deficit variance of £7.0m against the £0.7m surplus in the APR is across all of our service lines.

6.2.2. The financial performance in 999 is £6.1m worse than the APR. The key drivers are the price of hours, with cost being higher than planned, as the recruitment is lower than the original workforce plan (resulting in a higher reliance on PAPs).

6.2.3. Hospital handover delays continue to affect job cycle time and remain higher than expected with over 7,700 additional hours lost in December compared to circa 5,800 hours in November. This is significantly worse compared to last year (by 89%) which is a reflection of the nationwide pressures on A&E departments. 7,700 hours is equivalent to 320 double crewed ambulance shifts lost in the month.

6.2.4. In improving grip and control within EOC, operational management have made changes in the way in which meal breaks are disturbed which will result in a drastic reduction in the number of claims made from early January onwards. The changes are in line with current policy and will not impact on the delivery of quality patient care. The YTD expenditure on meal breaks is currently tracking £1.0m above planned levels which are based on previous years.

6.2.5. Fleet is overspent by £0.6m and the vehicle maintenance regime is being adjusted to reduce costs while maintaining safe levels.

6.2.6. The performance in PTS remains poor with a YTD deficit of £0.7m which is £0.4m worse than the plan. Activity is 32% below expectations, resulting in a 13% variance on income, which is the main reason for the adverse variance. The reduction in hours to match this lower activity is yet to be realised but is receiving attention.

6.2.7. The financial performance in KMSS111 continues to be challenging but improved in December, recording a surplus of £0.1m resulting in a YTD adverse variance to plan of £0.3m. High levels of attrition since January have resulted in over reliance on agency Health and Clinical Advisors at a significant premium to operate the service, along with the associated training costs and effect on planned average handling time. The management in 111 are working collaboratively with HR to address the agency staff issue.

6.2.8. Medicines spend continues to be of concern, as do the benefits realisation from investments in MRC and Clinical Education. These innovations help the wider health economy by reducing admissions and conveyance to hospital but are financially unsustainable for SECAmb unless there is appropriate recompense.

6.2.9. Further cost pressures include a £1.4m YTD spend on the improvements required following the CQC report.

6.2.10. The YTD capital expenditure of £11.7m is £5.6m below the APR mainly because of delays in the vehicle replacement programme.

6.2.11. The Trust's YTD cash balance of £6.3m is £4.9m lower than the original plan, this has improved from the last month position due to the in-month surplus. The Trust has secured a working capital facility of £15m from NHSI should it be required.

6.3. Finance Scorecard

ID**	KPI	Current Month (Plan)	Current Month (Actual)	Current Month (Prev. Yr.)	YTD (Plan)	YTD (Actual)	YTD (Prev. Yr.)
F-1	Income (£'000)	£ 17,333	£ 17,536	£ 18,537	£145,274	£146,818	£150,762
F-2	Expenditure (£'000)	£ 16,404	£ 17,446	£ 17,528	£144,433	£153,056	£151,693
F-6	Surplus/(Deficit)	£ 929	-£ 90	£ 1,010	£ 841	£ 6,238	-£ 931

ID**	KPI	Current Quarter (Plan)	Current Quarter (Actual)*	Current Quarter (Prev. Yr.)	YTD (Plan)	YTD (Actual)*	YTD (Prev. Yr.)
F-5	CQUIN - Quarterly (£'000)*	£ 716		£ 913	£ 2,686		£ 2,675

ID**	KPI	Current Month (Plan)	Current Month (Actual)	Current Month (Prev. Yr.)	YTD (Plan)	YTD (Actual)	YTD (Prev. Yr.)
F-3	Capital Expenditure (£'000)	£ 1,153	£ 1,395	£ 2,012	£ 17,353	£ 12,360	£ 13,841
F-7	Cash Position (£'000)	£ 11,190	£ 6,307	£ 18,508	£ 11,190	£ 6,307	£ 18,508
F-4	Cost Improv. Prog. (CIP) (£'000)	£ 677	£ 537	£ 1,149	£ 5,370	£ 5,023	£ 7,282
F-8	Agency Spend (£'000)	£ 339	£ 543	£ 668	£ 3,017	£ 5,041	£ 5,090

6.4. Finance Charts

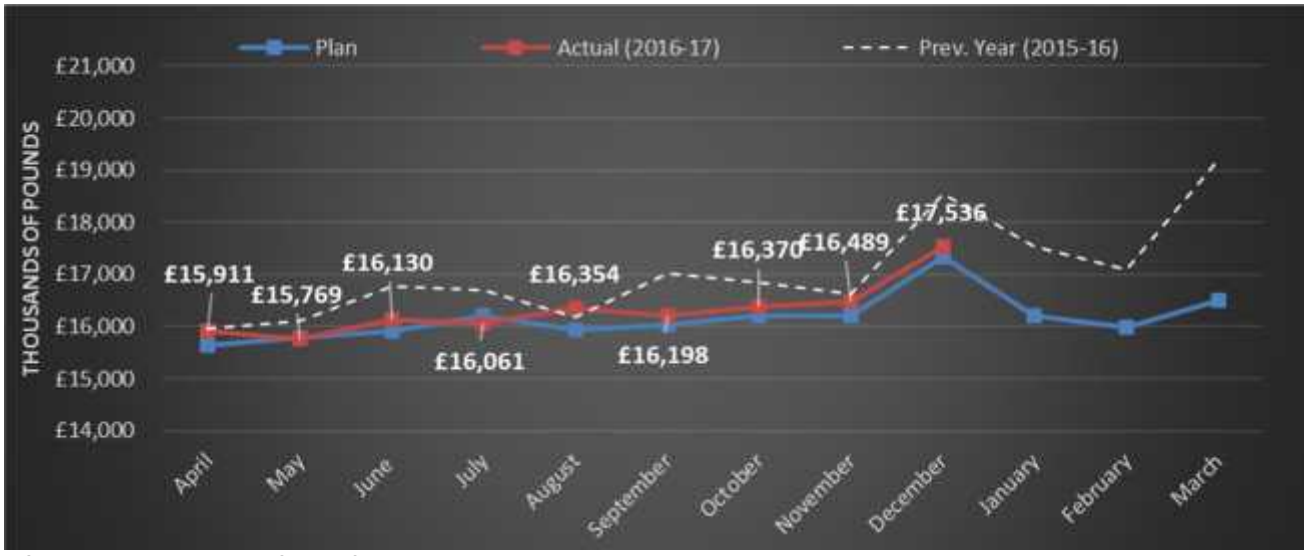


Figure.F-1 - Income (£'000)

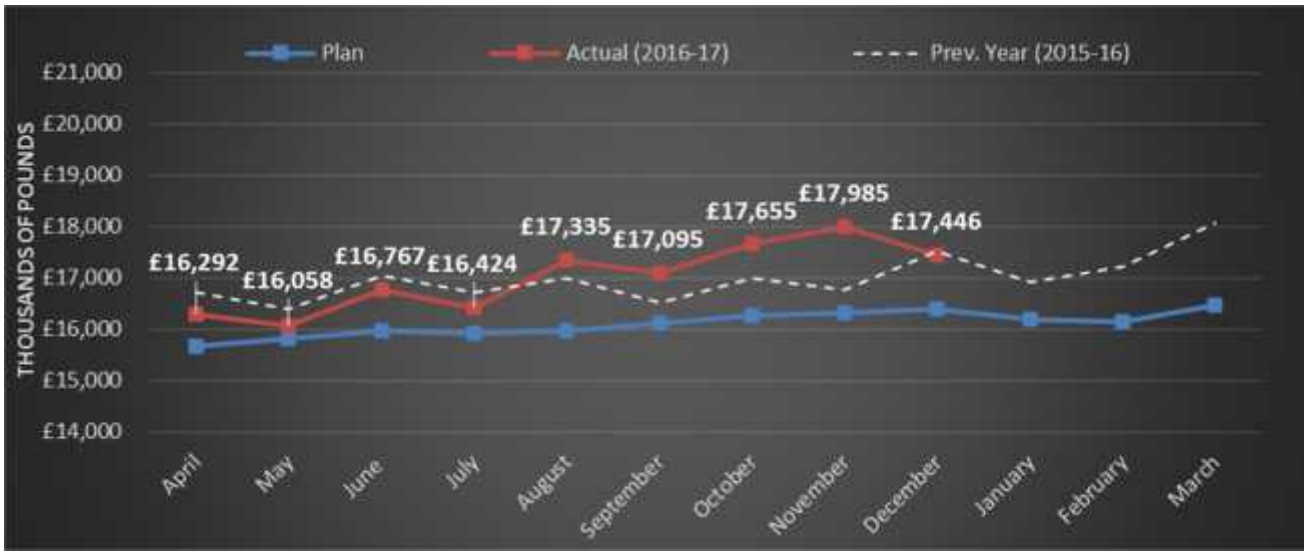


Figure.F-2 - Expenditure (£'000)

Figure.F-6 - Surplus/(Deficit) (Year To Date)

*Figure.F-5 – CQUIN - Quarterly (£'000)**

Figure.F-8 – Agency Spend (£'000)

Figure.F-3 – Capital Expenditure (£'000)

Figure.F-7 – Cash Position (£'000)

Figure.F-4 - Cost Improv. Prog. (CIP) (£'000)

Appendix 1: Balanced Scorecard

Integrated Performance Dashboard Balanced Scorecard for the January 2017 Board Meeting

Workforce Commentary :- Data from December 2016 and November 2016

ID	KPI	Current Month (Plan)	Current Month (Actual)	Current Month (Prev. Yr.)	YTD (Plan)	YTD (Actual)	YTD (Prev. Yr.)
Wf-1A	Short Term Sickness - Rate		2.5%	2.4%		2.5%	
Wf-1B	Long Term Sickness - Rate		2.6%	3.3%		2.6%	
Wf-2	Staff Appraisals	67.5%	46.7%	57.7%			
Wf-3	Mandatory Training Compliance (All Courses)	91.0%	77.3%	87.6%			
Wf-4	Total injuries		54	72		550	559
Wf-5	Total physical assaults		20	15		166	145
Wf-6	Vacancies (Total WTE)		325			324.7	
Wf-7	Annual Rolling Staff Turnover		16.9%	14.1%			
Wf-8	Reported Bullying & Harassment Cases		0			13	
Wf-9	Cases of Whistle Blowing		0			2	

Operational Performance Scorecard:- Data From December 2016

ID	KPI	Current Month (Plan*)	Current Month (Actual)	Current Month (Prev. Yr.)	YTD (Plan*)	YTD (Actual)	YTD (Prev. Yr.)
999-1	Red 1 response <8 min	65.3%	62.9%	74.5%		64.3%	73.6%
999-2	Red 2 response <8 min	54.2%	51.6%	71.0%		53.8%	71.4%
999-3	Red 19 Transport <19 min	89.9%	87.8%	95.4%		89.7%	95.0%
999-4	Activity: Actual vs Commissioned	72563	76641	69268	591018	619732	582751
999-5	Hospital Turn-around Delays (Hrs lost >30 min.)	2799	7726	3864	21168	49564	31649
999-6	Call Pick up within 5 Seconds	85%	83.4%	92.9%		73.9%	87.2%
999-7	CFR Red 1 Unique Performance Contribution	1%	1.9%	0.0%	0	0.0%	0.0%
999-8	CFR Red 2 Unique Performance Contribution	1%	1.5%	0.0%	0%	0.0%	0.0%
111-1	Total Number of calls offered		104132	114006		865816	864538
111-2	% answered calls within 60 seconds	75%	80.8%	77.9%	75.0%	77.2%	85.4%
111-3	% of Abandoned call within 30s of the end of intro message excluding phantom calls (NQR 8)	2.0%	1.4%	1.4%	2.0%	1.3%	1.1%
111-4	Abandoned calls as % of offered after 30 secs	6.0%	3.9%	6.1%	6.0%	4.7%	2.4%
111-5	Combined Clinical KPI (% of Call Back >10mins & % of all 111 calls warm referred to a Clinician)	75%	72.5%	88.4%		74.0%	88.3%
PTS-1	PTS Activity (Surrey)	11337	9511	12063	107563	95874	137428
PTS-2	Arrival - % patients to arrive <= 15 min after appt. time. (Surrey)	95%	87.7%	86.3%	95%	86.4%	83.7%
PTS-3	Departure - % patients collected <= 60 min of planned collection time (Surrey)	95%	86.5%	86.0%	95%	86.2%	84.0%
PTS-4	Discharge - % patients collected <= 120 min of booked time to travel (Surrey)	95%	80.8%	77.3%	95%	79.9%	75.8%

** For the following KPI's, the "Plan" in the table above is the Unified Recovery Plan (URP) target agreed with commissioners. The URP targets and the standard national targets are both shown in the Charts on the following few pages. KPIs affected: 999-1 to 999-3; 999-6; 111-2, 111-4 and 111-5.*

SECAMB Regulation Statistics

ID	KPI	Value
R1(b)	Use of Resources Metric (Financial Risk Rating)	4 (Red)
R2	Governance Risk Rating	Red
R3	CQC Compliance Status	Trust: Inadequate (Special Measures) 111 service: Requires improvement
R5	IG Toolkit Assessment	Level 2 - Satisfactory
R6	REAP Level	3

Clinical Effectiveness KPI Scorecard:- Data From August 2016

ID	KPI	Current Month (Nat. Av.*)	Current Month (Actual)	Current Month (Prev. Yr.)	YTD (Nat. Av.*)	YTD (Actual)	YTD (Prev. Yr.)
CE-1	Cardiac arrest - ROSC on arrival at hospital (Utstein)	52.8%	48.1%	50.0%	53.0%	56.6%	45.7%
CE-2	Cardiac arrest - Return of spontaneous circulation on arrival at hospital (All)	27.2%	26.0%	27.6%	29.0%	28.4%	27.0%
CE-3	Cardiac arrest -Survival to discharge - Utstein	29.1%	34.8%	25.0%	27.4%	28.6%	22.5%
CE-4	Cardiac arrest -Survival to discharge - All	9.4%	8.9%	8.6%	8.9%	8.2%	8.5%
CE-5	Acute ST-elevation myocardial infarction - Outcome from STEMI (Care bundle)	79.0%	72.7%	65.6%	79.5%	67.8%	66.8%
CE-6	Acute ST-elevation myocardial infarction - Proportion receiving primary angioplasty within 150 minutes	85.9%	89.9%	100.0%	86.2%	91.7%	94.0%
CE-7	% of FAST-positive patients potentially eligible for stroke thrombolysis arriving at a hyperacute stroke unit within 60 minutes	56.6%	66.8%	67.1%	55.0%	68.0%	65.4%
CE-8	% of suspected stroke patients assessed face to face who received an appropriate care bundle	97.4%	94.2%	96.2%	97.7%	96.1%	96.3%

** The Clinical AQIs (CE-1 to 8) do not have a target, and so are benchmarked against the national average.*

Finance Scorecard:- : Data from December 2016

ID**	KPI	Current Month (Plan)	Current Month (Actual)	Current Month (Prev. Yr.)	YTD (Plan)	YTD (Actual)	YTD (Prev. Yr.)
F-1	Income (£'000)	£17,332.8	£17,536.0	£18,537.3	£145,273.9	£146,818.3	£150,762.2
F-2	Expenditure (£'000)	£16,403.8	£17,446.0	£17,527.8	£144,432.9	£153,056.0	£151,693.0
F-6	Surplus/(Deficit)	£929.0	-£90.0	£1,009.5	£841.0	£6,237.7	-£930.8
ID**	**KPI**	**Current Quarter (Plan)**	**Current Quarter (Actual)***	**Current Quarter (Prev. Yr.)**	**YTD (Plan)**	**YTD (Actual)***	**YTD (Prev. Yr.)**
F-5	CQUIN - Quarterly (£'000)*	£716.0		£913.0	£2,686.0		£2,675.0
ID**	**KPI**	**Current Month (Plan)**	**Current Month (Actual)**	**Current Month (Prev. Yr.)**	**YTD (Plan)**	**YTD (Actual)**	**YTD (Prev. Yr.)**
F-3	Capital Expenditure (£'000)	£1,153.0	£1,394.9	£2,012.0	£17,353.0	£12,359.7	£13,841.0
F-7	Cash Position (£'000)	£11,190.0	£6,307.0	£18,508.0	£11,190.0	£6,307.0	£18,508.0
F-4	Cost Improv. Prog. (CIP) (£'000)	£677.0	£537.0	£1,148.7	£5,370.0	£5,023.0	£7,281.8
F-8	Agency Spend (£'000)	£338.6	£543.0	£667.9	£3,017.2	£5,040.7	£5,090.3

** Each Quarter's data will not be available until the completion of the Quarter (e.g. Q1 will be available in July)*
*** KPI's have been re-ordered (Sep '16) however each KPI's ID has remained the same for consistency (hence the ID ordering is out of sync).*

Quality & Safety KPI Scorecard:- Data From December 2016

ID	KPI	Current Month (Target)	Current Month (Actual)	Current Month (Prev. Yr.)	YTD (Target)	YTD (Actual)	YTD (Prev. Yr.)
QS1a	SI Reporting timeliness (72hrs)	0.0%	25.0%				
QS1b	SI Investigation timeliness (60 days)	100.0%	#N/A	100.0%	100.0%	64.3%	100.0%
QS1c	Number of Incidents reported		512	468		4559	3958
QS1d	Number of Incidents reported that were SI's		2	3		19	21
QS1e	Duty of Candour Compliance	In Development					
QS2a	Number of Complaints		114	149		114	149
QS2b	Complaints reporting timeliness (All Complaints)	95.0%	72.6%	50.0%	95.0%	62.9%	61.8%
QS3a	Number of Safeguarding Referrals		886	906		7994	7854
QS3b	Safeguarding Referrals relating to SECAmb staff or services		0	0		3	2
QS3c	Safeguarding Training Completed (Adult) Level 1		193				
QS3d	Safeguarding Training Completed (Children) Level 1		195				
QS3e	Safeguarding Training Completed (Adult) Level 2		2629				
QS3f	Safeguarding Training Completed (Children) Level 2		2642				

Appendix 2: Notes on Data Supplied in this Report

7.1. Preamble:

7.1.1. This Appendix serves to inform the reader of any significant changes to measurement or data provided in the Integrated Performance Dashboard.

7.1.2. Two months history are kept for easy reference and to cover when there is a month with no board meeting.

7.2. Executive Summary:

7.2.1. No changes of note.

7.3. Workforce Section:

7.3.1. Some of the data in the workforce section is one month in arrears.

7.4. Operational Performance Section:

7.4.1. No changes of note for the January Board meeting papers however, for the December board papers the following changes where implemented:

- The "Answered in 60" recovery plan target for November was agreed to be reduced to 75% due to additional East Kent volumes SECAmb handled as a contract extension.
- The unique contribution to performance due to Community First Responders for Red 1 & 2 performance has been added as a new pair of KPIs. Targets as per Unified Recovery Plan.

7.5. Quality and Outcome Section: Now 'Clinical Effectiveness (Dec 2016)

7.5.1. The Clinical Outcome data (now CE-1 to 8) are all reported a number of months in arrears as per the titles of the sections.

7.5.2. December Board Changes:

- Serious Incidents & Complaints metrics have been removed from this section of the report;
- This section has been renamed 'Clinical Effectiveness' and focuses on the Clinical Outcome AQIs.

7.6. Quality and Patient Safety Section: Added Dec. 2016

7.6.1. January Board Changes:

- Duty of Candour, Number of Safeguarding Referrals, Safeguarding Referrals relating to SECAmb staff or services, and Safeguarding Training have all been added with data.
- Complaints timeliness (QS2b) now reported with a 25 day due date timeframe (was 30 days).

7.6.2. December Board Changes:

- This is a new section of the report expanding on the existing KPIs for Serious Incidents and Complaints and adding a section on Safeguarding. In Development.

7.7. Finance Section:

7.7.1. The Financial Sustainability Risk Rating (FSRR) has been replaced with the "Use of Resources Metric" as of October 2016.

7.7.2. December Board Changes:

- Agency Spend added as a new KPI

South East Coast Ambulance Service NHS Foundation Trust

SECAMB Board

QPS Escalation report to the Board

Date of meetings	8th December 2016 & 12th January 2017
Overview of issues/areas covered at the meeting:	Since the last board meeting in November, the Quality & Patient Safety Committee has met twice and considered the following items: *Management Response* • Medicines Management & Medical Gases *Scrutiny Items* • Quality Account Planning • ePCR Roll-out • Patient Care Records • NHSI Diagnostic *Quality & Safety Reporting* • CQC Must-Do & Should-do Progress update & Exception Reports • Infection Control Annual Report 15/16 • Quality and Patient Safety Report update
Reports *not* received as per the annual work plan and action required	**Patient Care Records** – the requested paper for December wasn't received. A verbal update was given and a paper followed in January. The issues identified were lost PCR's, delay in PCR submission, completion of PCR's to appropriate standard & Audit of PCR's by line management prior to submission. **NHSI Diagnostic**- This was not available as it has not yet been signed off.
Changes to significant risk profile of the trust identified and actions required	**Medicines Management-** At its meeting in December the committee was not assured that medicines were being appropriately managed in line with Regulation 13 of the Health and Social Care Act for security and storage, and no assurance could be provided that disseminated drugs alerts are read and understood. In addition, other issues were identified that gave cause for concern and the committee asked management to respond to these concerns at the January meeting. At its meeting in January the committee asked that medicines management be escalated as a paper to Board due to the non-compliance with Regulation 13. In particular, the concerns related to security and storage, usage of drugs, and dissemination of drug alerts. The Executive confirmed that it is taking immediate action to – • undertake a diagnostic to ensure all issues are identified and a rectification plan • appointing an interim pharmacist ASAP to take immediate action with the assistance of NHSI • Recruitment of full-time pharmacist (offer made)

	999 Performance- the committee noted that the performance trajectory was not achieved for R1,R2 or R19 in December. Demand was close to forecast. The primary reason for the negative variation is the record level of *45min+* handover delays where December was 18% higher than the next highest month and over 60% higher than Dec 14. The committee asked this be escalated urgently to NHSI to help support the trust in discussions with hospitals and that the commitments made at the Quality Summit to support the Trust are honoured. The committee also noted that response ratios are higher than planned and there was an increase in frequent callers in December which also contributed to the negative variance. **999 Tail** – The exception report for the CQC performance trajectory plan highlighted a risk to patient safety regarding the tail particularly for green calls and the committee asked that this be escalated to the board as this represents a risk for patient safety. **Patient Care Records** – Concern relating to the robustness of the PCR process including lost PCR's, delay in PCR submission, completion of PCR's to appropriate standard & Audit of PCR's by line management prior to submission. The executive will under-take a multi-disciplinary review of Patient Care Records and report back to QPS.
Weaknesses in the design or effectiveness of the system of internal control identified and action required	**Quality Account Planning** - An action plan was presented but the committee noted that there was a lack of accountability against allocated tasks & some actions that had been completed were still indicated as "red". The committee agreed that until these actions were completed it could not be assured that the Quality Account planning process was on track and asked the plan to be re-submitted to the January QPS meeting. It was noted a successful stakeholder event had been held on the 5th December. In January the committee received an updated plan with leads allocated to each action. The committee was assured that we are on track with the development of the Quality Account this year. **CQC Must-do and Should-do Progress Update** - The committee reviewed the action plan in December for the first time. Feedback was positive but there were some areas identified where the report could be improved in format and concerns raised on the accuracy of progress reported. The committee requested that there should be early discussion on 'red' items. The committee asked an overview of the key areas at risk be shared at the Board meeting in December. In January the committee received a further update, focussing on the exception reports relating to the actions 'at risk'. **Medicines Management** - see above **Patient Care Records** – see above
Any other matters the Committee wishes to escalate to the Board	It has been agreed the committee will receive a quarterly Quality and Patient Safety Report this will include a summary of all SI's raised and action plans relating to these. The committee was assured that the Quality Account is on track for delivery. A review of the ePCR roll-out enabled by the iPad roll-out was discussed and the committee

	were assured that the appropriate policies are in place, ePCR will only be used for non-conveyed patients until the reporting issues have been resolved (end March), IG issues have been addressed and legal advice given, there is capability for adhoc reporting and clinical sign-off has been received. The risks noted were roll-out momentum and also potential impact on job-cycle time as the new technology is embedded. An issue was raised with regard to 111 out of hour GP's relating to both the closure of the service and issues with the call centre and the impact this had over the Christmas period. It is planned a future paper will be bought to the committee on this topic.

South East Coast Ambulance Service NHS
NHS Foundation Trust

Agenda No	175/16

Name of meeting	Trust Board
Date	26 January 2017
Name of paper	Medicines Management
Responsible Executive	Dr Andy Carson, Interim Medical Director
Author	Fiona Wray, Associate Director, Medical Directorate
Synopsis	The Quality and Patient Safety Committee has been scrutinising the system of internal control relating to medicines management and for reasons set out in the escalation report(s) to the Board, has not been assured by the management responses. This paper was therefore requested by the Committee, in order to ensure the Board is sighted on the current issues.
Recommendations, decisions or actions sought	The Board is asked to consider the issues arising from medicines management and seek assurance that the right remedial action is being taken

Does this paper, or the subject of this paper, require an equality impact analysis ('EIA')? (EIAs are required for all strategies, policies, procedures, guidelines, plans and business cases).	**No**

1. Introduction

1.1. This report provides an overview of the issues relating to medicines management in the Trust and the progress made addressing these. The actions describe the action being taken to mitigate the risks associated with the identified medicine management issues.

2. Background

2.1. In 2014 it was reported that the last two inspections by the Care Quality Commission (CQC) and frequent inspections by NHS Protect had highlighted non-compliance with medicines management. In addition, Internal Audit, Counter Fraud and the Police Controlled Drug Liaison Officers all advised the Trust to review and revise the existing arrangements for medicines supply and distribution to provide greater compliance and assurance.

2.2. In May 2016 concerns about medicines management were raised by the CQC following its comprehensive inspection, which resulted in the Trust being served with a 'Warning notice' under Section 29A of the Health and Social Care Act 2008.

2.3. While the CQC inspection identified specific issues, the Trust's own systems of internal control and assurance has identified other medicine management concerns. The associated risks have been explored by the Executive Management Board and shared with the Quality and Patient Safety Committee of the Board. There is consensus that compliance with medicines management standards requires urgent action.

2.4. Several internal and external reviews of the Trust's medicine's management systems and processes have been undertaken in the past three months. These reviews have identified, in general terms, the areas for improvement in governance, systems and processes.

2.5. A 'root and branch' review is therefore needed, and we have engaged NHS Improvement (NHSI) to support us with this review. We are currently in the planning stages of this review.

3. Medicines Management issues and action taken to-date

3.1. **Governance of 'Medicines Management'**.

3.1.1. An initial internal review of the Trust's current medicine management system identified there is no clear evidence that the range of drugs and quantity used is aligned to the demographics and local health profiles of the South East Coast region (produced by Public Health England). This raised questions regarding the procurement of medicines and of the services' effectiveness.

3.1.2. The Trust has an arrangement to receive weekly deliveries of medicines from our suppliers and if necessary receive ad hoc orders within 24 hours. An internal review of stock levels of medicines found that we have medicines with value exceeding £130,000.

3.1.3. As a result of the above concerns, a medicine management service review was proposed and agreed by the Executive Management Board in December 2016. With the support of NHSI, this aims to review the systems and processes in place, taking into account the cost effectiveness of the service. A range of areas will be reviewed which include; benchmarking, staffing, commissioning, training, and budget management.

3.2. **Progress to date**

3.2.1. A meeting was held with NHSI on Friday 6 January 2017 to discuss the scope and timescales for this review. It was agreed that the review will be supported by external pharmacy support.

3.2.2. At a follow up meeting on Tuesday 17 January 2017, between NHSI and the Trust, it was agreed that the Trust would develop an audit tool that would be used to provide an independent view of current practice. It is planned that this audit will take place week commencing 13 February 2017.

3.3. **Actions completed to date**

3.3.1 Development of an audit tool to be used at the audit has been completed.

4. Controlled Drugs

4.1. Several issues relating to the storage and disposal of controlled drugs were identified both by the CQC and through other reviews.

4.2. **Progress to date**

4.2.1. A survey of locks on controlled drug cupboards has been undertaken by medicine champions at each centre/station and the results of the survey feedback to the Trust's Medicines Management Lead.

4.2.2. A suitable lock for these cupboards has been identified and a pilot scheme has been introduced on a number of ambulances.

4.2.3. The business case for replacing all locks on ambulances has been approved and a trajectory for the completion of this work has been agreed. This work will be completed by March 2017.

4.2.4. The trust has introduced a revised disposal system; this includes each location being provided with a single use disposal container for out of date drugs, which is returned to a central location. The waste medicine is then checked by a member of the medicines management team and documented onto a central database. This not only facilitates improvements in the disposal of medicines but also allows the monitoring of trends and financial loss

.

5. Single signatures for Controlled drugs

5.1. During an internal review of the medication it was identified that at 21 stations, staff on single response vehicles (SRV) were routinely checking out controlled drugs from the medicine's cabinet without a second checker. This is not in line with best practice / guidance.

5.2. Controlled drugs should be checked out by two members of staff and a record of the drug and quantity recorded in the controlled drug's register that is held at each station. This register should be regularly audited to review compliance with completion and the quality of recording.

Actions completed to date

5.2.1 A survey to identify the number of times single signature for controlled drugs occurred was completed for each station and Make Ready Station (MRC). Between 7 and 33% of entries were single signatures.

5.2.2 The survey returns found that 64% of stations or MRCs currently run a rota that has a car starting when no other staff are on site. However 55% of these locations also said they had 24/7 staffing so we need to explore why single checking has been occurring.

5.3. **Actions to be completed**

5.3.1. As part of the external medicines management review planned for February 2017, we will review the controlled drugs registers and report the number of times they have been signed out by one person only. This information will be part of the review feedback to the Executive.

5.3.2. As at the end of February 2017 we will enforce the practice of completing an incident form for any single signatory. Feedback on the number of incidents, supported by rota information and staffing to provide some background data for each location.

5.3.3. Date will be shared with clinical operation managers on single signatures for controlled drugs monthly, following the medicines management review.

5.3.4. Agree and develop thresholds for the number of times per week it is acceptable for controlled drugs to be signed out by one person for each station, as provided by exception in national guidance.

5.3.5. By the end of February 2017 we will draft and circulate a revised operational instruction highlighting the professional and legal requirements for checking out controlled drugs

6. Ampoule Breakages

6.1. The Trust policy is that only controlled drug ampoules that are broken are reported in line with our incident reporting policy.

6.2. When compared with other ambulance trusts SECAmb has a high incidence of ampoule breakage. The data below shows the number of medicine's incidents including drug errors and breakages.

	2016-17				2015-16				
	Q1	Q2	Q3	YTD	Q1	Q2	Q3	Q4	YTD
Total No. Meds Mgt Incidents	201	183	179	563		236	241		866
% of incidents relating to controlled drugs		73.77% (135)	81.56% (146)	79.93% (450)		83.05% (196)	80.08 % (193)		80.37% (696)
% Broken Ampules		92.35% (169)	110% (197)	92.22% (563)		97.03% (229)	98.76 % (238)		97.69% (846)

6.3. **Progress to date**

6.3.1. The Trust continues to monitor ampoule breakages and now provides data to each Operating Unit Manager on a weekly basis to enable local management of breakages with a desire to reduce numbers. This data is also displayed on a notice board at every location so all staff are fully informed of the current performance for that location.

7. Inappropriate storage of medicines at Paddock Wood Make Ready Centre

7.1. All medicines are received and packed at the Medicines Distribution Centre at Paddock Wood by the Trust's Medicines Management Team. The team are located on the mezzanine area of Paddock Wood Make Ready Centre. The Medicines Distribution Centre can be accessed by other members of staff therefore this is not a suitable area to store medicines.

7.2. **Progress to date**

7.2.1 Several options have been considered for improving the safe storage of medicines at this location. These options have included moving the service off site, undertaking building work at Paddock Wood and relocation of the service but are considered not to be suitable options.

7.3 **Actions required**

7.3.1 In partnership with Estates by the end of January 2017 we will identify alternative cost effective options to ensure drugs are stored securely.

8. Trust estate and temperature control

8.1. The Trust's estates plan was to move to only use 'make ready centres' rather than ambulance stations, by the end of 2015. This would have meant that by 2016 the Trust would be only operating out of 15 sites, these being 10 make ready centres, three head offices, Lewes Vehicle Management Centre (VMC) and from Eastbourne commissioning. However, this was not achieved and the Trust still has an estate of over 60 buildings as the plan was not realised due to local planning consent issues and other estate issues.

8.2. The storage of medicines at the correct temperature to ensure they are fit for purpose is a key priority for the Trust. The Trust has a mixed estate with new build make ready centres that have air conditioned drug rooms and older stations where it is not possible to install air conditioning.

8.3. All areas used to store medicines have the environmental temperature monitored to ensure drugs are stored at recommended temperatures. This is done either by an active monitor installed into an Omnicell or by a standalone unit which will alarm should the parameters be breached.

8.4. During the hot weather in the summer of 2016 temperatures exceeded the recommended range on 23 occasions and around £46,000 of drugs had to be destroyed.

8.5. To facilitate the storage of medicines at the optimal temperature a range of approaches have been considered including exploring the use of portable air con units, reduction of stock levels.

8.6. **Progress to date**

8.6.1 An escalation procedure for when temperatures are outside the recommended range has been introduced and to date this procedure has been used 23 times in the Summer of 2016.

8.7 Actions required

8.7.1 By April 2017 we will explore costs of hiring/purchasing air conditioning units and the feasibility of installing these in non-omnicell stations

8.7.2 Following a stock take of medicines at the end of January 2017, stock levels and range of medicines to be discussed at the March 2017 Drug and Therapeutic Committee.

9. Overspent Medicines Budget

9.1. The current year-end forecast drug spend is approximately £666,000. This is double what had been budgeted.

9.2. Associated budgets for medical gases and consumables have not increased at the same rate as the medicine's budget and are not significantly overspent. On investigation of the

rationale for this it was noted that all stations are supported by either a Make Ready Centre (MRC) or a Vehicle Preparation Programme (VPP) for gases and consumables.

9.3. The medicine's budget is managed by the Head of Procurement (Finance) despite not having any direct control on how the budget is spent. Activity over the past two years has increased; (in 2014/15 – activity increase by 13% and 2015/16 the increase was 8%), however, this does not match the 50% increase in medicines spend over the last 12 months. It is anticipated that this budget will be transferred to the Medical Directorate in 2017/18.

9.4. The initial findings of a recent counter fraud investigation which investigated the increase in spend, found no misuse of funds but did report that the current governance arrangements relating to the management of medicines and introduction of new roles/medicines were not effective. For example, a business case had been approved that impacted on the medicines budget but this element was not taken into account during the approval process.

9.5. The final counter fraud report and recommendations are due to be received in February 2017. Once this report has been reviewed action plans will be developed to address the findings.

9.6. **Actions required**

9.6.1 External medicines management review to be undertaken with support of NHSI; proposed date for this review is 21 and 22 February 2017. The review will visit all stations and MRC. We plan to speak to staff and patients at six of our receiving A/E departments.

10. Staffing

10.1. We employ a range of staff in the team but it is unclear if the current roles and responsibilities of the medicine management team meet service need. The team has been without a substantive pharmacist for a significant period of time. This role has been covered by a pharmacist providing advice on a consultancy basis.

10.1.1. Pharmacist

10.1.2. Medicines Management Lead

10.1.3. Pharmacy Technician

10.1.4. Medicines Support Worker x 4

10.1.5. Mobile Medicines Support Worker x 2

10.1.6. Medicines Management Administrator

10.2. **Progress to date**

10.2.1. A one-month consultation commenced on the role of the two mobile medicine support workers. This role initially ensured stock rotation in Omincells, however, it is

considered this role is no longer required as stock levels are managed in Omnicells effectively.

10.2.2. A Chief Pharmacist has been appointed (start date to be confirmed).

11. IV Aspirin

11.1. It was identified that we were using this medicine, which was labelled in French and not always over-labelled in English. This drug is used for post return of spontaneous circulation (ROSC) unconscious cardiac patients. It is used on average 35 times annually.

11.2. Following in-depth discussions by the Executive, culminating at its meeting in December 2016, a decision was made to temporarily suspend the use of this medicine as assurance could not be sought that it was consistently being over-labelled in English, resulting in the inability of Paramedics to check the drug safely. In addition, concerns were raised by staff regarding the safety of using this drug as only Critical Care Paramedics (CCP) were trained to administer it, yet non-CCPs were required to be 'second checkers'.

11.3. On 5 January 2017, an extraordinary meeting of the Professional Practice Group was held and the decision to the continued suspension was made. On the 6 January 2017 a clinical instruction (C204) was issued to inform staff of this confirming that it would remain in place until such time that appropriate governance arrangements were in place.

11.4. **Progress to date**

11.4.1. All IV Aspirin has been withdrawn and has been quarantined at the MDC at Paddock Wood.

12.0 Over labelling of drugs

12.1 Currently we over label some drugs such as antibiotics that paramedic practitioners (PP) provide to patients. The process of over labelling drugs has previously been discussed with the pharmacist providing advice to the Trust. However, on review, this practice of over-labelling is not considered good practice as it should be directly supervised by a pharmacist. While the pharmacist contacted to provide advice to the Trust is aware of the process he is not directly supervising it.

12.2 Actions required

12.2.1 Review current Clinical Commissioning Group (CCG) contracts to explore which CCGs are commissioning the PP service which requires the use of over-labelled medication.

12.2.2 Determine the most effective way to deliver this service that is in line with best practice.

12.2.3 By April 2017 a review of the options for over labelling of drugs, identifying cost implications, current contract arrangements and produce option appraisal paper for the Executive to consider.

SECAMB Board

Escalation report to the Board from the Audit Committee

Date of meeting	**6 December 2016**
Overview of issues/areas covered at the meeting:	The Committee was unable to gain assurance that appropriate arrangements are in place in key areas, specifically the Board Assurance Framework (BAF), the identification and management of corporate risks and specific functions where weaknesses were found in internal control environments. Internal Audit reports highlighted deficiencies in the design of the control framework for financial reporting and budget setting, and a number of significant deficiencies in both the design of and compliance with the control framework for safeguarding. Internal Audit also identified that reasonable progress had been made in implementing previous audit recommendations relating to Clinical Audit.
Reports *not* received as per the annual work plan and action required	**Board Assurance Framework (BAF**) There has not been an effective BAF in place for the past year. Whilst reference is included in this escalation report to the Board, it was considered that this must also be a substantive matter for consideration by the Board. **Action:** The Company Secretary to present to the Board at its meeting on 26 January 2017 a clear structure and content of a revised BAF, linked to the Trust's key objectives and Unified Recovery Plan.
Changes to significant risk profile of the trust identified and actions required	The **Corporate Risk Register** had not been updated for several months in a number of areas, and was assessed as not being fit for purpose. In addition, there was no clear strategy which could be evidenced for the management of risk. **Action:** The Executive to present to the Board a corporate plan for the management of risk in 2017/18, for adoption by the Board at its meeting on 26 January 2017.
Weaknesses in the design or effectiveness of the system of internal control identified and action required	Actions identified as being required to improve the **BAF** and **Corporate Risk Register** are referred to above. Internal Audit identified weaknesses in the design and effectiveness of internal control systems in respect of **Financial Reporting and Budget Setting** and **Safeguarding**, which resulted in an audit opinion of only "partial assurance" being given in each case. The recommendations made and actions required to be taken, all of which have been accepted by management, were set out within respective Internal Audit reports with clear dates for implementation.
Any other matters the Committee wishes to escalate to the Board	Internal Audit Reviews undertaken during the year have identified a significant number of specific areas where **the design and application of internal control systems are weak**, resulting in audit opinions of either "partial assurance" or "no assurance". Each of these will be referred to in the Head of Internal Audit Opinion at the financial year end. It is imperative that the recommendations made by Internal Audit for improvements in the control environment are implemented in accordance with agreed timescales.

South East Coast Ambulance Service NHS Foundation Trust

SECAMB Board

Escalation report to the Board from the Workforce and Wellbeing Committee

Date of meeting	19th January 2017
Overview of issues/areas covered at the meeting:	**Review of o/s actions on** **a. Policies and procedures –** Assurance was received that adequate processes are in place to both update and disseminate Trust policies. There was **no assurance on any follow up about understanding or compliance** – see last section. (Also note that all HR policies will not be fully up-to-date until the rolling programme of revision is completed during 2017-18) b. **Move to Crawley –** The pause in dealing with individual employees has now ended and one-to-one consultations recently restarted. Director of Workforce expects to be able to give assurance on this matter at the next WWC meeting (March) **c. Internal Controls on training – Assurance was given on the system of recording all forms of training** and that there is a clear understanding about where the responsibility for content sign-off lies. However concern was expressed as to the accuracy of some of the currently reported numbers on the Integrated Performance Report (because of historical methods of reporting). The Executive were asked to review and report back to the Committee **Culture work stream –** The Committee received an update on the Improving Culture work stream in the URP. Most of the projects are in the early phases and significant improvements are unlikely to show through until the third quarter 2017/18 at the earliest. An agreed system of monitoring outcomes needs to be agreed (see last section) and at this point the Committee is **only able to give assurance on the intended actions and not their effectiveness**. **Committee Assurance dashboard –** The Committee agreed the format for a set of KPI's required to provide on-going assurance on workforce related issues. The first full report with exception reporting will be available from the March meeting. **Meal breaks/Shift over-runs –** The Committee received **full assurance** from the Director of Operations that adequate monitoring of both meal breaks and shift overruns had been implemented and were being effective. **Workforce Plan –** The Committee reviewed the assumptions and process to be used to produce the 2017-18 workforce plan. Whilst there was assurance that the process was very comprehensive, caution was expressed that this exercise should have local departmental ownership and not be seen as a central bureaucratic burden. This assurance was received. **Risk Register –** The Committee reviewed the red rated risks and **received assurances** that adequate plans were in place (other than as recorded elsewhere in this report) to address these.

Reports *not* received as per the annual work plan and action required	) Paper on operation of PMO to contain assurances on how workforce issues are dealt with. Deferred by Executive until March meeting.) Assurance Framework – Deferred until after presentation to Board later in month
Changes to significant risk profile of the trust identified and actions required	**No changes to previously reported risk profile – significant risks remain about sufficient manpower; culture; move to Crawley; and appraisal completion**
Weaknesses in the design or effectiveness of the system of internal control identified and action required	**Dissemination of policies –** There is no established and accepted means of determining whether policies that have been correctly updated and disseminated have actually been read and understood and are being followed by staff. This weakness manifests itself when external inspections (CQC etc) are unable to satisfy themselves on this point when policy non-compliance is uncovered. **Culture –** There is no established and accepted set of measured outcomes whereby the Board can receive assurance that the various work streams currently in place to 'change/improve' the culture, are being effective. The Executive have been asked to recommend a set of measures as a matter of urgency.
Any other matters the Committee wishes to escalate to the Board	**Workforce Plan –** Due to the uncertainties around commissioning, the Executive have drawn attention to the fact that a robust plan is unlikely to be completed before the start of the 2017/18 financial year. **Recruitment strategy –** The Committee received assurance around the recruitment process to ensure that the Trust has sufficient manpower resources within the limitations of the budgetary settlement with Commissioners. However, the strategy concerning the mix of skills and makeup of the workforce whilst entirely logical, represents a fundamental shift from the accepted strategy reaffirmed some 2 years ago. As such the Board may want to consider a separate discussion on this point particularly if any overall strategy refresh debate is not imminent(because decisions and actions on recruitment need to be taken now) **Bullying & Harassment –** The need for a comprehensive discussion and agreement on action plan by the whole Board is still outstanding.

South East Coast Ambulance Service NHS Foundation Trust

SECAMB Board

Escalation report to the Board from the Finance & Investment Committee

Date of meeting	23 January 2017
Overview of issues/areas covered at the meeting:	This meeting was the quarterly FIC. It considered the Trust's financial positon including cash; the plan for 17/18; assurance on projects (HQ/EOC move, CAD replacement, EPCR); Fleet diagnostic which highlighted immediate vehicle replacements required. The Committee explored the financial position to the year end 16/17, the assumptions and the impact of the recurrent and non-recurrent elements. The FIC acknowledged the risks in to delivering the FOT of £7.1M deficit and received a presentation on the plans in place to curtail costs in 16/17. Assurance was provided on the cash position which was as expected following an initial draw down against the NHSI facility. The 17/18 plan was discussed and the uncertainty around the funding gap of £26M was raised as a concern although the process around the PID and joint work with Commissioners and NHSI/NHSE was understood. The FIC acknowledged the work undertaken to date on the Fleet deep dive and will continue to monitor the development of the Fleet strategy. The need to procure a number of vehicles within the next month was noted and a business case will follow the Trusts normal governance process.
Reports *not* received as per the annual work plan and action required	All reports received as requested
Changes to significant risk profile of the trust identified and actions required	Whilst not a significant change to risks previously shared, the draft plans highlighted the size of the gap between the Trust and the CCGs. The plans presented were based on the achievement of hitting constitutional targets which the Committee agreed was the correct approach. The trade-off between funding available from Commissioners and the performance levels at which they chose to commission the Trust was also discussed.
Weaknesses in the design or effectiveness of the system of internal control	None identified at this meeting.

identified and action required	
Any other matters the Committee wishes to escalate to the Board	N/A